Basic Maternal and Newborn Care:

Basic Childbirth, Postpartum, and Newborn Care

Course Notebook for Trainers
The Maternal and Neonatal Health (MNH) Program is committed to saving mothers’ lives by increasing the timely use of key maternal and neonatal health and nutrition practices. The MNH Program is jointly implemented by JHPIEGO, the Johns Hopkins University Center for Communication Programs, the Centre for Development and Population Activities, and the Program for Appropriate Technology in Health.

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SKILLS PRACTICE SESSIONS
Skills Practice Session 1: Assessment of the Woman in Labor...............................................65
Skills Practice Session 2: Assisting Normal Birth..................................................................................67
Skills Practice Session 3: Episiotomy and Repair..............................................................................69
Skills Practice Session 4: Repair of 1st and 2nd Degree Vaginal and Perineal Tears...............70
Skills Practice Session 5: Assessment of the Newborn........................................................................71
Skills Practice Session 6: Postpartum Assessment and Care..........................................................73
Skills Practice Session 7: Newborn Resuscitation..............................................................................75
Skills Practice Session 8: Manual Removal of Placenta.................................................................76
Skills Practice Session 9: Bimanual Compression of the Uterus.......................................................77
Skills Practice Session 10: Compression of the Abdominal Aorta...................................................78
Skills Practice Session 11: Repair of Cervical Tears............................................................................79

LEARNING GUIDES AND PRACTICE CHECKLISTS
Using the Learning Guides and Practice Checklists...........................................................................80
Learning Guide and Checklist 1: Assessment of the Woman in Labor..............................................83
Learning Guide and Checklist 2: Assisting Normal Birth......................................................................93
Learning Guide and Checklist 3: Episiotomy and Repair.................................................................98
Learning Guide and Checklist 4: Repair of 1st and 2nd Degree Vaginal and Perineal Tears.................102
Learning Guide and Checklist 5: Assessment of the Newborn........................................................106
Learning Guide and Checklist 6: Postpartum Assessment and Care.................................................113
Learning Guide and Checklist 7: Newborn Resuscitation...............................................................124
Learning Guide and Checklist 9: Bimanual Compression of the Uterus...........................................132
Learning Guide and Checklist 10: Compression of the Abdominal Aorta........................................134
Learning Guide and Checklist 11: Repair of Cervical Tears............................................................136

ILLUSTRATED LECTURE HANDOUTS
Using Illustrated Lectures..............................................................................................................141
Presentation 1A: Fundamentals of Basic Care..................................................................................143
Presentation 1B: Key Tools in Basic Care I: Clinical Decision-Making, Interpersonal Skills, Record Keeping..........................................................152
Presentation 1C: Key Tools in Basic Care II: Infection Prevention Practices.....................................160
Presentation 2A: Introduction to Childbirth, Postpartum, and Newborn Care.................................169
Presentation 2B: Basic Assessment during Labor..................................................................................181
Presentation 2C: Basic Care during the First Stage of Labor............................................................193
Presentation 2D: Basic Care during the Second and Third Stage of Labor......................................200
Presentation 3A: Basic Care during the Fourth Stage of Labor........................................................207
Presentation 4A: Additional Care I: Common Discomforts of Labor/Childbirth and the Postpartum/Newborn Period.................................................................217
Presentation 4B: Additional Care II: Special Needs of Labor/Childbirth and the Postpartum/Newborn Period.........................................................................................231
Presentation 4C: Basic Postpartum Assessment..................................................................................257
Presentation 4D: Basic Postpartum Care............................................................................................270
Presentation 5A: Continuing Care of the Newborn...........................................................................284
Presentation 5B: Additional Care III: Life-Threatening Complications of Labor/Childbirth and the Postpartum/Newborn Period.........................................................293

COURSE EVALUATION
SECTION TWO: GUIDE FOR TRAINERS

MODEL COURSE OUTLINE ...........................................................................................................................................1

PRECOURSE QUESTIONNAIRE ANSWER KEY
   Using the Individual and Group Assessment Matrix ..................................................................................................25
   Precourse Questionnaire Answer Key ..........................................................................................................................26

KNOWLEDGE ASSESSMENT QUESTIONNAIRE
   Using the Questionnaire ....................................................................................................................................................31
   Knowledge Assessment Questionnaire ............................................................................................................................33
   Knowledge Assessment Questionnaire Answer Sheet ......................................................................................................43
   Knowledge Assessment Questionnaire Answer Key .........................................................................................................45

ROLE PLAYS AND EXERCISE ANSWER KEY
   Role Play 1: Reassuring the Women in Labor Answer Key ............................................................................................55
   Role Play 2: Parent Education and Support for Care of the Newborn Answer Key ............................................................57
   Exercise 1: Using the Partograph Answer Key ..................................................................................................................59

CASE STUDIES
   Using the Case Studies ........................................................................................................................................................67
   Case Study 1: Childbirth Assessment and Care Answer Key ............................................................................................68
   Case Study 2: Childbirth Assessment and Care Answer Key ............................................................................................73
   Case Study 3: Postpartum Assessment and Care Answer Key ............................................................................................77
   Case Study 4: Postpartum Assessment and Care Answer Key ............................................................................................81
   Case Study 5: Newborn Assessment and Care Answer Key ............................................................................................85
   Case Study 6: Newborn Assessment and Care Answer Key ............................................................................................89

SKILLS PRACTICE SESSIONS
   Conducting Skills Practice Sessions ................................................................................................................................93

EMERGENCY DRILL .............................................................................................................................................................95
**SECTION THREE: TIPS FOR TRAINERS**

**BEING AN EFFECTIVE TRAINER IN THE CLASSROOM**
- Characteristics of an Effective Trainer and Coach ................................................................. 1
- Skill Transfer and Assessment: The Coaching Process ............................................................. 2

**CREATING A POSITIVE LEARNING ENVIRONMENT IN THE CLASSROOM**
- Preparing for the Course ........................................................................................................... 5
- Understanding How People Learn ............................................................................................ 7
- Using Effective Presentation Skills ......................................................................................... 11

**CONDUCTING LEARNING ACTIVITIES IN THE CLASSROOM**
- Delivering Interactive Presentations ......................................................................................... 13
- Facilitating Group Discussions ................................................................................................. 17
- Facilitating a Brainstorming Session ......................................................................................... 19
- Facilitating Small Group Activities .......................................................................................... 20
- Conducting an Effective Clinical Demonstration ...................................................................... 22

**TEACHING CLINICAL DECISION-MAKING** ........................................................................ 25

**MANAGING CLINICAL PRACTICE**
- Performing Clinical Procedures with Clients ........................................................................... 29
- Creating Opportunities for Learning ......................................................................................... 30
- Conducting Pre- and Post-Clinical Practice Meetings .............................................................. 33
- The Trainer as Supervisor ......................................................................................................... 34
- The Trainer as Coach ............................................................................................................... 36
OVERVIEW

Training interventions to improve worker performance are among the most important aspects of performance management and support for human resources development. Healthcare providers must have the knowledge, attitudes, and skills required to perform their jobs in a competent and caring manner. Clinical training deals primarily with making sure that participants acquire the knowledge, attitudes, and skills needed to carry out a specific procedure or activity (e.g., newborn care, infection prevention and control, or counseling for HIV testing) and helping participants apply this procedure or activity on the job. The goal of clinical training is to assist healthcare workers in learning to provide safe, high-quality reproductive healthcare services through improved work performance.

COMPETENCY-BASED TRAINING

This clinical training course is designed to enable participants to immediately apply, on the job, the new information and skill(s) they have learned, and thus improve their performance. The course uses a competency-based learning approach that focuses on the specific knowledge, attitudes, and skills needed to carry out a procedure or activity. Competency-based learning is learning by doing—learning that emphasizes how the participant performs (i.e., a combination of knowledge, attitudes, and, most important, skills). The trainer assesses participants’ skill competency by evaluating their overall performance.

Learning to perform a skill occurs in three stages:

Skill acquisition: The participant knows the steps and their sequence (if necessary) to perform the required skill or activity but needs assistance.

Skill competency: The participant knows the steps and their sequence (if necessary) and can perform the required skill or activity.

Skill proficiency: The participant knows the steps and their sequence (if necessary) and efficiently performs the required skill or activity.

In the first stage, skill acquisition, participants attend a series of interactive and participatory sessions conducted by the trainer. The trainer involves the participants through a variety of learning methods including the use of questions, role play, case studies, problem-solving activities, and other exercises. In addition, the trainer demonstrates skills through the role play or emergency drill in a simulated setting, or
with anatomic models, as participants observe and follow the steps in a competency-based learning guide (see below). As participants practice these skills, the trainer observes, provides feedback, and encourages the participants to assess each other using the learning guide. Participants practice until they achieve skill competency and feel confident performing the procedure. The final stage, skill proficiency, occurs only with repeated practice over time.

The use of competency-based learning guides and checklists to measure clinical skills or other observable behaviors in comparison to a predetermined standard is an integral part of learning new skills. A learning guide contains the individual steps or tasks in sequence (if necessary) required to perform a skill or activity in a standard way.

A clinical skill or activity is standardized by identification of its essential steps. Each step is analyzed to determine the most efficient and safe way to perform and learn it. This process is called “standardization.” Once a procedure has been standardized, competency-based learning guides and checklists can be developed for it.

Learning guides

- help the participant learn the correct steps and sequence in which they should be performed (skill acquisition), and

- measure learning in small steps as the participant gains confidence and skill (skill competency).

Checklists are based on the learning guides and focus only on key steps or tasks. They allow the trainer to objectively assess a participant’s skill competency and overall performance.

### ASSESSMENT OF KNOWLEDGE AND SKILLS

Assessment of participants’ knowledge and skills is an essential component of training and learning interventions. Participants should be aware of how and when they will be assessed. Assessment of their knowledge and skill performance should be made throughout the course using objective assessment methods, described below.

- Knowledge assessment occurs with the administration of a precourse questionnaire on the first day of the course. Participants score their own questionnaires because the purpose is to help them see the important content areas of the course.
• The trainer gives a midcourse questionnaire at the point during the course when all of the knowledge content has been presented. Participants must achieve a score of at least 85% to demonstrate that they have achieved the learning objectives. The trainer gives participants who did not achieve a score of at least 85% correct another opportunity to study and answer the items they missed.

• The trainer assesses participants’ skills using a performance checklist. Once participants demonstrate skill competency during the role play and emergency drill in a simulated setting, or with anatomic models, they progress to learn other skills, or, in some courses, to gain additional skill practice in a clinical setting with clients.

This means that participants know, from the beginning of the course, the basis upon which the trainer will assess their competency. In addition, participants will have an opportunity to practice the skill(s) using the same checklist the trainer will use. Assessment of learning in competency-based training is

• dynamic, because participants receive continual feedback and have ample opportunity for review and discussion with the trainer; and

• less stressful, because participants know from the beginning what they are expected to learn.

This interactive approach is the essence of competency-based training—and it is distinctively different from traditional training. In competency-based training, the participant is an active participant in the learning process. The trainer acts as a coach and is also actively involved in transferring new knowledge, attitudes, and skills through demonstration and regular feedback:

• Before skills practice—The trainer and participants meet briefly before each practice session to review the skill/activity, including the steps or tasks that will be emphasized during the session.

• During skills practice—The trainer observes, coaches, and provides feedback to the participant as s/he performs the steps or tasks outlined in the learning guide.

• After skills practice—Immediately after practice, the trainer uses the learning guide to discuss the strengths of the participant’s performance and also offer specific suggestions for improvement.
THE USE OF SIMULATIONS AND ANATOMIC MODELS

Another key component of competency-based training is the use of simulations and anatomic models to provide participants the opportunity to practice new skills before working in an actual clinical site. Practicing with the role play or emergency drill in a simulated setting, or with anatomic models, reduces stress for the participant. Only when participants have demonstrated skill competency and some degree of skill proficiency should they be allowed to apply their new skills in a clinical setting. Work with simulations and anatomic models also provides ample opportunity for practice before final evaluation for qualification in the clinical skill or activity being learned.

A SUPPORTIVE ENVIRONMENT FOR LEARNING

Competency-based training is most effective when there is a supportive environment at the participant’s workplace. In addition to the healthcare worker who attends the course and the trainer who conducts it, supervisors and coworkers play a critical role in helping to create and maintain this environment. All of these individuals have responsibilities before, during, and after a training course. By working as partners, they can help sustain the knowledge and skills learned during training and, ultimately, the quality of clinical services. This process is called “transfer of learning.” It is described in the next section.

TRANSFER OF LEARNING\(^1\)

Transfer of learning is defined as \textit{ensuring that the knowledge and skills acquired during a learning intervention are applied on the job.}\n
The clinical knowledge and skills of providers are a critical factor in providing high-quality healthcare services. However, providers may acquire new knowledge and skills only to find that they are unable to use, or transfer, these new skills at their workplace. There are several inter-related factors that support good performance in the workplace, as described below.

<table>
<thead>
<tr>
<th>THE PERFORMANCE FACTORS</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
</table>
   *Do providers know what they are supposed to do?*  
   Create the necessary channels to communicate job roles and responsibilities effectively. |
| 2. Performance feedback   | Offer timely, constructive, and comprehensive information about how well performance is meeting expectations.  
   *Do providers know how well they are doing?* |
| 3. Physical environment and tools | Develop logistical and maintenance systems to provide a satisfactory physical environment and maintain adequate supplies and equipment.  
   *What is the work environment like, and what systems are in place to support it?*  
   Design work space to suit activities. |
| 4. Motivation             | Seek provider input to identify incentives for good performance.  
   *Do people have a reason to perform as they are asked to perform? Does anyone notice?*  
   Provide positive consequences for good performance and neutral or negative consequences for below standard performance.  
   Encourage coworkers to support new skills. |
| 5. Skills and knowledge to do the job | Ensure job candidates have prerequisite skills.  
   *Do providers know how to do the job?*  
   Provide access to trainers and information resources.  
   Offer appropriate learning opportunities. |

The final factor on the list, required knowledge and skills, is addressed primarily through training and learning interventions. Transfer of learning to the workplace is critical to improving job performance. The key individuals involved in this process include:

**Supervisors**—responsible for monitoring and maintaining the quality of services and ensuring that healthcare workers are properly supported in the workplace

**Trainers**—responsible for helping healthcare workers acquire the necessary knowledge and skills to perform well on the job

**Healthcare workers**—responsible for the delivery of high-quality services (e.g., clinicians, counselors, administrators, cleaners)

**Coworkers**—responsible for supporting participants while they are engaged in training and as they apply new knowledge and skills at the workplace

The “transfer of learning” process describes the tasks that supervisors, trainers, participants, and coworkers undertake before, during, and after training in order to ensure transfer of knowledge and skills to the workplace. The goal is for participants to transfer 100% of their new knowledge and skills to their jobs. The following matrix outlines these specific tasks. The tasks that trainers and participants should do during the learning experience appear **in bold** in the matrix.
### TRANSFER OF LEARNING MATRIX

<table>
<thead>
<tr>
<th>Before Learning</th>
<th>During Learning</th>
<th>After Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supervisors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand the performance need</td>
<td>Participate in or observe training</td>
<td>Monitor progress of action plans with participants and revise as needed</td>
</tr>
<tr>
<td>Participate in any additional assessments required for training</td>
<td>Protect participants from interruptions</td>
<td>Conduct post-training debriefing with participants and coworkers</td>
</tr>
<tr>
<td>Influence selection of participants</td>
<td>Plan pre-training debriefing</td>
<td>Be a coach and role model—provide encouragement and feedback</td>
</tr>
<tr>
<td>Communicate with trainers about the learning intervention</td>
<td>Provide supplies and space and schedule opportunities for participants to practice</td>
<td>Evaluate participants’ performance</td>
</tr>
<tr>
<td>Help participants create a preliminary action plan</td>
<td></td>
<td>Stay in contact with trainers</td>
</tr>
<tr>
<td>Support and encourage participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trainers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validate and supplement the results of the performance needs assessment</td>
<td>Provide work-related exercises and appropriate job aids</td>
<td>Conduct follow-up activities in a timely manner</td>
</tr>
<tr>
<td>Use instructional design and learning principles to develop or adapt the course</td>
<td>Give immediate and clear feedback</td>
<td>Help strengthen supervisors’ skills</td>
</tr>
<tr>
<td>Send the course syllabus, objectives and precourse learning activities in advance</td>
<td>Help participants develop realistic action plans</td>
<td>Facilitate review of action plans with supervisors and participants</td>
</tr>
<tr>
<td></td>
<td>Conduct training evaluations</td>
<td>Share observations with supervisors and participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maintain communication with supervisors and participants</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in needs assessments and planning</td>
<td>Participate actively in the course</td>
<td>Meet with supervisor to review action plan</td>
</tr>
<tr>
<td>Review course objectives and expectations and prepare preliminary action plans</td>
<td>Develop realistic action plans for transferring learning</td>
<td>Apply new skills and implement action plan</td>
</tr>
<tr>
<td>Begin establishing a support network</td>
<td></td>
<td>Use job aids</td>
</tr>
<tr>
<td>Complete precourse learning activities</td>
<td></td>
<td>Network with other participants and trainers for support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor your own performance</td>
</tr>
<tr>
<td><strong>Coworkers and others</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in needs assessments and discussions of the training’s intended impact</td>
<td>Complete participants’ reassigned work duties</td>
<td>Be supportive of participants’ accomplishments</td>
</tr>
<tr>
<td>Ask participants to bring back key learning points to share with the work group</td>
<td>Participate in learning exercises at the request of participants</td>
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As reflected in the matrix, transfer of learning is a complex process. An action plan can help make the process easier for all of the individuals involved. An action plan is a written document that describes the steps that supervisors, trainers, participants, and coworkers will complete to help maximize the transfer of learning. An action plan should be initiated before the training intervention so that everyone who can support the transfer of learning is involved.
from the beginning. The participants refine their plan during the
training course and usually do not complete it until after the course
when they are using their new skills on the job. The content and layout
of an action plan should support the users of the plan, especially the
participants. In developing an action plan, keep in mind these
important points:

- Write activities as discrete steps that are realistic, measurable, and
  attainable.

- Identify clear responsibilities for participants, supervisors,
coworkers, and trainers.

- Develop a specific time schedule for completing activities.

- Identify resources necessary to complete the activities, including
  plans for acquiring those resources.

- Instruct participants to use a learning journal to help facilitate the
development of an action plan. A learning journal is a notebook in
which participants document issues, problems, additional skills
they need to develop, and questions that arise as they apply their
new knowledge and skills on the job.

If time permits, the development of an action plan can be included in
the training course. If it is not, however, participants can take the
initiative to develop an action plan on their own. See page 8 for an
example of a completed action plan. This example is more detailed
than may be necessary in a given situation. The level of detail required
should depend on the performance problem and the learning
intervention being undertaken. A blank action plan format can be
found on page 9. Participants may copy this for their use or develop
their own format.
**EXAMPLE OF A COMPLETED ACTION PLAN**

**Action Plan Goal:** Implementation of the New National Guidelines for Essential Maternal and Neonatal Care (EMNC)

**Facility:** Mercy Hospital

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>WHO DOES IT?</th>
<th>RESOURCES NEEDED</th>
<th>DATE NEEDED</th>
<th>HOW TO MONITOR THE ACTIVITY</th>
<th>RESULT AND HOW TO MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acquire sufficient quantities of the service delivery guidelines to serve the needs of the facility.</td>
<td>Sister-in-charge</td>
<td>Copies of the service provision guidelines</td>
<td>31 March 2004</td>
<td>Copies of the service provision guidelines are available and used by all staff.</td>
<td>By December 2004, 90% of doctors and nurses will be providing basic maternal and newborn care services according to new national service provision guidelines. Observe clinical practice in comparison with clinical protocols.</td>
</tr>
<tr>
<td>Conduct orientation of all staff from the Antenatal Clinic.</td>
<td>Sister-in-charge and senior nurse/midwife</td>
<td>Copies of the service provision guidelines</td>
<td>31 May 2004</td>
<td>Staff demonstrates familiarity with contents of service provision guidelines through participatory discussion led by sister-in-charge.</td>
<td></td>
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<tr>
<td>Form Job Aids Committee.</td>
<td>Senior nurse/ midwife</td>
<td>None</td>
<td>31 May 2004</td>
<td>Committee exists and is creating job aids.</td>
<td></td>
</tr>
<tr>
<td>Have Job Aids Committee review guidelines and identify clinical protocols to post on the walls of the Antenatal Clinic.</td>
<td>Senior nurse/ midwife</td>
<td>Copies of the service provision guidelines, pen and paper</td>
<td>15 June 2004</td>
<td>Observe minutes of the meeting.</td>
<td></td>
</tr>
<tr>
<td>Make enlarged photocopies of the selected clinical protocols.</td>
<td>Job Aids Committee representative</td>
<td>Transport and funds to make photocopies</td>
<td>21 June 2004</td>
<td>Photocopies exist.</td>
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<tr>
<td>Post clinical protocols on the walls and show to staff.</td>
<td>Job Aids Committee representative</td>
<td>Tape</td>
<td>30 June 2004</td>
<td>Observe that protocols are posted on the walls and referred to on a regular basis.</td>
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EXAMPLE OF A BLANK ACTION PLAN

Performance Gap Addressed: ____________________________________________

Action Plan Goal: ______________________________________________________

Facility: _____________________________________________________________

<table>
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<tr>
<th>ACTIVITY</th>
<th>WHO DOES IT?</th>
<th>RESOURCES NEEDED</th>
<th>DATE NEEDED</th>
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<th>RESULT AND HOW TO MEASURE</th>
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INTRODUCTION

TRAINING IN BASIC CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE

The reduction of maternal and neonatal mortality and morbidity continues to be one of the greatest challenges to human development. Each year, approximately 600,000 women die from complications of pregnancy or childbirth, and more than 3 million babies die during the first week of life. However, most pregnancies and births are normal, and are followed by normal postpartum and newborn periods; thus, basic maternal and newborn care is sufficient for the majority of women and newborns. The aim in this course is, therefore, to ensure that skilled healthcare providers (i.e., midwives, doctors, and nurses with midwifery and life-saving skills) have the knowledge and skills needed to provide basic care throughout normal labor/childbirth and the postpartum/newborn periods. Basic care includes assessment of maternal and fetal well-being, preventive measures, preparation of a complication readiness plan, and health messages and counseling.

USING THE CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE TRAINING PACKAGE

In designing the training materials for this course, particular attention has been paid to making them “user friendly” and to permitting the course participants and clinical trainer the widest possible latitude in adapting the training to the participants' (group and individual) learning needs. For example, at the beginning of the course, an assessment is made of each participant's knowledge. The participants and trainer(s) use the results of this precourse assessment to adapt the course content as needed so that the training focuses on acquisition of new information and skills.

A second feature relates to the use of the reference manual and course handbook. The reference manual is designed to provide all of the essential information needed to conduct the course in a logical manner. Because it serves as the “text” for the participants and the “reference source” for the trainer, special handouts or supplemental materials are not needed. In addition, because the manual only contains information that is consistent with the course goals and objectives, it becomes an integral part of all classroom activities, such as giving an illustrated lecture or leading a discussion.

The reference manual used for this course is Basic Maternal and Newborn Care: A Guide for Skilled Providers (BMNC):
- Section One: Fundamentals of Basic Care (Chapters 1 through 3);
- Section Two: Core Components of Basic Care (Chapters 4 and 6 through 8);
- Section Three: Additional Care (Chapters 9 through 11—selections relevant to childbirth, postpartum, and newborn care); and
- Section Four: Annexes (Annex 5—selections relevant to childbirth, postpartum, and newborn care; and Annexes 6 and 7).

The **course handbook**, on the other hand, serves a dual function. First, and foremost, it is the road map that guides the participant through each phase of the course. It contains the course syllabus and course schedule, as well as all supplemental printed materials needed during the course, including precourse questionnaire, competency-based skills learning guides and practice checklists, case studies, role plays, and other exercises; instructions for using the tools; illustrated lecture handouts; log book; and course evaluation.

The **trainer’s notebook** contains the same material as the course handbook for participants as well as material for the trainer, including answer keys for the questionnaires, competency-based skills checklists, case studies, role play, and other exercises; instructions for conducting activities; and additional guidance for trainers.

### COURSE DESIGN

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

Specific characteristics of this course are as follows:

- During the morning of the first day, participants demonstrate their knowledge relevant to basic childbirth, postpartum, and newborn care by completing a written test (**Precourse Questionnaire**).

- Classroom and clinical sessions focus on key aspects of basic childbirth, postpartum, and newborn care.

- Progress in knowledge-based learning is measured during the course using standardized written assessments (**Knowledge Assessment Questionnaire**).
Clinical skills training builds on the participant's previous experience relevant to providing basic childbirth, postpartum, and newborn care. For most of the skills, participants practice first in a simulated setting, usually on anatomic models, using learning guides that list the key steps in performing the skills/procedures for basic childbirth, postpartum, and newborn care. In this way, they learn more quickly the skills needed in a standardized way.

Progress in learning new skills is guided using the clinical skills learning guides.

A clinical trainer uses competency-based skills checklists to evaluate each participant's performance.

Participants learn and are evaluated in clinical decision-making through case studies and simulated exercises and during clinical practice with clients/patients.

Participants learn appropriate interpersonal skills through behavior modeling and role play and are evaluated during clinical practice with clients/patients.

Successful completion of the course is based on successful completion of the knowledge and skills components, as well as satisfactory overall performance in providing basic childbirth, postpartum, and newborn care.

EVALUATION

This clinical training course is designed to produce healthcare providers (i.e., midwives, doctors, and nurses with midwifery and life-saving skills) who are qualified to provide basic childbirth, postpartum, and newborn care. Qualification is a statement by the training institution(s) that the participant has met the requirements of the course in knowledge, skills, and practice. Qualification does not imply certification. Only an authorized organization or agency can certify personnel.

Qualification is based on the participant's achievement in three areas:

- **Knowledge**—A score of at least 85% on the Knowledge Assessment Questionnaire
- **Skills**—Satisfactory performance of clinical skills for basic childbirth, postpartum, and newborn care
• Practice—Demonstrated ability to provide basic childbirth, postpartum, and newborn care in the clinical setting

The participant and the trainer share responsibility for the qualification of the participant.

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

• Knowledge Assessment Questionnaire. Knowledge will be assessed at the end of the course. A score of 85% or more correct indicates knowledge-based mastery of the material presented during classroom sessions. For those participants scoring less than 85% on their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the reference manual(s) to learn the required information. Arrangements should be made for participants scoring less than 85% to complete the Knowledge Assessment Questionnaire again.

• Clinical Skills. The clinical trainer will use a skills checklist to evaluate each participant as they perform the skills and procedures needed to provide basic childbirth, postpartum, and newborn care. Participants should be able to perform all of the steps/tasks for a particular skill/procedure, before the trainer assesses skill competency using the relevant checklist. Assessment of competency should take place in the simulated setting and then at a clinical site; however, if the number of clients at clinical sites is limited, or clinical experience with some rare events (e.g., complications) is not available while the course is in progress, it may be necessary for some skills to be taught, practiced, and evaluated in the simulated setting.

In addition, case studies will be used to assess problem-solving and decision-making skills. Evaluation of the interpersonal communication skills of each participant may take place at any time during the course through observation of participants during the role plays, whereas evaluation of the clinical skills, including problem-solving and decision-making skills, will take place at various points throughout the course.

• Clinical Practice. During the course, it is the clinical trainer's responsibility to observe each participant's overall performance relevant to providing basic childbirth, postpartum, and newborn care. This includes observing the participant's attitude—a critical component of quality service provision—to women and their newborns and to co-workers. By doing this, the clinical trainer assesses how the participant uses what s/he has learned.
COURSE SYLLABUS

**Course Description.** This 12-day clinical training course, together with the follow-up recommended after the course, is designed to prepare participants to provide basic childbirth, postpartum, and newborn care.

**Course Goals**

- To influence in a positive way the attitude of the participant toward globally accepted, evidence-based practices in childbirth, postpartum, and newborn care.

- To provide the participant with the knowledge and clinical skills needed to ensure, support, and maintain maternal and fetal/newborn well-being throughout normal labor/childbirth and the postpartum/newborn period.

- To enable the participant to recognize and respond to a woman or newborn when life-threatening complications are experienced during labor/childbirth and the postpartum/newborn period.

**Participant Learning Objectives**

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

1. Describe the fundamentals of basic maternal and newborn care and their application to care during labor, childbirth, and the postpartum/newborn period.

2. Use the recommended clinical decision-making framework when providing care during labor, childbirth, and the postpartum/newborn period.

3. Use interpersonal communication techniques that facilitate the development of a caring and trusting relationship with the woman while providing care during labor, childbirth, and the postpartum/newborn period.

4. Use recommended infection prevention practices while providing care during labor, childbirth, and the postpartum/newborn period.

5. After a quick check has been conducted, take a history of the woman in labor, including personal information, estimated date of childbirth/menstrual history, present pregnancy, present labor/childbirth, obstetric history, and medical history.
6. Perform a physical examination of the woman in labor, including assessment of well-being, measurement of vital signs, visual inspection of breasts, abdominal examination, vaginal examination, and cervical examination.

7. Diagnose the stages and phases of labor and, using the partograph, provide ongoing assessment and supportive care during the first, second, and third stages of labor.

8. Assist in a normal vaginal birth and perform immediate care of the newborn, active management of the third stage, examination of the placenta, and inspection of the vagina and perineum for tears.

9. Perform an episiotomy and repair of episiotomy and first and second degree vaginal and perineal tears.

10. Provide ongoing assessment and supportive care of the mother and newborn during the fourth stage of labor.

11. Perform the first complete physical examination of the newborn.

12. Identify women and newborns with common discomforts/concerns or special needs during labor, childbirth, and the postpartum/newborn period and respond to these needs appropriately.

13. After a quick check has been conducted, take a postpartum history, including personal information, daily habits and lifestyle, present pregnancy and childbirth, present and previous postpartum periods, medical history, contraceptive history, and interim history.

14. Perform a postpartum physical examination—including general well-being, measurement of vital signs, breast examination, abdominal examination, leg examination, genital examination, and assessment of mother-newborn bonding and breastfeeding—and conduct laboratory testing.

15. Provide basic postpartum care, including breastfeeding and breast care, complication readiness, mother-baby and family relationships, family planning, nutrition, self care and other healthy behaviors, HIV counseling, immunization and other preventive measures, and scheduling a return visit.

16. After a quick check has been conducted, conduct a newborn assessment and provide continuing newborn care, including health messages and counseling on breastfeeding, complication readiness, maintaining warmth, hygiene, washing and bathing, cord care, and management of common newborn problems.
17. Explain the recognition and appropriate response to common life-threatening complications related to labor, childbirth, postpartum, and newborn care.

18. Perform newborn resuscitation using a bag and mask.

19. Manage common complications of the immediate postpartum period, such as:
   - Manual removal of placenta
   - Bimanual compression of the uterus
   - Compression of the abdominal aorta
   - Repair of cervical tears

**Training/Learning Methods**

- Illustrated lectures and group discussions
- Case studies
- Role plays and other exercises
- Simulated practice with anatomic models
- Emergency drills
- Guided clinical activities (in assessment and provision of care through labor/childbirth and the postpartum/newborn period)

**Learning Materials.** The learning materials for the course are as follows:

- Presentation graphics on topics related to childbirth, postpartum, and newborn care
- Instruments and equipment:
  - For general classroom activities: overhead projector and screen, flipchart with markers
  - For learning activities: partographs; childbirth, postpartum, and newborn record cards
  - For the infection prevention demonstration: soap/antiseptic hand cleanser, nail brush, gloves, plastic apron, instruments, needles and syringes, plastic receptacles, chlorine solution
For clinic-based activities (See the Annex 2 in the reference manual.)

Anatomic models:
- Childbirth simulator
- Pelvic model, fetal model, placenta/cord/amnion model
- Newborn resuscitation model
- Foam models for suturing

Participant Selection Criteria

- Participants for this course should be practicing clinicians (midwives, doctors, and nurses with midwifery and life-saving skills) who provide or will provide basic childbirth, postpartum, and newborn care.
- Participants should have the support of their supervisors or managers to attend the course, and their supervisors should be willing to support transfer of learning at the participant’s job site.

Methods of Evaluation

Participant
- Precourse and Knowledge Assessment Questionnaires
- Learning Guides and Checklists for the skills/procedures relevant to basic childbirth, postpartum, and newborn care

Course
- Course Evaluation (to be completed by each participant)

Course Duration
- 12-days (24 sessions)—the 12 days are divided into a 7-day classroom/clinical laboratory block followed by a 5-day clinical experience block; between these two blocks, participants could be given 1 or 2 days off

Suggested Course Composition
- 16 participants (a combination of midwives, doctors, and nurses)
- 4 clinical trainers
### MODEL BASIC CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE COURSE SCHEDULE (12 days, 24 sessions)

<table>
<thead>
<tr>
<th>DAY 1</th>
<th>DAY 2</th>
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<th>DAY 4</th>
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<td>Welcome</td>
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<tr>
<td>Participant introductions</td>
<td>Illustrated Lecture-Discussion (PPT2A): Introduction to basic childbirth, postpartum, and newborn care</td>
<td>Skill Demonstration and Simulated Practice (SPS2): Assisting normal birth</td>
<td>Illustrated Lecture-Discussion (PPT4A): Common discomforts of labor/childbirth and the postpartum/newborn period</td>
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<td>Skill Demonstration and Simulated Practice (SPS5): Basic postpartum assessment</td>
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<tr>
<td>Participant introductions</td>
<td>Illustrated Lecture-Discussion (PPT2B): Assessment of the woman in labor</td>
<td>Case Studies (CS1 &amp; 2):</td>
<td>Illustrate Lecture-Discussion (PPT4B): Special needs of labor/childbirth and the postpartum/newborn period</td>
<td></td>
<td>Illustrate Lecture-Discussion (PPT5B): Life-threatening complications of labor/childbirth and the postpartum/newborn period</td>
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<tr>
<td>Overview of the Course</td>
<td>Skill Demonstration and Simulated Practice (SPS1): Assessment of the woman in labor</td>
<td>Supporting the woman in labor</td>
<td>Supporting the woman in labor</td>
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<tr>
<td>Goals, objectives, schedule</td>
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<td>Approach to training</td>
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<td>Review of course materials</td>
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<td><strong>Precourse Questionnaire</strong></td>
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<td>Assess participants’ precourse knowledge</td>
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<td>Identify individual and group learning needs</td>
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<tr>
<td>Illustrated Lecture-Discussion (PPT1A): Fundamentals of basic care</td>
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<td>Illustrated Lecture-Discussion (PPT1B): Key tools in basic care</td>
<td>Illustrated Lecture-Discussion (PPT1C): Key tools in basic care: Infection prevention practices</td>
<td>Skill Demonstration: Infection prevention practices</td>
<td>Review of Day’s Activities</td>
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<td>Review of Day’s Activities</td>
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<td>Key tools in basic care</td>
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<td>Clinical decision-making</td>
<td>Interpersonal skills</td>
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<td>Record keeping</td>
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<tr>
<td>Illustrated Lecture-Discussion (PPT1C): Key tools in basic care: Infection prevention practices</td>
<td>Illustrated Lecture-Discussion (PPT1B): Key tools in basic care</td>
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<td>Skills Demonstration: Infection prevention practices</td>
<td>Skills Demonstration: Infection prevention practices</td>
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<td>Review of Day’s Activities</td>
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<td><strong>Reading Assignment:</strong> BMNC—Section 1, Chapters 1 to 3; Section 2: Chapters 4 and 6 (through “Key Actions for the 3rd Stage of Labor”); Section 4: Annexes 3, 6, and 7</td>
<td><strong>Reading Assignment:</strong> BMNC—Section 2: Chapter 6 (“Key Actions for the 4th Stage of Labor”) and Chapter 8 (“Physical Examination/Observation” only); Section 4: Annex 4 (pages 4-18 to 4-22: “Episiotomy,” “Examination of the Vagina, Perineum, and Cervix for Tears”; pages 4-37 to 4-40: “Repair of Episiotomy” and “Repair of 1st and 2nd Degree Tears”</td>
<td><strong>Reading Assignment:</strong> BMNC—Section 2: Chapters 7 and 8; Section 3: Chapter 9 (all childbirth, postpartum, and newborn-related entries) and Chapter 10; Annex 5</td>
<td><strong>Reading Assignment:</strong> BMNC—Section 3: Chapter 11</td>
<td><strong>Reading Assignment:</strong> BMNC—Section 4: Annex 4 (the remaining entries, except “Pelvic examination” and “Testing”)</td>
<td><strong>Reading Assignment:</strong> Prepare for Knowledge Assessment Questionnaire; review Learning Guides; use practice Checklists</td>
</tr>
<tr>
<td><strong>Reading Assignment:</strong> BMNC—Section 1, Chapters 1 to 3; Section 2: Chapters 4 and 6 (through “Key Actions for the 3rd Stage of Labor”); Section 4: Annexes 3, 6, and 7</td>
<td><strong>Reading Assignment:</strong> BMNC—Section 2: Chapter 6 (“Key Actions for the 4th Stage of Labor”) and Chapter 8 (“Physical Examination/Observation” only); Section 4: Annex 4 (pages 4-18 to 4-22: “Episiotomy,” “Examination of the Vagina, Perineum, and Cervix for Tears”; pages 4-37 to 4-40: “Repair of Episiotomy” and “Repair of 1st and 2nd Degree Tears”</td>
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<td>DAY 7</td>
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| AM (3.5 Hours)  
Agenda and Opening Activity  
Simulated Practice: All skills included in course (based on individual learning needs)  
Knowledge Assessment Questionnaire | AM (3.5 Hours)  
Agenda and Opening Activity  
Supervised Clinical Practice  
Teams 1 & 2: Postpartum clinic  
Teams 3 & 4: Labor and birth wards | AM (3.5 Hours)  
Agenda and Opening Activity  
Supervised Clinical Practice  
Teams 1 & 2: Labor and birth wards  
Teams 3 & 4: Postpartum clinic | A.M. (3.5 Hours)  
Agenda and Opening Activity  
Supervised Clinical Practice  
Teams 1 & 2: Labor and birth wards  
Teams 3 & 4: Postpartum clinic | AM (3.5 Hours)  
Agenda and Opening Activity  
Supervised Clinical Practice  
Teams 1 & 2: Postpartum clinic  
Teams 3 & 4: Labor and birth wards |
| **LUNCH** | **LUNCH** | **LUNCH** | **LUNCH** | **LUNCH** | **LUNCH** |
| PM (3.5 Hours)  
Review of Knowledge Assessment Questionnaire  
Discussion: Participants’ ongoing learning needs  
Discussion: Preparation for supervised clinical practice  
Tour of Clinical Facilities  
Review of Day’s Activities | PM (3.5 Hours)  
Supervised Clinical Practice  
Teams 1 & 2: Postpartum ward  
Teams 3 & 4: Labor and birth wards  
Post-Clinical Conference and Review of Day’s Activities | PM (3.5 Hours)  
Supervised Clinical Practice  
Teams 1 & 2: Labor and birth wards  
Teams 3 & 4: Postpartum ward  
Post-Clinical Conference and Review of Day’s Activities | PM (3.5 Hours)  
Supervised Clinical Practice  
Teams 1 & 2: Postpartum ward  
Teams 3 & 4: Labor and birth wards  
Post-Clinical Conference and Review of Day’s Activities | PM (3.5 Hours)  
Discussion: Individual discussion with participants about ongoing learning needs  
Course Evaluation  
Closing |
| Reading Assignment: BMNC—Review text based on individual needs | Reading Assignment: BMNC—Review text based on individual needs | Reading Assignment: BMNC—Review text based on individual needs | Reading Assignment: BMNC—Review text based on individual needs | Reading Assignment: BMNC—Review text based on individual needs |
INSTRUCTIONS FOR USING ANATOMIC MODELS

The following anatomic models are suggested for the simulated teaching of the clinical skills included in the course:

- Childbirth simulator
- Vinyl or cloth pelvic model
- Fetal model
- Placenta/cord/amnion model
- Newborn resuscitation model

CHILDBIRTH SIMULATOR

A Gaumard® S500 AOA Advanced Childbirth Simulator is a model of a full-sized, pregnant adult female lower torso (abdomen and pelvis). It is a versatile training tool developed to assist in teaching the processes and skills needed to perform many childbirth techniques. The Childbirth Simulator is ideal for demonstrating and practicing the following procedures:

- Palpation of the fetal backbone, knees, and elbow
- Normal vaginal childbirth
- Complete, frank, and footling childbirth
- Vertex presentation
- Intra-uterine manipulation
- Multiple births, including vertex/vertex, vertex breech, breech/vertex and breech/breech presentation
- Prolapse of umbilical cord
- Placenta previa: total, partial and marginal
- Vacuum extraction (with optional vacuum childbirth fetus)
Contents of the Childbirth Simulator

The Gaumard® S500 AOA Advanced Childbirth Simulator kit includes the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborns (one male, one female)</td>
<td>2</td>
</tr>
<tr>
<td>Placentas</td>
<td>2</td>
</tr>
<tr>
<td>Detachable umbilical cords</td>
<td>6</td>
</tr>
<tr>
<td>Stomach covers</td>
<td>2</td>
</tr>
<tr>
<td>Vulval inserts</td>
<td>3</td>
</tr>
<tr>
<td>Umbilical cord clamp</td>
<td>1</td>
</tr>
<tr>
<td>Container of talcum powder</td>
<td>1</td>
</tr>
<tr>
<td>Soft nylon carrying bag</td>
<td>1</td>
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</tbody>
</table>

The simulator may also be purchased with specialized modules to demonstrate Leopold maneuvers and cervical effacement. A 19-piece articulating newborn for demonstration of many unusual birth presentations is also available. An optional module is available to simulate the conditions of the cervix and vagina before and during labor, and an optional vacuum childbirth fetus is also available for practicing that skill with the simulator.

Instructions for Use

The simulator is placed flat on its back to demonstrate one possible childbirth position. It can also be used to simulate other birthing positions such as sitting and squatting. The life-size pelvic cavity has all major anatomic landmarks and a hand-painted outline of the bony pelvis. It is designed with both an open abdomen, which has a soft, detachable, replaceable vinyl cover that attaches with snaps to the outside of the abdominal wall, and an open diaphragm on the torso, which has an end plate that may be removed by unscrewing the three nuts that secure the end plate to the simulator. The birth canal is of average/normal dimensions and the vulval/perineal insert is manufactured in soft plastic and is replaceable.

The simulator is provided with two newborns to allow the demonstration of multiple births. The newborns each measure approximately 48 cm (19 in). Relevant landmarks, such as the fontanelles (“soft spots” on the skull where unfused cranial bones meet), orbit, nose, mouth, ears and vertebral column are palpable. A detachable umbilical cord is attached to each newborn so that the cord
can be removed without cutting. The umbilical cord has a simulated umbilical blue vein and two red arteries. The hand-painted placenta is detachable from the umbilical cord and is attached to the interior abdominal wall with velcro. This simulates the placement of the placenta on the uterine wall.

**Procedures with the Childbirth Simulator**

**Normal Labor and Childbirth**

**Fetal Palpation**

The fetus may be palpated while in the abdominal cavity. To palpate the backbone, do the following:

- Place the fetus face down in the abdominal cavity.
- Snap the abdominal cover into place.
- Gently press on the cover until the length of the backbone can be felt.

To palpate the head and facial features, place the fetus face-up in the abdominal cavity and repeat the above procedure. The fetus may be placed in the abdominal cavity so that the presenting part is either the head or the feet.

**Fetal Descent**

To simulate fetal descent, do the following:

- Apply talcum powder to the fetal head and shoulders and inside the vulval insert to simulate amniotic fluid.
- Remove the diaphragm end plate or the abdominal cover.
- Insert one hand in the abdominal cavity and gently grasp the fetal body above the shoulders to allow greater control.
- Move the newborn caudally (downward through the birth canal).

**Internal/External Rotation**

Internal rotation of the head takes place as the fetal head meets the muscles of the pelvic floor. Thus, the fetus rotates so that it is face down or face up in the pelvis. Internal rotation may be simulated by manually turning the fetus as it enters the upper portion of the vaginal canal.
External rotation can be demonstrated by manually rotating the newborn within the vaginal canal through the open diaphragm or abdomen after the head has been delivered.

**Expulsion**

Expulsion can be demonstrated by allowing the provider who is delivering the newborn to gently pull down and then up on the fetus to deliver both shoulders. Once the shoulders have been delivered, the rest of the newborn should deliver easily. After expulsion, the newborn may be placed on the simulator’s stomach while the cord is detached.

**Active Management of the Third Stage of Labor**

This stage may be simulated by first gently disengaging the placenta from the interior abdominal wall. The placenta may then be gently pulled through the vaginal opening using the umbilical cord. Manual exploration of the uterus may also be demonstrated by inserting a hand up through the vaginal opening.

**Abnormal Labor and Childbirth**

**Prolapse of the Umbilical Cord**

This condition can be demonstrated by placing the umbilical cord in the front of the presenting part of the fetus before it is placed in the birth canal.

**Placenta Previa**

To simulate this condition, place the placenta in the uterine cavity in the desired position to simulate total, partial or marginal placenta previa, with the maternal side against the uterine wall or cervical os. Then, place the fetus within the uterine cavity, with the presenting part closest to the placenta.

**Care and Maintenance of the Models**

The following information applies to both the simulator and the newborns included in the kit:

- The models are constructed of material that approximates skin texture. Therefore, in handling them, use the same gentle techniques as you would in working with a patient.

- To avoid tearing the models’ skin when performing a procedure, use talcum powder to lubricate the newborn’s head or shoulders and inside the vulval insert. **DO NOT** use too much talcum powder.
within the abdominal cavity of the model because this will prevent the velcro from keeping the placenta in place.

- Clean the models after every training session using a mild detergent solution; rinse with clean water.
- Store the models in the carrying case and plastic bag provided with your kit.
- **DO NOT** wrap the models in other plastic bags, newspaper, plastic wrap or any other kinds of material, as these may discolor their skin.
- **DO NOT** write on the models with any type of marker or pen, as these marks may not wash off.
- **DO NOT** use alcohol, acetone or Betadine® or any other antiseptic solution that contains iodine on the models. They will damage or stain the skin.
- **DO NOT** use excessive force to push the newborn out the vaginal opening or to remove the placenta during active management of the third stage of labor because this may damage the models.
- **DO NOT** cut the model’s skin to demonstrate any procedure such as episiotomy or cesarean section. These cuts cannot be repaired and will damage the model.
- **DO NOT** cut the umbilical cord. Instead, simulate cutting it so that it may be used repeatedly.

**PELVIC MODEL, FETAL MODEL, OR PLACENTA/CORD/AMNION MODEL**

The cloth or vinyl pelvic model, fetal model, and placenta/cord/amnion model are designed to be used individually or together to assist in teaching the processes and skills needed to perform many childbirth techniques. These models are ideal for demonstrating and practicing the following:

- Physiology of the placenta, cord, amnion, and chorion
- Obstetric aspects of the fetal head
- Pelvic station
- Fetal lie and presentation
- Fetal position, attitude and rotation
- Mechanism and maneuvers of normal labor and childbirth
- Cord clamping and cord difficulties
Instructions for Use

Physiology of the Placenta, Cord, Amnion, and Chorion

Attach the umbilical cord to the fetal model and put them both inside the amniotic sac. Use this to show the fetal and maternal sides of the placenta. It also demonstrates how the amniotic sac attaches across the surface of the fetal side and envelopes the fetus.

Obstetric Aspects of the Fetal Head

Identify the sutures and fontanelles on the head of the fetal model. Explain how they are used to identify fetal position during childbirth. Flex the chin of the fetal model to its chest to show how this movement helps to present the smallest surface of the head as it moves through the birth canal during childbirth.

Pelvic Station

Pick up the fetal model by the shoulders. Place the fetal head just above the inlet of the pelvic model. While holding a pencil at the level of the ischial spines (zero station), lower the fetal head indicating the -4, -3, -2, and -1 locations until the widest transverse diameter of the fetal head (biparietal diameter) is just below the level of the pencil/spines (engagement). Show further descent to the pelvic floor while describing the +1, +2, +3, and +4 (on the perineum).

Fetal Lie and Presentation

Fetal lie refers to the long axis of the fetus as it relates to the mother’s pelvis. To demonstrate fetal lie, fold the legs of the fetal model up to its chest and hold it perpendicular to the inlet of the pelvic model. The fetal model can also be held in the transverse and oblique positions. Presentation is determined by the part of the fetus that first enters the pelvic inlet, and can be demonstrated with the fetal and pelvic models. A breech presentation, for example, can be demonstrated by having the buttocks enter first.

Fetal Position, Attitude, and Rotation

Position refers to the direction in which the fetus is facing in the birth canal. All of the vertex positions can be demonstrated using the pelvic and fetal models.

Attitude is the angle of the fetal head as it approaches the pelvic inlet. Holding the head in normal alignment with the trunk shows synclitism. Tilting the head of the fetal model to the left or right while holding the
fetal model in the pelvic model can show asynclitism, either anterior or posterior.

During childbirth, the fetal head turns, or rotates, within the birth canal to help it move more easily through the canal. Usually the head rotates so that it is facing the mother’s back and then rotates so that it is facing upward once the head is out and the shoulders are being delivered.

Rotation can be demonstrated by rotating the fetal model while moving it through the pelvic model. The posterior position and the more extensive rotation required for childbirth can also be demonstrated the same way. This demonstration is useful to show that a fetal head in the posterior position does not fit easily under the pelvic arch.

**Mechanisms and Maneuvers of Normal Childbirth**

Move the fetal model while a learner holds the pelvic model.

**Engagement**

Hold the fetal model by the shoulders and let the head enter the pelvic model inlet in a left occiput transverse position. Put the other hand just below the level of the ischial spines and lower the head to “zero station.”

**Descent**

Move the fetal model further into the pelvis. Tip the pelvis forward to show that the head is well into the pelvis. Then turn the shoulder to align it with the side-to-side pelvic inlet axis. Slightly rotate the head to the occiput anterior position (facing the mother’s back).

**Flexion**

Using one hand, hold the fetal model at the hips. Place the other hand under the pelvic model so that the palm can represent the pelvic floor muscles. Allow the fetal head to touch this hand to show how the fetus will flex its chin to its chest.

**Internal Rotation**

Turn the fetal head to complete its rotation to face the mother’s back.

**Extension**

Reach into the pelvic inlet and put one hand under the trunk of the fetal model. Grasp the fetal head at the mouth or chin with the thumb
and index finger. Apply pressure with the thumb to the chin to push it upward. This movement occurs during childbirth because the structure of the pelvic floor muscles combine with the mother pushing.

As the fetal head extends upward, place the other hand over the head to represent the vaginal opening. Discuss episiotomies at this time, if appropriate. While pushing the head forward, open the other hand over the crown of the head (crowning). At this time, how to suction mucus or check for a cord around the newborn’s neck can be demonstrated.

**External Restitution (Rotation)**

Demonstrate how the shoulders, which are still in the birth canal, rotate to align vertically with the pelvic and vaginal outlets. Rotate the head to the side to realign it with the shoulders so that the head is facing the same direction that it was when it entered the pelvis.

**Expulsion**

Remove the hand from the body of the fetal model and use both hands to “catch” the newborn. Support the head and pull gently downward to free the upper shoulder under the pubic bone. Pull upward to free the lower shoulder and let the whole newborn slide out of the pelvis.

A full demonstration of vaginal breech childbirth can also be performed using the fetal and pelvic models.

**Cord Difficulties**

By attaching the umbilical cord to the fetal model, it is possible to demonstrate how to unwrap the umbilical cord from around the newborn’s neck. Hold the placenta and sac under one arm and wrap the umbilical cord around the newborn’s neck. Then, deliver the newborn through the pelvic model. As the head reaches the pelvic outlet, show how to check for the cord and slip it over the head, if necessary. By allowing the cord to drop below the fetal head as it is delivered through the pelvic model, prolapsed cord can also be demonstrated.

**Care and Maintenance of the Models**

The following instructions apply to the pelvic model, fetal model and placental/cord/amnion model.

- When handling the models, use the same gentle techniques as you would in working with a patient.
• The vinyl pelvic model and the head of the fetal model are made of vinyl. To clean them, wipe them with a mild detergent solution and rinse with clean water.

• The fetal model, cloth pelvic model and placenta/cord/amnion models may be washed with a mild, liquid soap. Allow them to air dry. Before washing the fetal model, remove the vinyl head by gently pushing first on one side of the head and then the other side. After washing the body, squeeze all the excess water out of the neck area. Air dry completely and then replace the vinyl head by compressing the cloth head as you insert it into the vinyl head.

• **DO NOT** write on the models with any type of marker or pen, as these marks may not wash off.

• **DO NOT** use alcohol, acetone or Betadine® or any other antiseptic solution that contains iodine on the models. They will damage or stain the skin.

### NEWBORN RESUSCITATION MODEL

This model is designed to assist in teaching the processes and skills needed to resuscitate a newborn using mouth-to-mouth resuscitation or a bag and a mask.

#### Contents of the Newborn Resuscitation Model

The model includes the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
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<tbody>
<tr>
<td>Newborn</td>
<td>1</td>
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<tr>
<td>Lungs (plastic bags)</td>
<td>3</td>
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</table>

#### Instructions for Use

When the model is used for practicing mouth-to-mouth resuscitation, the plastic bag should be changed for each user. Replacement plastic bags are available in packages of 100.

**Airway Installation**

Fold the left side of the face shield end of the plastic bag toward the center of the bag (see figure below). Do the same for the right side. Insert the plastic bag through the mouth of the newborn. Tilt the head back and lay the plastic bag flat against the chest. Snap the chest
overlay into place. Form the face shield to cover the newborn’s face from nose to chin.

Airway Removal

First, unsnap the chest overlay from the shoulders and peel down. Then, pull the plastic bag through the face.
PRECURSE QUESTIONNAIRE

HOW THE RESULTS WILL BE USED

The main objective of the Precourse Questionnaire is to assist both the trainer and the participant as they begin their work together in the course by assessing what participants, individually and as a group, know about the course topic. This allows the trainer to identify topics that may need additional emphasis during the course. Providing the results of the precourse assessment to the participants enables them to focus on their individual learning needs. In addition, the questions alert participants to the content that will be presented in the course.

The questions are presented in the true-false format. A special form, the Individual and Group Assessment Matrix (page 38), is provided to record the scores of all course participants. Using this form, the trainer and participants can quickly chart the number of correct answers for each of the 50 questions. By examining the data in the matrix, the group members can easily determine their collective strengths and weaknesses and jointly plan the desired learning objectives.

For the clinical trainer, the questionnaire results will identify particular topics that may need additional emphasis during the learning sessions. Conversely, for those categories where 85% or more of participants answer the questions correctly, the clinical trainer may elect to use some of the allotted time for other purposes. For example, if the participants as a group did well (85% or more correct) in answering the questions in the category “Fundamentals of Basic Care” (Questions 1 through 5), the clinical trainer may elect to assign Section 1 of the reference manual as homework rather than discussing this information in class.

For the participants, the learning objective(s) related to each question and the corresponding section(s) in the reference manual are noted beside the answer column. To make the best use of the limited course time, participants are encouraged to address their individual learning needs by studying the designated chapter(s).
PRE COURSE QUESTIONNAIRE

FUNDAMENTALS OF BASIC CARE

1. The presence of a skilled healthcare provider during childbirth and the immediate postpartum/newborn period is a critical aspect in saving the lives of women and newborns. _____ Participant Objective 1 (Chapter 1)

2. The clinical decision making process is based on two steps: gathering information and providing care. _____ Participant Objective 2 (Chapter 3)

3. Good communication skills are an essential aspect of providing quality healthcare services to the woman and her newborn. _____ Participant Objective 3 (Chapter 3)

4. Infection prevention practices focus on preventing both infection and disease transmission in clients and healthcare workers. _____ Participant Objective 4 (Chapter 3)

5. Handwashing is of little importance with respect to preventing the spread of infection. _____ Participant Objective 4 (Chapter 3)

BASIC ASSESSMENT IN LABOR/CHILDBIRTH

6. A history of the woman’s present labor/childbirth should include asking if her membranes have ruptured and when contractions began. _____ Participant Objective 5 (Chapter 6)

7. Amniotic fluid has a distinct, but not foul-smelling, mild odor. _____ Participant Objective 5 (Chapter 6)

8. The best way to determine the intensity of a woman’s contractions is to observe her facial expressions. _____ Participant Objective 5 (Chapter 6)

9. In a term pregnancy, the fundus is about 30 to 32 cm above the symphysis pubis _____ Participant Objective 6 (Chapter 6)

10. To determine descent by abdominal palpation the fetal head is assessed in fifths above the symphysis pubis. _____ Participant Objective 6 (Chapter 6)
11. The fetal heart rate should be counted between contractions.  
12. Cervical dilatation is less than 4 cm in the latent phase of the first stage of labor.  
13. Cervical dilatation reaches 10 cm before the end of the first stage of labor.  
14. The partograph should be started in the latent phase of the first stage of labor.  
15. The fetal heart rate should be monitored every five minutes during the second stage of labor.  

**BASIC CARE DURING LABOR/CHILDBIRTH**

16. The birth of the head should be controlled by applying firm, gentle downward pressure to maintain flexion.  
17. If the cord is around the baby’s neck, it must be clamped and cut immediately.  
18. Controlled cord traction is used during active management of the third stage of labor.  
19. The placenta should be disposed of as soon as it is delivered.  
20. Episiotomy is an important routine procedure.  
21. Absorbable sutures should be used for closure of vaginal and perineal tears.  
22. Vigilant monitoring of the immediate postpartum woman is necessary only if there was a complication during labor or birth.  
23. An antimicrobial preparation should be instilled in the baby’s eyes within one hour of birth.  
24. It is not abnormal for a newborn’s head to be extremely large in proportion to its body.
25. Relief measures for abdominal (or groin) pain during labor include having the woman change position frequently.  

26. Lack of food and fluids is the usual anatomic/physiologic cause of dizziness or fainting during the 1st to 3rd stage of labor.  

27. The woman who is HIV positive should be provided counseling about infant feeding options.  

28. Adolescents have the same needs during pregnancy as older women.  

29. A postpartum history must include asking the woman about the color and amount of her lochia.  

30. Information about the woman’s intended use of a family method is not important in the early postpartum period.  

31. During the postpartum period, it is normal for the fundal height to increase slightly.  

32. Assessment of breastfeeding is an important part of postpartum follow-up.  

33. Breastfeeding has benefits for the baby only.  

34. Ensuring that the woman and her family know the maternal and newborn danger signs is an important part of the complication readiness plan for the postpartum period.  

35. Women who breastfeed exclusively may be protected from becoming pregnant for up to nine months.
36. Hygiene is extremely important to the postpartum woman because she is very vulnerable to infection.  

37. Iron/folate should be discontinued as soon as the woman has given birth.  

38. Delaying the baby’s first bath after birth has no affect on maintaining warmth.  

39. The baby’s cord should be placed outside the diaper to prevent contamination with urine and feces.  

40. The only immunization necessary for the newborn is for tuberculosis.  

41. An infected umbilicus should be cleaned thoroughly with soap and water, dried, and sealed with a clean dressing.  

ADDITIONAL CARE: LIFE-THREATENING COMPLICATIONS

42. An atonic uterus is a common cause of immediate postpartum hemorrhage.  

43. Lack of continuous fetal descent is the best measure of unsatisfactory progress in labor.  

44. A fever of up to 38°C after childbirth is normal.  

45. If a newborn has pus draining from both eyes, gonococcal infection should be suspected.  

46. During the procedure of newborn resuscitation, the newborn’s head should be slightly extended.  

47. After successful resuscitation, the newborn should be taken to the nursery for observation.  

48. Prophylactic antibiotics should be given before performing manual removal of placenta.
49. Bimanual compression of the uterus may be used to manage bleeding associated with an atonic uterus.

50. Interrupted sutures should be used to repair a cervical tear.
## INDIVIDUAL AND GROUP ASSESSMENT MATRIX

**COURSE:** ___________________________  **DATES:** ___________________________  **TRAINER(S):** ___________________________

<table>
<thead>
<tr>
<th>QUESTION NUMBER</th>
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<td>FUNDAMENTALS OF BASIC CARE</td>
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*Basic Maternal and Newborn Care: Basic Childbirth, Postpartum, and Newborn Care*

*JHPIEGO/Maternal and Neonatal Health Program*
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**BASIC CARE DURING LABOR/CHILDBIRTH**

**BASIC POSTPARTUM/NEWBORN ASSESSMENT**
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**BASIC POSTPARTUM/NEWBORN CARE**

**ADDITIONAL CARE: LIFE-THREATENING COMPLICATIONS**
USING THE ROLE PLAYS AND EXERCISE

USING THE ROLE PLAY AND EXERCISE

Role Play 1: Reassuring the Women in Labor

The purpose of the role play is to provide an opportunity for participants to understand the importance of ongoing supportive measures when providing care during labor and childbirth. The emphasis in the role play is on providing reassurance to the woman, making her as comfortable as possible, and demonstrating good communication skills. There are directions for the trainer, together with discussion questions to facilitate discussion after the role play. There is also an answer key. It is important for the trainer to become familiar with the answer key before conducting the role play. Although the key contains “likely” responses, other responses provided by participants may be equally acceptable.

Role Play 2: Parent Education and Support for Care of the Newborn

The purpose of the role play is to provide an opportunity for participants to understand the importance of individualized advice and counseling for parents of a newborn. The emphasis in the role play is on providing health messages in a way that is non-judgmental, supportive, and encouraging to the parents, while demonstrating good communication skills. There are directions for the trainer, together with discussion questions to facilitate discussion after the role play. There is also an answer key. It is important for the trainer to become familiar with the answer key before conducting the role play. Although the key contains “likely” responses, other responses provided by participants may be equally acceptable.

Exercise 1: Using the Partograph

The exercise is designed to help the participant practice using the partograph. Instructions are provided for the trainer and the resources required for the exercise are listed. An answer key is also provided for the trainer to use after participants have completed the exercise.
ROLE PLAY 1: REASSURING THE WOMAN IN LABOR

DIRECTIONS

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

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

PARTICIPANT ROLES

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

Woman in labor: Mrs. A is 16 years old. This is her first pregnancy.

SITUATION

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

FOCUS OF THE ROLE PLAY

The focus of the role play is the interpersonal interaction between the midwife and Mrs. A and the appropriateness of the midwife’s verbal and non-verbal communication skills.

DISCUSSION QUESTIONS

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

1. How did the midwife demonstrate respect and kindness during her interaction with Mrs. A?
2. How did the midwife provide emotional support and reassurance to Mrs. A?
3. What non-verbal behaviors did the midwife use to encourage interaction between herself and Mrs. A?
ROLE PLAY 2: PARENT EDUCATION AND SUPPORT FOR CARE OF 
THE NEWBORN

DIRECTIONS

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

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

PARTICIPANT ROLES

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

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

SITUATION

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

FOCUS OF THE ROLE PLAY

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

DISCUSSION QUESTIONS

1. How did the healthcare provider demonstrate respect and kindness during her interaction 
with Mrs. B?

2. What key health messages related to hygiene and cord care did the healthcare provider 
discuss with Mrs. B?

3. What did the healthcare provider do to ensure that Mrs. B understood the health messages?
EXERCISE 1: USING THE PARTOGRAPH

PURPOSE

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

INSTRUCTIONS

The trainer should review the partograph form with participants before beginning the exercise.

Each participant should be three blank partograph forms, one for each of the following cases.

- **Case 1**: The trainer should read each step to the class, plot the information on the poster-size laminated partograph, and ask the questions included in each of the steps. At the same time, participants should plot the information on one of their partograph forms.

- **Case 2**: The trainer should read each step to the class and have participants plot the information on another of their partograph forms. The questions included in each step should be asked as they arise.

- **Case 3**: The trainer should read each step to the class and have participants plot the information on the third of their partograph forms. The questions should then be asked when the partograph is completed.

Throughout the exercise, the trainer should ensure that participants have completed their partograph forms correctly.

The trainer should provide participants with the three completed partograph forms from the Answer Key and have them compare these with the partograph forms they have completed. The trainer should discuss and resolve any differences between the partographs completed by participants and those in the Answer Key.

RESOURCES

- Partograph forms (three for each participant)
- Poster-size laminated partograph
- Exercise: Using the Partograph Answer Key
CASE 1

STEP 1

- Mrs. A was admitted at 05.00 on 12.9.2003
- Membranes ruptured 04.00
- Gravida 3, Para 2+0
- Hospital number 7886
- On admission the fetal head was 4/5 palpable above the symphysis pubis and the cervix was 2 cm dilated

Answer the following question:
Q: What should be recorded on the partograph?

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

STEP 2

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

Answer the following question:
Q: What should you now record on the partograph?

Note: Mrs. A is now in the active phase of labor. Plot this and the following information on the partograph:
- 3 contractions in 10 minutes, each lasting 20–40 seconds
- Fetal heart rate (FHR) 120
- Membranes ruptured, amniotic fluid clear
- Sutures of the skull bones are apposed
- Blood pressure 120/70 mmHg
- Temperature 36.8°C
- Pulse 80/minute
- Urine output 200 mL; negative protein and acetone

Answer the following questions:
Q: What steps should be taken?
Q: What advice should be given?
Q: What do you expect to find at 13.00?
STEP 3

Plot the following information on the partograph:

09.30  FHR 120, Contractions 3/10 each 30 seconds, Pulse 80/minute
10.00  FHR 136, Contractions 3/10 each 30 seconds, Pulse 80/minute
10.30  FHR 140, Contractions 3/10 each 35 seconds, Pulse 88/minute
11.00  FHR 130, Contractions 3/10 each 40 seconds, Pulse 88/minute, Temperature 37°C
11.30  FHR 136, Contractions 4/10 each 40 seconds, Pulse 84/minute, Head is 2/5 palpable
12.00  FHR 140, Contractions 4/10 each 40 seconds, Pulse 88/minute
12.30  FHR 130, Contractions 4/10 each 45 seconds, Pulse 88/minute
13.00  FHR 140, Contractions 4/10 each 45 seconds, Pulse 90/minute, Temperature 37°C

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

Answer the following questions:

Q: What steps should be taken?
Q: What advice should be given?
Q: What do you expect to happen next?

STEP 4

Record the following information on the partograph:

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

Answer the following questions:

Q: How long was the active phase of the first stage of labor?
Q: How long was the second stage of labor?
CASE 2

STEP 1

- Mrs. B was admitted at 10.00 on 12.9.2003
- Membranes intact
- Gravida 1, Para 0+0
- Hospital number 1443

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

Answer the following questions:
Q: What is your diagnosis?
Q: What action will you take?

STEP 2

Plot the following information on the partograph:
- 10.30 FHR 140, Contractions 2/10 each 15 sec, Pulse 90/minute
- 11.00 FHR 136, Contractions 2/10 each 15 sec, Pulse 88/minute
- 11.30 FHR 140, Contractions 2/10 each 20 sec, Pulse 84/minute
- 12.00 FHR 136, Contractions 2/10 each 15 sec, Pulse 88/minute, Temperature 36.2°C, Membranes intact

- 12.00:
  - The fetal head is 5/5 palpable above the symphysis pubis
  - The cervix is 4 cm dilated, membranes intact

Answer the following questions:
Q: What is your diagnosis?
Q: What action will you take?
STEP 3

Plot the following information on the partograph:

12.30  FHR 136, Contractions 1/10 each 15 sec, Pulse 90/minute
13.00  FHR 140, Contractions 1/10 each 15 sec, Pulse 88/minute
13.30  FHR 130, Contractions 1/10 each 20 sec, Pulse 88/minute
14.00  FHR 140, Contractions 2/10 each 20 sec, Pulse 90/minute, Temperature 36.8°C, Blood pressure 100/70 mmHg

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

Answer the following questions:

**Q: What is your diagnosis?**

**Q: What will you do?**

Plot the following information on the partograph:

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

STEP 4

Plot the following information on the partograph:

- 14.30:
  - 2 contractions in 10 minutes, each lasting 30 seconds
  - Infusion rate increased to 20 dpm
  - FHR 140, Pulse 90/minute
- 15.00:
  - 3 contractions in 10 minutes, each lasting 30 seconds
  - Infusion rate increased to 30 dpm
  - FHR 140, Pulse 90/minute
- 15:30:
  - 3 contractions in 10 minutes, each lasting 30 seconds
  - Infusion rate increased to 40 dpm
  - FHR 140, Pulse 88/minute
- 16.00:
  - Fetal head 2/5 palpable above the symphysis pubis
  - Cervix 6 cm dilated; sutures apposed
  - 3 contractions in 10 minutes, each lasting 30 seconds
  - Infusion rate increased to 50 dpm
  - FHR 144, Pulse 92/minute
  - Amniotic fluid clear

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

Answer the following question:
Q: What steps would you take?

**STEP 5**

Plot the following information on the partograph:
17.00  FHR 138, Pulse 92/minute, Contractions 3/10 each 40 sec, Maintain at 50 dpm
17.30  FHR 140, Pulse 94/minute, Contractions 3/10 each 45 sec, Maintain at 50 dpm
18.00  FHR 140, Pulse 96/minute, Contractions 4/10 each 50 sec, Maintain at 50 dpm
18.30  FHR 144, Pulse 94/minute, Contractions 4/10 each 50 sec, Maintain at 50 dpm

**STEP 6**

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

**STEP 7**

Record the following information on the partograph:
- 19.30:
  - 4 contractions in 10 minutes, each lasting 50 seconds
  - FHR 142, Pulse 100/minute
20.00:
- 4 contractions in 10 minutes, each lasting 50 seconds
- FHR 146, Pulse 110/minute

20.10:
- Spontaneous birth of a live male infant weighing 2,654 g

Answer the following questions:
Q: How long was the active phase of the first stage of labor?
Q: How long was the second stage of labor?
Q: Why was labor augmented?
CASE 3

STEP 1
- Mrs. C was admitted at 10.00 on 12.9.2003
- Membranes ruptured 09.00
- Gravida 4, Para 3+0
- Hospital number 6639

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

STEP 2

Plot the following information in the partograph:
- 10.30 FHR 130, Contractions 3/10 each 35 sec, Pulse 80/minute
- 11.00 FHR 136, Contractions 3/10 each 40 sec, Pulse 90/minute
- 11.30 FHR 140, Contractions 3/10 each 40 sec, Pulse 88/minute
- 12.00 FHR 140, Contractions 3/10 each 40 sec, Pulse 90/minute, Temperature 37°C, Head 3/5 palpable
- 12.30 FHR 130, Contractions 3/10 each 40 sec, Pulse 90/minute
- 13.00 FHR 130, Contractions 3/10 each 45 sec, Pulse 88/minute
- 13.30 FHR 120, Contractions 3/10 each 45 sec, Pulse 88/minute
- 14.00 FHR 130, Contractions 4/10 each 45 sec, Pulse 90/minute, Temperature 37°C, Blood pressure 100/70 mmHg

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

14.30 FHR 120, Contractions 4/10 each 40 sec, Pulse 90/minute, Clear fluid
15.00 FHR 120, Contractions 4/10 each 40 sec, Pulse 88/minute, Blood-stained fluid
15.30 FHR 100, Contractions 4/10 each 45 sec, Pulse 100/minute
16.00 FHR 90, Contractions 4/10 each 50 sec, Pulse 100/minute, Temperature 37°C
16.30 FHR 96, Contractions 4/10 each 50 sec, Pulse 100/minute
17.00 FHR 90, Contractions 4/10 each 50 sec, Pulse 110/minute

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

STEP 4

Record the following information on the partograph:

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

Answer the following questions:

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

CASE STUDY 1: CHILDBIRTH ASSESSMENT AND CARE

DIRECTIONS

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

CLIENT PROFILE

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

PRE-ASSESSMENT

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

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

2. What history will you include in your assessment of Mrs. A and why?

3. What physical examination will you include in your assessment of Mrs. A and why?

4. What laboratory tests will you include in your assessment of Mrs. A and why?

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

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

- Mrs. A kneels to the floor and cries out with each contraction.
- On measurement of vital signs: Respirations are 18 per minute, BP is 120/82, Pulse is 88 beats per minute, Temperature is 37.8\(^\circ\) C.
- On abdominal examination:
  - Fundal height is 33 cm
  - Presenting part is four-fifths above the pelvic brim
  - Fetal heart tones are 124 beats per minute
  - Contractions are irregular every 8-10 minutes and last 14-18 seconds
- On cervical examination:
  - Dilation of the cervix is 3 cm
  - Membranes are intact
  - Presentation is vertex and there is no molding
- Her physical exam reveals no abnormal findings.

Testing:

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

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

CARE PROVISION (implementing plan of care and interventions)

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

EVALUATION

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

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

REFERENCES

BMNC—Section 1, Chapter 3, Interpersonal Skills; Section Two: Core Components of Basic Care, Chapters 4 and 6
CASE STUDY 2: CHILDBIRTH ASSESSMENT AND CARE

DIRECTIONS

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

CLIENT PROFILE

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

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

1. What history will you include in your assessment of Mrs. B and why?
2. What physical examination will you include in your assessment of Mrs. B and why?
3. What laboratory tests will you include in your assessment of Mrs. B and why?

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

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

Physical Examination:

- Vital signs are as follows: Respirations are 20 per minute, BP is 130/82, Pulse is 88 beats per minute, Temperature is 37.8°C.
- On abdominal examination:
  - No scars are noted and uterus is oval-shaped
Fundal height is 34 cm
One set of fetal parts are palpable
Fetus is longitudinal in lie and cephalic presentation
Presenting part is not palpable above the symphysis
Fetal heart tones are 148 per minute
Bladder is not palpable
Contractions are 3 per 10 minutes, 40–50 seconds in duration each

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

Testing:
Test results not yet back at this stage

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

CARE PROVISION (implementing plan of care and interventions)

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

EVALUATION

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

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

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 6
CASE STUDY 3: POSTPARTUM ASSESSMENT AND CARE

DIRECTIONS

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

CLIENT PROFILE

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

PRE-ASSESSMENT

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

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

2. What history will you include in your assessment of Mrs. C and why?

3. What physical examination will you include in your assessment of Mrs. C and why?

4. What laboratory tests will you include in your assessment of Mrs. C and why?

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

- Mrs. C is feeling well.
- Mrs. C reports no complications or problems during this pregnancy, labor/childbirth, or postpartum period. Her medical history is not significant: she is taking no medications, nor does she have any chronic conditions or illnesses.
- Mrs. C’s first child is well and was breastfed for 6 months.
- She is exclusively breastfeeding her baby and intends to do so for at least 6 months.
- She wants to know whether she should start using contraception now, as she does not want to become pregnant again for at least 2 years.
• All other aspects of her history are normal or without significance.

Physical Examination:

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

Testing:

HIV test is negative.

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

CARE PROVISION (implementing plan of care and interventions)

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

EVALUATION

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

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

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 7; Section Four: Annexes, Annex 5
CASE STUDY 4: POSTPARTUM ASSESSMENT AND CARE

DIRECTIONS

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

CLIENT PROFILE

Mrs. A is 18 years of age and gave birth to her first baby at home 10 days ago. Her pregnancy, labor, and birth were uncomplicated. The midwife who attended the birth checked Mrs. A and her baby the day after the birth. She has not seen a healthcare provider since then. This is her first postpartum clinic visit. Mrs. A has come to the clinic because she has sore, red nipples. Her baby is with her.

PRE-ASSESSMENT

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

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

2. What history will you include in your assessment of Mrs. A and why?

3. What physical examination will you include in your assessment of Mrs. A and why?

4. What laboratory tests will you include in your assessment of Mrs. A and why?

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

• Mrs. A is feeling well but has sore, red nipples.
• She reports that the baby breastfeeds approximately every 2 hours.
• All other aspects of her history are normal or without significance.
Physical Examination:

- Mrs. A generally appears well.
- Vital signs are as follows: BP is 110/72, Pulse is 76 beats per minute; Temperature is 37.6°C.
- There is no redness, tenderness, streaking, or masses palpable in the breast tissue; however, during observation of breastfeeding, it was found that the baby was not attaching well to the breast.
- All findings on examination of the baby are within normal range and without significance.
- All other aspects of her physical examination are within normal range and without significance.

Testing:

HIV test is negative.

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

CARE PROVISION (implementing plan of care and interventions)

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

EVALUATION

- Mrs. A returns to the clinic in 2 days.
- You find that her nipples are less sore and red, and attachment has improved, although the problem has not fully resolved.
- Mrs. A is very eager to continue breastfeeding

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

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 6; Section Three: Additional Care, Chapter 10; Section Four: Annexes, Annex 5
CASE STUDY 5: NEWBORN ASSESSMENT AND CARE

DIRECTIONS

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

CLIENT PROFILE

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

PRE-ASSESSMENT

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

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

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

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

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

DIAGNOSIS (interpreting information to identify problems/needs)

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

Quick Check:

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

RIA:

No significant findings nor need for resuscitation.

History:

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

**Physical Examination:**

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

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

**CARE PROVISION (implementing plan of care and interventions)**

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

**EVALUATION**

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

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

**REFERENCES**

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 8; Section Three: Additional Care, Chapter 11
CASE STUDY 6: NEWBORN ASSESSMENT AND CARE

DIRECTIONS

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

CLIENT PROFILE

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

PRE-ASSESSMENT

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

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

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

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

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

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

- Record review reveals that Mrs. F has no running water in her home and must carry water for household use from a river that is known to be polluted.
- Mrs. F reports that the rash began 3 days ago.
- She denies putting any substance on the baby’s skin.
- She reports that the baby is feeding well.
- All other aspects of the baby’s history are normal or without significance.
Physical Examination:

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

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

CARE PROVISION (implementing plan of care and interventions)

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

EVALUATION

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

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

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 8; Section Three: Additional Care, Chapters 9 and 11
SKILLS PRACTICE SESSIONS

SKILLS PRACTICE SESSION 1:
ASSESSMENT OF THE WOMAN IN LABOR

PURPOSE

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

INSTRUCTIONS

This activity should be conducted in a simulated setting using the appropriate pelvic and fetal models.

Participants should review Learning Guide 1 before beginning the activity.

The trainer should demonstrate the steps/tasks in taking a **history** from the woman in labor for participants. Under the guidance of the trainer, participants should then work in groups of three to practice the steps/tasks and observe each other’s performance; while one participant takes a history from another, the third participant should use the relevant section of Learning Guide 1 to observe performance. Participants should then reverse roles until each has had an opportunity to take a history and be observed. Participants should be able to perform the steps/tasks relevant to taking a history from the woman in labor before progressing to physical examination of the woman in labor.

The trainer should demonstrate the steps/tasks in **physical examination** of the woman in labor for participants. Under the guidance of the trainer, participants should then work in pairs and, using the childbirth simulator, practice the steps/tasks and observe each other’s performance; while one participant does the physical examination, the second participant should use the relevant section of Learning Guide 1 to observe performance. Participants should then reverse roles. Participants should be able to perform all of the steps/tasks in Learning Guide 1 before skills competency is assessed in the simulated setting by the trainer, using Checklist 1.

Finally, following supervised practice at a clinical site, the trainer should assess the skills competency of each participant using Checklist 1.

RESOURCES

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

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Learning Guide 1: Assessment of the Woman in Labor

Checklist 2.1: Assessment of the Woman in Labor
SKILLS PRACTICE SESSION 2: ASSISTING IN NORMAL BIRTH

PURPOSE

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

INSTRUCTIONS

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

Participants should review Learning Guide 2 before beginning the activity.

The trainer should demonstrate the steps/tasks in assisting the birth (up to but not including active management of third stage). Under the guidance of the trainer, participants should then work in pairs and, using the childbirth simulator, practice the steps/tasks and observe each other’s performance; while one participant assists the birth, the second participant should use the relevant section of Learning Guide 2 to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks relevant to assisting the birth before progressing to active management of third stage, examination of placenta, and inspection of vagina and perineum.

The trainer should demonstrate the steps/tasks in active management of third stage, as well as the following steps of examination of the placenta and inspection of the vagina and perineum for tears. Under the guidance of the trainer, participants should then work in pairs and, using the childbirth simulator, practice the steps/tasks and observe each other’s performance; while one participant performs active management of third stage, examination of the placenta, and inspection of the vagina and perineum for tears, the second participant should use the relevant section of Learning Guide 2 to observe performance. Participants should then reverse roles. Participants should be able to perform all of the steps/tasks in Learning Guide 2 before skills competency is assessed in the simulated setting by the trainer, using Checklist 2.

Finally, following supervised practice at a clinical site, the trainer should assess the skills competency of each participant, using Checklist 2.

RESOURCES

- Childbirth simulator
- High-level disinfected or surgical gloves
- Personal protective barriers
- Delivery kit/pack
- 0.5% chlorine solution and receptacle for decontamination
- Leakproof container or plastic bag
The BMNC

Learning Guide 2: Assisting in Normal Birth

Checklist 2: Assisting in Normal Birth
SKILLS PRACTICE SESSION 3:
EPISIOTOMY AND REPAIR

PURPOSE

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

INSTRUCTIONS

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

Participants should review the Learning Guide 3 before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of episiotomy and repair for participants. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other’s performance, using Learning Guide 3.

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

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

Note: If patients are not available at clinical sites for participants to practice episiotomy and repair, the skills should be taught, practiced, and assessed in the simulated setting.

RESOURCES

- Pelvic model or “foam block” that would enable episiotomy and repair to be performed
- High-level disinfected or surgical gloves
- Personal protective barriers
- Examination light
- Local anesthetic
- Needle and syringe
- Suture materials

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Learning Guide 3: Episiotomy and Repair

Check List 3: Episiotomy and Repair
SKILLS PRACTICE SESSION 4:
REPAIR OF 1st AND 2nd DEGREE VAGINAL AND PERINEAL TEARS

PURPOSE

The purpose of this activity is to enable participants to practice repair of 1st and 2nd degree vaginal and perineal tears and achieve competency in the skills required.

INSTRUCTIONS

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

Participants should review the Learning Guide 4 before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of episiotomy and repair for participants. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other’s performance, using Learning Guide 4.

Participants should be able to perform the steps/tasks in Learning Guide 4 before skill competency is assessed in the simulated setting by the trainer, using Checklist 4.

Finally, following supervised practice at a clinical site, the trainer should assess the skill competency of each participant, using Checklist 4.

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

RESOURCES

- Pelvic model or “foam block” that would enable episiotomy and repair to be performed
- High-level disinfected or surgical gloves
- Personal protective barriers
- Examination light
- Local anesthetic
- Needle and syringe
- Suture materials

The BMNC

Learning Guide 4: Repair of 1st and 2nd Degree Vaginal and Perineal Tears

Checklist 4: Repair of 1st and 2nd Degree Vaginal and Perineal Tears
SKILLS PRACTICE SESSION 5: ASSESSMENT OF THE NEWBORN

PURPOSE

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

INSTRUCTIONS

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

Participants should review Learning Guide 5, before beginning the activity.

The trainer should demonstrate the steps/tasks in taking a newborn **history** for participants. Under the guidance of the trainer, participants should then work in groups of three to practice the steps/tasks and observe each other’s performance; while one participant takes a history from another, the third participant should use the relevant section of Learning Guide 5 to observe performance. Participants should then reverse roles until each has had an opportunity to take a history and be observed. Participants should be able to perform the steps/tasks relevant to taking a newborn history before progressing to physical examination of the newborn.

The trainer should demonstrate the steps/tasks in **physical examination** of the newborn for participants. Under the guidance of the trainer, participants should then work in pairs and, using the newborn doll, practice the steps/tasks and observe each other’s performance; while one participant does the physical examination, the second participant should use the relevant section of Learning Guide 5 to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks in taking a newborn history and doing a newborn physical examination, as outlined Learning Guide 5, before skills competency is assessed in the simulated setting by the trainer, using Checklist 5.

Finally, following supervised practice at a clinical site, the trainer should assess the skills competency of each participant using Checklist 5, including breastfeeding and mother-baby bonding.

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

RESOURCES

- Newborn doll
- Cloth or baby blanket to wrap doll
- Baby weigh scale
- Thermometer
- Newborn record
The BMNC

Learning Guide 5: Assessment of the Newborn

Checklist 5: Assessment of the Newborn
SKILLS PRACTICE SESSION 6:
POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

PURPOSE

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

INSTRUCTIONS

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

Participants should review the Learning Guide 6 before beginning the activity.

The trainer should demonstrate the steps/tasks in taking a postpartum history for participants. Under the guidance of the trainer, participants should then work in groups of three to practice the steps/tasks and observe each other’s performance; while one participant takes a history from another, the third participant should use the relevant section of Learning Guide 6 to observe performance. Participants should then reverse roles until each has had an opportunity to take a history and be observed. Participants should be able to perform the steps/tasks relevant to taking a postpartum history before progressing to physical examination.

The trainer should demonstrate the steps/tasks in physical examination of the postpartum woman for participants. Under the guidance of the trainer, participants should then work in pairs and, using the appropriate model(s), practice the steps/tasks and observe each other’s performance; while one participant does the physical examination, the second participant should use the relevant section of Learning Guide 6 to observe performance. Participants should then reverse roles. Participants should be able to perform the steps/tasks for postpartum history and physical examination before skills competency is assessed in the simulated setting by the trainer, using Checklist 6.

The provision of postpartum care should be demonstrated in a postpartum clinic or ward and participants should then be supervised in the practice of postpartum assessment and care.

Finally, following supervised practice at a clinical site, the trainer should assess the skills competency of each participant using Checklist 6.

RESOURCES

- Pelvic model
- Sphygmomanometer and stethoscope
• Examination gloves
• 0.5% chlorine solution and receptacle for decontamination
• Leakproof container or plastic bag
• Postpartum record

The BMNC

Learning Guide 6: Postpartum Assessment (History and Physical Examination) and Care

Checklist 6: Postpartum Assessment (History and Physical Examination) and Care
SKILLS PRACTICE SESSION 7:
NEWBORN RESUSCITATION

PURPOSE

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

INSTRUCTIONS

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

Participants should review Learning Guide 7, before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of newborn resuscitation using a bag and mask. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other’s performance, using Learning Guide 7.

Participants should be able to perform the steps/tasks in Learning Guide 7, before skill competency is assessed by the trainer in the simulated setting, using Checklist 7.

Finally, following supervised practice at a clinical site, the trainer should assess the skill competency of each participant, using Checklist 7.

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

RESOURCES

- Table
- Newborn resuscitation model
- Cloth or baby blanket to wrap model
- Suction apparatus
- Self-inflating bag (newborn)
- Infant face masks, size 0 and size 1
- Clock

The BMNC

Learning Guide 7: Newborn Resuscitation

Checklist 7: Newborn Resuscitation
SKILLS PRACTICE SESSION 8:
MANUAL REMOVAL OF PLACENTA

PURPOSE

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

INSTRUCTIONS

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

Participants should review Learning Guide 8 before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of manual removal of the placenta for participants. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other’s performance, using Learning Guide 8.

Participants should be able to perform the steps/tasks in Learning Guide 8 before skill competency is assessed by the trainer in the simulated setting, using Checklist 8.

Finally, following supervised practice at a clinical site, the trainer should assess the skill competency of each participant, using Checklist 8.

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

RESOURCES

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

The BMNC

Learning Guide 8: Manual Removal of Placenta

Checklist 8: Manual Removal of Placenta
SKILLS PRACTICE SESSION 9:
BIMANUAL COMPRESSION OF THE UTERUS

PURPOSE

The purpose of this activity is to enable participants to practice bimanual compression of the uterus and achieve competency in the skills required.

INSTRUCTIONS

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

Participants should review Learning Guide 9 before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of bimanual compression of the uterus for participants. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other’s performance, using Learning Guide 9.

Participants should be able to perform the steps/tasks in Learning Guide 9 before skill competency is assessed by the trainer in the simulated setting, using Checklist 9 to assess each other’s performance.

Finally, following supervised practice at a clinical site, the trainer should assess the skill competency of each participant, using Checklist 9.

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

RESOURCES

- Childbirth simulator
- Delivery instrument kit
- High-level disinfected or sterile surgical gloves
- Personal protective barriers

The BMNC

Learning Guide 9: Bimanual Compression of the Uterus

Checklist 9: Bimanual Compression of the Uterus
SKILLS PRACTICE SESSION 10:
COMPRESSION OF THE ABDOMINAL AORTA

PURPOSE

The purpose of this activity is to enable participants to practice compression of the abdominal aorta and achieve competency in the skills required.

INSTRUCTIONS

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

Participants should review Learning Guide 10 before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of compression of the abdominal aorta for participants. Under the guidance of the trainer, participants should then work in groups of three to practice the steps/task; while one participant performs the procedure on another, the third participant should use Learning Guide 10 to observe performance. Participants should then reverse roles until each has had an opportunity to perform the procedure and be observed.

Participants should be able to perform the steps/tasks in Learning Guide 10 before skill competency is assessed by the trainer in the simulated setting, using Checklist 10.

Finally, following supervised practice at a clinical site, the trainer should assess the skill competency of each participant, using Checklist 10.

Note: If patients are not available at clinical sites for learners to practice the procedure of compression of the abdominal aorta, the skills should be taught, practiced, and assessed in a simulated setting.

RESOURCES

- Childbirth simulator

The BMNC

Learning Guide 10: Compression of the Abdominal Aorta

Checklist 10: Compression of the Abdominal Aorta
SKILLS PRACTICE SESSION 11:
REPAIR OF CERVICAL TEARS

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

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

Participants should review Learning Guide 11 before beginning the activity.

The trainer should demonstrate the steps/tasks in the procedure of repair of cervical tears for participants. Under the guidance of the trainer, participants should then work in pairs to practice the steps/tasks and observe each other’s performance, using Learning Guide 11.

Participants should be able to perform the steps/tasks in Learning Guide 11 before skill competency is assessed by the trainer in the simulated setting, using Checklist 11.

Finally, following supervised practice at a clinical site, the trainer should assess the skill competency of each participant, using Checklist 11.

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

RESOURCES

- Foam block to simulate a vagina and cervix
- High-level disinfected or sterile surgical gloves
- Personal protective barriers
- Examination light
- Vaginal speculum
- Ring or sponge forceps
- Suture materials

The BMNC

Learning Guide 11: Repair of Cervical Tears

Checklist 11: Repair of Cervical Tears
LEARNING GUIDES AND PRACTICE CHECKLISTS

The Learning Guides and Practice Checklists are designed to help the participant learn the steps or tasks involved in providing basic childbirth, postpartum, and newborn care.

USING THE LEARNING GUIDE

There are eleven learning guides in this handbook:

- Learning Guide 1: Assessment of the Woman in Labor
- Learning Guide 2: Assisting Normal Birth
- Learning Guide 3: Episiotomy and Repair
- Learning Guide 4: Repair of 1st and 2nd Degree Vaginal and Perineal Tears
- Learning Guide 5: Assessment of the Newborn
- Learning Guide 6: Postpartum Assessment (History and Physical Examination) and Care
- Learning Guide 7: Newborn Resuscitation
- Learning Guide 9: Bimanual Compression of the Uterus
- Learning Guide 10: Compression of Abdominal Aorta
- Learning Guide 11: Repair of Cervical Tears

The learning guide contains the steps or tasks relevant to each skill/procedure, and correspond to the information presented in the applicable chapters/annexes of the reference manual for the course.

- Initially, participants can follow the learning guide as the trainer demonstrates the steps or tasks for a particular procedure.

- Subsequently, during classroom and clinic practice sessions, it serves as a step-by-step guide for the participant as she/he performs the skills. During this phase, participants work in groups of two or three, using the learning guides to rate each other’s performance or prompt each other as necessary. The clinical trainer(s) will provide guidance to each group to ensure that learning is progressing and that participants are following the steps outlined in the learning guides.
Because the learning guides are used to help in developing skills, it is important that the rating (scoring) be done carefully and as objectively as possible. The participant’s performance of each step is rated on a three-point scale as follows:

<table>
<thead>
<tr>
<th></th>
<th>Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Competently Performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently</td>
</tr>
<tr>
<td>3</td>
<td>Proficiently Performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)</td>
</tr>
</tbody>
</table>

**USING THE CHECKLIST**

There are eleven checklists for the course:

- Checklist 1: Assessment of the Woman in Labor
- Checklist 2: Assisting Normal Birth
- Checklist 3: Episiotomy and Repair
- Checklist 4: Repair of 1st and 2nd Degree Vaginal and Perineal Tears
- Checklist 5: Assessment of the Newborn
- Checklist 6: Postpartum Assessment (History and Physical Examination) and Care
- Checklist 7: Newborn Resuscitation
- Checklist 8: Manual Removal of Placenta
- Checklist 9: Bimanual Compression of the Uterus
- Checklist 10: Compression of Abdominal Aorta
- Checklist 11: Repair of Cervical Tears

The checklist is based on the information provided in the learning guide. Unlike the learning guide, which is quite detailed, the checklist focuses on the key steps in the entire process.

*Using the Checklist for Practice*

As the participant progresses through the course and gains experience, dependence on the detailed learning guide decreases and the checklist may be used in its place. The checklist can also be used by the
Using the Checklist for Evaluation

This checklist, which the participant uses for practice, is the same as the checklist that the clinical trainer will use to evaluate the participant’s performance in providing basic childbirth, postpartum, and newborn care at the end of the course.

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

In determining whether the participant is qualified, the trainer(s) will observe and rate the participant’s performance on each step/task of a skill or procedure. The participant must be rated as “Satisfactory” for each step/task in the checklist to be assessed as qualified. The rating scale used is described below:

| Satisfactory: | Performs the step or task according to the standard procedure or guidelines |
| Unsatisfactory: | Unable to perform the step or task according to the standard procedure or guidelines |
| Not Observed: | Step or task not performed by participant during evaluation by trainer |
Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted.

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

3. **Proficiently Performed**: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary).

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Greet the woman respectfully and with kindness.</td>
<td></td>
</tr>
<tr>
<td>3. Tell the woman (and her support person) what is going to be done, listen to her attentively, and respond to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Provide continual emotional support and reassurance, as possible.</td>
<td></td>
</tr>
<tr>
<td>HISTORY (Ask the following questions if the information is not available on the woman’s ANC record)</td>
<td></td>
</tr>
<tr>
<td>Personal Information</td>
<td></td>
</tr>
<tr>
<td>1. What is your name, age, address, and phone number?</td>
<td></td>
</tr>
<tr>
<td>- If the woman is less than 20 years of age, determine the circumstances surrounding the pregnancy and rule out an abusive or unsafe relationship and barriers to care.</td>
<td></td>
</tr>
<tr>
<td>2. How many previous pregnancies and births have you had?</td>
<td></td>
</tr>
<tr>
<td>3. Do you have a complication readiness plan if there are any problems during labor or childbirth?</td>
<td></td>
</tr>
<tr>
<td>- If Yes, confirm that arrangements have been made for all essential components of complication readiness.</td>
<td></td>
</tr>
<tr>
<td>- If No, make arrangements for all essential components of complication readiness.</td>
<td></td>
</tr>
</tbody>
</table>
### LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Are you having a particular problem at present? If Yes, find out what the</td>
<td></td>
</tr>
<tr>
<td>problem is and ask the following additional questions:</td>
<td></td>
</tr>
<tr>
<td>• When did the problem first start?</td>
<td></td>
</tr>
<tr>
<td>• Did it occur suddenly or develop gradually?</td>
<td></td>
</tr>
<tr>
<td>• When and how often does the problem occur?</td>
<td></td>
</tr>
<tr>
<td>• What may have caused the problem?</td>
<td></td>
</tr>
<tr>
<td>• Did anything unusual occur before it started?</td>
<td></td>
</tr>
<tr>
<td>• How does the problem affect you?</td>
<td></td>
</tr>
<tr>
<td>• Are you eating, sleeping, and doing other things normally?</td>
<td></td>
</tr>
<tr>
<td>• Has the problem become more severe?</td>
<td></td>
</tr>
<tr>
<td>• Are there other signs and conditions related to the problem? If Yes, ask</td>
<td></td>
</tr>
<tr>
<td>what they are.</td>
<td></td>
</tr>
<tr>
<td>• Have you received treatment for the problem? If Yes, ask who provided</td>
<td></td>
</tr>
<tr>
<td>the treatment, what it involved, and whether it helped.</td>
<td></td>
</tr>
<tr>
<td>5. Have you received care from another caregiver? If Yes, ask the following</td>
<td></td>
</tr>
<tr>
<td>additional questions:</td>
<td></td>
</tr>
<tr>
<td>• Who provided the care?</td>
<td></td>
</tr>
<tr>
<td>• Why did you seek care from another caregiver?</td>
<td></td>
</tr>
<tr>
<td>• What did the care involve?</td>
<td></td>
</tr>
<tr>
<td>• What was the outcome of this care?</td>
<td></td>
</tr>
</tbody>
</table>

### Estimated Date of Childbirth/Menstrual History

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. When is your baby due?</td>
<td></td>
</tr>
<tr>
<td>• If she does not know, estimate gestational age using onset of signs and</td>
<td></td>
</tr>
<tr>
<td>symptoms of pregnancy or first day of last menstrual period.</td>
<td></td>
</tr>
<tr>
<td>• If she does know, but is less than 37 weeks gestation and labor has</td>
<td></td>
</tr>
<tr>
<td>started, conduct a rapid initial assessment and manage according to</td>
<td></td>
</tr>
<tr>
<td>findings.</td>
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</table>

### Present Pregnancy

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Did you receive antenatal care during this pregnancy?</td>
<td></td>
</tr>
<tr>
<td>• If Yes, ask who provided antenatal care, how many visits, and what was included.</td>
<td></td>
</tr>
<tr>
<td>8. Have you had any (other) problems during this pregnancy? If yes, follow-up questions (see item 4 above).</td>
<td></td>
</tr>
</tbody>
</table>

### Present Labor/Childbirth

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Have your membranes ruptured/waters broken?</td>
<td></td>
</tr>
<tr>
<td>• If Yes, ask when, what color the fluid was, and whether it smelled foul/bad.</td>
<td></td>
</tr>
<tr>
<td>10. Have regular contractions started?</td>
<td></td>
</tr>
<tr>
<td>• If No, assess the woman for false labor.</td>
<td></td>
</tr>
<tr>
<td>• If Yes, ask when they began.</td>
<td></td>
</tr>
<tr>
<td>11. How often are you having contractions and how long does each one last?</td>
<td></td>
</tr>
<tr>
<td>12. Have you felt the baby move in the past 24 hours?</td>
<td></td>
</tr>
<tr>
<td>13. Have you taken any alcohol, drugs, herbs, or other preparations in the last 24 hours?</td>
<td></td>
</tr>
<tr>
<td>14. When did you last eat or drink?</td>
<td></td>
</tr>
</tbody>
</table>
### Obstetric History

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Have you had a cesarean section, ruptured uterus, or any surgery to the uterus during a previous childbirth?</td>
<td></td>
</tr>
<tr>
<td>16. Have you had any other complications during a previous pregnancy, childbirth, or postpartum/newborn period (e.g., convulsions [pre-eclampsia/eclampsia] during previous pregnancy, extensive tears [third- or fourth-degree] during previous births, previous stillbirths, preterm or low birthweight babies, babies who died before one month of age)?</td>
<td></td>
</tr>
<tr>
<td>- If Yes, obtain additional information about the particular complication(s).</td>
<td></td>
</tr>
<tr>
<td>17. Have you had any previous problems breastfeeding?</td>
<td></td>
</tr>
</tbody>
</table>

### Medical History

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Do you have any allergies?</td>
<td></td>
</tr>
<tr>
<td>19. Have you been tested for HIV? If Yes, ask whether the result was positive.</td>
<td></td>
</tr>
<tr>
<td>20. Have you had anemia recently (within last three months)? If Yes, obtain additional information about signs and symptoms and possible cause.</td>
<td></td>
</tr>
<tr>
<td>21. Have you been tested for syphilis? If Yes, ask whether the result was positive and if and when and with what she was treated.</td>
<td></td>
</tr>
<tr>
<td>22. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or other serious chronic diseases?</td>
<td></td>
</tr>
<tr>
<td>23. Have you ever been in hospital or had surgery/an operation?</td>
<td></td>
</tr>
<tr>
<td>24. Are you taking any drugs/medications (including traditions/local preparations, herbal remedies, over-the-counter drugs, vitamins, or dietary supplements)?</td>
<td></td>
</tr>
<tr>
<td>25. Have you had a complete series of five tetanus toxoid (TT) immunizations? If Yes, find out if it has been less than 10 years since the woman’s last booster.</td>
<td></td>
</tr>
</tbody>
</table>

### PHYSICAL EXAMINATION

#### Assessment of General Well-Being

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Observe gait and movements, and behavior and vocalizations.</td>
<td></td>
</tr>
<tr>
<td>- If not normal for the woman’s culture, ask if she:</td>
<td></td>
</tr>
<tr>
<td>- has been without food or fluids for a prolonged period;</td>
<td></td>
</tr>
<tr>
<td>- has been taking drugs, herbs, etc.;</td>
<td></td>
</tr>
<tr>
<td>- has had an injury;</td>
<td></td>
</tr>
<tr>
<td>- is in the middle of a contraction.</td>
<td></td>
</tr>
<tr>
<td>2. Check skin, noting lesions or bruises.</td>
<td></td>
</tr>
<tr>
<td>3. Check conjunctiva for pallor.</td>
<td></td>
</tr>
</tbody>
</table>

#### Vital Signs Measurements

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have the woman remain seated or lying down with knees slightly bent, ensuring that she is comfortable and relaxed.</td>
<td></td>
</tr>
<tr>
<td>5. Observe breathing, noting gasping, wheezing, or rales.</td>
<td></td>
</tr>
<tr>
<td>6. Measure blood pressure, temperature, and pulse.</td>
<td></td>
</tr>
</tbody>
</table>

#### Visual Inspection of Breasts (This part of the examination should only be performed if the woman is in the latent [or early active] phase of the first stage of labor and is not in acute distress.)
<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Explain to the woman the next steps in the physical examination and obtain her consent to proceed.</td>
<td></td>
</tr>
<tr>
<td>8. Ask the woman to empty her bladder.</td>
<td></td>
</tr>
<tr>
<td>9. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>10. Ask the woman to uncover her body from the waist up, and have her remain seated with her arms at her sides.</td>
<td></td>
</tr>
<tr>
<td>11. Check the contours and skin of the breasts, noting dimpling or visible lumps, scaliness, thickening, redness, lesions, sores, and scars.</td>
<td></td>
</tr>
</tbody>
</table>
| 12. Check the nipples, noting any abnormal discharge, and inversion of nipples:  
  - If nipples appear inverted, test for protactility by placing the thumb and fingers on either side of areola and gently squeezing;  
  - If the nipple goes in when it is gently squeezed, it is inverted. |       |
| **Abdominal Examination** |       |
| 13. Ask the woman to uncover her stomach. |       |
| 14. Have her lie on her back with her knees slightly bent. |       |
| 15. Check the surface of the abdomen:  
  - If there is a scar ask if it is from a cesarean section or other uterine surgery. |       |
| 16. Check the shape of the uterus, noting if it is longer horizontally than vertically. |       |
| **Fundal Height** |       |
| 17. Measure fundal height:  
  - Place zero line of tape measure on the upper edge of symphysis pubis;  
  - Stretch tape measure across the contour of abdomen to top of fundus;  
  - Use the abdominal midline as line of measurement. |       |
| **Lie and Presentation** |       |
| 18. Carry out fundal palpation:  
  - Make sure hands are clean and warm;  
  - Stand at the woman’s side, facing her head;  
  - Place both hands on the sides of the fundus;  
  - Make sure woman is not having a contraction;  
  - Apply gentle but firm pressure to assess consistency and mobility of the fetal part:  
    - the buttocks feel softer and more irregular than the head and cannot be moved independently of body;  
    - the head feels harder than the buttocks and can be moved back and forth with both hands. |       |
LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR  
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Carry out lateral palpation:</td>
<td></td>
</tr>
<tr>
<td>• Move hands smoothly down sides of uterus to feel for fetal back:</td>
<td></td>
</tr>
<tr>
<td>- the back feels firm and smooth in contrast to the small parts, which</td>
<td></td>
</tr>
<tr>
<td>will feel knobby and easily moveable;</td>
<td></td>
</tr>
<tr>
<td>• Keep dominant hand steady against the side of uterus while using palm</td>
<td></td>
</tr>
<tr>
<td>of other hand to apply gentle but deep pressure to explore opposite</td>
<td></td>
</tr>
<tr>
<td>side of uterus;</td>
<td></td>
</tr>
<tr>
<td>• Repeat procedure on other side of uterus.</td>
<td></td>
</tr>
<tr>
<td>20. Carry out pelvic palpation:</td>
<td></td>
</tr>
<tr>
<td>• Turn and face the woman’s feet (the woman’s knees should already be</td>
<td></td>
</tr>
<tr>
<td>bent slightly to relax abdominal muscles);</td>
<td></td>
</tr>
<tr>
<td>• Place hands on either side of uterus with palms below the level of</td>
<td></td>
</tr>
<tr>
<td>the umbilicus and fingers pointing to symphysis pubis;</td>
<td></td>
</tr>
<tr>
<td>• Grasp fetal part snugly between hands:</td>
<td></td>
</tr>
<tr>
<td>- If fetal part is above symphysis pubis, feel shape, size,</td>
<td></td>
</tr>
<tr>
<td>consistency and mobility;</td>
<td></td>
</tr>
<tr>
<td>- If head is presenting, a hard mass with a distinctive round</td>
<td></td>
</tr>
<tr>
<td>surface will be felt;</td>
<td></td>
</tr>
<tr>
<td>- Observe the woman’s face for signs of pain/tenderness during</td>
<td></td>
</tr>
<tr>
<td>palpation.</td>
<td></td>
</tr>
<tr>
<td>Descent</td>
<td></td>
</tr>
<tr>
<td>21. Feel the head above symphysis pubis with right hand.</td>
<td></td>
</tr>
<tr>
<td>22. Using abdominal palpation, assess descent in terms of fifths of head</td>
<td></td>
</tr>
<tr>
<td>palpable above symphysis pubis:</td>
<td></td>
</tr>
<tr>
<td>• Locate anterior shoulder of fetus with one hand;</td>
<td></td>
</tr>
<tr>
<td>• Place fingers of other hand horizontally on the woman’s abdomen</td>
<td></td>
</tr>
<tr>
<td>above the symphysis pubis;</td>
<td></td>
</tr>
<tr>
<td>• Calculate the number of finger-breadths of head above the symphysis</td>
<td></td>
</tr>
<tr>
<td>pubis:</td>
<td></td>
</tr>
<tr>
<td>- A head that is entirely above the symphysis pubis is five-fifths</td>
<td></td>
</tr>
<tr>
<td>(5/5) palpable;</td>
<td></td>
</tr>
<tr>
<td>- A head that is entirely below the symphysis pubis is zero-fifths</td>
<td></td>
</tr>
<tr>
<td>(0/5) palpable.</td>
<td></td>
</tr>
<tr>
<td>Fetal Heart Rate</td>
<td></td>
</tr>
<tr>
<td>23. Between contractions, place fetal stethoscope (fetoscope) on the</td>
<td></td>
</tr>
<tr>
<td>woman’s abdomen at right angles to it (on same side that you</td>
<td></td>
</tr>
<tr>
<td>palpated fetal back.</td>
<td></td>
</tr>
<tr>
<td>24. Listen to the fetal heart rate:</td>
<td></td>
</tr>
<tr>
<td>• Place your ear in close, firm contact with fetal stethoscope;</td>
<td></td>
</tr>
<tr>
<td>• Move fetal stethoscope around to where fetal heart is heard most</td>
<td></td>
</tr>
<tr>
<td>clearly;</td>
<td></td>
</tr>
<tr>
<td>• Remove hands from fetal stethoscope and listen to fetal heart;</td>
<td></td>
</tr>
<tr>
<td>• Listen for a full minute, counting beats against second hand of</td>
<td></td>
</tr>
<tr>
<td>clock/watch;</td>
<td></td>
</tr>
<tr>
<td>• Feel the woman’s pulse at wrist, simultaneously, to ensure that</td>
<td></td>
</tr>
<tr>
<td>fetal heart tones, and not maternal pulse, are being measured.</td>
<td></td>
</tr>
</tbody>
</table>
### LEARNING GUIDE FOR ASSESSMENT OF THE WOMAN IN LABOR

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraction</strong>s</td>
<td></td>
</tr>
<tr>
<td>25. Place a hand on the woman’s abdomen and palpate contractions from beginning of a contraction to end of contraction and on to beginning of next contraction.</td>
<td></td>
</tr>
</tbody>
</table>
| 26. Use a clock or watch to calculate frequency and duration of contractions:  
  - Frequency is the number of contractions in 10 minutes;  
  - Duration of contractions is the number of seconds from the beginning to the end of a contraction. | | |
| **Genital Examination** | | |
| 27. Ask the woman to uncover her genital area, and cover or drape her to preserve privacy and respect modesty. | | |
| 28. Ask the woman to separate her legs while continuing to bend her knees slightly. | | |
| 29. Turn on light and direct it toward genital area. | | |
| 30. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry. | | |
| 31. Put new examination or high-level disinfected gloves on both hands. | | |
| 32. Touch the inside of the woman’s thigh before touching any part of her genital area. | | |
| 33. Separate labia majora with two fingers, check labia minora, clitoris, urethral opening and vaginal opening, noting anything protruding from the vagina, signs of female genital cutting, sores, ulcers, warts, nits, lice, blood or foul-smelling discharge, urine, or stool coming from vaginal opening. | | |
| 34. Palpate the labia minora:  
  - Look for swelling, discharge, tenderness, ulcers, and fistulas;  
  - Feel for irregularities and nodules. | | |
| 35. Look at perineum, noting scars, lesions, inflammation, or cracks in skin. | | |
| 36. Separate labia with gloved hand and observe introitus for visible bulging of membranes or fetal head/parts. | | |
| **Vaginal Examination** | | |
| 37. Gently insert index and middle fingers of exam hand into vagina, maintaining light downward pressure, moving fingers toward cervix:  
  - Palpate mucosa and structural integrity along vaginal walls;  
  - Insert middle and index fingers into open cervix and gently open them to cervical rim. (The distance between the outer aspect of both fingers is the dilatation in centimeters.) | | |
| 38. Assess condition of amniotic fluid and membranes:  
  - With middle and index fingers still inserted into cervix, evaluate if bag of water is intact or ruptured:  
    - presence of a smooth membrane palpated over presenting part indicates presence of intact bag of waters;  
    - if bag of waters is ruptured, presenting part will be felt directly. | | |
<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td>39. Assess presentation and position of fetus and molding:</td>
<td></td>
</tr>
<tr>
<td>• With index fingers still inserted into cervix:</td>
<td></td>
</tr>
<tr>
<td>- Feel fetal skull to confirm cephalic presentation and assess molding,</td>
<td></td>
</tr>
<tr>
<td>noting whether bones touch or overlap;</td>
<td></td>
</tr>
<tr>
<td>- Withdraw examination hand and inspect glove for blood and/or</td>
<td></td>
</tr>
<tr>
<td>meconium.</td>
<td></td>
</tr>
<tr>
<td>40. Immerse both gloved hands briefly in a container filled with 0.5%</td>
<td></td>
</tr>
<tr>
<td>chlorine solution; then remove gloves by turning them inside out:</td>
<td></td>
</tr>
<tr>
<td>• If disposing of gloves (examination gloves and surgical gloves that</td>
<td></td>
</tr>
<tr>
<td>will not be reused), place in a plastic bag or leakproof, covered</td>
<td></td>
</tr>
<tr>
<td>waste container;</td>
<td></td>
</tr>
<tr>
<td>• If reusing surgical gloves, submerge in 0.5% chlorine solution for 20</td>
<td></td>
</tr>
<tr>
<td>minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>41. Wash hands thoroughly with soap and water and dry with a clean, dry</td>
<td></td>
</tr>
<tr>
<td>cloth or air dry.</td>
<td></td>
</tr>
</tbody>
</table>
CHECKLIST 1: ASSESSMENT OF THE WOMAN IN LABOR
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

PARTICIPANT ____________________________ Date Observed ________________

<table>
<thead>
<tr>
<th>CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Some of the following steps/tasks should be performed simultaneously.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Greet the woman respectfully and with kindness.</td>
<td></td>
</tr>
<tr>
<td>3. Tell the woman (and her support person) what is going to be done, listen to her attentively, and respond to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Provide continual emotional support and reassurance, as possible.</td>
<td></td>
</tr>
</tbody>
</table>

SKILL/ACTIVITY PERFORMED SATISFACTORYLY

HISTORY (Ask the following questions if the information is not available on the woman’s ANC record)

Personal Information
1. What is your name, age, address, and phone number?
2. How many previous pregnancies and births have you had?
3. Do you have a complication readiness plan if there are any problems during labor or childbirth?
4. Are you having a particular problem at present?
5. Have you received care from another caregiver?

Estimated Date of Childbirth/Menstrual History
6. When is your baby due?

Present Pregnancy
7. Did you receive antenatal care during this pregnancy?
8. Have you had any (other) problems during this pregnancy?

Present Labor/Childbirth
9. Have your membranes ruptured/waters broken?
10. Have regular contractions started?
11. How often are you having contractions and how long does each one last?
## CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Have you felt the baby move in the past 24 hours?</td>
<td></td>
</tr>
<tr>
<td>13. Have you taken any alcohol, drugs, herbs, or other preparations in the last 24 hours?</td>
<td></td>
</tr>
<tr>
<td>14. When did you last eat or drink?</td>
<td></td>
</tr>
</tbody>
</table>

### Obstetric History

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Have you had a cesarean section, ruptured uterus, or any surgery to the uterus during a previous childbirth?</td>
<td></td>
</tr>
<tr>
<td>16. Have you had any other complications during a previous pregnancy, childbirth, or postpartum/newborn period?</td>
<td></td>
</tr>
<tr>
<td>17. Have you had any previous problems breastfeeding?</td>
<td></td>
</tr>
</tbody>
</table>

### Medical History

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Do you have any allergies?</td>
<td></td>
</tr>
<tr>
<td>19. Have you been tested for HIV?</td>
<td></td>
</tr>
<tr>
<td>20. Have you had anemia recently?</td>
<td></td>
</tr>
<tr>
<td>21. Have you been tested for syphilis?</td>
<td></td>
</tr>
<tr>
<td>22. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or other serious chronic disease?</td>
<td></td>
</tr>
<tr>
<td>23. Have you ever been in hospital or had surgery/an operation?</td>
<td></td>
</tr>
<tr>
<td>24. Are you taking any drugs/medications?</td>
<td></td>
</tr>
<tr>
<td>25. Have you had a complete series of five tetanus toxoid (TT) immunizations?</td>
<td></td>
</tr>
</tbody>
</table>

### SKILL/ACTIVITY PERFORMED SATISFACTORILY

## PHYSICAL EXAMINATION

### Assessment of General Well-Being

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Observe gait and movements, and behavior and vocalizations.</td>
<td></td>
</tr>
<tr>
<td>2. Check skin, noting lesions or bruises.</td>
<td></td>
</tr>
<tr>
<td>3. Check conjunctiva for pallor.</td>
<td></td>
</tr>
</tbody>
</table>

### Vital Signs Measurements

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have the woman remain seated or lying down, ensuring that she is comfortable and relaxed, and observe breathing and measure blood pressure, temperature, and pulse.</td>
<td></td>
</tr>
</tbody>
</table>

### Visual Inspection of Breasts (This part of the examination should only be performed if the woman is in the latent [or early active] phase of the first stage of labor and is not in acute distress.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Explain to the woman the next steps in the physical examination and obtain her consent to proceed.</td>
<td></td>
</tr>
<tr>
<td>6. Ask the woman to empty her bladder.</td>
<td></td>
</tr>
<tr>
<td>7. Wash hands thoroughly.</td>
<td></td>
</tr>
<tr>
<td>8. Ask the woman to uncover her body from the waist up, have her remain seated with her arms at her sides, and check her breasts, noting any abnormalities.</td>
<td></td>
</tr>
</tbody>
</table>
### CHECKLIST FOR ASSESSMENT OF THE WOMAN IN LABOR

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal Examination</strong></td>
<td></td>
</tr>
<tr>
<td>9. Ask the woman to uncover her stomach and lie on her back with her knees</td>
<td></td>
</tr>
<tr>
<td>slightly bent.</td>
<td></td>
</tr>
<tr>
<td>10. Check the surface of the abdomen and the shape of the uterus, and measure fundal height.</td>
<td></td>
</tr>
<tr>
<td>11. Make sure hands are clean and warm.</td>
<td></td>
</tr>
<tr>
<td>12. Stand at the woman’s side, facing her head, make sure she is not having a contraction, and determine fetal lie and presentation.</td>
<td></td>
</tr>
<tr>
<td>13. Determine descent through abdominal palpation.</td>
<td></td>
</tr>
<tr>
<td>14. Between contractions, listen to fetal heart for a full minute.</td>
<td></td>
</tr>
<tr>
<td>15. Palpate contractions from beginning of a contraction to end of contraction and on to beginning of next contraction.</td>
<td></td>
</tr>
<tr>
<td><strong>Genital and Vaginal Examination</strong></td>
<td></td>
</tr>
<tr>
<td>16. Ask the woman to uncover her genital area, cover or drape her to preserve privacy and respect modesty, and ask her to separate her legs while keeping her knees slightly bent.</td>
<td></td>
</tr>
<tr>
<td>17. Turn on light and direct it toward genital area.</td>
<td></td>
</tr>
<tr>
<td>18. Wash hands thoroughly and put new examination or high-level disinfected gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>19. Inspect the labia, clitoris, and perineum and palpate the labia minora, noting any abnormalities.</td>
<td></td>
</tr>
<tr>
<td>20. Assess dilatation of cervix, membranes, and presenting part.</td>
<td></td>
</tr>
<tr>
<td>21. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:</td>
<td></td>
</tr>
<tr>
<td>• If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;</td>
<td></td>
</tr>
<tr>
<td>• If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>22. Wash hands thoroughly.</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
LEARNING GUIDE 2: ASSISTING NORMAL BIRTH
(To be completed by Participants)

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

1. Needs Improvement: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. Proficiently Performed: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

LEARNING GUIDE FOR ASSISTING NORMAL BIRTH
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Encourage the woman to adopt the position of choice and continue spontaneous bearing down efforts.</td>
<td></td>
</tr>
<tr>
<td>3. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Provide continual emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td>5. Put on personal protective barriers.</td>
<td></td>
</tr>
<tr>
<td>ASSISTING THE BIRTH</td>
<td></td>
</tr>
<tr>
<td>1. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>2. Put high-level disinfected or sterile surgical gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>3. Place one sterile drape from delivery pack under the woman’s buttocks, one over her abdomen, and use the third drape to receive the baby.</td>
<td></td>
</tr>
<tr>
<td>Birth of the Head</td>
<td></td>
</tr>
<tr>
<td>4. Clean the woman’s perineum with a cloth or compress, wet with antiseptic solution or soap and water, wiping from front to back.</td>
<td></td>
</tr>
<tr>
<td>5. Ask the woman to pant or give only small pushes with contractions as the baby’s head is born.</td>
<td></td>
</tr>
<tr>
<td>6. As the pressure of the head thins out the perineum, control the birth of the head with the fingers of one hand, applying a firm, gentle downward (but not restrictive) pressure to maintain flexion, allow natural stretching of the perineal tissue, and prevent tears.</td>
<td></td>
</tr>
<tr>
<td>7. Use the other hand to support the perineum using a compress or cloth, and allow the head to crown slowly and be born spontaneously.</td>
<td></td>
</tr>
<tr>
<td>8. Wipe the mucus (and membranes, if necessary) from the baby’s mouth and nose with a clean cloth.</td>
<td></td>
</tr>
</tbody>
</table>
LEARNING GUIDE FOR ASSISTING NORMAL BIRTH
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</thead>
</table>
| 9. Feel around the baby’s neck to ensure the umbilical cord is not around the neck:  
  - If the cord is around the neck but is loose, slip it over the baby’s head;  
  - If the cord is loose but cannot reach over the baby’s head, slip it backwards over the shoulders;  
  - If the cord is tight around the neck, clamp the cord with two artery forceps, placed 3 cm apart, and cut the cord between the two clamps. |   |

Completing the Birth

10. Allow the baby’s head to turn spontaneously.

11. After the head turns, place a hand on each side of the baby’s head, over the ears, and apply slow, gentle pressure downward (toward the mother’s spine) and outward until the anterior shoulder slips under the pubic bone.

12. When the arm fold is seen, guide the head upward toward the mother’s abdomen as the posterior shoulder is born over the perineum.

13. Lift the baby’s head anteriorly to deliver the posterior shoulder.

14. Move the topmost hand from the head to support the rest of the baby’s body as it slides out.

15. Place the baby on the mother’s abdomen (if the mother is unable to hold the baby, ask her birth companion or an assistant to care for the baby).

16. Thoroughly dry the baby and cover with a clean, dry cloth:  
  - Assess breathing while drying the baby and if s/he does not breath immediately, begin resuscitative measures (see Learning Guide 7: Newborn Resuscitation)

17. Clamp and cut the umbilical cord:  
  - Tie the cord at about 3 cm and 5 cm from the umbilicus;  
  - Cut the cord between the ties.

18. Ensure the baby is kept warm and in skin-to-skin contact on the mother’s chest, and cover the baby with a cloth or blanket, including the head.

19. Palpate the mother’s abdomen to rule out the presence of additional baby(ies) and proceed with active management of the third stage.

ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR

1. Give oxytocin 10 units IM.

2. Clamp the cord close to the perineum and hold the clamped cord and the end of the clamp in one hand.

3. Place the other hand just above the pubic bone and gently apply counter traction (push upwards on the uterus) to stabilize the uterus and prevent uterine inversion.

4. Keep light tension on the cord and wait for a strong uterine contraction (two to three minutes).

5. When the uterus becomes rounded or the cord lengthens, very gently pull downward on the cord to deliver the placenta.

6. Continue to apply counter traction with the other hand.
## LEARNING GUIDE FOR ASSISTING NORMAL BIRTH
(Some of the following steps/tasks should be performed simultaneously.)

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</thead>
<tbody>
<tr>
<td>7. If the placenta does not descend during 30 to 40 seconds of controlled cord traction, relax the tension and repeat with the next contraction.</td>
<td></td>
</tr>
<tr>
<td>8. As the placenta delivers, hold it with both hands and twist slowly so the membranes are expelled intact: • If the membranes do not slip out spontaneously, gently twist them into a rope and move up and down to assist separation without tearing them.</td>
<td></td>
</tr>
<tr>
<td>9. Slowly pull to complete delivery.</td>
<td></td>
</tr>
<tr>
<td>10. Massage the uterus if it is not well contracted.</td>
<td></td>
</tr>
</tbody>
</table>

### Examination of Placenta

11. Hold placenta in palms of hands, with maternal side facing upwards, and check whether all lobules are present and fit together.

12. Hold cord with one hand and allow placenta and membranes to hang down: • Insert fingers of other hand inside membranes, with fingers spread out, and inspect membranes for completeness; • Note position of cord insertion.

13. Inspect cut end of cord for presence of two arteries and one vein.

### Examination of Vagina and Perineum for Tears

14. Gently separate the labia and inspect lower vagina for lacerations/tears.

15. Inspect the perineum for lacerations/tears.

16. Gently cleanse the perineum with warm water and a clean cloth.

17. Apply a clean pad or cloth to the vulva.

### POST-PROCEDURE TASKS

1. Place any contaminated items (e.g., swabs) in a plastic bag or leakproof, covered waste container.

2. Decontaminate instruments by placing in a container filled with 0.5% chlorine solution for 10 minutes.

3. Decontaminate needles and or syringes: • If disposing of needle and syringe, hold the needle under the surface of a 0.5% chlorine solution, fill the syringe, and push out (flush) three times; then place in a puncture-resistant sharps container; • If reusing the syringe (and needle), fill syringe with needle attached with 0.5% chlorine solution and soak in chlorine solution for 10 minutes for decontamination.

4. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out: • If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container; • If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.

5. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.
CHECKLIST 2: ASSISTING NORMAL BIRTH
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

| PARTICIPANT ___________________________ | Date Observed _____________ |

### CHECKLIST FOR ASSISTING NORMAL BIRTH
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Encourage the woman to adopt the position of choice and continue spontaneous bearing down efforts.</td>
<td></td>
</tr>
<tr>
<td>3. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Provide continual emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td>5. Put on personal protective barriers.</td>
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</tr>
</tbody>
</table>

### SKILL/ACTIVITY PERFORMED SATISFACTORILY

### ASSISTING THE BIRTH

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wash hands thoroughly, put on high-level disinfected or sterile surgical gloves, and place drapes from the delivery pack on the woman.</td>
<td></td>
</tr>
<tr>
<td>2. Clean the woman’s perineum, and ask her to pant or give only small pushes with contractions.</td>
<td></td>
</tr>
<tr>
<td>3. Control the birth of the head with the fingers of one hand to maintain flexion, allow natural stretching of the perineal tissue, and prevent tears, and use the other hand to support the perineum.</td>
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</tr>
<tr>
<td>4. Wipe the mucus (and membranes, if necessary) from the baby’s mouth and nose.</td>
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</tr>
<tr>
<td>5. Feel around the baby’s neck for the cord and respond appropriately if the cord is present.</td>
<td></td>
</tr>
<tr>
<td>6. Allow the baby’s head to turn spontaneously and, with the hands on either side of the baby’s head, deliver the anterior shoulder.</td>
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</tr>
<tr>
<td>7. When the arm fold is seen, guide the head upward as the posterior shoulder is born over the perineum and lift the baby’s head anteriorly to deliver the posterior shoulder</td>
<td></td>
</tr>
<tr>
<td>8. Support the rest of the baby’s body with one hand as it slides out, and place the baby on the mother’s abdomen.</td>
<td></td>
</tr>
</tbody>
</table>
## CHECKLIST FOR ASSISTING NORMAL BIRTH
(Some of the following steps/tasks should be performed simultaneously.)

9. Thoroughly dry the baby and cover with a clean, dry cloth, and assess breathing. If baby does not breathe immediately, begin resuscitative measures (see **Checklist 7: Newborn Resuscitation**).

10. Clamp and cut the umbilical cord and ensure the baby is kept warm and skin-to-skin contact on the mother’s chest.

11. Palpate the mother’s abdomen to rule out the presence of additional baby(ies) and proceed with active management of the third stage.

### SKILL/ACTIVITY PERFORMED SATISFACTORILY

### ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR

1. Give oxytocin 10 units IM and clamp the cord close to the perineum.

2. Apply counter traction to stabilize the uterus.

3. Keep light tension on the cord and wait for a strong uterine contraction, then very gently pull downward on the cord to deliver the placenta.

4. As the placenta delivers, hold it with both hands and twist slowly so the membranes are expelled intact.

5. Examine the placenta, membranes, and cord.

6. Massage the uterus if it is not well contracted.

7. Examine the lower vagina and perineum for lacerations/tears.

8. Cleanse perineum and apply a pad or cloth to vulva.

### POST-PROCEDURE TASKS

1. Dispose of contaminated items in a plastic bag or leakproof, covered waste container.

2. Decontaminate instruments by placing in a container filled with 0.5% chlorine solution for 10 minutes.

3. Decontaminate needles and or syringes:
   - If disposing of needle and syringe, hold the needle under the surface of a 0.5% chlorine solution, fill the syringe, and push out (flush) three times; then place in a puncture-resistant sharps container;
   - If reusing the syringe (and needle), fill syringe with needle attached with 0.5% chlorine solution and soak in chlorine solution for 10 minutes for decontamination.

4. Immers both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:
   - If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;
   - If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.

5. Wash hands thoroughly.

### SKILL/ACTIVITY PERFORMED SATISFACTORILY
LEARNING GUIDE 3: EPISIOTOMY AND REPAIR
(To be completed by Participants)

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

1. **Needs Improvement:** Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. **Proficiently Performed:** Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

### LEARNING GUIDE FOR EPISIOTOMY AND REPAIR
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Tell the woman what is going to be done and encourage her to ask questions.</td>
<td></td>
</tr>
<tr>
<td>3. Listen to what the woman has to say.</td>
<td></td>
</tr>
<tr>
<td>4. Make sure that the woman has no allergies to lidocaine or related drugs.</td>
<td></td>
</tr>
<tr>
<td>5. Provide emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td><strong>ADMINISTERING LOCAL ANESTHETIC</strong></td>
<td></td>
</tr>
<tr>
<td>1. Cleanse perineum with antiseptic solution.</td>
<td></td>
</tr>
<tr>
<td>2. Draw 10 ml of 0.5% lidocaine into a syringe.</td>
<td></td>
</tr>
<tr>
<td>3. Place two fingers into vagina along proposed incision line.</td>
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</tr>
<tr>
<td>4. Insert needle beneath skin for 4–5 cm following same line.</td>
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<tr>
<td>5. Draw back the plunger of syringe to make sure that needle is not in a blood vessel:</td>
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</tr>
<tr>
<td>• If blood is returned in syringe, remove needle, recheck position carefully, and try again;</td>
<td></td>
</tr>
<tr>
<td>• If no blood is withdrawn, continue as follows.</td>
<td></td>
</tr>
<tr>
<td>6. Inject lidocaine into vaginal mucosa, beneath skin of perineum and deeply into perineal muscle.</td>
<td></td>
</tr>
<tr>
<td>7. Wait two minutes and then pinch incision site with forceps.</td>
<td></td>
</tr>
<tr>
<td>8. If the woman feels the pinch, wait two more minutes and then retest.</td>
<td></td>
</tr>
<tr>
<td><strong>MAKING THE EPISIOTOMY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Wait to perform episiotomy until:</td>
<td></td>
</tr>
<tr>
<td>• perineum is thinned out;</td>
<td></td>
</tr>
<tr>
<td>• 3–4 cm of the baby's head is visible during a contraction.</td>
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</tr>
<tr>
<td>2. Wearing high-level disinfected gloves, insert two fingers into the vagina between the baby’s head and the perineum.</td>
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</tbody>
</table>
**LEARNING GUIDE FOR EPISIOTOMY AND REPAIR**
(Some of the following steps/tasks should be performed simultaneously.)

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<tr>
<th>STEP/TASK</th>
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<tr>
<td>3. Insert open blade of scissors between perineum and two fingers:</td>
<td></td>
</tr>
<tr>
<td>• Cut the perineum about 3–4 cm in a mediolateral direction (45º angle to the midline towards a point midway between ischial tuberosity and anus);</td>
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<tr>
<td>• Cut 2–3 cm up middle of posterior vagina.</td>
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<tr>
<td>4. If birth of head does not follow immediately, apply pressure to episiotomy site between contractions, using a piece of gauze, to minimize bleeding.</td>
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</tr>
<tr>
<td>5. Control birth of head and shoulders to avoid extension of the episiotomy.</td>
<td></td>
</tr>
</tbody>
</table>

**REPAIRING THE EPISIOTOMY**

1. Ask the woman to position her buttocks toward lower end of bed or table (use stirrups if available).
2. Ask an assistant to direct a strong light onto the woman’s perineum.
3. Apply antiseptic solution to area around episiotomy.
4. Using 2-0 suture, insert suture needle just above (1 cm) episiotomy.
5. Use a continuous suture from apex downward to level of vaginal opening.
6. At opening of vagina, bring together cut edges.
7. Bring needle under vaginal opening and out through incision, and tie.
8. Use interrupted sutures to repair perineal muscle, working from top of perineal incision downward.
9. Use interrupted or subcuticular sutures to bring together skin edges.
10. Wash perineal area with antiseptic, pat dry, and place a sterile sanitary pad over the vulva and perineum.

**POST-PROCEDURE TASKS**

1. Dispose of waste materials (e.g., blood-contaminated swabs) in a leakproof container or plastic bag.
2. Decontaminate instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.
3. Decontaminate or dispose of syringe and needle:
   - If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination;
   - If disposing of needle and syringe, flush needle and syringe with 0.5% chlorine solution three times, then place in a puncture proof container.
4. Immerse both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out:
   - If disposing of gloves, place in leakproof container or plastic bag;
   - If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.
5. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.
6. Record procedure on woman’s record.
CHECKLIST 3: EPISIOTOMY AND REPAIR
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “✗” if it is not performed satisfactorily, or N/O if not observed.

**Satisfactory:** Performs the step or task according to the standard procedure or guidelines

**Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines

**Not Observed:** Step or task not performed by participant during evaluation by trainer

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<th>CHECKLIST FOR EPISIOTOMY AND REPAIR</th>
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<td>2. Tell the woman what is going to be done and encourage her to ask questions.</td>
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<td>3. Listen to what the woman has to say.</td>
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<td>4. Make sure that the woman has no allergies to lidocaine or related drugs.</td>
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<td>5. Provide emotional support and reassurance, as feasible.</td>
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<td><strong>SKILL/ACTIVITY PERFORMED SATISFACTORILY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MAKING THE EPISIOTOMY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Clean perineum with antiseptic solution.</td>
<td></td>
</tr>
<tr>
<td>2. Administer local anesthesia.</td>
<td></td>
</tr>
<tr>
<td>3. Wait to perform episiotomy until the perineum is thinned out and the baby’s head is visible during a contraction.</td>
<td></td>
</tr>
<tr>
<td>4. Insert two fingers into the vagina between the baby’s head and the perineum.</td>
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<tr>
<td>5. Insert open blade of scissors between perineum and fingers, and make a cut in a mediolateral direction.</td>
<td></td>
</tr>
<tr>
<td>6. If birth of the head does not follow immediately, apply pressure to episiotomy site between contractions.</td>
<td></td>
</tr>
<tr>
<td>7. Control birth of head and shoulders to avoid extension of the episiotomy.</td>
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</tr>
<tr>
<td><strong>SKILL/ACTIVITY PERFORMED SATISFACTORILY</strong></td>
<td></td>
</tr>
<tr>
<td><strong>REPAIRING THE EPISIOTOMY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Apply antiseptic solution to area around episiotomy.</td>
<td></td>
</tr>
<tr>
<td>2. Use a continuous suture from apex downward to repair vaginal incision.</td>
<td></td>
</tr>
<tr>
<td>3. At opening of vagina, bring together cut edges.</td>
<td></td>
</tr>
<tr>
<td>4. Bring needle under vaginal opening and out through incision, and tie.</td>
<td></td>
</tr>
<tr>
<td>5. Use interrupted sutures to repair perineal muscle, working from top of perineal incision downward.</td>
<td></td>
</tr>
<tr>
<td>6. Use interrupted or subcuticular sutures to bring together skin edges.</td>
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<tr>
<td>STEP/TASK</td>
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<tr>
<td>7. Wash perineal area and cover with a sterile sanitary napkin.</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

### POST-PROCEDURE TASKS

1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.
2. Decontaminate instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.
3. Decontaminate or dispose of syringe and needle:
   - If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination;
   - If disposing of needle and syringe, flush needle and syringe with 0.5% chlorine solution three times, then place in a puncture proof container.
4. Immerse both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out:
   - If disposing of gloves, place in leakproof container or plastic bag;
   - If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.
5. Wash hands thoroughly.
6. Record procedure on woman’s record.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

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<table>
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<tr>
<th>STEP/TASK</th>
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</thead>
</table>

### LEARNING GUIDE FOR REPAIR OF 1ST AND 2ND DEGREE TEARS
(To be completed by *Participants*)

### GETTING READY
1. Prepare the necessary equipment.
2. Tell the woman what is going to be done and encourage her to ask questions.
3. Listen to what the woman has to say.
4. Make sure that the woman has no allergies to lidocaine or related drugs.
5. Provide emotional support and reassurance, as feasible.

### ADMINISTERING LOCAL ANESTHETIC
1. Complete inspection of vagina, perineum, and cervix to rule out additional tears.
2. Cleanse perineum with antiseptic solution.
3. Draw 10 ml of 0.5% lidocaine into a syringe.
4. Insert the needle beneath the vaginal mucosa, beneath the skin of the perineum, and deeply into the perineal muscle along the borders of the tear(s).
5. Draw back the plunger of syringe to make sure that needle is not in a blood vessel:
   - If blood is returned in syringe, remove needle, recheck position carefully, and try again;
   - If no blood is withdrawn, continue as follows.
6. Inject lidocaine into vaginal mucosa, beneath skin of perineum and deeply into perineal muscle.
7. Wait two minutes and then pinch the area with forceps.
8. If the woman feels the pinch, wait two more minutes and then retest.

### REPAIRING THE TEARS
1. Ask an assistant to direct a strong light onto the woman’s perineum.
2. Using 2-0 suture, insert suture needle just above (1 cm) the apex of the vaginal tear.
3. Use a continuous suture from apex downward to level of vaginal opening.
4. At opening of vagina, bring together the torn edges.
## LEARNING GUIDE FOR REPAIR OF 1\textsuperscript{ST} AND 2\textsuperscript{ND} DEGREE TEARS
(Some of the following steps/tasks should be performed simultaneously.)

<table>
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<tr>
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<tbody>
<tr>
<td>5.  Bring needle under vaginal opening and out through the tear and tie.</td>
<td></td>
</tr>
<tr>
<td>6.  Use 2-0 interrupted sutures to repair perineal muscle, working from top of perineal tear downward.</td>
<td></td>
</tr>
<tr>
<td>7.  Use interrupted or subcuticular sutures to bring together skin edges.</td>
<td></td>
</tr>
<tr>
<td>8.  Wash perineal area with antiseptic, pat dry, and place a sterile sanitary pad over the vulva and perineum.</td>
<td></td>
</tr>
<tr>
<td>9.  Gently lay the woman’s legs down together at the same time, and make her comfortable.</td>
<td></td>
</tr>
</tbody>
</table>

## POST-PROCEDURE TASKS

1. Dispose of waste materials (e.g., blood-contaminated swabs) in a leakproof container or plastic bag.

2. Decontaminate instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.

3. Decontaminate or dispose of syringe and needle:
   - If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination;
   - If disposing of needle and syringe, flush needle and syringe with 0.5% chlorine solution three times, then place in a puncture proof container.

4. Immerse both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out:
   - If disposing of gloves, place in leakproof container or plastic bag;
   - If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.

5. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.

6. Record procedure on woman’s record.
CHECKLIST 4: REPAIR OF 1st AND 2nd DEGREE VAGINAL AND PERINEAL TEARS
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “✗” if it is not performed satisfactorily, or N/O if not observed.

**Satisfactory:** Performs the step or task according to the standard procedure or guidelines

**Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines

**Not Observed:** Step or task not performed by participant during evaluation by trainer

| PARTICIPANT ____________________________ | Date Observed ____________________ |

| CHECKLIST FOR REPAIR OF 1st AND 2nd DEGREE TEARS |  |
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<td>1. Prepare the necessary equipment.</td>
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<td>2. Tell the woman what is going to be done and encourage her to ask questions.</td>
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</tr>
<tr>
<td>3. Listen to what the woman has to say.</td>
<td></td>
</tr>
<tr>
<td>4. Make sure that the woman has no allergies to lidocaine or related drugs.</td>
<td></td>
</tr>
<tr>
<td>5. Provide emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td>REPAIRING THE EPSIOTOMY</td>
<td></td>
</tr>
<tr>
<td>1. Cleanse perineum with antiseptic solution.</td>
<td></td>
</tr>
<tr>
<td>2. Administer local anesthetic.</td>
<td></td>
</tr>
<tr>
<td>3. Use a continuous suture from apex of tear downward to repair vaginal tear(s).</td>
<td></td>
</tr>
<tr>
<td>4. At opening of vagina, bring together torn edges.</td>
<td></td>
</tr>
<tr>
<td>5. Bring needle under vaginal opening and out through the tear and tie.</td>
<td></td>
</tr>
<tr>
<td>6. Use interrupted sutures to repair perineal muscle, working from top of perineal tear downward.</td>
<td></td>
</tr>
<tr>
<td>7. Use interrupted or subcuticular sutures to bring together skin edges.</td>
<td></td>
</tr>
<tr>
<td>8. Wash perineal area and cover with a sterile sanitary pad.</td>
<td></td>
</tr>
<tr>
<td>SKILL/ACTIVITY PERFORMED SATISFACTORILY</td>
<td></td>
</tr>
<tr>
<td>POST-PROCEDURE TASKS</td>
<td></td>
</tr>
<tr>
<td>1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.</td>
<td></td>
</tr>
<tr>
<td>2. Decontaminate instruments by placing in a plastic container filled with 0.5% chlorine solution for 10 minutes.</td>
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### CHECKLIST FOR REPAIR OF 1st AND 2nd DEGREE TEARS
(Some of the following steps/tasks should be performed simultaneously.)

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<tr>
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<tbody>
<tr>
<td><strong>3. Decontaminate or dispose of syringe and needle:</strong></td>
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</tr>
<tr>
<td>• If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination;</td>
<td></td>
</tr>
<tr>
<td>• If disposing of needle and syringe, flush needle and syringe with 0.5% chlorine solution three times, then place in a puncture proof container.</td>
<td></td>
</tr>
<tr>
<td><strong>4. Immerse both gloved hands in 0.5% chlorine solution and remove gloves by turning them inside out:</strong></td>
<td></td>
</tr>
<tr>
<td>• If disposing of gloves, place in leakproof container or plastic bag;</td>
<td></td>
</tr>
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<td>• If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate.</td>
<td></td>
</tr>
<tr>
<td><strong>5. Wash hands thoroughly.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>6. Record procedure on woman’s record.</strong></td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
Rate the performance of each step or task observed using the following rating scale:

1. **Needs Improvement**: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. **Proficiently Performed**: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

---

### LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
</table>

#### GETTING READY

1. Prepare the necessary equipment.
2. Tell the mother what you are going to do, encourage her to ask questions, and listen to what she has to say.

#### HISTORY (Ask the following questions if the information is not available on the mother’s/baby’s record.)

**Personal Information (First Visit)**

1. What is your name, address, and phone number?
2. What is the name and sex of your baby?
3. When was your baby born?
4. Do you have access to reliable transportation?
5. What sources of income/financial support do you/your family have?
6. How many times have you been pregnant and how many children have you had?
7. Is your baby having a particular problem at present? If Yes, find out what the problem is and ask the following additional questions:
   - When did the problem first start?
   - Did it occur suddenly or develop gradually?
   - When and how often does the problem occur?
   - What may have caused the problem?
   - Did anything unusual occur before it started?
   - How does the problem affect your baby?
   - Is the baby eating, sleeping, and behaving normally?
   - Has the problem become more severe?
   - Are there other signs and conditions related to the problem? If Yes, ask what they are.
   - Has the baby received treatment for the problem? If Yes, ask who provided the treatment, what it involved, and whether it helped.
LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN
(Some of the following steps/tasks should be performed simultaneously.)

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<tbody>
<tr>
<td>8. Has your baby received care from another caregiver? If Yes, ask the following additional questions:</td>
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</tr>
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<td>• Who provided the care?</td>
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<td>• Why did you seek care from another caregiver?</td>
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<td>• What did the care involve?</td>
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<td>10. Did you have an infection (in the uterus) or fever during labor or birth?</td>
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<td>11. Did your bag of water break more than 18 hours before the birth?</td>
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<td>12. Were there any complications during the birth that may have caused injury to the baby (e.g., shoulder dystocia, breech birth, large baby, vacuum extraction, or forceps)?</td>
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<td>13. Did the baby need resuscitation (help to breathe) at birth?</td>
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<td>14. How much did the baby weigh at birth?</td>
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<td>15. Do you have diabetes?</td>
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<td>16. Have you had any infectious diseases such as hepatitis B, HIV, syphilis, or TB?</td>
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<tr>
<td>18. Has the baby received newborn immunizations such as for polio, TB, and hepatitis B?</td>
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<td>19. Do you feel good about your baby and your ability to take care of her/him? If No, ask the following additional questions:</td>
<td></td>
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<tr>
<td>• Are you feeling sad or overwhelmed?</td>
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</tr>
<tr>
<td>• Are you not sleeping or eating well?</td>
<td></td>
</tr>
<tr>
<td>• Have you been crying or feeling more irritable than usual?</td>
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</tr>
<tr>
<td>20. Is your family adjusting to the baby?</td>
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<td>21. Do you feel that breastfeeding is going well?</td>
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<td>26. When was the last time the baby passed stool? What was the color/consistency?</td>
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<tr>
<td>27. Is your baby having a problem at present? Has he/she had any problem since the last visit? If Yes, ask the follow-up questions under item 7, above.</td>
<td></td>
</tr>
</tbody>
</table>
LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN
(Some of the following steps/tasks should be performed simultaneously.)

<table>
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<tr>
<th>STEP/TASK</th>
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</thead>
<tbody>
<tr>
<td>28. Has your baby received care from another caregiver since the last visit? If Yes, ask the follow-up questions under item 8, above.</td>
<td></td>
</tr>
<tr>
<td>29. Have there been any changes in your address or phone number since the last visit?</td>
<td></td>
</tr>
<tr>
<td>30. Have there been any changes in the baby’s habits or behaviors since the last visit?</td>
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</tr>
<tr>
<td>31. Have you been able to care for the baby as discussed at the last visit?</td>
<td></td>
</tr>
<tr>
<td>32. Has the baby had any reactions or side effects from immunizations, drugs/medications, or any care provided since the last visit?</td>
<td></td>
</tr>
</tbody>
</table>

EXAMINING THE NEWBORN

Assessment of Overall Appearance/Well-Being (Every Visit)

1. Tell the mother what you are going to do, encourage her to ask questions, and listen to what she has to say.
2. Wash hands thoroughly with soap and water and dry with a clean dry cloth or air dry.
3. Wear clean examination gloves if the baby has not been bathed since birth, if the cord is touched, or if there is blood, urine, and/or stool present.
4. Place the baby on a clean, warm surface or examine her/him in the mother’s arms.
5. Weigh the baby.
6. Count the respiratory rate for one full minute and observe whether there is grunting or chest indrawing.
7. Measure the temperature:
   - Shake the thermometer until it is below 35°C;
   - Place the tip of the thermometer high in the apex of the baby’s axilla, and hold the arm continuously against the baby’s side for at least three minutes;
   - Remove the thermometer and read the temperature.
8. Observe color, noting any central cyanosis, jaundice, or pallor.
9. Observe movements and posture, noting any asymmetrical movements, convulsions, spasms, or opisthotonos.
10. Observe level of alertness and muscle tone, noting response to stimuli, arousal from sleep, floppiness or lethargy, and irritability.
11. Observe skin, noting any bruises, cuts, and abrasions.

Head, Face and Mouth, Eyes

12. Examine head, noting size and shape.
13. Examine face, noting facial features and movements.
14. Examine mouth, noting intactness of tongue, gums, and palate:
   - Use the little finger to feel the palate for any subcutaneous cleft.
15. Examine eyes, noting any swelling, redness, or pus draining from them.

Chest, Abdomen and Cord, and External Genitalia
LEARNING GUIDE FOR ASSESSMENT OF THE NEWBORN
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td>16. Examine chest, noting regularity and symmetry of movements.</td>
<td></td>
</tr>
<tr>
<td>17. Examine abdomen and cord, noting shape of abdomen and whether blood is oozing from cord or whether there is any redness or hardened skin around the umbilicus, or an offensive odor.</td>
<td></td>
</tr>
<tr>
<td>18. Examine genitals and anus (the urethral opening is at the end of the penis in term baby boys; term baby girls may have a mucoid or bloody vaginal discharge; genitals in both sexes may be swollen after birth; and patency of anus is confirmed when meconium is passed).</td>
<td></td>
</tr>
</tbody>
</table>

**Back and Limbs**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. Examine back, noting any swelling, lesions, dimples, or hairy patches.</td>
<td></td>
</tr>
<tr>
<td>20. Examine limbs, noting position and appearance, symmetrical movements, swelling over bone, or crying when arm, shoulder, or leg is touched.</td>
<td></td>
</tr>
</tbody>
</table>
| 21. Immerse both gloved hands in 0.5% chlorine solution:  
  • Remove gloves by turning them inside out;  
  • If disposing of gloves, place in leakproof container or plastic bag;  
  • If reusing gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate. |     |
| 22. Wash hands thoroughly with soap and water and dry them with a clean, dry cloth or allow them to air dry. |     |

**Breastfeeding (Every Visit)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Help the woman feel relaxed and confident throughout the observation.</td>
<td></td>
</tr>
</tbody>
</table>
| 24. Look for signs of good positioning:  
  • Mother is comfortable with back and arms supported;  
  • Baby’s head and body are aligned and abdomen turned toward mother;  
  • Baby’s face is facing breast with nose opposite nipple;  
  • Baby’s body is held close to mother;  
  • Baby’s whole body is supported. |     |
| 25. Look for signs of good attachment:  
  • Nipple and areola are drawn into baby’s mouth;  
  • Mouth is wide open;  
  • Lower lip is curled back below base of nipple. |     |
| 26. Look for signs of effective suckling:  
  • Slow deep sucks, often with visible or audible swallowing;  
  • Baby pauses occasionally. |     |
| 27. Look for signs of finishing breastfeed:  
  • Baby should release breast her/himself;  
  • Feeding may vary in length from four to 40 minutes per breast;  
  • Breasts are softer at end of feeding. |     |

**Mother-Baby Bonding (Every Visit)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
</table>
| 28. Look for the following signs of bonding:  
  • Mother appears to enjoy physical contact with baby;  
  • Mother caresses, talks to, and makes eye contact with baby;  
  • Mother responds with active concern to baby’s crying or need for attention. |     |
CHECKLIST 5: ASSESSMENT OF THE NEWBORN
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

PARTICIPANT __________________________ Date Observed ________________

CHECKLIST FOR ASSESSMENT OF THE NEWBORN
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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GETTING READY

1. Prepare the necessary equipment.

2. Tell the mother what you are going to do, encourage her to ask questions, and listen to what she has to say.

SKILL/ACTIVITY PERFORMED SATISFACTORILY

HISTORY (Ask the following questions if the information is not available on the mother’s/baby’s record.)

Personal Information (First Visit)

1. What is your name, address, and phone number?

2. What is the name and sex of your baby?

3. When was your baby born?

4. Do you have access to reliable transportation?

5. What sources of income/financial support do you/your family have?

6. How many times have you been pregnant and how many children have you had?

7. Is your baby having a particular problem at present?

8. Has your baby received care from another caregiver?

The Birth (First Visit)

9. Where was your baby born and who attended the birth?

10. Did you have an infection (in the uterus) or fever during labor or birth?

11. Did your bag of water break more than 18 hours before the birth?

12. Were there any complications during the birth that may have caused injury to the baby?

13. Did the baby need resuscitation (help to breathe) at birth?

14. How much did the baby weigh at birth?
### CHECKLIST FOR ASSESSMENT OF THE NEWBORN
(Some of the following steps/tasks should be performed simultaneously.)

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<tbody>
<tr>
<td><strong>Medical History (First Visit)</strong></td>
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<tr>
<td>15. Do you have diabetes?</td>
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<td><strong>Newborn Period (Every Visit)</strong></td>
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<td>19. Do you feel good about your baby and your ability to take care of her/him?</td>
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<td><strong>Interim History (Return Visits)</strong></td>
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<tr>
<td>27. Is your baby having a problem at present? Has s/he had any problem since the last visit?</td>
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<td>28. Has your baby received care from another caregiver since the last visit?</td>
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### SKILL/ACTIVITY PERFORMED SATISFACTORILY

### EXAMINING THE NEWBORN

#### Assessment of Overall Appearance/Well-Being (Every Visit)

1. Tell the mother what you are going to do, encourage her to ask questions, and listen to what she has to say.
2. Wash hands thoroughly and put on clean examination gloves, if necessary.
3. Place the baby on a clean, warm surface or examine her/him in the mother’s arms.
4. Weigh the baby.
5. Measure respiratory rate and temperature.
### CHECKLIST FOR ASSESSMENT OF THE NEWBORN
*(Some of the following steps/tasks should be performed simultaneously.)*

<table>
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<th>STEP/TASK</th>
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<tbody>
<tr>
<td>6. Observe color, movements and posture, level of alertness and muscle tone, and skin, noting any abnormalities.</td>
<td></td>
</tr>
<tr>
<td>7. Examine head, face and mouth, eyes, noting any abnormalities.</td>
<td></td>
</tr>
<tr>
<td>8. Examine chest, abdomen and cord, and external genitalia, noting any abnormalities.</td>
<td></td>
</tr>
<tr>
<td>9. Examine back and limbs, noting any abnormalities.</td>
<td></td>
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</table>
| 10. Immerse both gloved hands in 0.5% chlorine solution:  
  - Remove gloves by turning them inside out;  
  - If disposing of gloves, place in leakproof container or plastic bag;  
  - If reusing gloves, submerge in 0.5% chlorine solution for 10 minutes to decontaminate. |       |
| 11. Wash hands thoroughly with soap and water and dry them with a clean, dry cloth or allow them to air dry. |       |

#### Breastfeeding (Every Visit)
12. Help the woman feel relaxed and confident throughout the observation.
13. Look for signs of good positioning and attachment
14. Look for signs of effective suckling.
15. Look for signs of finishing breastfeed.

#### Mother-Baby Bonding (Every Visit)
16. Look for signs of bonding.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
LEARNING GUIDE 6: POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE
(To be completed by Participants)

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

1. **Needs Improvement**: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. **Proficiently Performed**: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

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**LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE**
(Some of the following steps/tasks should be performed simultaneously.)

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</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Greet the woman respectfully and with kindness.</td>
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<tr>
<td>3. Tell the woman (and her support person) what is going to be done, listen to her attentively, and respond to her questions and concerns.</td>
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<tr>
<td>4. Provide continual emotional support and reassurance, as possible.</td>
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</tbody>
</table>

**HISTORY (Ask the following questions if the information is not available on the woman’s record.)**

**Personal Information (Every Visit for items followed with an “*”; First Visit for other items)**

1. What is your name and age, and the name of your baby?
   - If the woman is less than 20 years old, determine the circumstances surrounding the pregnancy (e.g., unprotected sex, multiple partners, incest, sexual abuse, rape, sexual exploitation, prostitution, forced marriage, or forced sex).

2. What is your address and your phone number?

3. Do you have access to reliable transportation?

4. What sources of income/financial support do you/your family have?

5. How many times have you been pregnant and how many children have you had?

6. How many of your children are still living?
### LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

(Some of the following steps/tasks should be performed simultaneously.)

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<tbody>
<tr>
<td>7. Are you having a particular problem at present?* If Yes, find out what the problem is and ask the following additional questions:</td>
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</tr>
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<td>• When did the problem first start?</td>
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<td>• Did it occur suddenly or develop gradually?</td>
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<td>• When and how often does the problem occur?</td>
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<tr>
<td>• What was the outcome of this care?</td>
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</table>

**Daily Habits and Lifestyle (Every Visit for items followed with an “*”; First Visit for other items)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</thead>
<tbody>
<tr>
<td>9. Do you work outside the home?</td>
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<tr>
<td>10. Do you walk long distances, carry heavy loads, or do physical labor?</td>
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<tr>
<td>11. Do you get enough sleep/rest?</td>
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<tr>
<td>12. What do you normally eat in a day?</td>
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<tr>
<td>13. Do you eat any substances such as dirt or clay?</td>
<td></td>
</tr>
<tr>
<td>14. Do you smoke, drink alcohol, or use any other possibly harmful substances?</td>
<td></td>
</tr>
<tr>
<td>15. Who do you live with?</td>
<td></td>
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<tr>
<td>16. Has anyone ever prevented you from seeing family or friends, stopped you from leaving your home, or threatened your life?</td>
<td></td>
</tr>
<tr>
<td>17. Have you ever been injured, hit, or forced to have sex by someone?</td>
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<tr>
<td>18. Are you frightened of anyone?</td>
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</tbody>
</table>

**Present Pregnancy and Childbirth (First Visit)**

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<th>STEP/TASK</th>
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<tbody>
<tr>
<td>19. When did you have your baby?</td>
<td></td>
</tr>
<tr>
<td>20. Where did you have your baby and who attended the birth?</td>
<td></td>
</tr>
<tr>
<td>21. Did you have any vaginal bleeding during this pregnancy?</td>
<td></td>
</tr>
<tr>
<td>22. Did you have any complications during this childbirth, such as convulsions (pre-eclampsia/eclampsia), cesarean section or other uterine surgery, vaginal or perineal tears, episiotomy, or defibulation?</td>
<td></td>
</tr>
<tr>
<td>23. Were there any complications with the baby?</td>
<td></td>
</tr>
<tr>
<td>STEP/TASK</td>
<td>CASES</td>
</tr>
<tr>
<td>-----------</td>
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</tbody>
</table>

**Present Postpartum Period (Every Visit)**

24. Have you had any heavy bleeding since you gave birth?

25. What color is your vaginal discharge and how often do you need to change your pad/cloth?

26. Have you had any problems with bowel or bladder function (e.g., incontinence, leakage of urine/feces from vagina, burning on urination, inability to urinate when urge is felt, constipation)?

27. Do you feel good about your baby and your ability to take care of her/him? If No, ask the following additional questions:
   - Are you feeling sad or overwhelmed?
   - Are you not eating or sleeping well?
   - Have you been crying or feeling more irritable than usual?

28. Is your family adjusting to the baby?

29. Do you feel that breastfeeding is going well?

**Previous Postpartum History (First Visit)**

30. Have you breastfed a baby before? If Yes, ask the following additional questions:
   - For how long did you breastfeed your baby(ies)?
   - Did you have any previous problems breastfeeding?

31. Did you have any complications, such as convulsions (pre-eclampsia/eclampsia) or postpartum depression/psychosis following previous births?

**Contraceptive History (First Visit)**

32. How many more children do you plan to have?

33. Have you used a family planning method before? If Yes, ask the following additional questions:
   - Which method(s) have you used?
   - Did you like the method(s) and why?
   - Which method did you like the most and why? (if more than one method used)
   - Would you like information about other methods?

34. Are you going to use family planning in the future?

**Medical History (Every Visit for items followed with an “**”; First Visit for other items)**

35. Do you have any allergies?

36. Have you been tested for HIV? If Yes, ask whether the result was positive.

37. Have you had anemia recently (within the last three months)? If Yes, obtain additional information about signs and symptoms and possible cause.

38. Have you been tested for syphilis? If Yes, ask whether the result was positive and if and when and with what she was treated.
<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or any other chronic illness?</td>
<td></td>
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<tr>
<td>40. Have you ever been in hospital or had surgery/an operation?</td>
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</tr>
<tr>
<td>41. Are you taking any drugs/medications, including traditional/local preparations, herbal remedies, over-the-counter drugs, vitamins, and dietary supplements?*</td>
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</tr>
<tr>
<td>42. Have you had a complete series of five tetanus toxoid immunizations?</td>
<td></td>
</tr>
<tr>
<td>43. When did you have your last booster of tetanus toxoid?</td>
<td></td>
</tr>
<tr>
<td><strong>Interim History (Return Visits)</strong></td>
<td></td>
</tr>
<tr>
<td>44. Do you have a problem at present? If Yes, ask follow-up questions under “Personal Information” item 7, above.</td>
<td></td>
</tr>
<tr>
<td>45. Have you had any problems since your last visit?</td>
<td></td>
</tr>
<tr>
<td>46. Has your address or phone number changed since your last visit?</td>
<td></td>
</tr>
<tr>
<td>47. Have your daily habits or lifestyle (workload, rest, dietary intake) changed since your last visit?</td>
<td></td>
</tr>
<tr>
<td>48. Have you received care from another caregiver since your last visit? If Yes, ask who provided the care, what care was provided, and what the outcome of care was?</td>
<td></td>
</tr>
<tr>
<td>49. Have you taken drugs/medications prescribed and followed the advice/recommendations (plan of care) provided at your last visit?</td>
<td></td>
</tr>
<tr>
<td>50. Have you had any reactions to or side effects from immunizations or drugs/medications given at your last visit?</td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL EXAMINATION**

**Assessment of General Well-Being (Every Visit)**

1. Observe gait and movements, and behavior and facial expressions.
   - If not normal for the woman’s culture, ask if she has:
     - been without food or drink for a prolonged period;
     - been taking drugs/medications;
     - had an injury

2. Observe general cleanliness, noting visible dirt and odor.

3. Check skin, noting lesions and bruises.

4. Check conjunctiva for pallor.

**Vital Signs Measurements (Every Visit)**

5. Have the woman remain seated and relaxed.

6. Measure blood pressure, temperature, and pulse.

**Breast Examination (Every Visit)**

7. Explain the next steps in the physical examination to the woman and obtain her consent to proceed.

8. Ask the woman to empty her bladder.
**Learning Guide for Postpartum Assessment (History and Physical Examination) and Care**

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</thead>
<tbody>
<tr>
<td>9. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>10. Ask the woman to uncover her body from the waist up, and have her lie comfortably on her back.</td>
<td></td>
</tr>
<tr>
<td>11. Check the contours and skin of the breasts, noting dimpling or visible lumps, scaliness, thickening, redness, lesions, sores, and rashes.</td>
<td></td>
</tr>
<tr>
<td>12. Gently palpate breasts, noting tenderness and swelling, and areas that are red and hot.</td>
<td></td>
</tr>
<tr>
<td>13. Check nipples, noting pus or bloody discharge, cracks, fissures, or other lesions, and whether nipples are inverted.</td>
<td></td>
</tr>
</tbody>
</table>

**Abdominal Examination (Every Visit)**

14. Ask the woman to uncover her stomach.
15. Have her lie on her back with her knees slightly bent.
16. Look for old or new incisions on the abdomen:
   - If there is an incision (sutures) from cesarean section or other uterine surgery, look for signs of infection.
17. Gently palpate abdomen between umbilicus and symphysis pubis, noting size and firmness of uterus.
18. Check whether bladder is palpable above the symphysis pubis.

**Leg Examination (Every Visit)**

19. Grasp one of the woman’s feet with one hand and gently but firmly move the foot upwards toward the woman’s knee, and observe whether this causes pain in the calf.
20. Repeat the procedure on the other leg.

**Vaginal Examination (Every Visit)**

21. Ask the woman to uncover her genital area and cover or drape her to preserve privacy and modesty.
22. Ask the woman to separate her legs while continuing to bend her knees slightly.
23. Turn on the light and direct it toward genital area.
24. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.
25. Put new examination or high-level disinfected gloves on both hands.
26. Touch the inside of the woman’s thigh before touching any part of her genital area.
27. Separate labia majora with two fingers, and check labia minora, clitoris, urethral opening, and vaginal opening, noting swelling, tears, episiotomy, defibulation, sores, ulcers, warts, nits, lice, or urine or stool coming from vaginal opening.
28. Palpate the labia minora, noting swelling, discharge, tenderness, ulcers, fistulas, irregularities, and nodules.
### LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td>29. Look at perineum, noting scars, lesions, inflammation, or cracks in skin, bruising, and color, odor and amount of lochia.</td>
<td></td>
</tr>
</tbody>
</table>
| 30. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:  
  - If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;  
  - If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination. |       |
| 31. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry. |       |

### CARE PROVISION

Note: Individualize the woman’s care by considering all information gathered during assessment.

#### HIV Counseling

1. If the woman does not know her HIV status or has not been tested for HIV, provide HIV counseling, covering:  
   - Individual risk factors for HIV/AIDS;  
   - How the virus is transmitted;  
   - Local myths and false rumors about HIV/AIDS;  
   - HIV testing and the results.

#### Breastfeeding and Breast Care

2. Based on the woman’s breastfeeding history, provide information about the following:  
   - Exclusive breastfeeding on demand;  
   - Comfortable positions for breastfeeding and use of both breasts;  
   - Adequate rest and sleep;  
   - Extra fluid and food intake;  
   - Breast care.

#### Complication Readiness

3. Review the woman’s complication readiness plan with her (or develop one if she does not have one), covering:  
   - Arrangements made since last visit;  
   - Changes;  
   - Obstacles or problems encountered.

#### Mother-Baby-Family Relationships

4. Encourage family involvement with the newborn and assist the family to identify challenges/obstacles and devise strategies for overcoming them.
# LEARNING GUIDE FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
</tr>
<tr>
<td>5. Introduce the concepts of birthspacing and family planning:</td>
<td></td>
</tr>
<tr>
<td>• Discuss the woman’s previous experience with and beliefs about contraception, as well as her preferences;</td>
<td></td>
</tr>
<tr>
<td>• Discuss the lactational amenorrhea method and its benefits;</td>
<td></td>
</tr>
<tr>
<td>• Advise on the availability and accessibility of family planning services.</td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Support</strong></td>
<td></td>
</tr>
<tr>
<td>6. Provide advice and counseling about diet and nutrition:</td>
<td></td>
</tr>
<tr>
<td>• All postpartum women should eat a balanced diet and a variety of foods rich in iron and vitamin A, calcium, magnesium, and vitamin C;</td>
<td></td>
</tr>
<tr>
<td>• Women who are breastfeeding should:</td>
<td></td>
</tr>
<tr>
<td>- eat two additional servings of staple food per day;</td>
<td></td>
</tr>
<tr>
<td>- eat three additional servings of calcium-rich foods;</td>
<td></td>
</tr>
<tr>
<td>- drink at least eight glasses of fluid (two liters) each day (including milk, water, and juices);</td>
<td></td>
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<tr>
<td>- eat smaller more frequent meals, if necessary;</td>
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<tr>
<td>- avoid alcohol and tobacco;</td>
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<tr>
<td>- try to decrease amount of heavy work and increase rest time.</td>
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<tr>
<td><strong>Self-Care and Other Healthy Behaviors</strong></td>
<td></td>
</tr>
<tr>
<td>7. Provide advice and counseling about:</td>
<td></td>
</tr>
<tr>
<td>• Prevention of infection/hygiene</td>
<td></td>
</tr>
<tr>
<td>• Rest and activity</td>
<td></td>
</tr>
<tr>
<td>• Sexual relations and safer sex</td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations and Other Prophylaxis</strong></td>
<td></td>
</tr>
<tr>
<td>8. Give tetanus toxoid (TT) based on woman’s need.</td>
<td></td>
</tr>
<tr>
<td>9. Dispense sufficient supply of iron/folate until next visit and counsel the woman about the following:</td>
<td></td>
</tr>
<tr>
<td>• Eat food rich in vitamin C;</td>
<td></td>
</tr>
<tr>
<td>• Avoid tea, coffee, and colas;</td>
<td></td>
</tr>
<tr>
<td>• Possible side effects and management.</td>
<td></td>
</tr>
<tr>
<td>10. Dispense medications as follows:</td>
<td></td>
</tr>
<tr>
<td>• Antimalarial tablets (based on region/population-specific need);</td>
<td></td>
</tr>
<tr>
<td>• Mebendazole (based on region/population-specific need);</td>
<td></td>
</tr>
<tr>
<td>• Vitamin A (based on region/population-specific need);</td>
<td></td>
</tr>
<tr>
<td>• Iodine (based on region/population-specific need).</td>
<td></td>
</tr>
<tr>
<td><strong>Return Visits</strong></td>
<td></td>
</tr>
<tr>
<td>11. Schedule the next antenatal visit:</td>
<td></td>
</tr>
<tr>
<td>• Make sure the woman knows when and where to come;</td>
<td></td>
</tr>
<tr>
<td>• Answer any additional questions or concerns;</td>
<td></td>
</tr>
<tr>
<td>• Advise her to bring her records with her to each visit;</td>
<td></td>
</tr>
<tr>
<td>• Make sure she understands that she can return any time before the next scheduled visit if she has a problem;</td>
<td></td>
</tr>
<tr>
<td>• Review danger signs and key points of the complication readiness plan;</td>
<td></td>
</tr>
<tr>
<td>• Thank the woman for coming.</td>
<td></td>
</tr>
</tbody>
</table>
CHECKLIST 6: POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

**Satisfactory:** Performs the step or task according to the standard procedure or guidelines

**Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines

**Not Observed:** Step or task not performed by participant during evaluation by trainer

| PARTICIPANT ______________________ | Date Observed ______________________ |

**CHECKLIST FOR POSTPARTUM ASSESSMENT (HISTORY AND PHYSICAL EXAMINATION) AND CARE**
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Greet the woman respectfully and with kindness.</td>
<td></td>
</tr>
<tr>
<td>3. Tell the woman (and her support person) what is going to be done,</td>
<td></td>
</tr>
<tr>
<td>listen to her attentively, and respond to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>4. Provide continual emotional support and reassurance, as possible.</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

**HISTORY** (Ask the following questions if the information is not available on the woman’s record.)

**Personal Information (Every Visit for items followed with an “*”; First Visit for other items)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your name and age, and the name of your baby?</td>
<td></td>
</tr>
<tr>
<td>2. What is your address and your phone number?</td>
<td></td>
</tr>
<tr>
<td>3. Do you have access to reliable transportation?</td>
<td></td>
</tr>
<tr>
<td>4. What sources of income/financial support do you/your family</td>
<td></td>
</tr>
<tr>
<td>have?</td>
<td></td>
</tr>
<tr>
<td>5. How many times have you been pregnant and how many children</td>
<td></td>
</tr>
<tr>
<td>have you had?</td>
<td></td>
</tr>
<tr>
<td>6. How many of your children are still living?</td>
<td></td>
</tr>
<tr>
<td>7. Are you having a particular problem at present?*</td>
<td></td>
</tr>
<tr>
<td>8. Have you received care from another caregiver?*</td>
<td></td>
</tr>
</tbody>
</table>

**Daily Habits and Lifestyle (Every Visit for items followed with an “*”; First Visit for other items)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Do you work outside the home?*</td>
<td></td>
</tr>
<tr>
<td>10. Do you walk long distances, carry heavy loads, or do</td>
<td></td>
</tr>
<tr>
<td>physical labor?*</td>
<td></td>
</tr>
<tr>
<td>11. Do you get enough sleep/rest?*</td>
<td></td>
</tr>
<tr>
<td>STEP/TASK</td>
<td>CASES</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>12. What do you normally eat in a day?*</td>
<td></td>
</tr>
<tr>
<td>13. Do you eat any substances such as dirt or clay?</td>
<td></td>
</tr>
<tr>
<td>14. Do you smoke, drink alcohol, or use any other possibly harmful substances?</td>
<td></td>
</tr>
<tr>
<td>15. Who do you live with?</td>
<td></td>
</tr>
<tr>
<td>16. Has anyone ever prevented you from seeing family or friends, stopped you from leaving your home, or threatened your life?</td>
<td></td>
</tr>
<tr>
<td>17. Have you ever been injured, hit, or forced to have sex by someone?</td>
<td></td>
</tr>
<tr>
<td>18. Are you frightened of anyone?</td>
<td></td>
</tr>
</tbody>
</table>

**Present Pregnancy and Childbirth (First Visit)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. When did you have your baby?</td>
<td></td>
</tr>
<tr>
<td>20. Where did you have your baby and who attended the birth?</td>
<td></td>
</tr>
<tr>
<td>21. Did you have any vaginal bleeding during this pregnancy?</td>
<td></td>
</tr>
<tr>
<td>22. Did you have any complications during this childbirth?</td>
<td></td>
</tr>
<tr>
<td>23. Were there any complications with the baby?</td>
<td></td>
</tr>
</tbody>
</table>

**Present Postpartum Period (Every Visit)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Have you had any heavy bleeding since you gave birth?</td>
<td></td>
</tr>
<tr>
<td>25. What color is your vaginal discharge and how often do you need to change your pad/cloth?</td>
<td></td>
</tr>
<tr>
<td>26. Have you had any problems with bowel or bladder function?</td>
<td></td>
</tr>
<tr>
<td>27. Do you feel good about your baby and your ability to take care of her/him?</td>
<td></td>
</tr>
<tr>
<td>28. Is your family adjusting to the baby?</td>
<td></td>
</tr>
<tr>
<td>29. Do you feel that breastfeeding is going well?</td>
<td></td>
</tr>
</tbody>
</table>

**Previous Postpartum History (First Visit)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td>30. Have you breastfed a baby before?</td>
<td></td>
</tr>
<tr>
<td>31. Did you have any complications following previous childbirths?</td>
<td></td>
</tr>
</tbody>
</table>

**Contraceptive History (First Visit)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. How many more children do you plan to have?</td>
<td></td>
</tr>
<tr>
<td>33. Have you used a family planning method before?</td>
<td></td>
</tr>
<tr>
<td>34. Are you going to use family planning in the future?</td>
<td></td>
</tr>
</tbody>
</table>

**Medical History (Every Visit for items followed with an ***; First Visit for other items)**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</thead>
<tbody>
<tr>
<td>35. Do you have any allergies?</td>
<td></td>
</tr>
<tr>
<td>36. Have you been tested for HIV?</td>
<td></td>
</tr>
<tr>
<td>37. Have you had anemia recently?</td>
<td></td>
</tr>
<tr>
<td>38. Have you been tested for syphilis?</td>
<td></td>
</tr>
</tbody>
</table>
## Checklist for Postpartum Assessment (History and Physical Examination) and Care

(Some of the following steps/tasks should be performed simultaneously.)

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<td>39. Have you had any chronic illness/condition, such as tuberculosis, hepatitis, heart disease, diabetes, or any other chronic illness?</td>
<td></td>
</tr>
<tr>
<td>40. Have you ever been in hospital or had surgery/an operation?</td>
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</tr>
<tr>
<td>41. Are you taking any drugs/medications, including traditional/local preparations, herbal remedies, over-the-counter drugs, vitamins, and dietary supplements?*</td>
<td></td>
</tr>
<tr>
<td>42. Have you had a complete series of five tetanus toxoid immunizations?</td>
<td></td>
</tr>
<tr>
<td>43. When did you have your last booster of tetanus toxoid?</td>
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</table>

### Interim History (Return Visits)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</thead>
<tbody>
<tr>
<td>44. Do you have a problem at present?</td>
<td></td>
</tr>
<tr>
<td>45. Have you had any problems since your last visit?</td>
<td></td>
</tr>
<tr>
<td>46. Has your address or phone number changed since your last visit?</td>
<td></td>
</tr>
<tr>
<td>47. Have your daily habits or lifestyle (workload, rest, dietary intake) changed since your last visit?</td>
<td></td>
</tr>
<tr>
<td>48. Have you received care from another caregiver since your last visit?</td>
<td></td>
</tr>
<tr>
<td>49. Have you taken drugs/medications prescribed and followed the advice/recommendations (plan of care) provided at your last visit?</td>
<td></td>
</tr>
<tr>
<td>50. Have you had any reactions to or side effects from immunizations or drugs/medications given at your last visit?</td>
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</tbody>
</table>

### Skill/Activity Performed Satisfactorily

**Physical Examination**

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</thead>
<tbody>
<tr>
<td>1. Observe gait and movements, and behavior and facial expressions.</td>
<td></td>
</tr>
<tr>
<td>2. Observe general hygiene, noting visible dirt and odor.</td>
<td></td>
</tr>
<tr>
<td>3. Check skin, noting lesions and bruises.</td>
<td></td>
</tr>
<tr>
<td>4. Check conjunctive for pallor.</td>
<td></td>
</tr>
<tr>
<td>5. Have the woman remain seated and relaxed, and measure her blood pressure, temperature, and pulse.</td>
<td></td>
</tr>
<tr>
<td>6. Explain the next steps in the physical examination to the woman and obtain her consent to proceed.</td>
<td></td>
</tr>
<tr>
<td>7. Ask the woman to empty her bladder.</td>
<td></td>
</tr>
<tr>
<td>8. Wash hands thoroughly.</td>
<td></td>
</tr>
<tr>
<td>9. Ask the woman to uncover her body from the waist up, have her lie comfortably on her back, and examine her breasts, noting any abnormalities.</td>
<td></td>
</tr>
<tr>
<td>10. Ask the woman to uncover her stomach and lie on her back with her knees slightly bent.</td>
<td></td>
</tr>
<tr>
<td>11. Look for old or new incisions on the abdomen, and gently palpate abdomen between umbilicus and symphysis pubis, noting size and firmness of uterus, and check whether bladder is palpable above the symphysis pubis.</td>
<td></td>
</tr>
<tr>
<td>12. Examine the woman’s legs, noting any calf pain.</td>
<td></td>
</tr>
</tbody>
</table>
## Checklist for Postpartum Assessment (History and Physical Examination) and Care

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Ask the woman to uncover her genital area, cover or drape her to preserve privacy and modesty, and ask her to separate her legs.</td>
<td></td>
</tr>
<tr>
<td>14. Turn on the light and direct it toward genital area.</td>
<td></td>
</tr>
<tr>
<td>15. Wash hands thoroughly and put new examination or high-level disinfected gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>16. Inspect/examine labia, clitoris, and perineum, noting lochia, scars, bruising, and skin integrity.</td>
<td></td>
</tr>
</tbody>
</table>
| 17. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:  
  - If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;  
  - If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination. |       |
| 18. Wash hands thoroughly. |       |

### Skill/activity performed satisfactorily

### Care provision

**Note:** Individualize the woman’s care by considering all information gathered during assessment.

1. If the woman does not know her HIV status or has not been tested for HIV, provide HIV counseling.
2. Based on the woman’s breastfeeding history, provide information about breast feeding and breast care.
3. Review the woman’s complication readiness plan with her (or develop one if she does not have one).
4. Encourage family involvement with the newborn and assist the family to identify challenges/obstacles and devise strategies for overcoming them.
5. Introduce the concepts of birthspacing and family planning.
6. Provide advice and counseling about diet and nutrition.
7. Provide advice and counseling about self-care.
8. Give tetanus toxoid (TT) based on woman’s need.
9. Dispense sufficient supply of iron/folate until next visit and counsel the woman about taking the pills.
10. Dispense other medications based on need.
11. Schedule the next antenatal visit.

**Skill/activity performed satisfactorily**
LEARNING GUIDE 7: NEWBORN RESUSCITATION
(To be completed by Participants)

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

1. Needs Improvement: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. Proficiently Performed: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

<table>
<thead>
<tr>
<th>LEARNING GUIDE FOR NEWBORN RESUSCITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Some of the following steps/tasks should be performed simultaneously.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
<td></td>
</tr>
<tr>
<td>1. Dry the baby, remove the wet cloth, and wrap the baby in a dry, warm cloth.</td>
<td></td>
</tr>
<tr>
<td>2. Place the baby on her/his back on a clean, warm surface and keep covered except for the face and chest.</td>
<td></td>
</tr>
<tr>
<td>RESUSCITATION USING BAG AND MASK</td>
<td></td>
</tr>
<tr>
<td>1. Position the head in a slightly extended position to open the airway.</td>
<td></td>
</tr>
<tr>
<td>2. Clear the airway by suctioning the mouth first and then the nose:</td>
<td></td>
</tr>
<tr>
<td>• Introduce catheter 5 cm into the baby’s mouth and suction while withdrawing catheter;</td>
<td></td>
</tr>
<tr>
<td>• Introduce catheter 3 cm into each nostril and suction while withdrawing catheter;</td>
<td></td>
</tr>
<tr>
<td>• Be especially thorough with suctioning if there is blood or meconium in the baby’s mouth and/or nose;</td>
<td></td>
</tr>
<tr>
<td>• If the baby is still not breathing after the airway has been suctioned, start ventilating.</td>
<td></td>
</tr>
<tr>
<td>3. Quickly recheck the position of the baby’s head to make sure that the neck is slightly extended.</td>
<td></td>
</tr>
<tr>
<td>4. Place the mask on the baby’s face so that it covers the chin, mouth, and nose to form a seal (size 1 mask for normal weight newborn and size 0 for a small newborn).</td>
<td></td>
</tr>
<tr>
<td>5. Squeeze the bag with two fingers only or with the whole hand, depending on the size of the bag.</td>
<td></td>
</tr>
<tr>
<td>6. Check the seal by ventilating two or three times and observing the rise of the chest.</td>
<td></td>
</tr>
<tr>
<td>7. If the baby’s chest is rising:</td>
<td></td>
</tr>
<tr>
<td>• Ventilate at a rate of 40 breaths per minute;</td>
<td></td>
</tr>
<tr>
<td>• Observe chest for an easy rise and fall.</td>
<td></td>
</tr>
</tbody>
</table>
### LEARNING GUIDE FOR NEWBORN RESUSCITATION

(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8.</strong> If the baby’s chest is not rising:</td>
<td></td>
</tr>
<tr>
<td>• Check the position of the head again to make sure the neck is slightly extended;</td>
<td></td>
</tr>
<tr>
<td>• Reposition the mask on the baby’s face to improve the seal between mask and face;</td>
<td></td>
</tr>
<tr>
<td>• Squeeze the bag with the whole hand to increase ventilation pressure;</td>
<td></td>
</tr>
<tr>
<td>• Repeat suction of mouth and nose to remove mucus, blood, or meconium from the airway.</td>
<td></td>
</tr>
<tr>
<td><strong>9.</strong> Ventilate for one minute, using oxygen, if available, and then stop and quickly assess the baby for spontaneous breathing and color:</td>
<td></td>
</tr>
<tr>
<td>• If breathing is normal (30–60 breaths per minute), stop ventilating and place the baby in skin-to-skin contact with the mother;</td>
<td></td>
</tr>
<tr>
<td>• If there is central cyanosis (blue tongue and lips), chest indrawing, grunting on expiration, or respiratory rate is less than 30 breaths per minute, treat the baby for breathing difficulty;</td>
<td></td>
</tr>
<tr>
<td>• If the baby is gasping, not breathing, or the respiratory rate is less than 20 breaths per minute, continue ventilating.</td>
<td></td>
</tr>
<tr>
<td><strong>10.</strong> If the baby starts crying, stop ventilating and observe the baby’s respiratory rate for five minutes after crying stops:</td>
<td></td>
</tr>
<tr>
<td>• If breathing is normal (30–60 breaths per minute), stop ventilating;</td>
<td></td>
</tr>
<tr>
<td>• If there is central cyanosis (blue tongue and lips), chest indrawing, grunting on expiration, or respiratory rate is 20 to 30 breaths per minute, treat the baby for breathing difficulty;</td>
<td></td>
</tr>
<tr>
<td>• If the baby is gasping, not breathing, or the respiratory rate is less than 20 breaths per minute, continue ventilating.</td>
<td></td>
</tr>
<tr>
<td><strong>11.</strong> If the baby is not breathing regularly after 20 minutes of ventilation:</td>
<td></td>
</tr>
<tr>
<td>• Continue ventilation with oxygen;</td>
<td></td>
</tr>
<tr>
<td>• Organize transfer and refer baby to a tertiary care center, continuing oxygen during transfer, if possible.</td>
<td></td>
</tr>
<tr>
<td><strong>12.</strong> If there is no gasping or breathing at all after 20 minutes of ventilation, stop ventilating and provide emotional support to mother and family.</td>
<td></td>
</tr>
</tbody>
</table>

### POST-RESUSCITATION TASKS

1. Soak suction catheters in 0.5% chlorine solution for 10 minutes for decontamination.
2. Wipe exposed surfaces of the bag and mask with a gauze pad soaked in 60–90% alcohol or 0.5% chlorine solution and rinse immediately.
3. Wash hands thoroughly with soap and water and dry with a clean, dry cloth (or air dry).
CHECKLIST 7: NEWBORN RESUSCITATION
(To be used by the Trainer at the end of the module)

Place a “✓” in case box if step/task is performed satisfactorily, an “✗” if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

PARTICIPANT ___________________________ Date Observed _________________________

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<td><strong>GETTING READY</strong></td>
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<td>2. Place the baby on her/his back on a clean, warm surface and keep covered except for the face and chest.</td>
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<tr>
<td><strong>SKILL/ACTIVITY PERFORMED SATISFACTORILY</strong></td>
</tr>
<tr>
<td>1. Position the head in a slightly extended position to open the airway.</td>
</tr>
<tr>
<td>2. Clear the airway by suctioning the mouth first and then the nose.</td>
</tr>
<tr>
<td>3. Place the mask on the baby’s face so that it covers the chin, mouth, and nose.</td>
</tr>
<tr>
<td>4. Squeeze the bag with two fingers only or with the whole hand, depending on the size of the bag.</td>
</tr>
<tr>
<td>5. Check the seal by ventilating two or three times and observing the rise of the chest.</td>
</tr>
<tr>
<td>6. If the baby’s chest is rising, ventilate at a rate of 40 breaths per minute, and observe the chest for an easy rise and fall.</td>
</tr>
<tr>
<td>7. If the baby’s chest is not rising, determine why, rectify problem, and continue to ventilate.</td>
</tr>
<tr>
<td>8. Ventilate for one minute, using oxygen, if available, and then stop and quickly assess the baby for spontaneous breathing and color; if breathing is normal, stop ventilating, and if breathing is not normal, manage accordingly.</td>
</tr>
<tr>
<td>9. If the baby starts crying, stop ventilating and observe the baby’s respiratory rate for five minutes after crying stops. If breathing is normal, stop ventilating; if breathing not normal, manage accordingly.</td>
</tr>
<tr>
<td>10. If the baby is not breathing regularly after 20 minutes of ventilation, continue ventilation with oxygen, organize transfer and refer baby to a tertiary care center, if possible.</td>
</tr>
<tr>
<td>11. If there is no gasping or breathing at all after 20 minutes of ventilation, stop ventilating, and provide emotional support to mother and family.</td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
### CHECKLIST FOR NEWBORN RESUSCITATION
(Some of the following steps/tasks should be performed simultaneously.)

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<tr>
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</tr>
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<tbody>
<tr>
<td><strong>POST-RESUSCITATION TASKS</strong></td>
<td></td>
</tr>
<tr>
<td>1. Soak suction catheters in 0.5% chlorine solution for 10 minutes for</td>
<td></td>
</tr>
<tr>
<td>decontamination.</td>
<td></td>
</tr>
<tr>
<td>2. Wipe exposed surfaces of the bag and mask with a gauze pad soaked in</td>
<td></td>
</tr>
<tr>
<td>60–90% alcohol or 0.5% chlorine solution and rinse immediately.</td>
<td></td>
</tr>
<tr>
<td>3. Wash hands thoroughly with soap and water and dry with a clean, dry</td>
<td></td>
</tr>
<tr>
<td>cloth (or air dry).</td>
<td></td>
</tr>
</tbody>
</table>

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
LEARNING GUIDE 8: MANUAL REMOVAL OF PLACENTA
(To be completed by Participants)

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

1. Needs Improvement: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. Proficiently Performed: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

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</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
<td></td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
<td></td>
</tr>
<tr>
<td>2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>3. Provide continual emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td>4. Ask the woman to empty her bladder or insert a catheter, if necessary.</td>
<td></td>
</tr>
<tr>
<td>5. Give anesthesia (pethidine and diazepam IV slowly or ketamine).</td>
<td></td>
</tr>
<tr>
<td>6. Give a single dose of prophylactic antibiotics:</td>
<td></td>
</tr>
<tr>
<td>• Ampicillin 2 g IV PLUS metronidazole 500 mg IV</td>
<td></td>
</tr>
<tr>
<td>• OR Cefazolin 1 g IV PLUS metronidazole 500 mg IV</td>
<td></td>
</tr>
<tr>
<td>7. Put on personal protective barriers.</td>
<td></td>
</tr>
</tbody>
</table>

MANUAL REMOVAL OF PLACENTA

1. Wash hands and forearms thoroughly with soap and water and dry with a clean, dry cloth or air dry.

2. Put high-level disinfected or sterile surgical gloves on both hands. (Note: elbow-length gloves should be used, if available.)

3. Hold the umbilical cord with a clamp.

4. Pull the cord gently until it is parallel to the floor.

5. Insert the other hand into the vagina and up into the uterus.

6. When the placenta has been located, let go of the cord and move that hand onto the abdomen to support the fundus abdominally and to provide countertraction to prevent uterine inversion.

7. Move the fingers of the hand in the uterus laterally until the edge of the placenta is located.

8. Detach the placenta from the implantation site by keeping the fingers tightly together and using the edge of the hand to gradually make a space between the placenta and the uterine wall.
### LEARNING GUIDE FOR MANUAL REMOVAL OF PLACENTA

*(Some of the following steps/tasks should be performed simultaneously.)*

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td>9. Proceed slowly all around the placental bed until the whole placenta is detached from the uterine wall:</td>
<td></td>
</tr>
<tr>
<td>- If the placenta does not separate from the uterine surface by gentle lateral movement of the fingertips, suspect placenta accreta and arrange for surgical intervention.</td>
<td></td>
</tr>
<tr>
<td>10. When the placenta is completely separated:</td>
<td></td>
</tr>
<tr>
<td>- Hold the placenta and slowly withdraw the hand from the uterus, bringing the placenta with it;</td>
<td></td>
</tr>
<tr>
<td>- With the other hand, continue to provide counter-traction to the fundus by pushing it in the opposite direction of the hand that is being withdrawn.</td>
<td></td>
</tr>
<tr>
<td>11. Palpate the inside of the uterine cavity to ensure that all placental tissue has been removed.</td>
<td></td>
</tr>
<tr>
<td>12. Give oxytocin 20 units in 1 L IV fluid (normal saline or Ringer’s lactate) at 60 drops/minute.</td>
<td></td>
</tr>
<tr>
<td>13. Have an assistant massage the fundus to encourage a tonic uterine contraction.</td>
<td></td>
</tr>
<tr>
<td>14. If there is continued heavy bleeding, give ergometrine 0.2 mg IM, or give prostaglandins.</td>
<td></td>
</tr>
<tr>
<td>15. Examine the uterine surface of the placenta to ensure that it is complete:</td>
<td></td>
</tr>
<tr>
<td>- If any placental lobe or tissue is missing, explore the uterine cavity to remove it.</td>
<td></td>
</tr>
<tr>
<td>16. Examine the woman carefully and repair any tears to the cervix or vagina, or repair episiotomy.</td>
<td></td>
</tr>
</tbody>
</table>

### POST-PROCEDURE TASKS

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:</td>
<td></td>
</tr>
<tr>
<td>- If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;</td>
<td></td>
</tr>
<tr>
<td>- If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.</td>
<td></td>
</tr>
<tr>
<td>2. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>3. Monitor vaginal bleeding and take the woman’s vital signs every 30 minutes for the next six hours.</td>
<td></td>
</tr>
<tr>
<td>4. Palpate the uterine fundus to ensure the uterus remains contracted.</td>
<td></td>
</tr>
</tbody>
</table>
CHECKLIST 8: MANUAL REMOVAL OF PLACENTA
(To be used by the Trainer at the end of the module)

Place a “T” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

| PARTICIPANT ______________________ | Date Observed ______________________ |

<table>
<thead>
<tr>
<th>CHECKLIST FOR MANUAL REMOVAL OF PLACENTA (Some of the following steps/tasks should be performed simultaneously.)</th>
</tr>
</thead>
</table>

### GETTING READY

1. Prepare the necessary equipment.
2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.
3. Provide continual emotional support and reassurance, as feasible.
4. Ask the woman to empty her bladder or insert a catheter.
5. Give anesthesia.
7. Put on personal protective barriers.

### SKILL/ACTIVITY PERFORMED SATISFACTORILY

#### MANUAL REMOVAL OF PLACENTA

1. Wash hands and forearms thoroughly and put on high-level disinfected or sterile surgical gloves (use elbow-length gloves, if available).
2. Hold the umbilical cord with a clamp and pull the cord gently.
3. Insert the other hand into the uterine cavity and locate the placenta.
4. Provide counter-traction abdominally.
5. Detach the placenta by slowly working around the placental bed until the whole placenta is separated from the uterine wall.
6. Withdraw the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally.
7. Ensure that all placental tissue has been removed.
8. Give oxytocin in IV fluid.
9. Have an assistant massage the fundus to encourage a tonic uterine contraction.
10. If there is continued heavy bleeding, give ergometrine by IM injection, or give prostaglandins.
11. Examine the uterine surface of the placenta to ensure that it is complete.
## CHECKLIST FOR MANUAL REMOVAL OF PLACENTA
(Some of the following steps/tasks should be performed simultaneously.)

### 12. Examine the woman carefully and repair any tears to the cervix or vagina, or repair episiotomy.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

### POST-PROCEDURE TASKS

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
</table>
| 2.   | Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:  
- If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;  
- If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination. |
| 3.   | Wash hands thoroughly.  
Monitor vaginal bleeding, take the woman’s vital signs, and ensure that the uterus is firmly contracted. |

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
LEARNING GUIDE 9: BIMANUAL COMPRESSION OF THE UTERUS
(To be completed by Participants)

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

1. Needs Improvement: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. Proficiently Performed: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

---

LEARNING GUIDE FOR BIMANUAL COMPRESSION OF THE UTERUS
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
</table>

### GETTING READY

1. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.
2. Provide continual emotional support and reassurance, as feasible.
3. Put on personal protective barriers.

**Note:** Steps 1 and 2 should be implemented at the same time as the following steps.

### BIMANUAL COMPRESSION

1. Wash hands and forearms thoroughly with soap and water and dry with a clean, dry cloth or air dry.
2. Clean the vulva and perineum with antiseptic solution.
3. Put high-level disinfected or sterile surgical gloves on both hands.
4. Insert one hand into the vagina and form a fist.
5. Place the fist into the anterior vaginal fornix and apply pressure against the anterior wall of the uterus.
6. Place the other hand on the abdomen behind the uterus.
7. Press the abdominal hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.
8. Maintain compression until bleeding is controlled and the uterus contracts.

### POST-PROCEDURE TASKS

1. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:
   - If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;
   - If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.
2. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.
3. Monitor vaginal bleeding and take the woman’s vital signs:
   - Every 15 minutes for one hour;
   - Then every 30 minutes for two hours.
4. Palpate the uterine fundus to ensure that the uterus remains firmly contracted.
CHECKLIST 9: BIMANUAL COMPRESSION OF THE UTERUS
(To be used by the Trainer at the end of the module)

Place a “T” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

- **Satisfactory**: Performs the step or task according to the standard procedure or guidelines
- **Unsatisfactory**: Unable to perform the step or task according to the standard procedure or guidelines
- **Not Observed**: Step or task not performed by participant during evaluation by trainer

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<th>PARTICIPANT ___________________________</th>
<th>Date Observed __________</th>
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### CHECKLIST FOR BIMANUAL COMPRESSION OF THE UTERUS
(Some of the following steps/tasks should be performed simultaneously.)

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<thead>
<tr>
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</table>

#### GETTING READY

1. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.

2. Provide continual emotional support and reassurance, as feasible.

3. Put on personal protective barriers.

#### SKILL/ACTIVITY PERFORMED SATISFACTORILY

#### BIMANUAL COMPRESSION

1. Wash hands and put on high-level disinfected or sterile gloves.

2. Clean the vulva and perineum with antiseptic solution.

3. Insert fist into anterior vaginal fornix and apply pressure against anterior wall of uterus.

4. Place the other hand on the abdomen behind the uterus, press the hand deeply into the abdomen, and apply pressure against the posterior wall of the uterus.

5. Maintain compression until bleeding is controlled and the uterus contracts.

#### SKILL/ACTIVITY PERFORMED SATISFACTORILY

#### POST-PROCEDURE TASKS

1. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out:
   - If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container;
   - If reusing surgical gloves, submerge in 0.5% chlorine solution for 20 minutes for decontamination.

2. Wash hands thoroughly.

3. Monitor vaginal bleeding, take the woman’s vital signs and make sure that the uterus is firmly contracted.

#### SKILL/ACTIVITY PERFORMED SATISFACTORILY
LEARNING GUIDE 10: COMPRESSION OF THE ABDOMINAL AORTA
(To be completed by Participants)

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

1. **Needs Improvement**: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted

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

3. **Proficiently Performed**: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary)

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<td><strong>GETTING READY</strong></td>
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<tr>
<td>1. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.</td>
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</tr>
<tr>
<td>2. Provide continual emotional support and reassurance, as feasible.</td>
<td></td>
</tr>
<tr>
<td><strong>Note</strong>: Steps 1 and 2 should be implemented at the same time as the following steps.</td>
<td></td>
</tr>
<tr>
<td><strong>COMPRESSION OF THE ABDOMINAL AORTA</strong></td>
<td></td>
</tr>
<tr>
<td>1. Place a closed fist just above the umbilicus and slightly to the left.</td>
<td></td>
</tr>
<tr>
<td>2. Apply downward pressure over the abdominal aorta directly through the abdominal wall.</td>
<td></td>
</tr>
</tbody>
</table>
| 3. With the other hand, palpate the femoral pulse to check the adequacy of compression:  
  - If the pulse is palpable during compression, the pressure is inadequate;  
  - If the pulse is not palpable during compression, the pressure is adequate. |       |
| 4. Maintain compression until bleeding is controlled. |       |
| **POST-PROCEDURE TASKS**                       |       |
| 1. Monitor vaginal bleeding and take the woman’s vital signs:  
  - Every 15 minutes for one hour;  
  - Then every 30 minutes for two hours. |       |
| 2. Palpate the uterine fundus to ensure that the uterus remains firmly contracted. |       |
CHECKLIST 10: COMPRESSION OF THE ABDOMINAL AORTA
(To be used by the Trainer at the end of the module)

Place a “T” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

PARTICIPANT ____________________________ Date Observed ___________

<table>
<thead>
<tr>
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</tr>
</thead>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP/TASK</th>
<th>CASES</th>
</tr>
</thead>
</table>

### GETTING READY

1. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.

2. Provide continual emotional support and reassurance, as feasible.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

### COMPRESSION OF THE ABDOMINAL AORTA

1. Place a closed fist just above the umbilicus and slightly to the left.

2. Apply downward pressure over the abdominal aorta directly through the abdominal wall.

3. With the other hand, palpate the femoral pulse to check the adequacy of compression.

4. Maintain compression until bleeding is controlled.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

### POST-PROCEDURE TASKS

1. Monitor vaginal bleeding, take the woman’s vital signs, and ensure the uterus is firmly contracted.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
LEARNING GUIDE 11: REPAIR OF CERVICAL TEARS
(To be completed by Participants)

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

1. **Needs Improvement**: Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted.

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

3. **Proficiently Performed**: Step or task is performed efficiently and precisely and in the proper sequence (if sequence necessary).

### LEARNING GUIDE FOR REPAIR OF CERVICAL TEARS
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
</tr>
</thead>
<tbody>
<tr>
<td>GETTING READY</td>
</tr>
<tr>
<td>1. Prepare the necessary equipment.</td>
</tr>
<tr>
<td>2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.</td>
</tr>
<tr>
<td>3. Provide continual emotional support and reassurance, as feasible.</td>
</tr>
<tr>
<td>4. Have the woman empty her bladder or insert a catheter, if necessary.</td>
</tr>
<tr>
<td>5. Give anesthesia (IV pethidine and diazepam, or ketamine), if necessary.</td>
</tr>
<tr>
<td>6. Put on personal protective barriers.</td>
</tr>
<tr>
<td>REPAIR OF CERVICAL TEARS</td>
</tr>
<tr>
<td>1. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.</td>
</tr>
<tr>
<td>2. Put high-level disinfected or sterile surgical gloves on both hands.</td>
</tr>
<tr>
<td>3. Have an assistant shine a light into the vagina.</td>
</tr>
<tr>
<td>4. Clean the vagina and cervix with antiseptic solution.</td>
</tr>
<tr>
<td>5. Have the assistant massage the uterus and provide fundal pressure.</td>
</tr>
<tr>
<td>6. Insert a ring or sponge forceps into the vagina and grasp the cervix on one side of the tear.</td>
</tr>
<tr>
<td>7. Insert a second ring or sponge forceps and grasp the cervix on other side of the tear.</td>
</tr>
</tbody>
</table>
| 8. Place the handles of both forceps in one hand:  
   - Hold the cervix steady by gently pulling the forceps toward you. |
| 9. Place the first suture at the top (the apex) of the tear. |
| 10. Close the tear with a continuous suture:  
   - Be sure to include the whole thickness of the cervix each time the suture needle is inserted. |
| 11. If a long section of the rim of the cervix is tattered, under-run it with a continuous suture. |
### LEARNING GUIDE FOR REPAIR OF CERVICAL TEARS
(Some of the following steps/tasks should be performed simultaneously.)

<table>
<thead>
<tr>
<th>STEP/TASK</th>
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<tbody>
<tr>
<td>12. If the apex is difficult to reach and ligate:</td>
<td></td>
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<tr>
<td>• Grasp the apex with artery or ring forceps;</td>
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</tr>
<tr>
<td>• Leave the forceps in place for four hours;</td>
<td></td>
</tr>
<tr>
<td>• After four hours, open the forceps partially but do not remove;</td>
<td></td>
</tr>
<tr>
<td>• After another four hours, remove the forceps completely.</td>
<td></td>
</tr>
</tbody>
</table>

### POST-PROCEDURE TASKS

1. Before removing gloves, dispose of waste materials in a leakproof container or plastic bag.

2. Place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.

3. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out:
   • If disposing of gloves, place them in a leakproof container or plastic bag;
   • If reusing surgical gloves, submerge them in 0.5% chlorine solution for 10 minutes for decontamination.

4. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry.
**CHECKLIST 11: REPAIR OF CERVICAL TEARS**  
(To be used by the **Trainer** at the end of the module)

Place a “T” in case box if step/task is performed satisfactorily, an “X” if it is not performed satisfactorily, or N/O if not observed.

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#### GETTING READY

1. Prepare the necessary equipment.
2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.
3. Provide continual emotional support and reassurance, as feasible.
4. Have the woman empty her bladder or insert a catheter.
5. Give anesthesia, if necessary.
6. Put on personal protective barriers.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

#### REPAIR OF CERVICAL TEARS

1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.
2. Clean the vagina and cervix with an antiseptic solution.
3. Grasp both sides of the cervix using ring or sponge forceps (one forceps for each side of tear).
4. Place the first suture at the top of the tear and close it with a continuous suture, including the whole thickness of the cervix each time the suture needle is inserted.
5. If a long section of the rim of the cervix is tattered, under-run it with a continuous suture.
6. If the apex is difficult to reach and ligate, grasp it with forceps and leave them in place for eight hours.

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
## CHECKLIST FOR REPAIR OF CERVICAL TEARS
(Some of the following steps/tasks should be performed simultaneously.)

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**SKILL/ACTIVITY PERFORMED SATISFACTORILY**
USING ILLUSTRATED LECTURES

Lectures should be used to present information about specific topics. The lecture content should be based on, but not necessarily limited to, the information in the reference manual.

There are two important activities that should be undertaken to prepare for each lecture or interactive presentation. First, the participants should be directed to read relevant sections of the reference manual (and other resource materials, if and when used) before each lecture. Second, the trainer should prepare for the lectures by becoming thoroughly familiar with lecture content.

During lectures, the trainer should direct questions to participants and also encourage them to ask questions at any point during the lecture. Another strategy that encourages interaction involves stopping at predetermined points during the lecture to discuss issues and information of particular importance.
PRESENTATION 1A
FUNDAMENTALS OF BASIC CARE

Slide 1

Basic Maternal and Newborn Care
Fundamentals of Basic Care

Slide 2

Session Objectives
By end of session, participants will be able to describe/define:
- The global maternal health situation
- Evidence-based care and rationales
- Core competencies/responsibilities of skilled provider
- An adequate care provision system
- Woman-friendly care
- Male involvement
- Culturally appropriate care
- Individualization of care

Slide 3

Maternal Mortality and Morbidity: Scope of Problem
- 180–200 million pregnancies per year
- 75 million unwanted pregnancies
- 50 million induced abortions and 20 million unsafe abortions
- 600,000 maternal deaths/year (1 per minute), 99% of which occur in developing countries
- 30 maternal morbidities for every 1 maternal death
Deaths Worldwide from Complications of Pregnancy and Childbirth

- Sepsis 15%
- HDP 13%
- Obstetric 7%
- Other 8%
- Unsafe abortion 15%
- Hemorrhage 16%
- Amniotic fluid embolism 16%
- Other 18%

Principles of Basic Care
- Based on evidence
- Given by skilled provider in functioning healthcare system
- Provided in manner respectful of woman, her newborn and family, and their culture
- Individualized to meet unique needs of woman, newborn, and family

Objectives of Evidence-Based Care
- Promote practices based on best available evidence
- Encourage clinicians to:
  - Value evidence above mere tradition or habit—“We’ve always done it this way.”
  - Access and evaluate new clinical data as it becomes available
  - Incorporate evidence into daily clinical practice (i.e., modify practices accordingly)
Slide 7

In an Ideal World...

- The most effective care for every condition is known
- Every clinician has access to and understands most up-to-date evidence
- Every clinician practices most effective care s/he knows

Slide 8

Levels of Evidence

<table>
<thead>
<tr>
<th>Level</th>
<th>Type</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 1a</td>
<td>Systematic review of randomized controlled trials</td>
<td></td>
</tr>
<tr>
<td>A 1b</td>
<td>Individual randomized controlled trials</td>
<td></td>
</tr>
<tr>
<td>B 2x</td>
<td>Systematic review of cohort studies</td>
<td></td>
</tr>
<tr>
<td>B 2b</td>
<td>Individual cohort studies</td>
<td></td>
</tr>
<tr>
<td>C 3a</td>
<td>Systematic review of case-control studies</td>
<td></td>
</tr>
<tr>
<td>C 3b</td>
<td>Individual case-control studies</td>
<td></td>
</tr>
<tr>
<td>C 4</td>
<td>Case studies</td>
<td></td>
</tr>
<tr>
<td>D 5</td>
<td>Expert opinion without explicit critical appraisal</td>
<td></td>
</tr>
</tbody>
</table>

Slide 9

Importance of Rationales

- Practices should be based on firm rationales
- Provider should know why practice is important:
  - What condition can be detected by conducting this part of examination?
  - What condition may be prevented by giving this supplement?
- Understanding rationales helps provider focus assessment and care provision
The Skilled Provider

- Term refers to person with certain core competencies rather than specific cadre of professionals
- Skilled provider:
  - has knowledge, skills, and qualifications needed to provide essential (basic and life-saving) care throughout child-bearing cycle
  - can provide this care in any setting (e.g., home, clinic, hospital)
- Presence of skilled provider can have significant impact on reducing maternal and newborn deaths

Core Competencies/Responsibilities of Skilled Provider

- Gathers relevant information: history, physical examination, testing
- Analyzes information to plan and implement appropriate care
- Provides quality care for woman and her baby throughout childbearing cycle
- Recognizes potential problems

Core Competencies/Responsibilities of Skilled Provider (cont.)

- Manages problems and complications: stabilizes (as needed), treats, and/or refers (as needed)
- Evaluates care on ongoing basis; modifies care plan as needed
- Continually learns and seeks to strengthen services
- Supports linkages among providers/facilities, communities, and families
Slide 13

Care Provision System

- Necessary infrastructure:
  - adequate facilities and human resources
  - essential supplies and equipment
  - financing systems/schemes
  - roads
- Functioning system for referral/transfer

Slide 14

Care Provision System (cont.)

- Quality assurance
  - service delivery guidelines
  - mechanisms for ongoing assessment and improvement of systems
  - Systems for developing and maintaining clinical competence (preservice and inservice)

Slide 15

Emergency-Response System

- Identification: Designated staff member performs quick check to assess for danger signs
- Initial response: If danger sign is identified, emergency-response procedures are initiated. Skilled provider is notified and performs:
  - Rapid initial assessment
  - Stabilization (if needed)
Emergency-Response System (cont.)

- Management or referral/transfer: Skilled provider manages complication/condition (depending on skills and resources) and/or urgently refers/transfers woman to CEOC facility
  - Responsibility beyond “pushing them out door”—must ensure:
    - safe, rapid transportation
    - care during transport
    - communication with referral facility
    - follow-up with client

---

CEOC Services

- Anesthesia
- Blood transfusion
- Surgical obstetrics, including:
  - Cesarean section
  - Repair of 3rd and 4th degree vaginal tears and extensive cervical tears
  - Laparotomy
- Care for sick or low birthweight newborns

---

Woman-Friendly Care

- Provides services that are acceptable to woman:
  - Respects beliefs, traditions, and culture
  - Involves family, partner, or other support person in care
  - Includes relevant and feasible advice
  - Empowers woman and her family to become active participants in care
Slide 19

**Woman-Friendly Care (cont.)**
- Considers rights of woman:
  - Right to information about her health
  - Right to be informed about what to expect during visit
  - Obtains permission/consent prior to exams and procedures
- Ensures that all healthcare staff use good interpersonal skills
- Considers emotional, psychological, and social well-being of woman

---

Slide 20

**Woman-Friendly Care (cont.)**
- Respects and supports mother-baby dyad:
  - Encourages bonding
  - Keeps baby with mother
  - Places baby on mother’s abdomen (at breast) immediately after birth

---

Slide 21

**Male Involvement**
- Works to decrease provider bias against involvement of male partner
- Helps male partner to feel comfortable participating in care
- Makes special effort to include male partner in birth preparedness and complication readiness
- Targets couple during relevant counseling and health promotion
Culturally Appropriate Care

- Recognizes richness and spiritual significance of community and culture
- Is aware of traditional beliefs regarding pregnancy and childbirth
- Promotes cooperation and liaisons with traditional healthcare system when possible
- Includes culturally sensitive practices

Culturally Sensitive Practices

- Speak to woman in her own language
- Observe rules and norms of her culture as appropriate
- Be aware of who makes decisions in her life and involve that person in discussions and decisions
- Work with traditional birth attendants when possible
- Learn about traditional practices:
  - Promote/build upon positive traditional practices
  - Offer alternatives to those that are harmful

Individualization of Care

The provider modifies standard basic care package to:
- Address woman’s individual needs
- Take into consideration:
  - Findings from current history, including daily habits and lifestyle
  - Findings from current physical exam and tests
  - Cultural beliefs and customs
  - Any other unique circumstances
Slide 25

**Linkages with Community**
- Invite community to learn about, and shape, services
- Be aware of traditional care being provided in community
- Collaborate with community in developing transportation, financing, and communication systems around healthcare
- Organize activities to raise safe motherhood awareness in community

Slide 26

**Working with Traditional Birth Attendants (TBAs)**
- Include TBA in support of woman and her family
- Enlist TBAs to communicate health messages
- Partner with TBAs in identifying pregnant women in community
- Respond respectfully and promptly when TBAs bring women to facility

Slide 27

**Summary**
Quality basic care is:
- Based on evidence and rationales
- Given by skilled provider in functioning healthcare system
- Provided in manner that is respectful of woman, her newborn and family, and their culture:
  - Individualized to meet unique needs of woman, newborn, and family
Basic Maternal and Newborn Care

Key Tools in Basic Care I:
- Clinical Decision-Making
- Interpersonal Skills
- Record Keeping

Session Objectives
By end of session, participants will be able to:
- Describe steps in clinical decision-making
- Discuss basic considerations in interpersonal skills
- Outline key principles of clear, concise, and accurate record keeping

Clinical Decision-Making
A purposeful, organized thinking process that links assessment with care provision and evaluation of care through series of logical steps
Slide 4

Steps in Clinical Decision-Making

1) Gather information
   - History
   - Physical examination
   - Testing

2) Interpret information
   - Consider each sign/symptom in context of other findings
   - Compare signs/symptoms to accepted descriptions/definitions of health and disease
   - Consult reliable sources of up-to-date information

 Slide 5

Clinical Decision-Making (cont.)

3) Develop care plan
   - Based on assessment
   - Individualized
   - Collaborative—responsibility shared by care provider, woman, and family

4) Implement care plan—also collaborative

 Slide 6

Clinical Decision-Making (cont.)

5) Evaluate care plan—and modify as needed
   - Monitor continuously
   - Compare present and past findings
   - Deem effective when:
     - Improves or maintains woman’s health
     - Restores abnormal findings to normal
     - Addresses woman’s needs
     - Is acknowledged as valuable by woman and her family
Interpersonal Skills
Verbal and nonverbal patterns of interaction that:
• Facilitate positive relationship with client
• Promote safe and comfortable environment
• Help ensure that client adheres to care plan and returns for continued care

Interpersonal Skills (cont.)
In general:
• Treat woman with respect and courtesy
• Use effective communication skills
• Ensure privacy and confidentiality
• Respond to woman’s emotional, as well as physical, needs
• Display professional attitude with both clients and coworkers

Effective Communication
Some key elements:
• Use simple, clear, and locally understood language
• Show respect for social norms and cultural beliefs
• Highlight important information by repetition or summarizing
Slide 10

Effective Communication (cont.)
- Encourage woman to ask questions and express concerns
- Listen carefully to what woman has to say
- Be honest, empathetic, and nonjudgmental

Slide 11

Privacy and Confidentiality
Some key considerations:
- Separate waiting area from care provision area
- Close and lock doors during visit and/or secure curtains to block view of client care area
- Allow woman to decide whether her companion will be included in all or any parts of her visit

Slide 12

Privacy and Confidentiality (cont.)
- Speak in low voice when discussing history or health status
- Have woman remove only necessary clothing; exit room while undressing; provide covering
- Store medical records securely
Slide 13

Interpersonal Skills for Physical Examination

• Explain to woman what is going to happen and why
• Be encouraging and supportive
• Preserve her privacy and respect her modesty
• Ensure that woman is as comfortable as possible on exam table

Slide 14

Interpersonal Skills for Physical Examination (cont.)

• Be gentle
• Obtain woman’s consent before proceeding with each part of examination
• Discuss findings as examination progresses

Slide 15

Key Principles in Effective Counseling

• Messages should:
  • be feasible
  • emphasize what woman needs to do and how to do it
  • be easy to understand and remember
Slide 16

Key Principles in Effective Counseling (cont.)

- Advice and counseling should:
  - be integrated with other components of care plan
  - be individualized to fit woman’s needs
  - be provided in manner that empowers woman to exercise informed choice
  - involve woman’s support system as appropriate

Slide 17

Tips for Effective Group Education

- Consider local needs for more information
- Ask questions to find out what group knows
- Introduce topic and state objective(s) at beginning
- Encourage all clients to participate and ask questions
- Use interactive approach and praise participation

Slide 18

Tips for Effective Group Education (cont.)

- Maintain eye contact with group
- Speak loudly enough for everyone to hear
- Use supplemental materials (e.g., visual aids) as appropriate
- Summarize key points at end
Slide 19

Record Keeping
Accurate record keeping is necessary for:
- Planning and evaluating client’s care
- Enabling continuity of care (over time)
- Facilitating communication (among healthcare workers and facilities)

Slide 20

Key Principles in Record-Keeping
- Prepare/update records as soon as possible
- Record all signs/symptoms that contribute to diagnosis
- Note absence of signs/symptoms relevant to diagnosis
- Note exact measurements and values where appropriate

Slide 21

Key Principles in Record-Keeping (cont.)
- Clearly distinguish between clinical observations and patient’s subjective experience
- Present findings as objectively as possible
- Be neat and avoid unnecessary abbreviations
- Store records in secure location
Integrated throughout, the following practices contribute to overall effectiveness of basic care:

- Clinical decision-making
- Interpersonal skills
- Record keeping
PRESENTATION 1C
KEY TOOLS IN BASIC CARE II: INFECTION PREVENTION PRACTICES

Slide 1

Basic Maternal and Newborn Care
Key Tools in Basic Care II:
Infection Prevention Practices

Slide 2

Session Objectives
By end of session, participants will be able to:
• Describe disease transmission cycle
• Describe how infection prevention (IP) practices work
• Outline key IP principles
• Discuss appropriate handwashing and antisepsis

Slide 3

Session Objectives (cont.)
• Discuss appropriate gloving and personal protective equipment
• Outline safe handling of sharps
• Discuss proper instrument processing and waste disposal
The Six Components of Disease Transmission Cycle

1. **Agent**: Disease-producing microorganisms
2. **Reservoir**: Place where agent lives, such as in or on humans, animals, plants, soil, air, or water
3. **Place of exit**: Where agent leaves host
4. **Mode of transmission**: How agent travels from place to place (or person to person)
5. **Place of entry**: Where agent enters next host
6. **Susceptible host**: Person who can become infected

---

How Can We Prevent Spread of Infection?

- Inhibiting or killing infectious agent (applying antiseptic to skin prior to surgery)
- Blocking agent’s means of getting from infected person to susceptible person (handwashing or using alcohol-based hand rub)

---

How Can We Prevent Spread of Infection? (cont.)

- Ensuring that people, especially healthcare workers, are immune or vaccinated
- Providing healthcare workers with proper protective equipment to prevent contact with infectious agents
Slide 7

Why is Infection Prevention Important?

- Protects patients/clients—helps provide quality care that is also safe
- Lowers healthcare costs—prevention is less expensive than treatment
- Prevents infection among healthcare staff and community
- Limits number and spread of infectious agents that can become antibiotic-resistant

Slide 8

Key Infection Prevention Precautions

- Regard all clients, patients, and healthcare staff as infectious and at risk of infection
- Wash hands or use alcohol-based hand rub—the single most important factor for preventing infections

Slide 9

Key Infection Prevention Precautions (cont.)

- Wear gloves before touching anything wet (e.g., broken skin, mucous membranes) or performing invasive procedures
- Wear personal protective equipment (PPE)—such as goggles, face masks, aprons, gloves—if splashes or spills of body fluids are anticipated
Key Infection Prevention Precautions (cont.)
• Use antiseptic agents before invasive procedures
• Follow safe work practices (e.g., proper waste disposal practices, not recapping or bending needles, proper instrument processing)
• Vaccinate staff who are in direct contact with patients/clients for: hepatitis B, rubella, measles, mumps, influenza

Handwashing
the single most practical procedure for preventing infection
When to wash hands:
• Before and after examining client
• After contact with blood, body fluids, or soiled instruments even if gloves are worn
• Before and after removing gloves
• Upon arriving at and before leaving workplace

Alcohol-Based Hand Rub
• More effective than handwashing unless hands are visibly soiled
• 2 mL emollient (e.g., glycerin) + 100 mL ethyl or isopropyl alcohol 60–90%
Antisepsis

- Antisepsis for mucus membranes
  - Ask about allergic reactions
  - Use water-based product (e.g., iodophor or chlorhexidine), as alcohols may burn or irritate mucus membranes
- Skin preparation for injections
  - If skin is clean, antisepsis is not necessary
  - If skin appears dirty, wash with soap and water
  - Before giving injection, dry with clean towel

When to Glove

- When there is reasonable chance of contact with broken skin, mucous membranes, blood, or other body fluids
- When performing invasive procedure
- When handling:
  - Soiled instruments
  - Medical, or contaminated, waste
  - When touching contaminated surfaces

Guidelines for Gloving

- Wear separate pair of gloves for each woman/newborn to prevent spreading infection from client to client
- Wear high level-disinfected gloves for procedures involving contact with broken skin or tissue under skin
- Wear examination gloves for starting IV, drawing blood, or handling blood or body fluids
Guidelines for Gloving (cont.)

- Wear utility gloves for cleaning instruments, handling waste, and cleaning up blood and body fluids
- Surgical gloves can be re-used if decontaminated, washed, rinsed, and sterilized or high level-disinfected
- Never use gloves that are cracked or peeling or have holes

Personal Protective Equipment

- Gloves: utility, examination, HLD/sterile
- Eyewear: face shields, goggles, glasses
- Aprons
  - Should be fluid-resistant
  - Should be decontaminated after use
- Footwear
  - Protects from injury from sharps or heavy items
  - Should cover entire foot

Safe Handling of Sharps

- Never pass sharp instrument from one hand directly to another person’s hand
- After use, decontaminate syringes and needles by flushing three times with chlorine solution
- Immediately dispose of sharps in puncture-proof container
Safe Handling of Sharps (cont.)

- Do not recap, bend, break, or disassemble needles before disposal
- Always use needle holder when suturing
- Never hold or guide needle with fingers

Instrument Processing

- Decontamination
  - Should be done immediately after use
  - Makes objects safer to handle

- Cleaning
  - Most effective way to reduce number of organisms
  - Removes visible dirt and debris

Instrument Processing (cont.)

- Sterilization
  - Destroys all microorganisms
  - Includes autoclave, dry heat, chemicals

- High level disinfection (HLD)
  - Destroys all microorganisms except bacterial endospores
  - Includes boiling, steaming, soaking

- Storage
  - After processing, must remain dry and clean
Slide 22

Housekeeping

- Each site should follow housekeeping schedule
- Always wear utility gloves when cleaning
- Clean from top to bottom
- Ensure that fresh bucket of disinfectant solution is available at all times

Slide 23

Housekeeping (cont.)

- Immediately clean up spills of blood or body fluids
- After each use, wipe off beds, tables, and procedure trolleys using disinfectant solution
- Decontaminate cleaning equipment with chlorine solution

Slide 24

Waste Disposal

- Separate contaminated waste from noncontaminated waste
- Use puncture-proof container for sharps and destroy when two-thirds full
Slide 25

Waste Disposal (cont.)

- Follow these steps to destroy contaminated waste and sharps:
  - Add small amount of kerosene to burn
  - Burn contaminated waste in open area downwind from care site
  - Dispose of waste at least 50 meters away from water sources

Slide 26

Summary

- Everyone (staff and patients) is at risk for infection
- This risk can be reduced through rigorous adherence to IP practices:
  - Handwashing or using alcohol-based hand rub
  - Antiseptics
  - Personal protective equipment, including gloving
  - Safe handling of sharps and needles
  - Instrument processing
  - Housekeeping and waste disposal
PRESENTATION 2A
INTRODUCTION TO CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE

Slide 1

Basic Maternal and Newborn Care
Introduction to Childbirth, Postpartum, and Newborn Care

Slide 2

Session Objectives
By end of session, participants will be able to:
• Explain goals of childbirth, postpartum, and newborn care (CPNC)
• Define scope of basic CPNC
• Outline components of basic care during labor and childbirth, and postpartum and newborn visits

Slide 3

Focused CPNC
• Relies on evidence-based, goal-directed interventions appropriate to stage/phase of labor or the childbirth cycle
• Is based on premise that every woman in labor or the postpartum and every newborn is at risk for complications
• Emphasizes quality of visits over quantity
• Targets most prevalent health issues affecting women, during labor/childbirth and postpartum, and newborns
• Is given by a skilled healthcare provider
Slide 4

Goals of CPNC

- Promotion of health and prevention of disease
- Detection of existing diseases and treatment
- Early detection and management of complications
- Complication readiness

Slide 5

Health Promotion

- Ongoing supportive care during labor/childbirth:
  - considers woman's emotional well-being, comfort, and desires in addition to physical requirements
  - helps promote good outcome
- Health messages and counseling empower women for:
  - informed decision-making
  - good self-care and care of their newborns

Slide 6

Health Promotion Topics

For woman's self-care:
- Breastfeeding and breast care
- Mother-baby-family relationships
- Family planning
- Nutrition
- Care for common discomforts
- Prevention of infection/hygiene
- Rest and activity
- Sexual relations and safer sex
- Counseling and testing for HIV
- Prevention of anemia and tetanus
Health Promotion Topics (cont.)

For care of newborn:
- Early and exclusive breastfeeding
- Maintaining warmth
- Prevention of infection/hygiene
- Washing and bathing
- Cord care
- Sleep and other behaviors/needs
- Immunization

Prevention Measures

During labor/childbirth:
- Use of infection prevention practices – helps prevent infection and transmission of diseases (including HIV)
- Use of partograph – helps prevent delays in taking appropriate action in case of unsatisfactory progress of labor by aiding in early detection

Prevention Measures (cont.)

During immediate postpartum/newborn period:
- Initiation of breastfeeding – helps prevent hypothermia (newborn) and may help prevent postpartum hemorrhage (woman)
- Active management of third stage of labor and continued uterine massage – helps prevent postpartum hemorrhage (woman)
- Antimicrobial eye care for newborn – helps prevent serious eye infection
- Vitamin K1 injection for newborn – helps prevent some bleeding problems
Prevention Measures (cont.)

During postpartum period:
- Tetanus toxoid immunization to prevent tetanus in woman (in future pregnancy)
- Iron/folate supplementation to prevent iron deficiency, which is most prevalent nutritional deficiency affecting woman and can lead to anemia

Prevention Measures (cont.)

During postpartum period (cont.):
- In disease- or deficiency-endemic areas:
  - Intermittent preventive treatment and insecticide-treated bednets for malaria
  - Presumptive treatment for hookworm infection
  - Vitamin A supplementation
  - Iodine supplementation

Prevention Measures (cont.)

During newborn period:
- Immunizations help prevent tuberculosis, polio, and hepatitis B
- In malaria-endemic areas, insecticide-treated bednets for malaria
Detection of Existing Diseases and Treatment

If not treated, existing diseases can complicate—or be complicated by—labor/childbirth or postpartum/newborn period. Examples include:
- Syphilis, HIV/AIDS, and other STIs
- Malaria
- Tuberculosis
- Anemia and malnutrition
- Heart disease
- Diabetes

Early Detection and Management…

...of the following complications can mean difference between survival and death for woman and baby:
- Hemorrhage (woman)
- Obstructed labor (woman and fetus)
- Sepsis/infection (woman and newborn)
- Pre-eclampsia/eclampsia (woman)
- Asphyxia (newborn)
- Hypothermia (newborn)

Complication Readiness

As part of focused CPNC, skilled provider assists woman and her family in developing complication readiness plan to:
- Help family prepare for possible emergency – as:
  - Every woman and newborn is at risk for complications
  - Most complications cannot be predicted
Complication Readiness (cont.)

Complication readiness includes making arrangements for the following:
- Emergency transportation to appropriate facility
- Emergency funds management of possible complications
- Support person/companion
- Danger signs
- Blood donor

Scope of Basic CPNC

Core components of basic care: to maintain normal

Additional care: to address common discomforts/concerns and special needs

Initial care for women/babies with life-threatening complications

Core Components of Basic CPNC

- Quick check
- Basic assessment
  - Including ongoing assessment from onset of labor up to 6 hours after childbirth
- Basic care provision
  - Including ongoing supportive care from onset of labor up to discharge
Slide 19

**Basic CPNC Assessment**

- Ensures maternal and fetal/newborn well-being
- Helps identify common discomforts/concerns and special needs
- Screens for conditions beyond scope of basic care, including life-threatening complications
- In labor, helps establish baseline for ongoing assessment

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Slide 20

**Basic CPNC Care Provision**

- Helps maintain normal labor/childbirth and postpartum/newborn period
- Empowers woman to adopt healthy practices for herself and her baby
- Prepares woman and family for possible complications
- Helps prevent certain diseases

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Slide 21

**Quick Check**

- Screens for danger signs or signs and symptoms of advanced labor
- Helps to quickly identify women and newborns who need immediate medical attention, stabilization (if necessary), and treatment or referral as quickly as possible
Quick Check (cont.)

Maternal danger signs:
At any time during childbearing cycle—
• Severe headache/blurred vision
• Convulsions/loss of consciousness
• Breathing difficulty
• Fever (feeling of hotness)
• Foul-smelling discharge/fluid from vagina

Signs/symptoms of advanced labor:
• Strong, regular contractions
• Urge to push
• Leaking of fluid from vagina
• Grunting or moaning

Maternal danger signs:
During labor, also—
• Vaginal bleeding
• Decreased/absent fetal movements
• Cord or fetal part visible at vaginal opening
• Leaking of greenish/brownish fluid from vagina
• Severe, continuous abdominal pain

During postpartum period, also—
• Vaginal bleeding (heavy or sudden increase)
• Pain in calf, with or without swelling
• Severe abdominal pain
• Verbalization/behavior indicating she may hurt self or baby; hallucinations

Newborn danger signs:
• Breathing difficulty
• Convulsion, spasms, loss of consciousness, or arching of back
• Cyanosis (blueness)
• Palor
• Flappyness
• Lethargy
• Cold to touch (fever)
• Bleeding
• Jaundice (yellowness)
• Not feeding or poor sucking
• Diarrhea
• Persistent vomiting or abdominal distension
• Pus or redness of umbilicus, eyes, or skin
• Swollen limb or joint
### Slide 25

**Childbirth Care (CBC)**

In context of manual*, CBC:
- Begins with onset of labor
- Ends 2 hours after childbirth, before transitioning to:
  - Postpartum care
  - Newborn care

* Basic Maternal and Newborn Care: A Guide for Skilled Providers

### Slide 26

**Basic CBC Assessment**

- Initial Assessment
  - History
  - Physical Examination
    - General
    - Vital signs
    - Breasts
    - Abdomen
    - Genitals
  - Cervix
  - Testing
    - RPR (or VDRL)
    - HIV (if woman does not “opt out”)
    - Blood group and Rh

- Ongoing Assessment
  - Guided by components of partograph (during active first stage of labor)

### Slide 27

**Basic CBC Care Provision**

Ongoing supportive care, including:
- Communication/attendance
- Rest and activity/positions
- Comfort
- Nutrition
- Elimination
- Hygiene/infection prevention
- Mother-baby bonding
Basic CBC Care Provision (cont.)

Key actions, including:

1st stage:
• Monitor labor using partograph (during active phase)

2nd and 3rd stages:
• Assist woman in pushing and birth
• Initiate immediate newborn care (dry and cover, check breathing, clamp and cut cord, skin-to-skin contact, breastfeeding)
• Perform active management of 3rd stage of labor

4th stage:
• Provide immediate postpartum and newborn care

Scheduling of Postpartum Care (PPC) Visits

For normally progressing postpartum periods, following scheduled visits are recommended:
• 1st visit – 6 hours*
• 2nd visit – 6 days
• 3rd visit – 6 weeks

*Woman receives ongoing monitoring/care up to/through this point

Basic PPC Assessment

• Ongoing assessment up to 6 hours after birth
• History
• Physical Examination
  • General
  • Vital signs
  • Breasts
  • Abdomen
  • Legs
  • Genitals
• Testing
  • HIV (if woman does not “opt out”)

Basic PPC Care Provision

- Ongoing supportive care up to discharge
- Breastfeeding and breast care
- Complication readiness
- Support for mother-baby-family relationships
- Family planning
- Self-care and other healthy practices
- HIV counseling
- Immunizations and other preventive measures

Scheduling of Newborn Care (NBC) Visits

For normally progressing newborn periods, following scheduled visits are recommended:

- 1st visit – 6 hours*
- 2nd visit – 6 days

*Newborn receives ongoing monitoring/care up to/through this point

Basic NBC Assessment

- Ongoing assessment up to 6 hours after birth
- History
- Physical Examination
  - General
  - Head, face and mouth, eyes
  - Chest, abdomen and cord, external genitalia
  - Back and limbs
  - Breastfeeding
  - Mother-baby bonding
Slide 34

**Basic NBC Care Provision**
- Ongoing supportive care up to discharge
- Early and exclusive breastfeeding
- Complication readiness
- Newborn care and other healthy practices
- Immunizations and other preventive measures

Slide 35

**Summary**
Through targeted assessment and individualized care provision, focused CPNC aims to:
- Promote health and prevent disease
- Detect and treat/refer existing diseases
- Detect and manage/refer complications
- Prepare woman and her family for possible complications
PRESENTATION 2B
BASIC ASSESSMENT DURING LABOR

Slide 1

Basic Childbirth Care
Basic Assessment during Labor

Slide 2

Session Objective
• By end of session, participants will be able to describe main principles and elements of basic assessment during labor/childbirth

Slide 3

Assessment during Labor
• Assessment precedes and is concurrent with other aspects of care provision
• Initial assessment (focus of this presentation) includes:
  • History taking
  • Physical examination
  • Testing
• Ongoing assessment (focus in next three presentations) is continuous process; includes use of partograph
Basic Childbirth Assessment

- Throughout assessment, provider adheres to principles of basic care and incorporates key tools:
  - Clinical decision-making
  - Interpersonal skills
  - Infection prevention practices
  - Record keeping

Basic Childbirth Assessment (cont.)

Before performing basic assessment:
- Welcome woman
- Offer her (and companion, if she desires) seat
- Ensure that she has undergone quick check

History

Focus history taking on the following areas:
- Personal history
- Estimated date of childbirth/menstrual history
- Present pregnancy and labor/childbirth
- Obstetric history
- Medical history
Slide 7

**Personal Information**

Ask about:
- Woman’s name, age, phone number, address
- Previous pregnancies and childbirths
- Complication readiness plan
- Current/recent problems or concerns
- Care from another provider

Slide 8

**Personal Information (cont.)**

- Consider this information in context of further assessment, and use to:
  - Guide counseling and other care
  - Identify special needs and other conditions that require additional care

Slide 9

**Estimated Date of Childbirth (EDC)/Menstrual History**

- Ask about EDC – to identify preterm birth (less than 37 weeks), size-date discrepancy, etc.
- If woman does no know her EDC, ask about last menstrual period (LMP)
Present Pregnancy and Labor/Childbirth
• Ask whether she received ANC
  • If yes, assess for quality of care and any problems identified during pregnancy
  • If no, be alert for problems not addressed during pregnancy

Present Pregnancy and Labor/Childbirth (cont.)
Ask about labor to confirm onset, assess stage/phase, and help identify problems:
• Rupture of membranes
• Contractions: frequency and duration
• Fetal movement in last 24 hours
• Use of potentially harmful substances in last 24 hours
• Eating and/or drinking in last 8 hours

Obstetric History
Note: Poor obstetric history does not necessarily require special care but helps provider:
• Understand woman’s concerns in this pregnancy, birth, and/or postpartum/newborn period
• Emphasize importance of skilled provider at every birth
Obstetric History (cont.)

- If not woman’s first pregnancy/childbirth, ask about complications during previous pregnancy, childbirth, or postpartum/newborn period
- If previous C-section, uterine rupture, or uterine surgery, woman requires urgent referral/transfer
- If other complications, woman requires further evaluation/additional care (special need)

Obstetric History (cont.)

- Ask whether she has had any problems with breastfeeding – to guide counseling and other care, and identify special needs and other problems

Medical History

Ask whether diagnosed with:
- Allergies – if yes, avoid known allergens
- HIV, anemia, or syphilis – if yes, woman has special need
- Heart disease, diabetes, or other chronic condition – if yes, woman requires nonurgent referral/transfer
Medical History (cont.)

Ask whether she has had:
- Previous hospitalization or surgery or is taking any medications/drugs — to guide counseling and other care, and identify special needs and other problems
- A complete series of tetanus toxoid (TT) vaccines — to assess her need for TT

Physical Examination

Focus physical examination on the following:
- General well-being
- Vital signs
- Breasts (can be postponed to postpartum period if necessary)
- Abdomen
- Genitals
- Cervix

General Well-Being

- Gait and movements — no limp, steady pace
- Behavior and vocalizations — appropriate/normal for culture
- Skin — no bruises or lesions
- Conjunctiva — pink; no pallor

Use findings to:
- Identify problems
- Guide counseling and other care
Vital Signs

- Respirations – no gasping, wheezing, or rales
- Temperature – less than 38°C
- Pulse – 90 to 110 beats/minute
  - If respirations, temperature or pulse abnormal, perform RIA

Vital Signs (cont.)

- Blood pressure – systolic 90 to 140 mmHg; diastolic less than 90 mmHg
  - If systolic < 90 or diastolic > 110 mmHg, perform RIA
  - If diastolic > 90 mmHg, woman requires urgent evaluation/additional care (life-threatening complication)

Visual Inspection of Breasts (if in latent labor and no distress)

- Assess:
  - Contours and skin – regular contour, smooth skin
  - Nipples – no abnormal discharge or inverted nipples
  - Normal variations: nipple/breast size and coloring, colostrum
  - If gross abnormalities, woman requires nonurgent referral/transfer
Abdominal Examination

- Abdominal surface – no scars from previous cesarean, uterine rupture, or uterine surgery
  - If yes, woman requires urgent referral/transfer
- Shape – longer vertically than horizontally
  - If no, be alert for transverse lie
- Fundal height – consistent with EDC
  - If no, woman has special need (preterm birth, size-date discrepancy, multiple gestation)

Abdominal Examination (cont.)

- Fetal parts and movement – to assess for multiple gestation and other problems
- Fetal lie and presentation – usually longitudinal and cephalic
  - If abnormal, be alert for transverse lie and/or breech presentation

Abdominal Examination (cont.)

- Descent – head in relation to symphysis pubis; to establish baseline for normal labor
- Fetal heart tones – 120 to 160 beats minute in latent phase; 100 to 180 beats minute in active phase
  - If abnormal or absent fetal heart tones, woman requires urgent further evaluation/additional care (life-threatening complication)
Abdominal Examination (cont.)
- Contractions
  - Frequency and duration – to confirm onset, assess stage/phase, and help identify problems
  - Character – complete relaxation in between; no constant or sudden pain
- If abnormal, woman requires urgent further evaluation/additional care (life-threatening complication)

Genital Examination
- Interpersonal skills reminders
  - Tell her what you are going to do before each step
  - Cover/drape woman to ensure privacy and respect modesty
  - Touch inside of thigh first
- Infection prevention reminders
  - Wash hands
  - Use new or high level-disinfected gloves on both hands

Genital Examination (cont.)
- Vaginal opening – nothing (e.g., cord, foot, hand) protruding from vagina; no signs of female genital cutting
- Skin – no sores, ulcers, warts, nits, or lice
- Labia – soft, not painful
- Vaginal secretions – no blood or foul-smelling, yellow/green discharge; no urine or stool
Genital Examination (cont.)

- Normal variations: mucus plug, bloody show, amniotic fluid
- If protrusions or blood, woman requires urgent further evaluation/additional care (life-threatening complication)
- If signs of FGC, woman has special need

Cervical Examination

- Dilation – dilation has begun and is continually progressing – to confirm onset, assess stage/phase, and identify problems

Cervical Examination (cont.)

- Membranes and amniotic fluid – spontaneous rupture; clear with distinct/mild odor
- If red, greenish/brownish, or foul-smelling, woman requires urgent further evaluation/additional care (life-threatening complication)
- If more than 18 hours since rupture, woman has special need
Cervical Examination (cont.)

- Presentation – cephalic
  - If abnormal, woman requires urgent further evaluation/additional care (life-threatening complication)
- Molding – fetal skull bones separated or just touching
  - If abnormal, be alert for s/s of unsatisfactory progress of labor

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Testing

Focus testing on following:
- RPR or VDRL for syphilis
- HIV (if woman does not “opt out”)
- Blood group and RH

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Rapid Plasma Reagent (RPR)* Test

- Normal: negative
- Positive test indicates syphilis and requires further evaluation/additional care (special need)

* Conduct VDRL (venereal disease research laboratory) if RPR not available
HIV Counseling and Testing
Conducted if woman does not “opt out”
- Positive test indicates HIV infection and requires further evaluation/additional care (special need)
- If woman opts out, test should be offered at all return visits
- Confidentiality of test and all HIV-related discussion essential

Blood Group and RH
- Most commonly: blood group is A, B, AB, or O; RH is positive
- If RH is negative, woman is candidate for anti-D immune globulin

Summary
- Critically consider information gathered through assessment: history, physical examination, testing
- Individualize the care plan based upon interpretation of those findings
PRESENTATION 2C
BASIC CARE DURING THE FIRST STAGE OF LABOR

Slide 1

Basic Childbirth Care
Basic Care during the First Stage of Labor

Slide 2

Session Objective
• By end of session, participants will be able to:
  • Define latent and active phases of first stage of labor
  • Describe care provision during first stage of labor

Slide 3

Stages of Labor
• 1st stage – from beginning of labor until complete (10 centimeters) dilation
• 2nd stage – from complete dilation to complete birth of baby
• 3rd stage – from complete birth of baby to complete birth of placenta
• 4th stage – from complete birth of placenta to 2 hours after birth
Slide 4

Phases of 1st Stage Labor
- Latent phase
  - Cervix: 1-3 centimeters dilated
  - Contractions: Irregular, variable frequency, duration < 20 seconds
- Active phase
  - Cervix: 4-10 centimeters
  - Contractions: Regular, increase to 3-5/10 min; duration may become > 40 seconds

Slide 5

False Labor
- No dilation or dilation is not progressive
- Contractions are irregular, less than 3 per 10 minutes, felt mainly in front
- No bloody show
- No progressive descent of presenting part

Slide 6

Care Provision during 1st Stage
- Ongoing assessment
- Ongoing supportive care
- Key action: once active phase begins, start a partograph
Basic Childbirth Care

- Throughout care provision, provider adheres to principles of basic care and incorporates key tools:
  - Clinical decision-making
  - Interpersonal skills
  - Infection prevention practices
  - Record keeping

Ongoing Assessment during 1st Stage

Latent phase:
- BP: every 4 hrs
- Temperature: every 4 hrs
- Pulse: every 4 hrs
- Fetal heart tones: every 4 hrs
- Membranes/fluids: during vaginal exam

Active phase:
- BP: every 4 hrs
- Temperature: every 2 hrs
- Pulse: every 30 min
- Fetal heart tones: every 30 min
- Membranes/fluids: during vaginal exam

Ongoing Assessment during 1st Stage (cont.)

Latent phase:
- Molding: during vaginal exam
- Descent: once
- Contractions: every 4 hrs
- Cervix: every 4 hrs
- Vaginal secretions: every 4 hrs
- Bladder: every 4 hrs
- Coping: continually

Active phase:
- Molding: during vaginal exam
- Descent: every 4 hrs
- Contractions: every 30 min
- Cervix: every 4 hrs
- Vaginal secretions: every 4 hrs
- Bladder: every 2 hrs
- Coping: continually
Supportive Care during Latent Phase: Attendance and Activity

- Attend to woman as she needs, at least every 4 hours
- Encourage presence of birth companion
- Allow woman to stay as active as she desires
- Encourage rest and sleep as possible

Supportive Care during Latent Phase: Nutrition and Elimination

- Provide plenty of nutritious drinks
- Encourage small meals as tolerated
- Encourage woman to empty bladder at least every 2 hours
- Do NOT give an enema

Supportive Care during Latent Phase: Hygiene

- Encourage bath before active phase begins
- Replace soiled blankets, sheets
- Use proper infection prevention procedures:
  - handwashing
  - antisepsis before exams
- Do not shave vulva
Slide 13

Supportive Care during Active Phase: Communication/Attendance

- Do not leave woman alone for more than 30 minutes (closer attention may be necessary if no birth companion)
- Speak reassuringly and provide information about her progress and baby’s well-being
- Tell her what is happening and what she can expect
- Never make false promises

Slide 14

Supportive Care during Active Phase: Activity and Comfort Measures

- Allow freedom to choose position
- Assist her in relaxing between contractions
- Encourage position changes throughout labor
- Massage or apply pressure to back as woman desires
- Coach in effective breathing
- Provide comfort measures such as cool cloth to face

Slide 15

Supportive Care during Active Phase: Nutrition and Elimination

- Encourage light food as tolerated
- Provide nutritious drinks to maintain hydration
- Encourage woman to empty bladder every 2 hours
- Record urine output on partograph
Slide 16

Supportive Care during Active Phase: Hygiene

- Maintain clean environment
- Clean genital area if needed prior to exam
- Wash hands before and after each exam
- Wear gloves for all vaginal exams
- Clean up spills immediately
- Replace soiled or wet blankets, sheets, or clothes

Slide 17

Key Action: Start Partograph

- A decision-making tool rather than only a record
- Start when dilation reaches 4 centimeters
- Use throughout labor to help:
  - Evaluate fetal and maternal well-being
  - Assess progress of labor
  - Identify problems
  - Guide decision making for care
  - Provide a record of findings

Slide 18

Key Action: Start Partograph (cont.)
Partograph Elements

- Identifying information
- Fetal well-being: fetal heart rate, amniotic fluid, molding
- Maternal well-being: pulse, BP, temperature, urine
- Progress of labor: cervical dilation, descent, contractions
- Oxytocin or other drugs given

Partograph Elements (cont.)

- Alert line – If plotted line stays to the left of the alert line, labor is considered to be progressing normally. If the line falls to the right, evaluate further for obstructed labor
- Action line – By the time the plotted line falls to the right of the alert line, action must be taken immediately to address prolonged labor

Summary

Help ensure maternal and fetal well-being and early detection of problems:

- Conduct ongoing assessment, provide supportive care, and perform key actions appropriate to stage/phase of labor
- Maintain clean environment
- Provide support/guidance for birth companion and family as well as for woman
PRESENTATION 2D
BASIC CARE DURING THE SECOND AND THIRD STAGE OF LABOR

Slide 1
Basic Childbirth Care
Basic Care during the Second and Third Stages of Labor

Slide 2
Session Objective
By end of session, participants will be able to:
• Define second and third stages of labor
• Describe care provision during the second stage of labor
• Describe care provision during the third stage of labor

Slide 3
Stages of Labor
• Second stage – from complete (10 cm) dilation to complete birth of baby
• Third stage – from complete birth of baby to complete birth of placenta
Care Provision during 2nd and 3rd Stages

- Ongoing assessment
- Ongoing supportive care
- Key actions:
  - Assist in pushing and normal birth
  - Initiate immediate newborn care
  - Perform active management of 3rd stage of labor

Ongoing Assessment during 2nd Stage

- BP: once
- Temperature: once
- Pulse: every 30 min
- Fetal heart tones: every 5 min
- Membranes/fluids: during vaginal exam
- Molding: during vaginal exam
- Descent: every 15 min
- Contractions: every 30 min
- Vaginal secretions: continually
- Bladder: every hour
- Coping: continually

Supportive Care during 2nd and 3rd Stages: Attendance and Communication

- Never leave the woman alone
- Look for nonverbal cues of her needs
- Use and expect minimal verbal interaction
- Give encouragement and praise
- Provide continual information and reassurance
- Never make false promises
- Encourage birth companion in support of woman
Supportive Care during 2nd and 3rd Stages: Activity/Positions

- Allow woman to choose position of most comfort (semi-sitting, squatting, hands and knees, lying on side) – guide her as needed
- Assist in relaxing between contractions
- Assist in changing positions between contractions

Supportive Care during 2nd Stage: Comfort Measures

- Lightly massage or rub back
- Apply pressure to lower back
- Stretch legs and dorsiflex foot to relieve cramps
- Provide cool cloth to face
- Continue to coach in effective breathing
- Do not encourage her to push when she has no urge

Supportive Care during 2nd Stage: Nutrition and Elimination

- Offer sips of fluid between contractions
- Have her empty her bladder before beginning to push
- Reassure her that it is normal to involuntarily lose urine and stool during birth
Slide 10

Supportive Care during 2nd and 3rd Stages: Hygiene
- Maintain clean environment
- Observe infection prevention principles
- Keep woman clean by wiping perineum whenever soiled

Slide 11

Key Actions during 2nd Stage of Labor: Pushing
- Encourage position that is comfortable and aids descent
- Have woman push in response to natural bearing-down reflex: Do NOT urge her to push
- Help her try different positions if descent is slow
- Offer encouraging feedback
- Wipe brow and offer sips of water between pushes
- Be patient – slow, steady progress is good

Slide 12

Key Actions during 2nd Stage of Labor: Normal Birth
- Ask woman to pant or give small pushes during birth of head
- Control birth of head to prevent tears
- Wipe mucus from baby’s mouth and nose as head is born
- Feel for cord around neck and manage if found
Key Actions during 2nd Stage of Labor: Completing Birth

- Allow spontaneous turning of head
- Guide birth of anterior, and then posterior, shoulder
- Support rest of body as it slips out and place on mother’s abdomen

Key Actions during 2nd Stage of Labor: No longer recommended

- Do not encourage to push when no urge
- Do not encourage sustained pushing
- No routine episiotomy
- No routine suctioning of baby

Key Actions during 3rd Stage of Labor: Immediate Newborn Care

- Thoroughly dry and cover baby, while assessing breathing – resuscitate if necessary
- Tie/clamp and cut cord
- Put in skin-to-skin contact with mother
- Encourage breastfeeding
- Palpate abdomen to rule out additional baby(ies)
Key Actions during 3rd Stage: Active Management – Why?
- Reduces length of time of 3rd stage
- Reduces amount of blood loss
- Reduces need for blood transfusions

Key Actions during 3rd Stage: Active Management – How?
- Within 1 minute of birth, give oxytocin 10 units IM
- Clamp cord close to perineum
- Apply slow, gentle traction with contraction
- Continually apply counter-traction with abdominal hand
- Hold and twist placenta with both hands as placenta delivers

Key Actions during 3rd Stage: Active Management – How? (cont.)
- Check placenta, cord and membranes
- If portion of placenta is missing or torn membranes with vessels – perform manual removal of placenta
Key Actions during 3rd Stage: Active Management – How? (cont.)

- Immediately massage uterus through abdomen until well contracted
- Inspect for tears of vagina or perineum

Summary

Help ensure maternal and fetal/newborn well-being and early detection of problems:

- Conduct ongoing assessment, provide supportive care, and perform key actions appropriate to stage/phase of labor
- Maintain clean environment
- Provide support/guidance for birth companion and family as well as for woman
PRESENTATION 3A
BASIC CARE DURING THE FOURTH STAGE OF LABOR

Slide 1

Basic Childbirth Care

Basic Care during the Fourth Stage of Labor

Slide 2

Session Objective

• By end of session, participants will be able to:
  • Define fourth stage of labor
  • Describe care provision during fourth stage of labor

Slide 3

Fourth Stage of Labor

• Begins with complete delivery of placenta
• Ends at 2 hours after birth of placenta
Slide 4

Care Provision during Fourth Stage

- Ongoing assessment of woman and baby
- Ongoing supportive care of woman and baby
- Key actions:
  - Initiate immediate postpartum care
  - Continue immediate newborn care

Slide 5

Ongoing Assessment of Woman during Fourth Stage

- BP: every 15 min
- Temperature: once
- Pulse: every 15 min
- Vaginal secretions/bleeding: every 15 min
- Bladder: every 15 min
- Coping: continually
- Uterine fundus: every 15 min

Slide 6

Ongoing Assessment of Newborn during Fourth Stage

- Breastfeeding: as appropriate
- Mother-baby bonding: continually
- Respirations: every 15 min
- Warmth: every 15 min
- Color: every 15 min
Supportive Care during Fourth Stage: Attendance and Communication

- Attend woman at least every 15 minutes
- Check bleeding, uterus, and vital signs
- Give continual encouragement and reassurance
- Provide information about her and her baby
- Encourage questions and expressions of feeling
- Encourage birth companion to stay with woman

Supportive Care during Fourth Stage: Rest and Comfort

- Ensure enough blankets to maintain warmth
- Maintain a calm environment that is conducive to rest

Supportive Care during Fourth Stage: Nutrition and Elimination

- Encourage woman to eat and drink as she desires
- Encourage woman to pass urine when urge is felt or bladder is palpable
Supportive Care during Fourth Stage: Hygiene

- Maintain clean environment
- Observe infection prevention principles
- Keep clean pads/cloths on perineum

Supportive Care during Fourth Stage: Mother-Baby Bonding

- Ensure that mother and newborn are kept together
  – facilitate rooming in
- Maintain skin-to-skin contact as much as possible
- Encourage early and exclusive breastfeeding
- Encourage mother to freely explore baby
- Encourage woman and family to hold and cuddle baby as they want
- Help build woman’s confidence with praise and encouragement

Key Action: Initiate Immediate Postpartum Care for Woman

- Measure her temperature
- Continue uterine massage every 15 minutes
- Help initiate breastfeeding
- Review danger signs and complication readiness plan before discharge
- Counsel on continuing uterine massage
Key Action: Continue Immediate Newborn Care

- Help initiate breastfeeding
- Securely attach identification
- Provide eye care: wipe at birth, instill antimicrobial within hour of birth
- Give Vitamin K IM
- Review danger signs and complication readiness plan before discharge
- Counsel on: maintaining warmth, feeding, and key aspects of newborn care
- May conduct newborn physical exam

Overall Appearance/General Well-Being (Every Visit)

- Weight/birth weight
  - Less than 2 kg requires urgent referral/transfer
  - More than 4 kg or 2-2.5 kg requires further evaluation/additional care (special need)
- Respirations – 30-60 breaths/minute; no gasping gruntling, or chest indrawing
- Temperature – 36.5-37.5°C

Overall Appearance/General Well-Being (cont.)

- Color – pink lips, tongue, nailbeds, soles/palms; no central cyanosis, pallor or jaundice
- Abnormal findings in respiration, temperature, or color require urgent referral/transfer or urgent further evaluation/additional care (life threatening complications)
Slide 16

**Overall Appearance/General Well-Being (cont.)**

- Movements and posture: regular and symmetrical; no convulsions, spasms (A), or opisthotonos (B)

---

Slide 17

**Overall Appearance/General Well-Being (cont.)**

- Irregular or symmetrical movements require nonurgent referral/transfer
- Convulsions, spasms, or opisthotonos requires newborn rapid initial assessment (RIA) (life-threatening complication)

---

Slide 18

**Overall Appearance/General Well-Being (cont.)**

- Level of alertness and muscle tone: baby should respond to handling, be easily roused from sleep and not overly irritable (consolable when upset)
  - Nonresponsiveness, flappiness, lethargy, or inconsolable crying requires urgent referral/transfer
  - For loss of consciousness, perform newborn RIA (life-threatening complication)
Overall Appearance/General Well-Being (cont.)

Skin:
- Clear, and free from bruises and abrasions
- Rash is a common concern; usually normal
- Bruises that appear within 2 or 3 days with no evidence of trauma require urgent referral/transfer
- Cuts and abrasions that:
  - Are not bleeding require further evaluation/additional care
  - Continue to bleed after 15 minutes of compression require urgent further evaluation/additional care

Head, Face and Mouth, Eyes

Head:
- Symmetrical
- Soft and flat fontanelles without wide sutures
- Size proportionate to body
- Swollen or misshapen head is common concern; often normal
- Bulging fontanelles, wide sutures, swelling that crosses sutural lines requires urgent referral/transfer
- Size not proportionate to body requires nonurgent transfer

Face and mouth:
- Features and movements are regular and symmetrical
- Lips, gums, and palate are intact
- Findings not within normal range require nonurgent referral/transfer
Head, Face and Mouth, Eyes (cont.)

Eyes:
- No swelling, redness, pus
- A bright red spot on eye is a common concern; often normal
- Other findings not within normal range require urgent further evaluation/additional care (life-threatening complication)

Chest, Abdomen and Cord, External Genitalia (Every Visit)

Chest:
- Regular, symmetrical movements
- No indrawing
- Findings not within normal range require urgent referral/transfer

Chest, Abdomen and Cord, External Genitalia (cont.)

- Abdomen is rounded, not distended
- Stump is dry; no blood, pus, redness, swelling, hardened skin, or offensive smell
- Umbilical hernia is a common concern; often normal
Slide 25

**Chest, Abdomen and Cord, External Genitalia (cont.)**

- Genitals are regular and symmetrical – swollen labia and scrotal sac are common concerns; usually normal
- Anus appears imperforate – if not, facilitate urgent referral/transfer

**NOTE:** Do not insert anything into anus to confirm patency.

Slide 26

**Back and Limbs**

- Back is free of swelling, lesions, dimples, hairy patches – if not, facilitate urgent referral/transfer
- Limbs are free of swelling and regular/symmetrical in appearance, position, movement – if not, facilitate nonurgent referral/transfer

Slide 27

**Breastfeeding**

Observe breastfeeding to assess:
- Positioning
- Holding
- Attachment and suckling
- Woman’s comfort
- Baby’s satisfaction and softness of breasts upon finishing feed
**Slide 28**

**Breastfeeding (cont.)**

Problems in any of these areas:
- require further evaluation/additional care (special need)
- may indicate need for breastfeeding support (techniques) or management of breast condition (mastitis, sore nipples, etc.)

**Slide 29**

**Mother-Baby Bonding (Every Visit)**

During breastfeeding and throughout visit, assess following:
- Physical contact: caressing, holding
- Communication: eye contact, talking
- Empathy: active concern for baby

Problems in any of these areas require further evaluation/additional care (special need)

**Slide 30**

**Summary**

Help ensure maternal and newborn well-being and early detection of problems:
- Conduct ongoing assessment, provide supportive care, and perform key actions appropriate to stage/phase of labor
- Maintain clean environment
- Always respect mother and baby dyad
PRESENTATION 4A
ADDITIONAL CARE I: COMMON DISCOMFORTS OF LABOR/CHILDBIRTH AND THE POSTPARTUM/NEWBORN PERIOD

Slide 1

Additional Care I
Common Discomforts of Labor/Childbirth and the Postpartum/Newborn Period

Slide 2

Session Objective
• By end of session, participants will be able to
  • explain some key common discomforts/concerns of childbirth and postpartum/newborn periods
  • describe additional care for women and newborns who have them

Slide 3

Overview
Common discomforts/concerns:
• changes, signs and symptoms, and physical and emotional behaviors that may occur during pregnancy, labor/childbirth, and postpartum/newborn period
• cause discomfort or concern but are usually normal
Overview (cont.)

• Women and newborns who present with s/s of common discomforts/concerns require care in addition to core components of basic care. This may consist of:
  • Additional assessment
  • Additional care

Overview (cont.)

• During assessment – confirm that discomfort/concern is within normal range
• During care provision:
  • Reassure – no threat to her or newborn
  • Explain anatomic/physiologic basis in simple terms
  • Counsel on prevention and relief measures
  • Advise to return for care if symptoms worsen or danger signs or alert signs arise

Common Discomforts: Women’s Abdomen, Breasts, and Legs (cont.)

• Afterpains – Cramps, contractions as in labor (4th stage of labor, days 2-4 postpartum)
• Leg cramps (labor) – Sudden in onset, of short duration (1st–2nd stage of labor)
• Swelling (edema) of ankles and feet – Appears after sitting standing long, disappears after rest and elevating feet (1st–2nd stage of labor)
### Example: Afterpains

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures - reassurance and</th>
<th>Alert sig – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine tenderness, abdominal distension – uterine infection or rupture</td>
<td>Uterine tenderness, abdominal distension</td>
<td>-</td>
</tr>
<tr>
<td>Flank/loin pain, increased or burning urination – UTI</td>
<td>Flank/loin pain, increased or burning urination</td>
<td>-</td>
</tr>
</tbody>
</table>

**Prevention and relief measures – reassurance and:**
- Lie face down with pillow under abdomen
- Massage/apply pressure
- Apply warm cloth
- Walk or change position
- Empty bladder often
- If no relief - seek help

### Example: Leg Cramps

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures - reassurance and</th>
<th>Alert sig – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localized deep vein - swelling – superficial thrombophlebitis</td>
<td>Localized deep vein - swelling – superficial thrombophlebitis</td>
<td>-</td>
</tr>
<tr>
<td>Cell tenderness, swelling with fever – deep vein thrombosis</td>
<td>Cell tenderness, swelling with fever – deep vein thrombosis</td>
<td>-</td>
</tr>
</tbody>
</table>

**Prevention and relief measures – reassurance and:**
- Massage/apply pressure
- Apply warm cloth
- Straighten knee and flex foot upward
- Change positions frequently
- Unclear etiology
- Possibly pressure from fetal head descending

### Example: Swelling of Ankles and Feet

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures - reassurance and</th>
<th>Alert sig – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache, blurred vision, other s/s of pre-eclampsia/eclampsia</td>
<td>Headache, blurred vision, other s/s of pre-eclampsia/eclampsia</td>
<td>-</td>
</tr>
<tr>
<td>Pallor, breathlessness, other s/s of severe anemia</td>
<td>Pallor, breathlessness, other s/s of severe anemia</td>
<td>-</td>
</tr>
<tr>
<td>Swelling of ankles and feet</td>
<td>Swelling of ankles and feet</td>
<td>-</td>
</tr>
</tbody>
</table>

**Prevention and relief measures – reassurance and:**
- Elevate feet
- Change positions frequently
- Increase intake of fluid
- Hormonal changes cause increased sodium, vein congestion, capillary leakage
- Pressure from enlarged uterus on veins
- Pregnancy varices
- Pregnancy edema
Common Discomforts: Women’s Digestion and Elimination

- Bowel function changes – constipation or diarrhea (throughout postpartum)
- Urination, increased (1st-2nd stage of labor and immediate postpartum)

Example: Bowel Function Changes

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and</th>
<th>Alert s/s – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>Advice: increased intake of fiber and fluids.</td>
<td>Rapidly progressing difficulty in defecating, gas, bloating and other s/s of bowel obstruction.</td>
</tr>
<tr>
<td></td>
<td>Delicate when urge in bladder. Avoid laxatives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walk within 6 hours of normal birth, increase exercise daily.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For diarrhea, also:</td>
<td>Ensure intake of electrolytes.</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Advice: increased intake of fiber and fluids.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delicate when urge in bladder. Avoid laxatives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Walk within 6 hours of normal birth, increase exercise daily.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For diarrhea, also:</td>
<td>Ensure intake of electrolytes.</td>
</tr>
</tbody>
</table>

Example: Urination, Increased

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and</th>
<th>Alert s/s – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure from uterus and fetus on bladder</td>
<td>Advice: void when urge is felt, lean forward to empty bladder completely. Avoid intake of coffee, tea, and cola but do not restrict fluid intake.</td>
<td>Increased blood and s/s of diabetes.</td>
</tr>
<tr>
<td>Increase of body fluid volume</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased blood flow to kidneys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased excretion of sodium and water</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Common Discomforts: Women’s Genitals

- Perineal pain (weeks 1-2 postpartum)
- Vaginal discharge (throughout labor)

Example: Perineal Pain

<table>
<thead>
<tr>
<th>Alert s/s – may indicate problem</th>
<th>Prevention and relief measures – reassurance and:</th>
<th>Anatomic/physiologic basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain in suture line or healing</td>
<td>Ensure good hygiene</td>
<td>Tissue trauma/tears or bruising due to birth</td>
</tr>
<tr>
<td>Ulcer, sloughing, or swelling</td>
<td>Soak in warm/sitz bath in disinfected tub or bowl</td>
<td></td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td>Maintain clean and dry vulva/perineum</td>
<td></td>
</tr>
<tr>
<td>Use ice pack or analgesic cream</td>
<td>Use pad when out of bed</td>
<td></td>
</tr>
<tr>
<td>Sitz or cushion with hole in center</td>
<td>Expulsion of mucus plug when cervix thins and dilates</td>
<td></td>
</tr>
<tr>
<td>Breastfeed while lying down</td>
<td>Bloody show as labor progresses</td>
<td></td>
</tr>
</tbody>
</table>

Example: Vaginal Discharge

<table>
<thead>
<tr>
<th>Alert s/s – may indicate problem</th>
<th>Prevention and relief measures – reassurance and:</th>
<th>Anatomic/physiologic basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sis of STI or vaginitis</td>
<td>Ensure good hygiene</td>
<td>Expulsion of mucus plug when cervix thins and dilates</td>
</tr>
<tr>
<td>Gush or persistent trickle of fluid before onset of labor</td>
<td>Maintain clean and dry vulva/perineum</td>
<td></td>
</tr>
<tr>
<td>Pre-labor rupture of membranes</td>
<td>Use pad when out of bed</td>
<td></td>
</tr>
<tr>
<td>Pre-labor rupture of membranes</td>
<td>Use ice pack or analgesic cream</td>
<td></td>
</tr>
<tr>
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<td>Use warm/sitz bath in disinfected tub or bowl</td>
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</tr>
<tr>
<td>Expulsion of mucus plug when cervix thins and dilates</td>
<td>Use ice pack or analgesic cream</td>
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</tr>
<tr>
<td>Bloody show as labor progresses</td>
<td>Use warm/sitz bath in disinfected tub or bowl</td>
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<tr>
<td>Use ice pack or analgesic cream</td>
<td>Maintain clean and dry vulva/perineum</td>
<td></td>
</tr>
<tr>
<td>Use warm/sitz bath in disinfected tub or bowl</td>
<td>Use mucus plug when cervix thins and dilates</td>
<td></td>
</tr>
</tbody>
</table>
Common Discomforts: Women’s Skin

- Varicose veins – swollen blue veins on legs or genitals, may be painful (1st-2nd stage of labor)

Example: Varicose Veins

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Pressure from enlarging uterus leads to venous congestion</td>
<td></td>
</tr>
<tr>
<td>- Smooth muscle relaxation due to hormonal changes</td>
<td></td>
</tr>
<tr>
<td>- Familial tendency</td>
<td></td>
</tr>
<tr>
<td>Relief - Change positions frequently</td>
<td></td>
</tr>
<tr>
<td>- Use physiologic pushing during second stage to decrease congestion</td>
<td></td>
</tr>
</tbody>
</table>

Alert s/s – may indicate problem:

- Signs of superficial thrombophlebitis and deep-vein thrombosis
- Hematoma of vulvar varicosity - rupture of varicosis

Common Discomforts: Women’s Sleep and Mental State

- Fatigue or sleepiness (week 1 postpartum)
- Feelings of inadequacy, worry, or fear during postpartum period (weeks 1-2 postpartum)
- Insomnia (week 1 postpartum)
- Mood swings (1st-2nd stage of labor)
Example: Fatigue or Sleepiness during Postpartum Period

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures — reassurance and:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional stress</td>
<td>Remind importance of adequate sleep; exercise and rest.</td>
</tr>
<tr>
<td>Reaction to hard work of labor</td>
<td>Avoid smoking, alcohol and over-exertion.</td>
</tr>
<tr>
<td>Interruptions</td>
<td>Encourage family to share responsibilities of newborn care.</td>
</tr>
</tbody>
</table>

Alert s/s — may indicate problem:
- Change in state of consciousness — may indicate impending convulsions.
- Inappropriate guilt or sadness — may indicate postpartum depression.
- Hallucinations, delusions — may indicate postpartum psychosis.

Example: Feelings of Inadequacy, Worry, or Fear during Postpartum Period

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures — reassurance and:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiologic changes</td>
<td>Praise and encourage her parenting abilities; listen to her concerns.</td>
</tr>
<tr>
<td>Importance (first-time mother)</td>
<td>Allow woman breaks for self or socializing.</td>
</tr>
<tr>
<td>Challenges of newborn care</td>
<td>Reinforce importance of adequate sleep, exercise, and rest.</td>
</tr>
</tbody>
</table>

Alert s/s — may indicate problem:
- Crying, sadness; feeling overwhelmed, irritable — postpartum depressive symptoms.
- Insomnia, excessive sadness or guilt; feeling worthless more than 1 week — postpartum depression.
- Marital or suicidal thoughts; hallucinations — postpartum psychosis.

Common Discomforts: Women’s Miscellaneous

- Back pain (1st-2nd stage of labor, week 1 postpartum)
- Feeling hot (1st-3rd stage of labor)
- Headache (1st-3rd stage of labor, day 1-2 postpartum)
Common Discomforts: Miscellaneous (cont.)

- Hemorrhoids – swollen veins in or around rectum, may be painful or itchy (1st-3rd stage of labor, week 1 postpartum)
- Hyperventilation or shortness of breath (1st-2nd stage of labor)
- Nasal stuffiness or nasal bleeding (1st-3rd stage of labor)

Common Discomforts: Miscellaneous (cont.)

- Numbness/tingling of fingers and toes – may also occur in buttocks, hips, thighs (1st-2nd stage of labor)
- Shivering and quivering (4th stage of labor)
- Walking awkwardly (waddling) or clumsiness (1st stage of labor)

Example: Headache

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures</th>
<th>Alert signs – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hormonal changes</td>
<td>Massage neck and shoulders</td>
<td>Sids of pre-eclampsia or headaches</td>
</tr>
<tr>
<td>Muscle spasm</td>
<td>Rest between contractions</td>
<td></td>
</tr>
<tr>
<td>Emotional stress</td>
<td>Drink plenty of fluids and eat small meals</td>
<td></td>
</tr>
<tr>
<td>Low blood sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dehydration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prevention and relief measures include:
- Massage neck and shoulders
- Rest between contractions
- Drink plenty of fluids and eat small meals
- Stop smoking
- Cut down on caffeine
- Drink water
- Sleep and rest
- Wear cool, lightweight clothing
- Take moderate exercise
- Eat a balanced diet
- Avoid bright lights
- Take a warm bath
- Stay away from bright lights
- Take deep breaths
- Use relaxation techniques
- Take a warm bath
- Take a warm shower
Example: Hemorrhoids

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and</th>
<th>Alert/s – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hormonal changes</td>
<td>• Increase fiber and fluids</td>
<td>Complain with anal pain and/or bleeding or anal fissures</td>
</tr>
<tr>
<td>• Enlargement</td>
<td>• Soak in warm/sitz bath</td>
<td></td>
</tr>
<tr>
<td>• Congestion of rectal</td>
<td>• Apply topical anesthetic ointment</td>
<td></td>
</tr>
<tr>
<td>• Pressure of uterus</td>
<td>• Avoid constipation</td>
<td></td>
</tr>
<tr>
<td>• Pressure of uterus and</td>
<td>• Assume position that takes pressure off</td>
<td></td>
</tr>
<tr>
<td>• Pressure on rectum</td>
<td>rectum (e.g., hands and knees)</td>
<td></td>
</tr>
<tr>
<td>• Extreme pressure on</td>
<td>• Use physiologic pushing during 2nd stage</td>
<td></td>
</tr>
<tr>
<td>rectum during pushing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Common Concerns:
Newborn Chest, Abdomen, Cord Stump, External Genitalia

- Mucoid or bloody vaginal discharge (1st week after birth)
- Swollen breasts (1st week after birth)
- Swollen labia (birth)
- Swollen scrotal sac – edema or hydrocele (birth)

Common Concerns:
Newborn Chest, Abdomen, Cord Stump, External Genitalia (cont.)

- Tight foreskin (birth)
- Umbilical hernia – profusion at base of umbilicus that is covered with skin (birth)
Example: Mucoid or Bloody Vaginal Discharge

Anatomic/physiologic basis
- Exposure to mother’s hormones during pregnancy

Prevention and relief measures – reassurance and:
- Advise:
  - Condition should resolve by 7 days after birth
  - No special care needed
  - Return if worsens or alert/danger signs arise

Example: Swollen Scrotal Sac

Anatomic/physiologic basis
- Edema – caused by pressure during labor
- Hydrocele – fluid leakage from peritoneal cavity into sac, when hole between them is not closed yet

Prevention and relief measures – reassurance and:
- Advise:
  - Edema should resolve by 7 days after birth; hydrocele by 6-12 months
  - No special care needed
  - Return if worsens or alert/danger signs arise

- Edema – caused by pressure during labor
- Hydrocele – fluid leaking from peritoneal cavity into sac when hole between them is not closed yet

Example: Umbilical Hernia

Anatomic/physiologic basis
- Fluid from abdomen or loop of bowel that protrudes through abdominal muscle

Prevention and relief measures – reassurance and:
- Advise:
  - Condition should resolve by 1 year of age
  - No special care needed
  - Do not bind baby to flatten bulge
  - Return if worsens or alert/danger signs arise

- Persistent vomiting, abnormal bowel – bowel obstruction
**Slide 31**

**Common Concerns: Newborn Head, Face, Mouth, Eyes**

- Caput succedaneum – edematous swelling over presenting part of head (birth)
- Cephalohematoma – swelling that does not cross suture lines, is firm and usually on one side of head (by 24 hours after birth)
- Epithelial pearls – white cysts on gums or roof of mouth (birth)

---

**Slide 32**

**Common Concerns: Newborn Head, Face, Mouth, Eyes (cont.)**

- Molding or chignon – misshapen head, artificial caput from instruments (birth)
- Subconjunctival hemorrhage – bright red spot on sclera (birth)
- Swollen or red eyes (birth)
- Tongue tie – tight or short band of tissue between tongue and floor of mouth (birth)

---

**Slide 33**

**Example: Caput Succedaneum**

<table>
<thead>
<tr>
<th>Anatomy/physiologic basis</th>
<th>Prevention and relief measures/reassurance and:</th>
<th>Alert s/s – may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caused by pressure on head during birth</td>
<td>Admnr</td>
<td>Failure to resolve within 72 hours – brain or skull malformation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Large head with wide sutures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hydrocephalus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Swelling that crosses suture lines and other s/s of subgaleal hemorrhage</td>
</tr>
</tbody>
</table>
Example: Cephalohematoma

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and:</th>
<th>Alert signs – may indicate problem:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caused by bleeding between outer surface of skull bones and scalp due to pressure on head during birth</td>
<td>Advice:</td>
<td>Failure to resolve by 12 weeks – brain or skull malformation:</td>
</tr>
<tr>
<td></td>
<td>Size may remain stable or increase 3-5 days after birth:</td>
<td>S/s of subgaleal hemorrhage:</td>
</tr>
<tr>
<td></td>
<td>Complication may take 12 weeks to completely resolve:</td>
<td>S/s of cyanosis:</td>
</tr>
<tr>
<td></td>
<td>No special care needed:</td>
<td>Yellowishness of skin – jaundice:</td>
</tr>
<tr>
<td></td>
<td>Return if it worsens or alert/danger signs arise</td>
<td></td>
</tr>
</tbody>
</table>

Example: Subconjunctival Hemorrhage

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and:</th>
<th>Alert signs – may indicate problem:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caused by bleeding from capillaries in sclera due to pressure on head and eyes during birth</td>
<td>Advice:</td>
<td>Failure to resolve by 3 weeks – trauma, congenital anomaly, other abnormal condition:</td>
</tr>
<tr>
<td></td>
<td>Condition should resolve by 2-3 weeks after birth:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No special care needed:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Return if it worsens or alert/danger signs arise</td>
<td></td>
</tr>
</tbody>
</table>

Common Concerns: Newborn Skin

- Acne – pinpoint red bumps on face, back chest (by 2 weeks)
- Diaper/nappy rash – diffuse redness/irritation in groin area (within first weeks)
- Erythema toxicum – patchy red rash with white area in middle, all over (by 2-3 days)
- Milia – tiny white bumps on face (within first weeks)
Common Concerns: Newborn Skin (cont.)

- Mongolian spots – purplish-gray flat marks on lower back/buttock area (birth)
- Port wine stains – red or purple flat marks on face and neck (birth)
- "Stork bites" – pink marks on nose, eyelids, back of neck (birth)

Example: Acne

<table>
<thead>
<tr>
<th>Acne/physiologic basis</th>
<th>Prevention and relief measures – reassurance and:</th>
<th>Alert sign – may indicate problem:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to mother's hormones during pregnancy</td>
<td>Pustules or small boils – skin infection</td>
<td></td>
</tr>
</tbody>
</table>

Alert: Condition often resolves within weeks but may remain up to 6 months of age
- No special care needed
- Return if it worsens or alert/danger signs arise

Common Concerns: Newborn Miscellaneous

- Crying, increased (within first month)
- Irregular breathing – respirations 20-60/min with occasional pauses of less than 6 seconds (within first weeks)
- Startle reflex – rapid, symmetrical stiffening in response to touch or noise (birth)
- Vomiting (within first week)
Example: Startle Reflex

<table>
<thead>
<tr>
<th>Anatomic/physiologic basis</th>
<th>Prevention and relief measures – reassurance and:</th>
<th>Alert signs — may indicate problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal neurologic reflex</td>
<td>Advise:</td>
<td>Continuous jitteriness — low blood glucose or sepsis</td>
</tr>
<tr>
<td></td>
<td>• Emphasize that reflex is not indication of brain problem</td>
<td>Asymmetrical movements of arms or legs — birth injury</td>
</tr>
<tr>
<td></td>
<td>• Observed within 2-4 months of age</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• No special care needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Return if worsens or alert/danger signs arise</td>
<td></td>
</tr>
</tbody>
</table>

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Summary

- Although common discomforts/concerns are normal, they require additional care
- The skilled provider should:
  - Reassure woman
  - Explain basis for her discomfort or concern
  - Counsel woman on prevention/relief measures
  - Advise her to return if condition worsens or danger or alert signs develop
PRESENTATION 4B
ADDITIONAL CARE II: SPECIAL NEEDS OF LABOR/CHILDBIRTH AND THE POSTPARTUM/NEWBORN PERIOD

Slide 1

Additional Care II
Special Needs of Labor/Childbirth and the Postpartum/Newborn Period

Slide 2

Session Objective
- By end of session, participants will be able to:
  - Explain some key special needs
  - Describe additional care for women and newborns who have these special needs

Slide 3

Overview
- Special needs are conditions or social/personal factors that should be taken into consideration when planning and implementing care
Overview (cont.)

Women and newborns with special needs require care in addition to core components of basic care. This may consist of:
- Additional assessment
- Additional care provision

Overview (cont.)

During assessment:
- Focus on certain elements of assessment and/or add new elements (e.g., tests)
- Confirm and/or assess nature of need (e.g., severity, related factors)
- Confirm that woman or newborn does not have more serious condition/problem

Overview (cont.)

During care provision:
- Explain benefits of addressing need
- Emphasize certain elements of care plan and/or add new elements (e.g., drugs, messages)
- Make special recommendations regarding complication readiness plan, if needed
Slide 7

Overview (cont.)

During care provision (cont.):
- Schedule additional healthcare visits, if needed
- Link woman and newborn to appropriate local sources of support or specialists, as appropriate
  - maintain up-to-date list of local resources
- Advise to return for care if symptoms worsen or danger or alert signs arise

Slide 8

Presenting Special Needs

- Adolescence (19 years of age and under)
- Anemia (mild to moderate)
- Breast and breastfeeding problems
- Breech presentation in labor
- Burning on urination
- False labor

Slide 9

Presenting Special Needs (cont.)

- Female genital cutting
- HIV
- Living in area of endemic:
  - Hookworm infection
  - Malaria infection
  - Vitamin A deficiency
  - Iodine deficiency
Presenting Special needs (cont.)

- Multiple pregnancy
- Poor obstetric history
- Postpartum sadness ("blues")
- Prelabor rupture of membranes or membranes ruptured for more than 18 hours before birth

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Presenting Special needs (cont.)

- Size-date discrepancy
  - After 22 weeks’ gestation
- Stillbirth or newborn death
- Syphilis
- Tears and incisions during postpartum period

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Presenting Special needs (cont.)

- Urinary retention
- Uterine subinvolution
- Violence against women
Anemia
Care for woman with mild to moderate anemia focuses on preventing severe anemia
- During pregnancy and breastfeeding – body requires more iron than usual
- Severe anemia during pregnancy – associated with premature birth, increased perinatal and maternal mortality, infection

Anemia: Additional Assessment
In addition to basic assessment:
- Recognize s/s of anemia:
  - Symptoms – weakness, tiredness, shortness of breath, dizziness, and fainting
  - Signs – pallor of conjunctiva; hemoglobin levels below 11 g/dL
  - If hemoglobin levels less than 7 g/dL, woman has severe anemia and requires urgent referral/transfer

Anemia: Additional Assessment (cont.)
Try to determine cause of anemia:
- Postpartum hemorrhage in last 2-3 years
- Living in area of endemic malaria or hookworm infection
- HIV
- Any of above – further evaluation/ additional care (special need)
Slide 16

**Anemia: Additional Assessment (cont.)**

Try to determine cause of anemia (cont.):
- Unknown – facilitate nonurgent referral/transfer
- Dietary iron deficiency – proceed with additional care provision

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Slide 17

**Anemia: Additional Care Provision**

- Reinforce importance of:
  - Eating iron-rich foods with vitamin C
  - Not eating iron-rich foods with foods that inhibit iron absorption – e.g. tea, coffee, bran
  - Taking iron/folate as prescribed and managing any side effects
  - Retest woman’s hemoglobin levels in 1 month – to ensure good response to iron therapy

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Slide 18

**Breast and Breastfeeding Problems**

- Ineffective attachment/suckling
- Improper technique (holding, positioning)
- Maternal pain or discomfort due to engorged breasts, blocked ducts, sore/cracked nipples, or mastitis
Breast and Breastfeeding Problems (cont.)

- Flat or inverted nipples
- Maternal concerns about insufficient milk supply
- Signs of inadequate intake (e.g., urinating less than 6 times/day after first 48 hours)

Breast and Breastfeeding Problems (cont.)

Depending on presenting s/s, additional assessment focuses on defining problem and determining underlying cause:
- signs of inadequate intake
- ineffective attachment/suckling
- illness/abnormal s/s in mother and newborn

Breast and Breastfeeding Problems (cont.)

Additional care focuses on addressing problem:
- Reassurance
- Breastfeeding support (techniques)
- Messages and treatment for prevention, relief, cure of breast problems
- Review of danger/alert signs and complication readiness
Example: Additional Care for Engorged Breasts/Blocked Ducts

• Explain that this is normal, even if painful, and should resolve over time
• Advise woman on methods for emptying breasts to lessen engorgement (e.g., warm compresses and massage before feed)

Example: Additional Care for Engorged Breasts/Blocked Ducts (cont.)

• Provide her with information on relieving discomfort (e.g., cold compresses between feeds)
• Advise her to return for care if she notes alert signs: red, warm, or more painful breasts, or fever/chills

Female Genital Cutting (FGC): Additional Assessment

Determine type of FGC that woman has:
• Clitoridectomy (Type I): partial clitoris removed
• Excision (Type II): partial clitoris and prepuce removed; partial/total excision of labia minora
• Infibulation (Type III): clitoris and labia minora removed; incised sides of labia majora stitched together
• Unclassified procedure
Slide 25

FGC - Type 1:
Area Cut (Left) and Healed (Right)

Slide 26

FGC - Type 2:
Area Cut (Left) and Healed (Right)

Slide 27

FGC - Type 3:
Area Cut (Left) and Healed (Right)
Slide 28

**FGC: Additional Assessment (cont.)**

Determine whether scar is well healed or complicated by other factors
- If well-healed Type I or II, proceed to additional care provision
- If well-healed Type III, proceed to additional care provision, which must include defibulation
- If FGC scar complicated by other factors (large keloids, dermoid cysts, infected ulcers, cysts), woman requires nonurgent referral/transfer

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Slide 29

**FGC: Additional Care Provision**

Well-healed Type I or II:
- Reassure woman – will not complicate childbirth

Well-healed Type III:
- Advise woman that defibulation is necessary for birth
  - Ideally during 2nd trimester of pregnancy
  - Can be done during 2nd stage of labor – but increased chance of infection and bleeding

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Slide 30

**FGC: Additional Care Provision (cont.)**

- Counseling – include partner/decision-maker:
  - Inform them that reinfibulation is unnecessary
  - Discuss medical risks of reinfibulation
  - Support woman in her decision
Slide 31

HIV

- Throughout childbearing cycle, women with HIV should receive same basic care provided to all women plus additional care
- While caring for HIV-positive woman, always:
  - Respect her confidentiality
  - Provide reassurance and encouragement
  - Be empathetic and nonjudgmental

Slide 32

Main Goals of CPNC for HIV-Positive Women

- Maximize and maintain health of mother
- Prevent mother-to-child-transmission (MTCT) of HIV
- Prevent HIV transmission to uninfected partners
- Linkage to appropriate healthcare or supportive services

Slide 33

HIV: Additional Assessment

- Ensure that she is under care of HIV specialist
- Determine whether receiving ARV therapy
- Assess support systems; risk of abandonment or abuse
- Assess for coexistent conditions and opportunistic infections
HIV: Post-Test Counseling for Positive Result

- Provide results, reassuring confidentiality
- Provide immediate emotional support
- Be alert for destructive reactions
- Ensure support during next hours/days
- Assess risk of abandonment and abuse
- Discuss/role play disclosure

HIV: Post-Test Counseling for Positive Result (cont.)

- Assess risk of abandonment and abuse
- Outline methods of preventing HIV
- Discuss importance of care with HIV specialist
- Inform her of local HIV programs, support groups, and other resources (linkage)
- Proceed with additional care provision

HIV: Additional Care Provision

- Help identify personal support system
- Assist in planning for future
- Discuss newborn feeding options
- Provide relevant health messages and counseling
- Discuss ARV treatment options
- Link to local HIV programs, support groups, and other resources
HIV: Newborn Feeding

- Counsel woman about feeding options: breastfeeding or replacement feeding (using breastmilk substitute)
- Discuss risks and benefits of each
  - Breastfeeding has many benefits for mother and newborn but increases risk of MTCT of HIV
  - Support woman in her decision

HIV: Newborn Feeding (cont.)

- If use of breastmilk substitute is feasible, acceptable, safe, affordable, available/accessible, avoidance of all breastfeeding is recommended for HIV-positive women – but it is still her decision to make

HIV: Newborn Feeding (cont.)

- If woman chooses replacement feeding – counsel on safe preparation and administration of breastmilk substitute
- If woman chooses breastfeeding – counsel on following:
  - Exclusivity – breastfeeding should not be alternated with replacement feeds (“mixed” feeding increases risk of MTCT)
Slide 40

HIV: Newborn Feeding (cont.)
- Discontinuation
  - As early as possible, between 4 and 6 months
  - Should be abrupt, not gradual, and followed by
    exclusive replacement feeding
- Prompt medical attention needed – for
  conditions such as mastitis, breast
  abscess, and fungal infection of nipples

Slide 41

HIV: Health Messages
and Counseling

Reinforce importance of:
- Reducing workload; increasing rest
- Consistent condom use during postpartum period
- Good nutrition
- Family planning
- Attending all PPC visits

Slide 42

HIV: Antiretroviral Therapy
- If woman is on ARV, advise her to
  continue therapy with HIV specialist
- If woman is not on ARV, provide therapy
  according to local guidelines
  - If no local guidelines, use following guidelines
**Slide 43**

**HIV: Antiretroviral Therapy (cont.)**

During labor/childbirth:
- Nevirapine (NVP)*
  - Woman: 200 mg orally at onset
  - Newborn: 2 mg/kg syrup by 72 hours
- Additional regimens available for scenarios such as no antenatal care, false labor, birth less than 2 hours after receiving NVP, cesarean section, home birth

**Slide 44**

**HIV: Antiretroviral Therapy (cont.)**

Zidovudine (ZDV, AZT, Retrovir):
- Woman:
  - Short course
    - 300 mg orally twice daily
    - from 36 weeks gestation to onset of labor (then 300 mg orally every 3 hours until birth)
  - Long course
    - 300 mg orally twice daily OR 200 mg orally 3 times daily OR 100 mg orally 5 times daily
    - from 14 to 34 weeks gestation to onset of labor (then 2 mg/kg IV for first hour, then 1 mg/kg per hour until birth)
- Newborn: 2 mg/kg syrup per 6 hours for 6 weeks

**Slide 45**

**HIV: Antiretroviral Therapy (cont.)**

Zidovudine (ZDV, AZT, Retrovir) and Lamivudine (3TC):
- Woman:
  - ZDV 400 mg plus 3TC 150 mg orally at onset, and
  - ZDV 300 mg per 3 hours plus 3TC 150 mg orally per 12 hours to birth
- Newborn: ZDV 4 mg/kg plus 3TC 2 mg/kg orally per 12 hours for 7 days
Slide 46

Living in Area of Endemic Disease/Deficiency

- Women living in endemic areas for following conditions require additional care
  - Malaria infection
  - Hookworm infection
  - Vitamin A deficiency
  - Iodine deficiency
- The goal of care is to prevent condition, or complications of condition, from developing

Slide 47

Malaria: Additional Assessment/Care

- Remaining alert to s/s of illness
- Intermittent preventive treatment (IPT)
- Use of insecticide-treated (bed)nets (ITNs), for mother and newborn

Slide 48

Malaria: Additional Assessment/Care (cont.)

- Health messages and counseling:
  - effects of illness
  - other preventive measures
- Management or referral/transfer for malaria illness – if s/s develop
Slide 49

**Hookworm Infection:**

**Additional Assessment/Care**

- Remaining alert to s/s of illness
- Presumptive antihelminthic treatment if woman:
  - has not received treatment in last 6 months, or
  - tested positive for hookworm infection
- Health messages and counseling:
  - effects of illness
  - other preventive measures

Slide 50

**Vitamin A and Iodine Deficiency:**

**Additional Assessment/Care**

- Remaining alert to s/s of deficiency
- Micronutrient supplementation
- Health messages and counseling:
  - Effects of deficiency
  - Importance of supplementation
  - Dietary sources of micronutrient

Slide 51

**Poor Obstetric History**

- Maternal, fetal, or newborn complications during previous pregnancy, labor/childbirth, postpartum/newborn period may indicate underlying medical or obstetric condition
- Reason to be vigilant, but may require no special intervention
Slide 52

Poor Obstetric History (cont.)
- Provides opportunity to:
  - reassure woman in present pregnancy
  - emphasize importance of having skilled provider attend birth

Slide 53

Poor Obstetric History: Additional Assessment
- Determine nature of previous complications
- Perform additional assessment and appropriate follow-up for following conditions:
  - Convulsions
  - Cesarean section or other uterine surgery
  - Newborn complications or death
- For other previous complications, proceed with additional care provision

Slide 54

Poor Obstetric History: Additional Assessment (cont.)
During labor, if woman has history of previous C-section or uterine surgery, facilitate urgent referral/transfer to facility equipped to perform emergency obstetric surgery.
Poor Obstetric History: Additional Assessment (cont.)

If history of newborn complication or death, determine nature/cause:

- Complications during labor/birth (e.g., c-section, maternal convulsions) – provide further evaluation/additional care as appropriate
- Newborn jaundice, feeding difficulties, other problems
  - for jaundice, plan to closely observe baby for first 5 days
  - for others, use information to guide counseling and other care

Previous Newborn Complications or Death (cont.)

- Maternal chronic conditions, lifestyle (e.g., use of harmful substances), other problems – provide further evaluation/additional care as appropriate

Poor Obstetric History: Additional Care Provision

- Listen to woman’s story and provide reassurance
- Emphasize importance of:
  - Care by skilled provider
  - Complication readiness plan
  - Adhering to plan of care
  - Practicing self-care and other healthy practices
  - Returning for continued care throughout childbearing cycle
Slide 58

Syphilis

Additional assessment:
- Check for signs of infection
- Perform RPR/VDRL if needed
- If diagnosed, determine whether treated and whether treatment was adequate (2.4 million units at least 30 days before birth)

Slide 59

Syphilis (cont.)

Additional care provision:
- If diagnosed with syphilis but not adequately treated:
  - If newly acquired signs, give benzathine benzylpenicillin 2.4 million units IM
  - If signs of unknown duration, give benzathine benzylpenicillin 2.4 million units IM weekly for 3 weeks
  - Follow local protocols for follow-up management of woman with positive RPR/VDRL

Slide 60

Syphilis (cont.)

- Give emotional support
- Provide counseling concerning:
  - Mode of transmission
  - Possible effects on, and care of, baby
  - Importance of condom use
  - Importance of testing partners
Slide 61

Urinary Retention

Additional assessment:
- Assess for fever
- If yes, facilitate urgent referral/transfer
- Assess for urine leaking from vagina
- If yes, facilitate nonurgent referral/transfer
- If neither, proceed with additional care provision

Slide 62

Urinary Retention (cont.)

Additional care provision:
- Help woman urinate using noninvasive methods
- If these fail:
  - During labor: insert catheter, drain urine, remove catheter
  - During postpartum: insert self-retaining catheter for 24-48 hours and provide antibiotics according to guidelines
- Encourage increased fluids

Slide 63

Tears and Incisions during Postpartum Period

Women with following conditions require additional care during postpartum period:
- Abdominal incisions
- Vaginal or perineal tears
- Episiotomy
- Defibulation
Tears and Incisions during Postpartum Period (cont.)

Additional assessment:
- Assess all tears and incisions carefully for signs of infection (pus, redness, pulling apart of skin edges) – if signs of infection:
  - urgent referral/transfer for abdominal incisions
  - further evaluation/additional care for all other tears and incisions

Tears and Incisions during Postpartum Period (cont.)

- Assess vaginal/perineal tears and incisions for repair:
  - For unrepaired 3rd degree tears – urgent referral/transfer
  - For unrepaired 1st and 2nd degree tears or episiotomy:
    - Perform repairs if less than 24 hours since birth
    - Proceed with additional care if more than 24 hours and no signs of infection

Additional care provision:
- Ensure good perineal hygiene
- Advise her to:
  - Lie on side while breastfeeding
  - Wait for at least 2 weeks to resume sex
  - Increase intake of fiber and fluids to avoid constipation
Newborn Special Needs

- Cuts or abrasions that are not bleeding
- Large baby (4 kg or more)
- Low birthweight baby (less than 2.5 kg)
- Mother with hepatitis B
- Mother with history of membranes ruptured for more than 18 hours before birth and/or uterine infection or fever during labor or birth

Newborn Special Needs (cont.)

- Mother with HIV
- Mother with syphilis
- Mother with tuberculosis

Cuts and Abrasions that are Not Bleeding

Additional assessment: Look for following alert signs:

- Swelling or tenderness over bone or joint
- Bruises
- Pallor
- Inconsolable crying
  - If any alert signs, facilitate urgent referral/transfer
  - If no alert signs, proceed with additional care
Cuts and Abrasions that are Not Bleeding (cont.)

Additional care:
- Clean cut or abrasion with antiseptic solution on gauze
- Keep clean and dry: cover cut with bandage; if edges are open, use butterfly bandage
- If signs of local infection, treat with topical antibiotic 3 times per day for 5 days
- Counsel mother concerning wound care and signs of infection
- Follow-up in 1 week to or earlier if signs of infection

Low Birthweight Baby (less than 2.5 kg)

- A baby weighing less than 2 kg requires urgent referral/transfer
- A baby weighing less than 2.5 kg (but not less than 2 kg) requires further evaluation/additional care

Low Birthweight Baby (less than 2.5 kg) (cont.)

Additional assessment: During 4th stage, be vigilant in observing every 15 minutes for:
- Breathing problems
- Low body temperature
- Feeding problems
  - If any of above, perform newborn rapid initial assessment
Slide 73

Low Birthweight Baby (less than 2.5 kg) (cont.)

Additional care: Facilitate/reinforce importance of:
- Skin-to-skin contact
- Covering baby’s head
- Keeping room warm (25°C) and draft-free
- Early and frequent breastfeeding (every 2-3 hours)
- Vitamin K1 1 mg IM within 6 hours of birth

Slide 74

Mother with Syphilis

If mother diagnosed with syphilis and not treated or inadequately treated, or treatment status unknown/uncertain, assess baby for signs of syphilis:
- Generalized edema
- Blistering skin
- Profuse runny nose
- Abdominal distension

Slide 75

Mother with Syphilis (cont.)

- If signs of syphilis – facilitate urgent referral/transfer
- If no signs of syphilis – proceed with additional care:
  - Give baby antibiotics:
    - procaine benzylpenicillin 100 mg/kg body weight IM as single injection, OR
    - benzathine benzylpenicillin 75 mg/kg body weight IM as single injection
  - Counsel mother concerning signs of syphilis
  - Follow-up in 4 weeks to re-assess for signs of syphilis, or earlier of signs of syphilis arise
Summary

- Be alert to special needs during labor/childbirth and postpartum/newborn period as they require care in addition to basic care
- May need to include:
  - Special counseling and care
  - Scheduling additional visits
  - Advising other providers involved in mother’s and newborn’s care
  - Linking woman to appropriate resources
PRESENTATION 4C
BASIC POSTPARTUM ASSESSMENT

Slide 1
Basic Postpartum Care

Slide 2
Session Objective
• By end of session, participants will be able to explain components of postpartum assessment

Slide 3
Basic Postpartum Care
Throughout assessment, apply key tools:
• Clinical decision-making
• Interpersonal skills
• Infection prevention practices
• Record-keeping
Consider each finding in context of other findings
Basic Postpartum Assessment (cont.)

During return visits:
- Ensure continued normal progress
- Identify changes, both positive and negative
- Determine whether care plan has been effective or requires modification

Basic Postpartum Assessment: Overview

- Ongoing assessment for first 6 hours
- Basic assessment
  - History
  - Physical Examination
  - Testing

Note: Before performing assessment:
- welcome woman
- offer her (and companion, if she desires) a seat
- ensure that she has undergone quick check

Basic Assessment: History

Focus history taking on following areas:
- Personal history (1st visit)
- Daily habits and lifestyle (1st visit)
- Present pregnancy and labor/birth (1st visit)
- Present postpartum period (every visit)
- Obstetric history (1st visit)
- Contraceptive history/plans (1st visit)
- Medical history (1st visit)
- Interim history (on return visits)
Slide 7

**Personal Information (1st Visit)**

Same as in CBC:
- Woman’s identifying and contact (including baby’s name)
- Reliable transportation and access to funds
- Previous pregnancies and childbirths
- Current/recent problems or concerns
- Care from another provider

______________________________
______________________________
______________________________
______________________________

Slide 8

**Daily Habits and Lifestyle (1st Visit)**

- Ask about:
  - daily workload
  - sleep/rest
  - dietary intake
  - birth in last year
  - currently breastfeeding
- Use this information to:
  - Determine whether there is a balance between physical demands and dietary intake
  - Guide counseling and other care

______________________________
______________________________
______________________________
______________________________

Slide 9

**Daily Habits and Lifestyle (cont.)**

- Ask whether she smokes, drinks alcohol, or uses other potentially harmful substances — to guide counseling and other care, and identify potential problems
- Inquire about her household (is she living with her husband, partner, children, or other family members?) — to guide complication readiness planning
Slide 10

Daily Habits and Lifestyle (cont.)

- Inform her that you are going to ask some personal questions that you ask of all clients:
  - Has anyone restricted her mobility or threatened her life?
  - Has anyone physically harmed her?
  - Is she frightened of anyone?
- If yes, she requires further evaluation/additional care (special need)
- If no or she is not comfortable answering, tell her she can discuss this issue with you at any time

Slide 11

Present Pregnancy and Labor/Birth (1st Visit)

- Ask about place, time attendance at birth
- Ask about complications during present pregnancy or childbirth
- Ask about vaginal bleeding, lochia, and bowel and bladder function to:
  - Confirm normal progress and identify potential problems (hemorrhage, subinvolution, infection, urinary retention)

Slide 12

Present Postpartum Period (cont.)

- Take note of her and her family’s feelings about baby, and about breastfeeding (i.e., is it going well?)
  - A woman who reports signs of postpartum sadness (crying, sadness, feeling overwhelmed, or irritability), or has not decided whether to breastfeed requires further evaluation/additional care (special need)
Slide 13

**Obstetric History (1st Visit)**

If not woman’s first pregnancy, ask about complications during previous postpartum/newborn period (e.g., neonatal death, maternal hemorrhage, postpartum psychosis, problems with breastfeeding)

**Note:** Poor obstetric history does not necessarily require special care but helps provider:
- Understand woman’s concerns in this postpartum/newborn period
- Emphasize importance of continued care with skilled provider

___________________________________
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Slide 14

**Contraceptive History/Plans (cont.)**

- Plans for more children:
  - How many?
  - When?
- Family planning methods:
  - Past use
  - Preferences
  - Plans for use now that baby is born

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Slide 15

**Medical History (1st Visit)**

Same as in CBC:
- Allergies
- HIV, anemia, or syphilis
- Heart disease, diabetes, or other chronic condition
- Hospitalization or surgery
- Medications/drugs
- Tetanus toxoid (TT) vaccines

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  ___________________________________
Interim History (Return Visits)

- Current/recent problems or concerns – if yes, ask general follow-up questions to determine nature of problem or concern
- Care from another provider – if yes, ask why she sought care and about care received

Interim History (cont.)

- Ask whether any of following have changed since her last visit:
  - personal information
  - daily habits or lifestyle
  - medical history
- Use this information to:
  - Maintain accuracy of woman’s medical records
  - Determine changes that need to be made in current plan of care

Interim History (cont.)

- Check whether she has been able to adhere to plan of care
- Note any reactions or side effects to immunizations or drugs/medications given at last visit
Basic Assessment: Physical Examination
Focus physical examination on following:
• General well-being (every visit)
• Vital signs (every visit)
• Breasts (every visit)
• Abdomen (every visit)
• Legs (every visit)
• Genitals (every visit)

Note: Information gathered through history-taking should be taken into consideration during physical examination.

General Well-Being (Every Visit)
Same as in CBC:
• Gait and movement – no limp, steady/moderately paced gait and movements
• Facial expression – alert, responsive, calm
• Behavior – normal for culture
• General cleanliness – no visible dirt, odor
• Condition of skin – no lesions, bruises
• Color of conjunctiva – pink
Slide 22

**Vital Signs Measurement**

(Every Visit)

Same as in CBC:
- Blood pressure:
  - Systolic 90 to 140 mmHg
  - Diastolic less than 90 mmHg
- Temperature: less than 38°C
- Pulse: 90-110 beats/minute

Slide 23

**Breast Examination**

(Every Visit)

Same as in CBC:
- Inspection of breasts (contours, texture) for gross abnormalities and for inverted nipples

Unique to PPC:
- Palpation of breasts for general/local areas of redness, heat, or tenderness
- Inspection of nipples for abnormal nipple discharge and cracks, fissures, lesions
- Any of above s/s requires further evaluation/additional care (special need)

Slide 24

**Abdominal Examination**

(Every Visit)

- Surface of abdomen
- Uterus/involution
- Bladder
Abdominal Examination (cont.)
- Inspect surface of abdomen for incision from cesarean or uterine surgery

Abdominal Examination (cont.)
- Uterus feels firm and not tender
  - Severely tender uterus requires urgent further evaluation/additional care (life-threatening complication)
- Height decreases about 1 cm per day
  - Increase/no decrease in height requires further evaluation/additional care (special need)

Postpartum Fundal Height
**Slide 28**

**Abdominal Examination**

**Bladder:**
- Bladder is not palpable
- A palpable bladder requires further evaluation/additional care (special need)

**Slide 29**

**Leg Examination (every visit)**

**Calves:**
- No pain in calf of leg when foot is forcibly dorsiflexed
- Pain in calf requires urgent further evaluation/additional care (life-threatening complication)

**Slide 30**

**Genital Examination**

**Vaginal opening, skin, and labia:**
- Purplish swelling in vulva or protruding from vagina requires urgent further evaluation/additional care (life-threatening complication)
- Incision requires further evaluation/additional care (special need)
- S/s of STIs requires nonurgent referral/transfer
Genital Examination (cont.)

Lochia (color and character):
- Day 1: bright red blood, like heavy menses
- Days 2-4: red lochia, fleshy odor, new pad every 2-4 hours
- Days 5-14: pink lochia, musty odor, decrease in amount
- Day 11 thru week 3 or 4: white lochia, decrease in amount

Genital Examination (cont.)

Lochia (cont.):
- Foul-smelling lochia requires urgent further evaluation/ additional care (life-threatening complication)
- Red lochia (lochia lubra) for more than 2 weeks requires further evaluation/additional care (special need)

Genital Examination (cont.)

Vaginal bleeding:
- The following s/s require urgent further evaluation/ additional care (life-threatening complication):
  - Frank heavy bleeding
  - Steady slow trickle
  - Intermittent gushes
  - Clots larger than lemons
Testing

- Focus testing on following:
  - HIV (1st visit/as needed, if woman does not "opt out")

Note: Information gathered through history-taking and physical examination should be taken into consideration during testing.

HIV – Counseling and Testing

Conducted at 1st visit, if woman does not "opt out"

- Positive test indicates HIV infection and requires further evaluation/additional care (special need)
- If woman opts out, test should be offered at all return visits
- Confidentiality of test and all HIV-related discussion essential

HIV – Counseling and Testing

Pretest Counseling

- Assure confidentiality
- Help woman assess individual risk factors
- Explain how virus is transmitted
- Address local myths and rumors
- Provide information about test
- Provide information about results
- Positive result indicates HIV infection
- Negative indicates absence of HIV infection, but "window" may exist between infection and positive result
HIV – Counseling and Testing
Post-test Counseling

If negative:
- Review risk factors
- Reinforce risk reduction practices
- Identify support for risk reduction

If positive:
- Provide emotional support
- Assess risk of abandonment/abuse
- Discuss issues of care, disclosure, impact on pregnancy, condom use, partner testing, immediate support needs

Summary
- Postpartum assessment includes:
  - Ongoing assessment up to 6 hours postpartum
  - Basic assessment
    - History
    - Physical Examination
    - Testing
  - It is foundation upon which postpartum care plan is designed and implemented
Basic Postpartum Care

Session Objective
• By end of session, participants will be able to explain steps of postpartum care provision

Basic Postpartum Care Provision
During every visit:
• Provide all elements of basic care package
• If abnormal s/s (based on assessment), provide additional care

Note: Information gathered through assessment should be taken into consideration during care provision.
Basic Postpartum Care Provision (cont.)

During return visit:
- Make necessary changes to care plan (based on assessment)
- Review and update birth and complication readiness plan
- Reinforce key messages
- Replenish supply of supplements and drugs/medications

Basic Postpartum Care Provision (cont.)

- Ongoing supportive care up to discharge
- Basic care package:
  - Breastfeeding and breast care
  - Complication readiness plan
  - Support for mother-baby-family relationships
  - Family planning
  - Nutritional support
  - Self-care and other healthy practices
  - HIV counseling and testing
  - Immunizations and other preventive measures

Breastfeeding and Breast Care

Early and exclusive breastfeeding (for HIV-negative women):
- Feeding guidelines
- Additional advice for woman
- Breast care
- Breastfeeding information and support – provide as needed
Breastfeeding and Breast Care (cont.)

Feeding guidelines:
- Breastfeed exclusively for first 6 months – no other food or fluids
- Breastfeed on demand day and night – every 2-3 hours during first weeks

Additional advice:
- Choose position that is comfortable and effective
- Use both breasts at each feed; do not limit time at either
- Ensure adequate sleep/rest – take nap when baby sleeps
- Ensure adequate food/fluid intake – glass of fluids per feed; extra meal per day

Breast care:
- To prevent engorgement, breastfeed every 2-3 hours
- Wear supportive (but not tight) bra or binder
- Keep nipples clean and dry
- Wash nipples with water only once per day
- After breastfeeding, leave milk on nipples and allow to air dry
Slide 10

Complication Readiness Plan

- At first visit after birth:
  - Introduce concept and each element
  - Assist in developing plan
- Return visits:
  - Check arrangements made
  - Note changes and problems

Slide 11

Complication Readiness Plan (cont.)

Components:
- Appropriate healthcare facility for emergency care
- Emergency transportation
- Emergency funds
- Decision-maker/decision-making process
- Support person/companion
- Blood donor
- Danger signs for mother and newborn

Slide 12

Complication Readiness Plan (cont.)

- Appropriate healthcare facility: Assist in deciding facility woman should go to if danger signs arise
- Emergency transportation: Ensure reliable/accessible transportation to appropriate facility for emergency care
Slide 13

Complication Readiness Plan (cont.)

- **Emergency funds**: Ensure availability of funds (private or community) for care during emergency
- **Decision-making**: Identify—
  - Key decision-maker
  - Who makes decisions in that person’s absence

Slide 14

Complication Readiness Plan (cont.)

- **Support**: Help choose individuals to—
  - Accompany her during transport
  - Take care of household during her absence
- **Blood donor**: Help choose appropriate blood donor in case of emergency

Slide 15

Complication Readiness Plan (cont.)

- **Danger signs**: ensure that woman and family know danger signs for her and her newborn, which indicate need to enact complication readiness plan
Maternal danger signs:
- Vaginal bleeding (heavy or sudden increase)
- Breathing difficulty
- Fever
- Severe abdominal pain
- Severe headache/blurry vision
- Convulsions/faintness

Foul-smelling discharge from vagina or tears/incisions
- Pain in calf, with or without swelling
- Verbalization/behavior indicating she may hurt self or baby: hallucinations

Newborn danger signs:
- Breathing difficulty
- Convulsion, spasm, loss of consciousness, or arching of back
- Cyanosis (blueness)
- Hot to touch (fever)
- Cold to touch
- Bleeding
- Jaundice (yellowish)
- Pains
- Diarrhea
- Persistent vomiting or abdominal distension
- Not feeding or poor sucking
- Pus or redness of umbilicus, eyes, or skin
- Swollen limb or joint
- Floppiness
- Lethargy

Support for Mother-Baby-Family Relationships
- As soon as possible after birth, discuss following issues with woman and, if she permits, partner, family, key decision-makers
- Return visits, check progress made in integrating care of baby into daily life
Slide 19

Support for Mother-Baby-Family Relationships (cont.)

- Bonding
  - Encourage touching, holding, exploring
  - Encourage Rooming-in
- Challenges
  - Discuss woman’s increased need for rest and (if breastfeeding) intake of food/fluids
  - Discuss woman’s increased workload

Slide 20

Support for Mother-Baby-Family Relationships (cont.)

- Support
  - Encourage sharing in care of newborn
  - Assist in devising strategies for overcoming challenges
- Information
  - Discuss key aspects of postpartum and newborn care
  - Encourage questions

Slide 21

Support for Mother-Baby-Family Relationships (cont.)

- Encouragement and praise
  - Help build confidence
  - Provide reassurance that woman is capable of caring for newborn
Family Planning
Discuss:
- Birthspacing – intervals of at least 3 years beneficial to women and babies
- Woman’s previous experience, beliefs, preferences regarding contraception
- Safe methods for postpartum women – benefits and limitations of each, how to access

Family Planning (cont.)
Discuss (cont.):
- Return of fertility after birth:
  - Not predictable
  - Can occur before menstruation resumes
  - On average, woman who:
    - Do not breastfeed, ovulate by 11 weeks
    - Breastfeed exclusively for 3 months, ovulate by 4-5 months
    - Breastfeed exclusively for 6 months, ovulate by 7 months (due to lactational amenorrhea)

Family Planning (cont.)
Discuss (cont.):
- Limitations of LAM, for women who choose this method
- Dual protection with condoms
- Assist woman in choosing a method that best meets her needs
Slide 25

**Nutritional Support**

General guidelines:
- Eat balanced diet including variety of foods each day
- Have at least one extra serving of staple food per day
- Try smaller, more frequent meals if necessary
- Take micronutrient supplements as directed

Slide 26

**Nutritional Support (cont.)**

Guidelines for breastfeeding women:
- Per day:
  - 2 extra servings of staple food per day
  - 3 extra servings of calcium-rich foods per day
  - 2 liters of fluid (include variety)
  - Decrease workload; increase rest
  - Also, avoid alcohol and tobacco, which can decrease milk production

Slide 27

**Self Care and Other Healthy Practices**

Tips:
- Individualize messages based on woman’s history and other relevant findings
- Encourage woman’s partner to be present during these discussions
Self Care and Other Healthy Practices (cont.)

Prevention of infection/hygiene:
- Good general hygiene (handwashing, safe food and water preparation/handling, bathing and general cleanliness)
- Good genital hygiene – especially important for postpartum women because more susceptible to infection

Self Care and Other Healthy Practices (cont.)

Good genital hygiene (cont.):
- Keep vulvar/vaginal area clean and dry
- Wash hands before and after touching
- Wash genitals after using toilet
- Change pads 6 times/day in first week; then 2 times/day
- Avoid douching, having sex, using tampons for at least 2 weeks or until lochia rubra stops

Self Care and Other Healthy Practices (cont.)

Rest and activity:
- Increase rest time
- All postpartum need additional rest to speed recovery
- Breastfeeding women need even more rest
- Wait at least 4 to 6 weeks to resume normal activity; start back gradually
Slide 31

Self Care and Other Healthy Practices (cont.)

Sexual relations and safer sex:
- Avoid sex for at least 2 weeks
- Increased susceptibility to STIs during postpartum period
- Abstinence or mutually monogamous sex with uninfected partner – only sure protection
- Consistent use of condoms
- Avoidance of sexual practices that may further increase risk of infection (e.g., anal sex)

Slide 32

HIV Counseling and Testing

- 1st visit:
  - Ensure confidentiality of testing and all HIV-related discussion
  - Provide pretest counseling
  - Return visit (after testing); provide post-test counseling

Slide 33

HIV Counseling and Testing (cont.)

Pretest counseling:
- Individual risk factors
- HIV transmission
- Risk reduction
- Local myths and false rumors
- Testing
Slide 34

HIV Counseling and Testing (cont.)

Post-test counseling:
  - For negative result:
    - Result
    - Individual risk factors – review
    - Risk reduction – review
    - Support for risk reduction
  - A positive result indicates HIV and requires special post-test counseling, plus further evaluation/additional care (special need)

Slide 35

Immunization and Other Preventive Measures

- Tetanus toxoid immunization
- Iron/folate supplementation
- Region/population-specific preventive measures

Slide 36

Immunization and Other Preventive Measures (cont.)

Tetanus Toxoid Immunization Schedule

<table>
<thead>
<tr>
<th>TT Injection</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT 1</td>
<td>At first contact with woman of child bearing age or as early as possible in pregnancy or in ANC visit.</td>
</tr>
<tr>
<td>TT 2</td>
<td>At least 4 weeks after TT 1.</td>
</tr>
<tr>
<td>TT 3</td>
<td>At least 6 months after TT 2.</td>
</tr>
<tr>
<td>TT 4</td>
<td>At least 1 year after TT 3.</td>
</tr>
<tr>
<td>TT 5</td>
<td>At least 1 year after TT 4.</td>
</tr>
</tbody>
</table>
Iron/folate supplementation:
• To prevent anemia, prescribe: iron 60 mg + folate 400 mcg orally once daily for 3 months
• Dispense supply to last until next visit
• Provide related messages/counseling...

Immunization and Other Preventive Measures (cont.):
• Eat foods rich in vitamin C, which help iron absorption
• Avoid tea, coffee, and colas, which inhibit iron absorption
• Possible side effects of iron/folate – black stools, constipation, and nausea
• Ways to lessen side effects

In areas of endemic disease/deficiency:
• Intermittent preventive treatment (IPT) and insecticide-treated nets (ITNs) for malaria
• Presumptive treatment for hookworm infection
• Vitamin A supplements
• Iodine supplements
Slide 40

**Scheduling a Return Visit**

- Advise her to bring her partner or other companion with her if possible
- Ensure that she understands that she should not wait for next appointment if she is having problems or develops any danger sign
- Review danger signs and complication readiness plan

Slide 41

**Summary**

Postpartum care provision includes:

- Ongoing supportive care up to discharge
- Basic care provision
  - Breastfeeding and breast care
  - Complication readiness plan
  - Support for mother-baby-family relationships
  - Family planning
  - Nutritional support
  - Self-care and other healthy practices
  - HIV counseling and testing
  - Immunizations and other preventive measures
- Care is individualized according to woman’s needs, history, and other findings
PRESENTATION 5A
CONTINUING CARE OF THE NEWBORN

Slide 1

Basic Newborn Care
Continuing Care of the Newborn

Slide 2

Session Objective
- By end of session, participants will be able to explain steps of newborn assessment

Slide 3

Basic Newborn Care
Throughout assessment, apply key tools:
- Clinical decision-making
- Interpersonal skills
- Infection prevention practices
- Record-keeping
Consider each finding in context of other findings
Basic Newborn Assessment:
Overview

- Ongoing assessment up to 6 hours after birth
- Basic assessment
  - History
  - Physical Examination

Note: Before performing assessment:
- welcome woman; warmly acknowledge newborn
- offer her (and companion, if she desires) a seat
- ensure that baby has undergone quick check

Basic Assessment: History

Focus history taking on following areas:
- Personal history (1st visit)
- Present labor/birth (1st visit)
- Maternal obstetric history (1st visit)
- Maternal medical history (1st visit)
- Present newborn period (every visit)
- Interim history (on return visits)

Personal Information (1st Visit)

Same as in CBC and PPC:
- Woman’s identifying and contact (including baby’s name)
- Reliable transportation and access to funds
- Previous pregnancies and childbirths
- Current/recent problems or concerns
- Care from another provider
Slide 7

Present Labor/Birth (1st Visit)
- Ask about place, time and attendance at birth
- Ask about complications during present pregnancy or childbirth:
  - Maternal uterine infection or fever
  - Rupture of membranes for more than 18 hours before birth
  - Complications that may have caused injury
  - Need for resuscitation

Slide 8

Present Labor/Birth (cont.)
- Ask about birth weight
- Consider this information in context of further assessment, and use to:
  - Guide counseling and other care
  - Identify special needs and other conditions that require additional care

Slide 9

Maternal Obstetric History (1st Visit)
- If not woman’s first pregnancy, ask about complications during previous newborn period (e.g., neonatal death, problems with breastfeeding)
- If yes, she requires further evaluation/additional care (special need)

Note: Poor obstetric history does not necessarily require special care but helps provider—
- Understand woman’s concerns in this newborn period
- Emphasize importance of continued care with skilled provider
Maternal Medical History (1st Visit)

Ask whether mother has been diagnosed with:
- Diabetes – if yes and baby is under 3 days of age, baby requires urgent referral/transfer
- Hepatitis B, HIV, syphilis, or tuberculosis anemia, or syphilis – if yes, baby requires further evaluation/additional care (special need)

Present Newborn Period (every visit)

- Take note of her and family’s feelings about baby
- Take note of mother’s feelings about breastfeeding (i.e., is it going well?)
- Ask about baby’s feeding habits: every 2-3 hours, at least 8 times/day, seems satisfied?
- Ask about baby’s urinating: at least once in first 24 hours, 6 times/day after 48 hours?

Present Newborn Period (cont.)

- Ask about baby’s passing stool:
  - Meconium stool within first 48 hours – no stool within 48 hours requires urgent referral/transfer
  - From 3 to 7 days, change in color and consistency – diarrhea requires urgent further evaluation/additional care (life-threatening complication)
  - From 3 to 7 days, at least 4-10 times/day for breastfed baby and 2-4 times/day for breastmilk substitute-fed baby – less than that requires further evaluation/additional care (special need)
Present Newborn Period (cont.)

- Has baby been diagnosed with congenital malformation (e.g., cleft lip or palate, club foot, imperforate anus)?
  - If yes and not adequately addressed, facilitate urgent or nonurgent referral as appropriate
- Is baby up-to-date on vaccines?
  - Use information to assess need for vaccines during this visit

Interim History (Return Visits)

Same as in PPC:
- Current/recent problems or concerns
- Care from another provider
- Changes since last visit
- Problems adhering to plan of care
- Any reactions or side effects to immunizations or drugs/medications given at last visit

Basic Assessment: Physical Examination

Note: Information gathered through history-taking should be taken into consideration during physical examination.
Basic Newborn Physical Examination*

- Overall appearance/general well-being:
  - Weight
  - Respiration
  - Temperature
  - Color
  - Movements and posture
  - Level of alertness and muscle tone
- Skin
- Head, face and mouth, eyes
- Chest, abdomen and cord, external genitalia
- Back and limbs
- Breastfeeding
- Mother-baby bonding

* Details of newborn physical exam in Fourth Stage of Labor presentation.

Basic Newborn Care Provision

Basic care:
- Early and exclusive breastfeeding
- Complication readiness plan
- Newborn-care and other healthy practices
- Immunizations and other preventive measures

Early and Exclusive Breastfeeding

- Breastfeeding guidelines, same as in PPC:
  - Give baby colostrum
  - Breastfeed immediately
  - Breastfeed exclusively and on demand
  - Information on benefits/general principles of breastfeeding; additional advice for mother, including breast care, and breastfeeding support – provide as needed
Complication Readiness
Same as in PPC—components include:
• Appropriate healthcare facility for emergency care
• Emergency transportation
• Emergency funds
• Decision-maker/decision-making process
• Support person/companion
• Blood donor
• Danger signs

Maintaining Warmth
• Skin-to-skin contact for first 6 hours
• Do not bathe in first 6 hours; and preferably not in the first 24 hours
• Avoid tight clothing
• Cover head
• Keep room warm (25°C), free of drafts
• Check feet every 4 hours for first day

Prevention of Infection/Hygiene
Baby’s immune system still developing
• Wash hands before touching baby; after changing diaper
• Take care of own baby as much as possible
• Avoid sharing equipment/supplies
• Keep baby away from sick family members
• Be alert for signs of infection
**Slide 22**

**Washing and Bathing**

- Only bathe after 6 hours (24 if possible), when baby's temperature is stable, and in warm/draft-free environment
- Thoroughly dry and clothe baby immediately after bath
- Before cord falls off, do not get cord wet while bathing

**Slide 23**

**Cord Care**

- Wash hands before and after cord care
- Avoid getting cord wet – if wet, dry immediately
- Apply no lotions, powders, etc.
- Keep cord outside of diaper
- If bleeding, retie immediately
- Cord should separate from umbilicus 2-7 days after birth
- Enact complication readiness plan for s/s of infection or delayed separation

**Slide 24**

**Sleep and Other Behaviors/Needs**

- **Sleeping:**
  - Should sleep on side or back
  - Will sleep about 20 hours/day at first; will gradually stay awake longer
- **Protection:**
  - Falls or harm by animals/other children
  - Suffocation (e.g., from pillows)
  - Crying – Address cause of discomfort (e.g., hunger, dirty diaper)
  - Mother-baby-family relationships – provide support
Immunizations and Other Preventive Measures

- Before discharge, give BCG, OPV-0, HB-1
- Advise mother to return for additional newborn vaccines at 6, 10, and 14 weeks
- Within 6 hours after birth, give vitamin K1 1 mg IM
- For newborns in malaria-endemic areas, counsel on sleeping beneath insecticide-treated bednet

Summary

- Newborn assessment
  - Includes ongoing assessment up to 6 hours after birth, and basic assessment
  - Is foundation upon which postpartum care plan is designed and implemented
- Newborn care provision includes:
  - Includes ongoing supportive care up to discharge, and basic care
  - Is individualized according to newborn and mother’s needs, history, and other findings
Slide 1

Additional Care III
Life-Threatening Complications of Labor/Childbirth and the Postpartum/Newborn Period

Slide 2

Session Objective
• By end of session, participants will be able to identify and respond to life-threatening complications encountered while caring for women—during labor/childbirth and the postpartum period—and newborns

Slide 3

Overview
• A danger sign indicates a potentially life-threatening complication
• Women or newborns presenting with danger signs – during quick check OR in course of basic CPNC – require care in addition to core components of basic care. This consists of:
  • Rapid initial assessment and, if necessary, stabilization
  • Additional assessment
  • Additional care provision
Overview (cont.)

- Rapid initial assessment determines:
  - Degree of illness
  - Need for emergency care/stabilization
  - Appropriate course of action to be taken
  - If stabilization is not needed – provide additional care per presenting danger sign
  - If stabilization is needed – follow appropriate stabilization procedure

Additional assessment per presenting danger sign (after RIA/stabilization):

- Focus on certain elements of assessment and/or add new elements (e.g., tests)
- Confirm and/or assess nature of need (e.g., severity, related factors)
- Confirm that woman or newborn does not have more serious condition/problem requiring urgent referral/transfer

Additional care provision per presenting danger sign (after RIA/stabilization and more serious conditions have been ruled out):

- Emphasize certain elements of care plan and/or add new elements (e.g., drugs, health messages)
- Make special recommendations regarding complication readiness plan, if needed
- If appropriate, provide initial management of condition and/or facilitate referral/transport
Rapid Initial Assessment

- Every woman presenting with a danger is assessed for:
  - Breathing difficulty (respiratory distress)
  - Convulsions/loss of consciousness
  - Shock
  - Hypertension with proteinuria
  - Fever

Rapid Initial Assessment (cont.)

- Assess for s/s of breathing difficulty:
  - Not breathing
  - Rapid breathing (30 breaths/minute or more)
  - Obstructed breathing or gasping
  - Wheezing or rales
  - Pallor or cyanosis
- If any above s/s present – follow stabilization procedure per next two slides before proceeding
- If not, proceed with rapid initial assessment

Stabilization: Respiratory Distress

- If woman is not breathing:
  - Keep her in supine position with head tilted backwards
  - Lift chin to open airway
  - Inspect mouth for foreign body and remove if found
  - Clear secretions from throat
  - Ventilate with bag and mask until breathing
- Once stabilized – facilitate urgent referral/transfer
Stabilization: Respiratory Distress (cont.)

- If woman is breathing:
  - Rapidly evaluate her vital signs (pulse, blood pressure, breathing)
  - Prop on left side
  - Give oxygen at 6-8 liters/minute
  - Continually ensure that airway is clear
- Once stabilized – facilitate urgent referral/transfer

Rapid Initial Assessment (cont.)

- Assess for convulsions or loss of consciousness
  - If any above s/s present – follow stabilization procedure (per next four slides) before proceeding
  - If not, proceed with rapid initial assessment

Stabilization: Convulsions, Unconsciousness, or Diastolic BP More than 110 mmHg with Proteinuria 2+ or More

- Rapidly evaluate woman’s vital signs (pulse, blood pressure, breathing)
- Never leave her alone
- Protect her from injury, but do not actively restrain
- If unconscious:
  - Check airway
  - Prop on left side
  - Check for neck rigidity
  - If rigid neck, use appropriate precautions for possible meningitis
Slide 13

Stabilization: Convulsions, Unconsciousness, or Diastolic BP More than 110 mmHg with Proteinuria 2+ or More (cont.)
- If convulsing – turn her on side to minimize risk of aspiration
- Give loading dose of magnesium sulfate solution (or diazepam, if not available)
  - Give 4 g IV over 5 minutes
  - Follow promptly with 10 g: 5 g in each buttock as deep IM injection with 1 mL of 2% lignocaine in same syringe

Slide 14

Stabilization: Convulsions, Unconsciousness, or Diastolic BP More than 110 mmHg with Proteinuria 2+ or More (cont.)
- If convulsions persist or recur after 15 minutes, give magnesium sulfate solution 2 g IV over 5 minutes*
- Once stabilized – facilitate urgent referral/transfer
  - If referral/transfer is delayed – continue according to maintenance dose schedule*

*See precautions on next slide

Slide 15

Stabilization: Convulsions, Unconsciousness, or Diastolic BP More than 110 mmHg with Proteinuria 2+ or More (cont.)
- Before giving another dose of magnesium sulfate solution, ensure that woman's:
  - Respiratory rate is at least 16 breaths/minute
  - Patellar reflexes are present
  - Urinary output is at least 30 mL/hour over 4 hours
- If respiratory arrest occurs:
  - Assist ventilation with mask and bag
  - Give calcium gluconate 1 gm (10 ml of 10% solution) IV slowly over 10 minutes
Slide 16

Rapid Initial Assessment (cont.)

- Measure woman’s blood pressure and take her temperature and pulse
- If systolic less than 90 mmHg, assess for other s/s of shock:
  - Pallor of conjunctiva
  - Perspiration
  - Cool and clammy skin
  - Rapid breathing
  - Anxiety or confusion
  - Unconscious or nearly unconscious
  - Scanty urine

Slide 17

Rapid Initial Assessment (cont.)

- If any above s/s present – follow stabilization procedure (per next two slides) before proceeding
- If not, proceed with rapid initial assessment

Slide 18

Stabilization: Shock

- Turn her on side to minimize risk of aspiration
- Ensure that she is breathing
- Keep woman warm, but do not overheat
- Elevate her legs to increase venous return (before and during transport)
- Start IV infusion or give oral rehydration solution (if woman is able to drink)
Slide 19

Stabilization: Shock (cont.)

- Monitor vital signs (pulse, blood pressure, breathing) and skin temperature every 15 minutes
- Once woman is stabilized – facilitate urgent referral/transport

Slide 20

Rapid Initial Assessment (cont.)

- If diastolic more than 110 mmHg, test urine for protein
  - If protein 2+ or more – follow same stabilization procedure as for convulsions/lack of consciousness before proceeding
  - If not, proceed to additional care guidelines per presenting danger sign

Slide 21

Additional Assessment and Care per Presenting Danger Sign

If woman is not in need of stabilization or has been stabilized, follow specific guidelines for danger sign:
- Vaginal bleeding after childbirth
- Severe headache, blurred vision, or elevated blood pressure
- Unsatisfactory progress of labor
- Inadequate uterine contractions
- Meconium-stained amniotic fluid, decreased or absent fetal movements, absent fetal heart tones, abnormal fetal heart rate
- Prolapsed cord
Slide 22

Additional Assessment and Care per Presenting Danger Sign (cont.)

If woman is not in need of stabilization or has been stabilized, follow specific guidelines for danger sign:
- Fetal hand or foot presenting
- Fever or foul-smelling vaginal discharge
- Pain in calf
- Pus, redness, or pulling apart of skin edges of perineal suture line; pus or drainage from unrepaired tear; severe pain from tear or episiotomy
- Severe abdominal pain after childbirth
- Verbalization/behavior that indicates woman may hurt herself or baby, or hallucinations

Slide 23

Vaginal Bleeding after Childbirth

WARNING: More than half of all maternal deaths occur within 24 hours of childbirth, mostly due to excessive bleeding. Postpartum hemorrhage (PPH) causes more than one-quarter of all maternal deaths worldwide, with uterine atony being the major factor. Rapid action in response is therefore critical.

Slide 24

Vaginal Bleeding after Childbirth: Additional Assessment

Assess for s/s of following conditions and perform appropriate follow-up action before proceeding:
- Uterine atony
- Tears of vagina, perineum, cervix
- Retained placenta or placental fragments
- Ruptured or inverted uterus
- Delayed postpartum hemorrhage (PPH)
Vaginal Bleeding after Childbirth: Additional Assessment (cont.)

- If s/s of uterine atony:
  - Massage uterus
  - Give oxytocin 10 units IM
  - Start IV infusion (plus oxytocin 20 units/liter IV fluids at 60 drops/minute) or ORS
  - Keep woman warm; elevate legs
  - Ensure urination (catheterize if needed)

Vaginal Bleeding after Childbirth: Additional Assessment (cont.)

- If bleeding continues:
  - Perform bimanual compression of uterus OR compression of abdominal aorta (per next two slides)
  - If bleeding continues, facilitate urgent referral/transfer
  - If bleeding stops, proceed with additional care plus measure woman’s hemoglobin in 2 or 3 hours

Bimanual Compression of Uterus

- Wearing HLD gloves, insert hand into vagina, form fist.
- Place fist into anterior fornix and apply pressure against anterior wall of uterus.
- With other hand, press deeply into abdomen behind uterus, applying pressure against posterior wall of uterus.
- Maintain compression until bleeding is controlled and uterus contracts.
Slide 28

Compression of Abdominal Aorta

- Apply downward pressure with closed fist over abdominal aorta directly through abdominal wall
- With other hand, palpate femoral pulse to check adequacy of compression
  - Pulse palpable = adequate
  - Pulse not palpable = inadequate
- Maintain compression until bleeding is controlled

Slide 29

Vaginal Bleeding after Childbirth Additional Assessment (cont.)

- If no s/s of uterine atony:
  - Examine vagina, perineum, cervix for tears
  - Start IV infusion or ORS
  - Keep woman warm; elevate legs
  - Ensure urination (catheterize if needed)
  - Proceed with assessment

Slide 30

Vaginal Bleeding after Childbirth Additional Assessment (cont.)

- If s/s of tears:
  - If extensive tears (3rd or 4th degree), facilitate urgent referral/transfer
  - If other tears, perform repairs
- If s/s of retained placenta, perform appropriate management to deliver placenta
- If s/s of retained placental fragments, perform appropriate management to remove fragments
Slide 31

Vaginal Bleeding after Childbirth
Additional Assessment (cont.)

• If s/s of ruptured uterus, facilitate urgent referral/transfer
• If s/s of inverted uterus, perform manual correction of inverted uterus
• If s/s of retained placenta or placental fragments:
  • Give uterotonic drug according to guidelines
  • Assess cervix for dilation

Slide 32

Vaginal Bleeding after Childbirth
Additional Assessment (cont.)

• If cervix is not dilated, facilitate urgent referral/transfer
• If cervix is dilated, perform appropriate management to remove fragments/tissue
  • If bleeding continues, perform bimanual compression of uterus OR compression of abdominal aorta

Slide 33

Vaginal Bleeding after Childbirth
Additional Assessment (cont.)

• If bleeding continues, facilitate urgent referral/transfer
• If bleeding stops, proceed with additional care plus measure woman’s hemoglobin in 2 or 3 hours
Slide 34

Vaginal Bleeding after Childbirth
Additional Care

- Provide reassurance
- Palpate uterus every 15 minutes
- Observe woman for at least 24 hours
- Review complication readiness plan
- Ensure that she knows where to go for help if danger or alert signs arise

Slide 35

Severe Headache, Blurred Vision, or Elevated Blood Pressure

Assess for following alert s/s:
- Diastolic BP more than 90 mmHg with proteinuria
- Difficulty chewing and opening mouth
- Fever/chills/rigors
- Stiff neck
- Muscle and joint pain
- Spasms of face, neck, trunk
- Arched back

Slide 36

Severe Headache, Blurred Vision, or Elevated Blood Pressure (cont.)

- If any of above s/s – facilitate urgent referral/transfer
- If none of above s/s – proceed with additional assessment and care provision
Severe Headache, Blurred Vision, or Elevated Blood Pressure (cont.)
- If diastolic BP is 90-110 mmHg with no proteinuria – recheck her BP in 1 hour
  - If diastolic BP is still 90 mmHg or more after 1 hour, facilitate urgent referral/transfer

Severe Headache, Blurred Vision, or Elevated Blood Pressure (cont.)
- If BP is normal:
  - Provide reassurance – headache may be normal
  - Review complication readiness plan
  - Ensure that she knows where to go for help if symptoms worsen or danger or alert signs arise

Meconium-Stained Amniotic Fluid, S/S of Fetal Distress
For slight meconium during labor:
- Prop woman up or place on left side
- Listen to fetal heart tones every 30 minutes minimum, both during and between contractions
  - If normal, proceed with basic care
  - If abnormal or absent, proceed according to guidelines under danger sign
**Slide 40**

**Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)**

*For thick meconium:*
- If 1st stage of labor:
  - Facilitate urgent referral/transfer
  - Give oxygen 4-6 L per minute before/during transport
- If 2nd stage of labor:
  - Deliver baby as quickly as possible using episiotomy and vacuum extraction if necessary and possible (head is at 0 station and no more than 2/5 palpable above symphysis pubis)
  - Prepare for newborn resuscitation

**Slide 41**

**Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)**

*If not possible:*
- Facilitate urgent referral/transfer
- Give oxygen 4-6 L per minute before and during transport
- Prepare for newborn resuscitation

**Slide 42**

**Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)**

*For decreased or absent fetal movements:*
- Palpate abdomen
- Ask if woman has had sedative drug
- Listen for fetal heart tones
  - If normal, proceed with basic care
  - If abnormal or absent, proceed according to guidelines under danger sign
**Slide 43**

Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)

- For **absent fetal heart tones**:
  - Ask others to listen
  - Use electronic fetal stethoscope
  - Obtain obstetric ultrasound, if available
  - If not heard on obstetric ultrasound, manage as stillbirth or newborn death (special need)

**Slide 44**

Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)

- If not heard using other methods – recheck in 15 minutes
  - If heard and rate is abnormal – follow specific guidelines for danger sign
  - If heard and rate is normal – provide reassurance and proceed with basic care
  - If still not heard – manage per next slide

**Slide 45**

Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)

- Inform woman of possible death of baby; provide emotional support
- Give woman oxygen 4-6 L per minute
- Prop woman up or place on left side
  - If 1st stage of labor, facilitate urgent referral/transfer
  - If 2nd stage of labor, manage per next slide
Slide 46

**Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)**

- Deliver baby as quickly as possible using episiotomy and vacuum extraction if necessary and possible
- If not possible, facilitate urgent referral/transfer

Slide 47

**Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)**

For abnormal fetal heart rate:
- Listen to fetal heart tones through at least three contractions
- If rate remains abnormal and woman is in 1st stage:
  - Give woman oxygen 4-6 L per minute
  - Prop woman up or place on left side
  - Listen through three more contractions
  - If rate remains abnormal, facilitate urgent referral/transfer
  - Prepare for newborn resuscitation

Slide 48

**Meconium-Stained Amniotic Fluid, S/S of Fetal Distress (cont.)**

For abnormal fetal heart rate:
- If rate remains abnormal and woman is in 2nd stage:
  - Deliver baby as quickly as possible using episiotomy and vacuum extraction if necessary and possible
  - If not possible, facilitate urgent referral/transfer
  - Prepare for newborn resuscitation
Newborn Rapid Initial Assessment

- Every newborn presenting with a danger sign is assessed for:
  - Breathing difficulty (respiratory distress)
  - Shock
  - Convulsions or spasms
  - Sepsis

Newborn Rapid Initial Assessment (cont.)

- Assess for s/s of breathing difficulty:
  - Not breathing
  - Gasping
  - Abnormal breathing (less than 20 or more than 60 breaths/minute)
  - Indrawing of chest or grunting on expiration
  - Asymmetrical or irregular chest movements
  - Central cyanosis

Newborn Rapid Initial Assessment (cont.)

- If newborn is not breathing, is gasping, or less than 20 breaths/minute, perform resuscitation (per next slides)
- Otherwise proceed with RIA
Newborn Stabilization: Respiratory Distress

- If not already done:
  - Dry baby, remove wet cloth, and wrap baby in dry/warm cloth
  - Clamp and cut cord
  - Place baby on back on clean, warm surface; keep covered except for face and chest
  - Position head slightly extended to open airway

Correct position of head

Clear airways by suctioning mouth and each nostril

Warning: Only suction if blood/mucus in nose/mouth or before resuscitation. Do not suction deep in throat as this may cause baby’s heart to slow or baby to stop breathing.
Slide 55

Newborn Stabilization: Respiratory Distress (cont.)

- If there is blood or meconium in mouth or nose, be especially thorough with suctioning
- If not breathing well after suctioning, begin ventilation
- If breathing well after suctioning, provide post-resuscitation care:
  - skin-to-skin contact
  - close observation (for breathing and temperature problems) for 4 hours
  - breastfeeding
  - counseling about risk of convulsions and feeding difficulties

Slide 56

Newborn Stabilization: Respiratory Distress (cont.)

- Before ventilation, recheck position of head
- Place mask over baby’s chin, mouth, and nose to form seal
- Squeeze Ambu bag attached to mask two or three times
- Ventilate baby with oxygen, if available; otherwise, use room air

Slide 57

Newborn Stabilization: Respiratory Distress (cont.)

- Observe chest
  - If rising, proceed with ventilation at about 40 breaths per minute
  - If not rising:
    - Recheck position of head
    - Reposition mask to improve seal
    - Increase ventilation pressure
    - Repeat suctioning of mouth and nose
Slide 58
Newborn Stabilization: Respiratory Distress (cont.)

- Ventilate 1 minute or until baby begins to cry or breathe spontaneously. Then stop to quickly assess baby’s breathing.
  - If at least 20 breaths/minute and no chest indrawing, stop ventilation and provide post-resuscitation care.

Slide 59
Newborn Stabilization: Respiratory Distress (cont.)

- If, after 20 minutes of ventilation, breathing but less than 30 or more than 60 breaths/minute and/or chest indrawing, central cyanosis, grunting on expiration:
  - Facilitate urgent referral/transfer
  - Provide continued ventilation and/or oxygen, as appropriate.

Slide 60
Newborn Stabilization: Respiratory Distress (cont.)

- If, after 20 minutes of ventilation, no gasping or breathing at all:
  - Stop ventilation
  - Provide emotional support to parents
  - Manage as newborn death

Basic Maternal and Newborn Care: Basic Childbirth, Postpartum, and Newborn Care
JHPIEGO/Maternal and Neonatal Health Program
Slide 61

Rapid Initial Assessment (cont.)

• Assess for shock:
  • Pallor
  • Central cyanosis
  • Cold to touch
  • Rapid breathing (more than 60 breaths/minute)
  • Unconscious or nearly unconscious

Slide 62

Rapid Initial Assessment (cont.)

• If shock:
  • Assess and provide appropriate follow-up for bleeding
  • Facilitate urgent referral/transfer
  • Otherwise proceed with RIA

Slide 63

Rapid Initial Assessment (cont.)

• Assess for:
  • Convulsions
  • Spasms
  • Opisthotonos
  • Unconsciousness
Rapid Initial Assessment (cont.)

- If any of above:
  - Complete RIA
  - Facilitate urgent referral/transfer
  - For convulsions or spasms, also give phenobarbital 20 mg/kg body weight IM
  - Otherwise proceed with RIA

Slide 64

Rapid Initial Assessment (cont.)

- Assess for sepsis:
  - Lethargy
  - Floppiness
  - Poor feeding
  - Persistent vomiting
  - Other signs

Slide 65

Rapid Initial Assessment (cont.)

- If any of above:
  - Facilitate urgent referral/transfer
  - Give baby antibiotics:
    - ampicillin 50 mg/kg body weight IM, plus
    - gentamicin 5 mg/kg (if 2 kg or more) or 4 mg/kg (if less than 2 kg) body weight IM

- If none of the above, proceed to additional care guidelines per presenting danger sign

Slide 66
Additional Assessment and Care per Presenting Danger Sign

If newborn is not in need of stabilization or has been stabilized, follow specific guidelines for danger sign:

- Abnormal body temperature
- Jaundice
- Diarrhea
- Abdominal distention
- Bleeding
- Pus or lesions of skin
- Pus or redness of eyes
- Redness or foul smell of umbilicus
- Swollen limb or joint

Abnormal Body Temperature (axillary less than 36.5°C or more than 37.5°C)

- Assess for alert signs:
  - Poor feeding after having fed well
  - Lethargy, drowsiness, or flappiness
  - Vomiting and/or abdominal distention
  - Irritability
  - Breathing difficulty
  - Temperature less than 32°C

Abnormal Body Temperature (cont.)

- If any of above:
  - Facilitate urgent referral/transfer
  - Give baby antibiotics (ampicillin plus gentamicin, as described above)

- If none of the above, proceed to additional care
Abnormal Body Temperature (cont.)

For axillary temperature less than 36.5°C:
- Rewarm baby using skin-to-skin contact if possible
- If not possible, rewarm baby by:
  - Adding clothing/layers, including hat
  - Using radiant warmer/incubator or covered hot water bottle

Abnormal Body Temperature (cont.)

- Ensure that room is warm (at least 25°C) and draft-free
- Encourage breastfeeding at least every 2 hours
- Have baby monitored continuously for danger signs
- Measure baby’s body temperature every hour

Abnormal Body Temperature (cont.)

- If temperature rises at least 0.5°C per hour:
  - continue measuring temperature every 2 hours until normal
  - proceed with basic care
- If temperature does not rise at least 0.5°C per hour, facilitate urgent referral/transfer
For axillary temperature more than 37.5°C:
- If not due to environmental heat:
  - Facilitate urgent referral/transfer.

Abnormal Body Temperature (cont.)

Before and during transport:
- Undress baby partially or fully
- If more than 39°C, sponge or bathe baby for 10-15 minutes, using water 4°C lower than current body temperature
- Encourage baby to breastfeed or give expressed milk by cup

If due to environmental heat:
- If more than 39°C, sponge or bathe baby for 10-15 minutes, using water 4°C lower than current body temperature
- Ensure that room is 25-28°C
- Undress baby partially or fully
Slide 76

**Abnormal Body Temperature (cont.)**

- Encourage baby to breastfeed or give expressed milk by cup
- Have baby monitored continuously for danger signs
- Measure baby’s body temperature every hour

---

Slide 77

**Abnormal Body Temperature (cont.)**

- If temperature returns to normal within 2 hours, proceed with basic care
- If temperature does not return to normal within 2 hours, facilitate urgent referral/transfer

---

Slide 78

**Diarrhea**

- Assess for alert signs:
  - Skin tent remains after 2 seconds
  - Stool green or contains mucus or blood
  - Birthweight less than 2.5 kg
  - Vomiting
  - Poor or no feeding
  - Floppiness or lethargy
  - Abdominal distention
  - Temperature instability
**Slide 79**

**Diarrhea (cont.)**

- If alert signs:
  - Facilitate urgent referral/transfer
  - Give baby antibiotics (ampicillin plus gentamicin, as already described)
  - Before and during transport
    - Give ORS
    - Keep in skin-to-skin contact
- If none of the above, proceed with additional care

---

**Slide 80**

**Diarrhea (cont.)**

- Advise woman to feed baby more often and for longer periods of time
- If baby spits up, wait 10 minutes and continue
- Gently pinch abdominal skin to assess hydration and amount of ORS needed:
  - If no tent forms, give ORS:
    - 125 mL/kg body weight daily, plus
    - An extra 50 mL for each loose stool

---

**Slide 81**

**Diarrhea (cont.)**

- If tent forms but disappears within 2 seconds, give ORS:
  - 200-400 mL daily, plus
  - An extra 50 mL for each loose stool
- If baby spits up while giving ORS, wait 10 minutes and continue
- Review complication readiness plan
- Advise woman to return for care if alert or danger signs arise
Summary

- Women and newborns presenting with danger signs – during quick check OR in course of basic care – require care in addition to core components of basic care. This consists of:
  - Rapid initial assessment and, if necessary, stabilization
  - Additional assessment
  - Additional care provision
  - Possible referral/transfer
Please indicate your opinion of the course components using the following rating scale:

5-Strongly Agree  4- Agree  3-No Opinion  2-Disagree  1-Strongly Disagree

<table>
<thead>
<tr>
<th>COURSE COMPONENT</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Precourse Questionnaire helped me to study more effectively during the</td>
<td></td>
</tr>
<tr>
<td>course.</td>
<td></td>
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<tr>
<td>2. The illustrated lectures and discussions helped me to understand the course</td>
<td></td>
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<tr>
<td>content.</td>
<td></td>
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<tr>
<td>3. The exercises were useful for learning about particular aspects of basic</td>
<td></td>
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<tr>
<td>childbirth, postpartum, and newborn care.</td>
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<tr>
<td>4. The role plays on interpersonal communications skills were helpful.</td>
<td></td>
</tr>
<tr>
<td>5. The case studies were useful for practicing clinical decision making.</td>
<td></td>
</tr>
<tr>
<td>6. The skills practice sessions made it easier for me to perform the skills for</td>
<td></td>
</tr>
<tr>
<td>basic childbirth, postpartum, and newborn assessment and care.</td>
<td></td>
</tr>
<tr>
<td>7. There was sufficient time scheduled for practicing skills with patients at</td>
<td></td>
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<tr>
<td>clinical sites.</td>
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<tr>
<td>8. There was sufficient time scheduled for practicing skills in the simulated</td>
<td></td>
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<tr>
<td>setting when patients were not available.</td>
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</tr>
<tr>
<td>9. The interactive learning approach used in this course made it easier for me</td>
<td></td>
</tr>
<tr>
<td>to learn about basic childbirth, postpartum, and newborn care.</td>
<td></td>
</tr>
<tr>
<td>10. I feel confident about providing basic childbirth, postpartum, and newborn</td>
<td></td>
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<tr>
<td>care.</td>
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<tr>
<td>11. I feel confident about using the recommended infection prevention practices</td>
<td></td>
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<tr>
<td>and interpersonal skills.</td>
<td></td>
</tr>
<tr>
<td>12. Twelve days was an adequate length of time for the course.</td>
<td></td>
</tr>
</tbody>
</table>
SECTION TWO: GUIDE FOR TRAINERS

MODEL COURSE OUTLINE ...........................................................................................................1

PRE COURSE QUESTIONNAIRE ANSWER KEY
   Using the Individual and Group Assessment Matrix .................................................................25
   Precourse Questionnaire Answer Key ....................................................................................26

KNOWLEDGE ASSESSMENT QUESTIONNAIRE
   Using the Questionnaire .........................................................................................................31
   Knowledge Assessment Questionnaire ....................................................................................33
   Knowledge Assessment Questionnaire Answer Sheet ...............................................................43
   Knowledge Assessment Questionnaire Answer Key .................................................................45

ROLE PLAYS AND EXERCISE ANSWER KEY
   Role Play 1: Reassuring the Women in Labor Answer Key ....................................................55
   Role Play 2: Parent Education and Support for Care of the Newborn Answer Key ...............57
   Exercise 1: Using the Partograph Answer Key ......................................................................59

CASE STUDIES
   Using the Case Studies ..........................................................................................................67
   Case Study 1: Childbirth Assessment and Care Answer Key ...................................................68
   Case Study 2: Childbirth Assessment and Care Answer Key ...................................................73
   Case Study 3: Postpartum Assessment and Care Answer Key ..................................................77
   Case Study 4: Postpartum Assessment and Care Answer Key ..................................................81
   Case Study 5: Newborn Assessment and Care Answer Key ....................................................85
   Case Study 6: Newborn Assessment and Care Answer Key ....................................................89

SKILLS PRACTICE SESSIONS
   Conducting Skills Practice Sessions .......................................................................................93

EMERGENCY DRILL ......................................................................................................................95
MODEL COURSE OUTLINE

The course outline presented here is a model plan of the training to be delivered. It presents objectives needed to accomplish the participant learning objectives described in the course syllabus. For each enabling objective, there are suggestions regarding appropriate learning activities and resources and materials needed. The trainer may develop other practice activities and prepare case studies, role plays or other learning situations which are specific to the country or group of participants.

The course outline is divided into four columns.

- **Time.** This section of the outline indicates the approximate amount of time to be devoted to each learning activity.

- **Objectives/Activities.** This column lists the enabling objectives and learning activities, which are presented here in order. The combination of the enabling objectives and activities (introductory activities, small-group exercises, clinical practice, breaks, etc.) outlines the flow of training.

- **Training/Learning Methods.** This column describes the various methods and strategies to be used to deliver the content and skills related to each enabling objective and activity.

- **Resources/Materials.** The fourth column in the course outline lists the resources and materials needed to support the learning activities.

Note that the course schedule is based on the course outline and that changes or modifications to one should be reflected in the other.
## MODEL COURSE OUTLINE: BASIC CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE

*(Standard Course: 12 days, 24 sessions)*

<table>
<thead>
<tr>
<th>TIME</th>
<th>OBJECTIVES/ ACTIVITIES</th>
<th>TRAINING/LEARNING METHODS</th>
<th>RESOURCE MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SESSION ONE: DAY 1, AM (240 MINUTES)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 minutes</td>
<td><strong>Activity:</strong> Welcome and introductions</td>
<td>Have participants divide into pairs, interview, and then introduce each other by name, position, and any unique characteristics. The trainers should also be involved in this activity.</td>
<td>CPNC Course Notebook: Refer to “Instruments and Equipment” in Course Syllabus</td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Activity:</strong> Identify participant expectations</td>
<td>Ask participants to share their expectations of the course and write their responses on a flip chart. Attach the flip chart page to the wall for reference throughout the course.</td>
<td></td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Activity:</strong> Provide an overview of the course</td>
<td>Outline the course syllabus and schedule. Discuss the goals of the course and participant learning objectives.</td>
<td>Participant’s Handbook: Introduction</td>
</tr>
<tr>
<td>20 minutes</td>
<td><strong>Activity:</strong> Provide an overview of the learning approach used in the course and course components</td>
<td>Outline competency-based training, assessment of knowledge and skills, use of simulations and anatomic models, supportive environment for learning, and transfer of learning.</td>
<td>Participant’s Handbook: Overview</td>
</tr>
<tr>
<td>10 minutes</td>
<td><strong>Activity:</strong> Review course materials</td>
<td>Distribute, review, and discuss materials used in this course.</td>
<td>Reference manual—<em>Basic Maternal and Newborn Care: A Guide for Skilled Providers (BMNC)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CPNC Course Notebook (Participant’s Handbook, Log Book, and Trainer’s Notebook)</td>
</tr>
<tr>
<td>40 minutes</td>
<td><strong>Activity:</strong> Assess participants' precourse knowledge</td>
<td>Ask participants to turn to the Precourse Questionnaire in their handbook and answer each question.</td>
<td>Participant’s Handbook: Precourse Questionnaire</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Break</td>
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</tr>
<tr>
<td>20 minutes</td>
<td><strong>Activity:</strong> Identify individual and group learning needs</td>
<td>Have participants grade questionnaires and complete the Individual and Group Assessment Matrix. Follow the directions in the Trainer’s Notebook.</td>
<td>Trainer’s Notebook: Precourse Questionnaire Answer Key and “Using the Individual and Group Assessment Matrix”</td>
</tr>
<tr>
<td>80 minutes</td>
<td><strong>Objective:</strong> Describe the general principles of basic care</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Present and discuss the concepts of evidence-based care; skilled care and the skilled care provider; the care provision system; facility-community linkages; women- and newborn-friendly care; and culturally appropriate care. Pause at appropriate intervals to emphasize particular points and encourage discussion.</td>
<td>BMNC Manual – Section One: Fundamentals of Basic Care – Chapter 1 Presentation: PPT1A</td>
</tr>
</tbody>
</table>

**LUNCH (60 MINUTES)**

---

2 - *Section Two: Guide for Trainers*  
*Basic Maternal and Newborn Care: Basic Childbirth, Postpartum, and Newborn Care*  
*JHPIEGO/Maternal and Neonatal Health Program*
<table>
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<th>TIME</th>
<th>OBJECTIVES/ACTIVITIES</th>
<th>TRAINING/LEARNING METHODS</th>
<th>RESOURCE MATERIALS</th>
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<tbody>
<tr>
<td>80 minutes</td>
<td><strong>Objective:</strong> Describe the key tools in basic care</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Present and discuss clinical decision-making; interpersonal skills; preparation of the client care area; referral/transport; and record keeping. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to consider the differences and similarities between the information presented and their present worksites/practices. Are there differences? Is there a need for change? If so, how can this be brought about?</td>
<td>BMNC Manual – Section One: Fundamentals of Basic Care – Chapter 3 Presentation: PPT1B</td>
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<tr>
<td>15 minutes</td>
<td><strong>Break</strong></td>
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<tr>
<td>60 minutes</td>
<td><strong>Objective:</strong> Describe infection prevention principles and practices</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Explain and discuss infection prevention principles and practices. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to compare the principles and practices presented with those currently used at their worksites. Ask if they routinely use decontamination, how they disinfect instruments and equipment, whether or not they have soap or facilities for handwashing between patient visits, etc. Is there a need for change? If so, how can this be brought about?</td>
<td>BMNC Manual – Section One: Fundamentals of Basic Care – Chapter 3 Presentation: PPT1C</td>
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| 70 minutes | **Activity:** Demonstrate infection prevention practices. | **Demonstration:** Carry out this demonstration in the classroom using the appropriate supplies. Draw a tap on a piece of flipchart paper can simulate running water. Demonstrate each of the following practices, provide an explanation of the steps involved, and encourage participants to ask questions at any point during the demonstration:  
  - hand washing  
  - protective barriers  
  - decontamination  
  - sharps handling and disposal  
  - waste disposal | Participant's Handbook: Refer to “Instruments and Equipment” in Course Syllabus |
| 15 minutes | **Activity:** Review of the day’s activities | | Participant’s Handbook: Model Childbirth, Postpartum, and Newborn Care Course Schedule |

**Reading Assignment:** BMNC—Section 1, Chapters 1 to 3; Section 2: Chapters 4 and 6 (through “Key Actions for the 3rd Stage of Labor”); Section 4: Annexes 3, 6, and 7
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<tr>
<td>10 minutes</td>
<td><strong>Activity:</strong> Agenda and opening activity</td>
<td>Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warm-up conduct it.</td>
<td>BMNC Manual – Section One: Fundamentals of Basic Care – Chapters 1 and 2; Section 2: Core Components of Basic Care – Chapters 4 and 6 to 8</td>
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<tr>
<td>60 minutes</td>
<td><strong>Objective:</strong> Provide an introduction to childbirth, postpartum, and newborn care</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Present and discuss the goals, scope, individualization, and core components of basic childbirth, postpartum, and newborn care. Also present and discuss the scheduling of visits for postpartum and newborn care. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to compare the information presented with their present practices. Are the goals consistent? Is the scope similar? Are the core components the same?</td>
<td>BMNC Manual – Section Two: Core Components of Basic Care – Chapter 6</td>
</tr>
<tr>
<td>70 minutes</td>
<td><strong>Objective:</strong> Describe assessment of the woman in labor</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Introduce the Quick Check occurring prior to assessment. Then ask participants to describe the components of routine assessment they use with women in labor. Explain and discuss assessment of the woman in labor, including the specific components of history and physical examination of the woman in labor. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to consider whether they cover each of the components presented when taking a history from the woman in labor and when conducting the physical examination. If there are components that they do not include, discuss reasons for this and how the additional components could be included.</td>
<td>BMNC Manual – Section Two: Core Components of Basic Care – Chapter 6</td>
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<tr>
<td>15 minutes</td>
<td><strong>Break</strong></td>
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<tr>
<td>85 minutes</td>
<td><strong>Activity:</strong> Practice assessment of the woman in labor</td>
<td><strong>Skill Demonstration and Practice:</strong> Before beginning the skill demonstration, explain to participants how learning guides and checklists will be used for this and the other skills included in the course. The skill is to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Session 1. Additional opportunities to practice the skill should be provided in the evening or on the weekend.</td>
<td>CPNC Course Notebook: Skills Practice Session 1, Learning Guide 1, and Checklist 1</td>
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<td>BMNC Manual – Section Two: Core Components of Basic Care – Chapter 6</td>
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<tr>
<td>60 minutes</td>
<td><strong>Objective:</strong> Describe basic care during the first stage of labor</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Explain and discuss the following aspects of basic care during the first stage of labor: ongoing assessment and care during first stage/latent phase and first stage/active phase. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to consider how they presently assess and care for the woman during the first stage of labor. Are there differences? Do they use a partograph? Is there a need for change? If so, how can this be brought about? Include a rationale for each component depending on the needs and interest of the group as revealed during the discussion.</td>
<td>BMNC Manual—Section Two: Core Components of Basic Care – Chapter 6 Presentation: PPT2C</td>
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<tr>
<td>60 minutes</td>
<td><strong>Activity:</strong> Practice using the partograph</td>
<td><strong>Exercise:</strong> Use Exercise 1 to help participants understand and practice how to use the partograph.</td>
<td>BMNC Manual – Section Four: Annexes – Annex 3 CPNC Course Handbook: Exercise 1 and Answer Key</td>
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<td>15 minutes</td>
<td>Break</td>
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<tr>
<td>90 minutes</td>
<td><strong>Objective:</strong> Describe basic care during the second and third stages of labor</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Explain and discuss the following aspects of basic care during the second and third stages of labor: ongoing assessment and care, assisting the birth, immediate care of the newborn, active management of third stage, examination of placenta, examination of vagina and perineum for lacerations/tears, episiotomy and repair, and repair of first- and second-degree tears. Ask individual participants to explain the rationale for various components. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to consider how they presently assess and care for the woman during the second and third stage of labor. Are there differences? Is there a need for change? If so, how can this be brought about?</td>
<td>BMNC Manual—Section Two: Core Components of Basic Care – Chapter 6 Presentation: PPT2D</td>
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<tr>
<td>15 minutes</td>
<td><strong>Activity:</strong> Review of the day’s activities</td>
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**Reading Assignment:** BMNC—Section 2: Chapter 6 (“Key Actions for the 4th Stage of Labor”) and Chapter 8 (“Physical Examination/Observation” only); Section 4: Annex 4 (pages 4-18 to 4-22: “Episiotomy,” “Examination of the Vagina, Perineum, and Cervix for Tears”; pages 4-37 to 4-40: “Repair of Episiotomy” and “Repair of 1st and 2nd Degree Tears”

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5 - Section Two: Guide for Trainer Basic Maternal and Newborn Care: Basic Childbirth, Postpartum, and Newborn Care JHPIEGO/Maternal and Neonatal Health Program
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<tr>
<td>10 minutes</td>
<td><strong>Activity:</strong> Agenda and opening activity</td>
<td>Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warm-up conduct it.</td>
<td>CPNC Course Handbook: Skills Practice Session 2, Learning Guide 2, and Checklist 2</td>
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<tr>
<td>135 minutes</td>
<td><strong>Activity:</strong> Practice assisting in normal birth</td>
<td><strong>Skill Demonstration and Practice:</strong> The skill is to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Session 2. Additional opportunities to practice the skill should be provided in the evening or on the weekend.</td>
<td>BMNC Manual – Section Two: Core Components of Basic Care – Chapter 6</td>
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<td>15 minutes</td>
<td><strong>Break</strong></td>
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<td>CPNC Course Notebook: Case Study 1, Case Study 2, and Answer Keys</td>
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<td>80 minutes</td>
<td><strong>Activity:</strong> Complete case studies relevant to care during labor and childbirth</td>
<td><strong>Case Studies:</strong> Introduce participants to case studies in general and explain how they facilitate the development of problem solving and decision-making skills. Use Case Studies 1 and 2 on supporting the woman in labor and during birth. Divide participants into groups of three or four. Allow approximately 40 minutes for the groups to work on the case studies, then allow five to ten minutes for one participant from each group to report back to the class as a whole. Use the case study answer keys to guide discussion.</td>
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| 80 minutes | **Objective:** Practice episiotomy and repair and repair of first- and second-degree tears | **Skill Demonstration and Practice:** The skill is to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Session 3 and Skills Practice Session 4. Additional opportunities to practice the skill should be provided in the evening or on the weekend. | **CPNC Course Handbook:** Skills Practice Session 3, Learning Guide 3, Checklist 3, Skills Practice Session 4, Learning Guide 4, and Checklist 4  
**BMNC Manual — Section Four: Annexes — Annex 4** |
| 60 minutes | **Objective:** Describe basic care during the fourth stage of labor | **Illustrated Lecture and Discussion:** Ask participants to describe the fourth stage of labor and why it is called a “stage of labor” even after the placenta is delivered. Explain and discuss the following aspects of basic care during the fourth stage of labor: ongoing assessment and care of mother and newborn, including newborn eye care, and the first complete physical examination of the newborn. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to consider how they presently assess and care for the woman during the fourth stage of labor. If there are differences, what are they and why? Insert into the discussion the rationale of each component. | **BMNC Manual — Section Two: Core Components of Basic Care** – Chapters 6  
**Presentation:** PPT3A |
| 15 minutes | **Activity:** Practice newborn physical examination | **Skill Demonstration and Practice:** The skill is to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Session 5. Additional opportunities to practice the skill should be provided in the evening or on the weekend. | **CPNC Course Notebook:** Skills Practice Session 5, Learning Guide 5, and Checklist 5  
**BMNC Manual — Section Two: Core Components of Basic Care** – Chapters 6 and 8 |
| 70 minutes | **Activity:** Review of the day’s activities | Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for next day on a flipchart, in preparation for the opening session. The schedule in the Participant’s Handbook should be used to do this. Ask one or more of the other participants to plan an opening activity or warm-up for next day. | |

Reading Assignment: BMNC — Section 2: Chapters 7 and 8; Section 3: Chapter 9 (all childbirth, postpartum, and newborn-related entries) and Chapter 10; Annex 5
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<th>TIME</th>
<th>OBJECTIVES/ACTIVITIES</th>
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<th>RESOURCE MATERIALS</th>
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<tr>
<td><strong>SESSION SEVEN: DAY 4, AM (240 MINUTES)</strong></td>
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<tr>
<td>10 minutes</td>
<td><strong>Activity:</strong> Agenda and opening activity</td>
<td>Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warmup conduct it.</td>
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| 60 minutes | **Objective:** Describe common discomforts of labor/childbirth and the postpartum and newborn periods | **Illustrated Lecture and Discussion:** Present an overview of the common discomforts experienced during labor/childbirth and the postpartum and newborn periods. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants which common discomforts they see in current practice and the prevention and relief measures provided. | **BMNC Manual – Section Three:** Additional Care – Chapter 9  
Presentation: PPT4A |
| 15 minutes | Break | | |
| 85 minutes | **Objective:** Describe the special needs of labor/childbirth and the postpartum and newborn periods | **Illustrated Lecture and Discussion:** Present an overview of the special needs related to labor and birth and the postpartum period. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants which special needs they see in current practice and how they respond to these needs. | **BMNC Manual – Section Three:** Additional Care – Chapter 10  
Presentation: PPT4B |
| 70 minutes | **Objective:** Describe assessment of the postpartum woman | **Illustrated Lecture and Discussion:** Explain and discuss assessment of the postpartum woman, including history, physical examination, and testing. Ask participants to consider whether they cover each of the components presented when taking a history from the postpartum woman, performing the physical examination, and conducting testing. Ask individual participants for the rationale of each component they currently practice. If there are components that they do not include, discuss reasons for this, and how they might implement changes in their own practice or teaching to be more consistent with best practices. | **BMNC Manual – Section Two:** Core Components of Basic Care – Chapter 7  
Presentation: PPT4C |
<p>| <strong>LUNCH</strong> | | | |</p>
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<th>TIME</th>
<th>OBJECTIVES/ACTIVITIES</th>
<th>TRAINING/LEARNING METHODS</th>
<th>RESOURCE MATERIALS</th>
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<tr>
<td>80 minutes</td>
<td><strong>Objective:</strong> Describe basic postpartum care</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Ask participants to list the components of basic postpartum care as they currently practice it. During this discussion, ask individual participants for the rationale for each component they list. Explain and discuss the following aspects of basic postpartum care: breastfeeding and breast care; complication readiness; mother-baby-family relationships; family planning; nutrition; self-care and other healthy behaviors; HIV counseling and testing; as well as iron folate, tetanus toxoid, and other preventive measures. Ask participants to consider present practices with respect to postpartum care. If current practices are different from the evidence-based approach described in this discussion, ask how they might implement changes in their own practice or teaching to be more consistent with best practices.</td>
<td>BMNC Manual – Section Two: Core Components of Basic Care – Chapters 6 and 7  Presentation: PPT4D</td>
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<tr>
<td>70 minutes</td>
<td><strong>Activity:</strong> Practice assessment of the postpartum woman</td>
<td><strong>Skill Demonstration and Practice:</strong> The skill is to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Session 6. Additional opportunities to practice the skill should be provided in the evening or on the weekend.</td>
<td>CPNC Course Handbook: Skills Practice Session 6, Learning Guide 6, and Checklist 6 BMNC Manual – Section Two: Core Components of Basic Care – Chapters 6 and 7</td>
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<td>15 minutes</td>
<td>Break</td>
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<tr>
<td>60 minutes</td>
<td><strong>Activity:</strong> Complete case studies relevant to postpartum assessment and care</td>
<td><strong>Case Studies:</strong> Use Case Studies 3 and 4 on postpartum assessment and care. Divide participants into groups of three or four. Allow approximately 40 minutes for the groups to work on the case studies, then allow five to ten minutes for one participant from one group to report back to the class as a whole on the first case study. Then ask one participant from each of the other groups to explain any of their answers that are different from those presented by the first group. Repeat this same procedure with the second case study. Use the case study answer keys to guide discussion.</td>
<td>CPNC Course Notebook: Case Study 3, Case Study 4, and Answer Keys</td>
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<tr>
<td>15 minutes</td>
<td><strong>Activity:</strong> Review of the day’s activities</td>
<td>**Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for next day on a flipchart, in preparation for the opening session. The schedule in the Participant’s Handbook should be used to do this. Ask one or more of the other participants to plan an opening activity or warmup for next day.</td>
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**Reading Assignment:** BMNC—Section 3: Chapter 11
### SESSION NINE: DAY 5, AM (240 MINUTES)

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<th>TIME</th>
<th>OBJECTIVES/ ACTIVITIES</th>
<th>TRAINING/LEARNING METHODS</th>
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<tr>
<td>10 minutes</td>
<td><strong>Activity:</strong> Agenda and opening activity</td>
<td>Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warmup conduct it.</td>
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<tr>
<td>70 minutes</td>
<td><strong>Objective:</strong> Describe continuing care of the newborn</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Explain and discuss the following aspects of basic newborn care: history, including maternal history; physical examination, including observation of breastfeeding and mother-baby bonding; complication readiness; breastfeeding/feeding guidelines; individualized counseling on maintaining warmth, hygiene/prevention of infection, cord care, bathing, etc.; and immunizations and other preventive measures. Pause at appropriate intervals to emphasize particular points and encourage discussion. For example, ask participants to consider present practices with respect to newborn care. If there are differences, what are they and why? What is the rationale for these practices?</td>
<td>BMNC Manual – Section Two: Core Components of Basic Care – Chapters 6 and 8&lt;br&gt;Presentation: PPT5A</td>
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<td>30 minutes</td>
<td><strong>Activity:</strong> Practice appropriate interpersonal skills related to care during labor, and to parent education and support for care of the newborn</td>
<td><strong>Role Play:</strong> Introduce Role Play 1 and Role Play 2 to participants and have them use these to practice using appropriate interpersonal skills related to care during labor, and to parent education and support for care of the newborn. Use the Answer Keys to guide discussion following the role plays. Encourage all participants to contribute to the discussion.</td>
<td>CPNC Course Notebook: Role Play 1, Role Play 2, and Answer Keys</td>
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<td>15 minutes</td>
<td><strong>Break</strong></td>
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<td>115 minutes</td>
<td><strong>Objective:</strong> Describe life-threatening complications of labor/childbirth and the postpartum and newborn periods</td>
<td><strong>Illustrated Lecture and Discussion:</strong> Explain and discuss rapid initial assessment; stabilization procedures, including newborn resuscitation; and referral/transport guidelines. Also, provide a brief explanation of the recognition and response to vaginal bleeding; severe headache/blurred vision, elevated blood pressure; unsatisfactory progress in labor; difficulty in breathing; fever; abdominal pain; calf muscle tenderness; severe pain at and pus draining from suture line; hallucinations and severe depression; bleeding in the newborn; temperature irregularities; umbilical, eye, and skin infections; jaundice; and vomiting and diarrhea. Ask individual participants to describe their current management of each of these conditions. Ask participants which life-threatening complications they have seen, how they dealt with them, and what the outcome was.</td>
<td>BMNC Manual – Section Three: Additional Care – Chapter 11; Section Four: Annexes – Annex 4&lt;br&gt;Presentation: PPT5B</td>
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## TIME | OBJECTIVES/ACTIVITIES | TRAINING/LEARNING METHODS | RESOURCE MATERIALS
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### SESSION TEN: DAY 5, PM (240 MINUTES)
60 minutes | **Activity:** Practice responding to an emergency situation | **Exercise:** Use Emergency Drill 1 to help participants understand and practice how to use respond to an emergency situation | **CPNC Course Notebook:** Emergency Drill 1

70 minutes | **Activity:** Complete case studies relevant to the management of common newborn problems | **Case Studies:** Use Case Studies 5 and 6 on the management of common newborn problems. Divide participants into groups of three or four. Allow approximately 40 minutes for the groups to work on the case studies, then allow five to ten minutes for one participant from one group to report back to the class as a whole on the first case study. Then have each of the other groups report only those elements in their answer that are different from the answers of the first group. Repeat this procedure for the second case study. Use the case study answer keys to guide discussion. | **CPNC Course Notebook:** Case Study 5, Case Study 6, and Answer Keys

15 minutes | **Break** |  | 

80 minutes | **Activity:** Practice newborn resuscitation | **Skill Demonstration and Practice:** The skill is to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Session 7. Additional opportunities to practice the skill should be provided in the evening or on the weekend. | **CPNC Course Notebook:** Skills Practice Session 7, Learning Guide 7, and Checklist 7
 | **BMNC Manual – Section Three:** Additional Care – Chapter 11

15 minutes | **Activity:** Review of the day’s activities | Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for next day on a flipchart, in preparation for the opening session. The schedule in the Participant’s Handbook should be used to do this. Ask one or more of the other participants to plan an opening activity or warmup for next day. |  

**Reading Assignment:** BMNC—Section 4: Annex 4 (the remaining entries, except “Pelvic examination” and “Testing”)
### MODEL COURSE OUTLINE: BASIC CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE

**TIME** | **OBJECTIVES/ACTIVITIES** | **TRAINING/LEARNING METHODS** | **RESOURCE MATERIALS**
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**SESSION ELEVEN: DAY 6, AM (240 MINUTES)**
10 minutes | **Activity:** Agenda and opening activity  
Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warmup conduct it. | Skill Demonstration and Practice: The skills are to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Sessions 8, 9, 10, and 11. Additional opportunities to practice the skill should be provided in the evening or on the weekend. | CPNC Course Notebook: Skills Practice Session 8, Learning Guide 8, and Checklist 8; Skills Practice Session 9, Learning Guide 9, and Checklist 9; Skills Practice Session 10, Learning Guide 10, and Checklist 10; Skills Practice Session 11, Learning Guide 11, and Checklist 11
215 minutes (plus 15 minute break) | **Activity:** Practice manual removal of placenta, bimanual compassion of the uterus, compression of abdominal aorta, and repair of cervical tears  
**Skill Demonstration and Practice:** The skills are to be demonstrated by trainers and practiced by participants in a simulated setting, as described in Skills Practice Sessions 8, 9, 10, and 11. Additional opportunities to practice the skill should be provided in the evening or on the weekend. | | BMNC Manual – Section Four: Annexes – Annex 4

**SESSION TWELVE: DAY 6, PM (210 MINUTES)**
185 minutes (plus 15 minute break) | **Activity:** Practice all skills included in course  
**Skills Practice:** Trainers should provide guidance for participants to use the relevant learning guides to practice the skills learned during the course. Participants should select the skills they practice during this session, based on their particular individual needs and skills they want to improve. Trainers can also provide guidance based on their work with individual participants and needs identified during the week. Trainers should use the relevant skills checklists to assess participants’ skills competency in the simulated setting. | | CPNC Course Notebook: All Learning Guides and Checklists
BMNC Manual – All relevant sections and chapters
15 minutes | **Activity:** Review of the day’s activities  
Involves participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for next day on a flipchart, in preparation for the opening session. The schedule in the Participant’s Handbook should be used to do this. Ask one or more of the other participants to plan an opening activity or warm-up for next day. | | **Reading Assignment:** Prepare for Knowledge Assessment Questionnaire; review Learning Guides; use practice Checklists
## MODEL COURSE OUTLINE: BASIC CHILDBIRTH, POSTPARTUM, AND NEWBORN CARE
(Standard Course: 12 days, 24 sessions)

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<th>TIME</th>
<th>OBJECTIVES/ ACTIVITIES</th>
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<td><strong>SESSION THIRTEEN: DAY 7, AM (240 MINUTES)</strong></td>
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<td>10 minutes</td>
<td><strong>Activity: Agenda and opening activity</strong></td>
<td>Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warm up conduct it.</td>
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<td>145 minutes</td>
<td><strong>Activity: Practice all skills included in course</strong></td>
<td><strong>Skills Practice:</strong> Trainers should provide guidance for participants to use the relevant learning guides to practice the skills learned during the course. Participants should select the skills they practice during this session, based on their particular individual needs. Trainers should use the relevant skills checklists to assess participants’ skills competency in the simulated setting.</td>
<td><strong>CPNC Course Notebook:</strong> All Learning Guides and Checklists&lt;br&gt;<strong>BMNC Manual</strong> – All relevant sections and chapters</td>
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<tr>
<td>15 minutes</td>
<td><strong>Break</strong></td>
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<tr>
<td>80 minutes</td>
<td><strong>Activity: Assess participants’ knowledge</strong></td>
<td>Have participants complete the knowledge assessment questionnaire. Trainers should then mark the questionnaires in preparation for individual discussions with participants.</td>
<td><strong>Trainer’s Notebook:</strong> Knowledge Assessment Questionnaire, Answer Sheet, and Answer Key</td>
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<td><strong>SESSION FOURTEEN: DAY 7, PM (210 MINUTES)</strong></td>
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<td>95 minutes</td>
<td><strong>Activity: Discuss participants’ ongoing learning needs</strong></td>
<td><strong>Discussion:</strong> The results of the knowledge assessment questionnaire should be reviewed with the class as a whole, emphasizing collective strengths and weaknesses. The trainer can review any previous presentation topic that the majority of participants missed questions on. Trainers must then meet with individual participants who scored less than 85% and discuss missed items and/or incorrect responses. Participants should then be advised to spend time studying the relevant topics and complete the knowledge assessment questionnaire again with the aim of achieving at least 85%. Time to re-take the questionnaire would be made available following the post-clinical session on Day 9.</td>
<td><strong>BMNC Manual</strong> – All relevant sections and chapters</td>
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Continuation of Session Fourteen: Day 7, PM (210 Minutes)

<table>
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<tr>
<th>Time</th>
<th>Activities</th>
<th>Training/Learning Methods</th>
<th>Resource Materials</th>
</tr>
</thead>
</table>
| 60 minutes | Activity: Provide instruction for supervised clinical practice  
Trainers should explain to participants how the next five days will be structured and what is expected of them as individual practitioners and as team members. Participants will be divided into four teams, each team having an equal number of each discipline if more than one discipline is attending the course. For instance, if both midwives and physicians are participating in the course, each team should have an equal number of physicians and midwives. One trainer should be identified for each of the four teams so that participants are clear about who will provide supervision and guidance during clinical practice. Trainers should also review the Clinical Experience Log Book with participants to ensure that they understand how it will be used during clinical practice. Trainers will also explain to participants that each participant should inform the trainer when (s)he is ready to be assessed for competency on a particular skill. A trainer will then assess the participant on that particular skill during the relevant clinical practice session. | Patient's Notebook: “Managing Clinical Practice” in Tips for Trainers  
Participant's Handbook: Clinical Experience Log Book | Resource Materials                                      |
| 15 minutes | Break  
Each trainer should take responsibility for her/his team of participants and guide them through the various wards/departments/clinics that will be used for clinical practice. Hospital/clinic staff should be introduced to participants and invited to provide information about their respective work areas. | Resource Materials                                      | Resource Materials                                      |
| 70 minutes | Activity: Tour of clinical facilities  
Each trainer should take responsibility for her/his team of participants and guide them through the various wards/departments/clinics that will be used for clinical practice. Hospital/clinic staff should be introduced to participants and invited to provide information about their respective work areas. | Resource Materials                                      | Resource Materials                                      |
### Supervised Clinical Practice

Trainers must hold a pre-clinical meeting with participants at the beginning of the day, as outlined in the Guidelines for Supervising Clinical Practice.

**Teams 1 & 2** go to the postpartum clinic to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.

**Teams 3 & 4** go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.

### Resource Materials

- **Participant’s Handbook**: All Learning Guides
- **Trainer’s Notebook**: All Checklists; “Managing Clinical Practice” in Tips for Trainers
- **BMNC Manual**: All relevant sections and chapters
### TIME

**SESSION SIXTEEN: DAY 8, PM (240 MINUTES)**

<table>
<thead>
<tr>
<th>TIME</th>
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<th>RESOURCE MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>240 minutes</td>
<td><strong>Activity:</strong> Practice skills with clients/patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Supervised Clinical Practice:** Trainers must hold a post-clinical meeting with participants at the end of the day, as outlined in the Guidelines for Supervising Clinical Practice.

**Teams 1 & 2** go to the postpartum ward to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.

**Teams 3 & 4** go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.

**Post-clinical conference** will allow time to discuss patients and conditions encountered during the clinical practice sessions. The trainers may call upon individual participants to present case studies based on patients whom they cared for during the session. Trainers can highlight issues, topics, skills, and decision-making illustrated by each case.

**Participant’s Handbook:** All Learning Guides

**Trainer’s Notebook:** All Checklists; “Managing Clinical Practice” in Tips for Trainers

**BMNC Manual** – All relevant sections and chapters

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**Reading Assignment:** BMNC—Review text based on individual needs
<table>
<thead>
<tr>
<th>TIME</th>
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</tr>
</thead>
<tbody>
<tr>
<td>240 minutes</td>
<td><strong>Activity:</strong> Practice skills with clients/patients</td>
<td><strong>Supervised Clinical Practice:</strong> Trainers must hold a pre-clinical meeting with participants at the beginning of the day, as outlined in the Guidelines for Supervising Clinical Practice</td>
<td>Participant’s Handbook: All Learning Guides</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Teams 3 &amp; 4</strong> go to the postpartum clinic to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.</td>
<td><strong>Trainer’s Notebook:</strong> All Checklists; “Managing Clinical Practice” in Tips for Trainers</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Teams 1 &amp; 2</strong> go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.</td>
<td><strong>BMNC Manual</strong> – All relevant sections and chapters</td>
</tr>
</tbody>
</table>
### SESSION EIGHTEEN: DAY 9, PM (240 MINUTES)

<table>
<thead>
<tr>
<th>TIME</th>
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<th>TRAINING/LEARNING METHODS</th>
<th>RESOURCE MATERIALS</th>
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</thead>
<tbody>
<tr>
<td>240 minutes</td>
<td><strong>Activity:</strong> Practice skills with clients/patients</td>
<td><strong>Supervised Clinical Practice:</strong> Trainers must hold a post-clinical meeting with participants at the end of the day, as outlined in the Guidelines for Supervising Clinical Practice</td>
<td><strong>Participant’s Handbook:</strong> All Learning Guides</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Teams 3 &amp; 4</strong> go to the postpartum ward to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.</td>
<td><strong>Trainer’s Notebook:</strong> All Checklists; “Managing Clinical Practice” in Tips for Trainers</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Teams 1 &amp; 2</strong> go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.</td>
<td><strong>BMNC Manual</strong> – All relevant sections and chapters</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Post-clinical conference</strong> will allow time to discuss patients and conditions encountered during the clinical practice sessions. The trainers may call upon individual participants to present case studies based on patients whom they cared for during the session. Trainers can highlight issues, topics, skills, and decision-making illustrated by each case. Also, participants who did not achieve 85% on their knowledge questionnaires will retake the questionnaire at the end of this post-clinical conference.</td>
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</tbody>
</table>

**Reading Assignment:** BMNC—Review text based on individual needs
<table>
<thead>
<tr>
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</table>
| 240 minutes | Activity: Practice skills with clients/patients | Supervised Clinical Practice: Trainers must hold a pre-clinical meeting with participants at the beginning of the day, as outlined in the Guidelines for Supervising Clinical Practice  
Teams **1 & 2** go to the postpartum clinic to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.  
Teams **3 & 4** go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists. | Participant’s Handbook: All Learning Guides  
Trainer’s Notebook: All Checklists; “Managing Clinical Practice” in Tips for Trainers  
BMNC Manual – All relevant sections and chapters |
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<tbody>
<tr>
<td>240 minutes</td>
<td>Activity: Practice skills with clients/patients</td>
<td>Supervised Clinical Practice: Trainers must hold a post-clinical meeting with participants at the end of the day, as outlined in the Guidelines for Supervising Clinical Practice</td>
<td>Participant’s Handbook: All Learning Guides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teams 3 &amp; 4 go to the postpartum clinic to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.</td>
<td>Trainer’s Notebook: All Checklists; “Managing Clinical Practice” in Tips for Trainers</td>
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<tr>
<td></td>
<td></td>
<td>Teams 1 &amp; 2 go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.</td>
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<td></td>
<td>Post-clinical conference will allow time to discuss patients and conditions encountered during the clinical practice sessions. The trainers may call upon individual participants to present case studies based on patients whom they cared for during the session. Trainers can highlight issues, topics, skills, and decision-making illustrated by each case.</td>
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Reading Assignment: BMNC—Review text based on individual needs
### Supervised Clinical Practice: Teams 3 & 4 go to the postpartum clinic to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.

### Teams 1 & 2 go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.
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<td><strong>Teams 3 &amp; 4</strong> go to the postpartum ward to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists.</td>
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<td></td>
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<td><strong>Teams 1 &amp; 2</strong> go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists.</td>
<td><strong>BMNC Manual</strong> – All relevant sections and chapters</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Reading Assignment:** BMNC—Review text based on individual needs
### Session Twenty-Three: Day 12, AM (240 Minutes)

<table>
<thead>
<tr>
<th>TIME</th>
<th>OBJECTIVES/ACTIVITIES</th>
<th>TRAINING/LEARNING METHODS</th>
<th>RESOURCE MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>240 minutes</td>
<td>Activity: Practice skills with clients/patients</td>
<td>Supervised Clinical Practice: Trainers must hold a pre-clinical meeting with participants at the beginning of the day, as outlined in the Guidelines for Supervising Clinical Practice. Teams 1 &amp; 2 go to the postpartum clinic to practice postpartum assessment and care (mother and baby). Under the guidance of trainers, participants work in pairs to practice the relevant skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ skills competency using the relevant checklists. Teams 3 &amp; 4 go to the labor and delivery wards to practice assessment of the woman in labor, use of the partograph, assisting normal birth, newborn examination, and, where possible, episiotomy and repair, repair of first- and second-degree tears, newborn resuscitation, manual removal of placenta, bimanual compression of the uterus, compression of abdominal aorta, and repair of cervical tears. Under the guidance of trainers, participants should work in pairs to practice the skills and observe each other’s performance using the relevant learning guides. Ultimately, trainers should assess participants’ competency using the relevant checklists. Post-clinical conference will allow time to discuss patients and conditions encountered during the clinical practice sessions. The trainers may call upon individual participants to present case studies based on patients whom they cared for during the session. Trainers can highlight issues, topics, skills, and decision-making illustrated by each case.</td>
<td>Participant’s Handbook: All Learning Guides Trainer’s Notebook: All Checklists; “Managing Clinical Practice” in Tips for Trainers BMNC Manual – All relevant sections and chapters</td>
</tr>
</tbody>
</table>

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23 - Section Two: Guide for Trainer  

Basic Maternal and Newborn Care: Basic Childbirth, Postpartum, and Newborn Care  

JHPIEGO/Maternal and Neonatal Health Program
<table>
<thead>
<tr>
<th>TIME</th>
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<th>RESOURCE MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90 minutes</td>
<td><strong>Activity:</strong> Discuss participant’s individual ongoing learning needs</td>
<td><strong>Discussion:</strong> Trainers meet with participants to identify and discuss ongoing learning needs, based on the performance during the course and results on the knowledge assessment questionnaire</td>
<td></td>
</tr>
<tr>
<td>30 minutes</td>
<td><strong>Activity:</strong> Identify course strengths and weaknesses</td>
<td><strong>Course Evaluation:</strong> Have participants complete the course evaluation form. Then discuss briefly with participants whether the course has met their expectations, as outlined on day one.</td>
<td><strong>Participant's Handbook:</strong> Course Evaluation Form</td>
</tr>
<tr>
<td>15 minutes</td>
<td><strong>Activity:</strong> Closing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PRE COURSE QUESTIONNAIRE ANSWER KEY

USING THE INDIVIDUAL AND GROUP ASSESSMENT MATRIX

The precourse questionnaire is not intended to be a test but rather an assessment of what the participants, individually and as a group, know about the course content. Participants, however, are often not aware of this and may become anxious about being “tested” in front of their colleagues on the first day of a course. The trainer should be sensitive to this attitude and administer the questionnaire in a neutral and nonthreatening way, as indicated in the following guidelines:

- Participants draw numbers to assure anonymity (e.g. from 1 to 16 if there are 16 participants in the course).
- Participants complete the precourse questionnaire.
- The trainer gives the answers to the question.
- The trainer passes around the individual and group assessment matrix for each participant to complete according to her/his number.
- The trainer posts the completed matrix.
- The trainer and participants discuss the results of the questionnaire as charted on the matrix and jointly decide how to allocate course time.
PRE COURSE QUESTIONNAIRE ANSWER KEY

FUNDAMENTALS OF BASIC CARE

1. The presence of a skilled healthcare provider during childbirth and the immediate postpartum/newborn period is a critical aspect in saving the lives of women and newborns.  
   TRUE  Participant Objective 1 (Chapter 1)

2. The clinical decision making process is based on two steps: gathering information and providing care.  
   FALSE  Participant Objective 2 (Chapter 3)

3. Good communication skills are an essential aspect of providing quality healthcare services to the woman and her newborn.  
   TRUE  Participant Objective 3 (Chapter 3)

4. Infection prevention practices focus on preventing both infection and disease transmission in clients and healthcare workers.  
   TRUE  Participant Objective 4 (Chapter 3)

5. Handwashing is of little importance with respect to preventing the spread of infection.  
   FALSE  Participant Objective 4 (Chapter 3)

BASIC ASSESSMENT IN LABOR/CHILDBIRTH

6. A history of the woman’s present labor/childbirth should include asking if her membranes have ruptured and when contractions began.  
   TRUE  Participant Objective 5 (Chapter 4)

7. Amniotic fluid has a distinct, but not foul-smelling, mild odor.  
   TRUE  Participant Objective 5 (Chapter 4)

8. The best way to determine the intensity of a woman’s contractions is to observe her facial expressions.  
   FALSE  Participant Objective 5 (Chapter 4)

9. In a term pregnancy, the fundus is about 30 to 32 cm above the symphysis pubis  
   FALSE  Participant Objective 6 (Chapter 4)

10. To determine descent by abdominal palpation the fetal head is assessed in fifths above the symphysis pubis.  
    TRUE  Participant Objective 6 (Chapter 4)
11. The fetal heart rate should be counted between contractions.  TRUE  Participant Objective 6 (Chapter 4)

12. Cervical dilatation is less than 4 cm in the latent phase of the first stage of labor.  TRUE  Participant Objective 7 (Chapter 4)

13. Cervical dilatation reaches 10 cm before the end of the first stage of labor.  FALSE  Participant Objective 7 (Chapter 4)

14. The partograph should be started in the latent phase of the first stage of labor.  FALSE  Participant Objective 7 (Chapter 4)

15. The fetal heart rate should be monitored every five minutes during the second stage of labor.  TRUE  Participant Objective 7 (Chapter 4)

BASIC CARE DURING LABOR/CHILDBIRTH

16. The birth of the head should be controlled by applying firm, gentle downward pressure to maintain flexion.  TRUE  Participant Objective 8 (Chapter 5)

17. If the cord is around the baby’s neck, it must be clamped and cut immediately.  FALSE  Participant Objective 8 (Chapter 5)

18. Controlled cord traction is used during active management of the third stage of labor.  TRUE  Participant Objective 8 (Chapter 5)

19. The placenta should be disposed of as soon as it is delivered.  FALSE  Participant Objective 8 (Chapter 5)

20. Episiotomy is an important routine procedure.  FALSE  Participant Objective 9 (Chapter 5)

21. Absorbable sutures should be used for closure of vaginal and perineal tears.  TRUE  Participant Objective 9 (Annex 4)

22. Vigilant monitoring of the postpartum woman is necessary only if there was a complication during labor or birth.  FALSE  Participant Objective 10 (Chapter 5)

23. An antimicrobial preparation should be instilled in the baby’s eyes within one hour of birth.  TRUE  Participant Objective 10 (Chapter 5)

24. It is not abnormal for a newborn’s head to be extremely large in proportion to its body.  FALSE  Participant Objective 11 (Chapter 5)
25. Relief measures for abdominal (or groin) pain during labor include having the woman change position frequently. **TRUE** Participant Objective 12 (Chapter 6)

26. Lack of food and fluids is the usual anatomic/physiologic cause of dizziness or fainting during the 1st to 3rd stage of labor. **FALSE** Participant Objective 12 (Chapter 6)

27. The woman who is HIV positive should be provided counseling about infant feeding options. **TRUE** Participant Objective 13 (Chapter 7)

28. Adolescents have the same needs during pregnancy as older women. **FALSE** Participant Objective 13 (Chapter 7)

**BASIC POSTPARTUM/NEWBORN ASSESSMENT**

29. A postpartum history must include asking the woman about the color and amount of her lochia. **TRUE** Participant Objective 14 (Chapter 4)

30. Information about the woman’s intended use of a family method is not important in the early postpartum period. **FALSE** Participant Objective 14 (Chapter 4)

31. During the postpartum period, it is normal for the fundal height to increase slightly. **FALSE** Participant Objective 15 (Chapter 4)

32. Assessment of breastfeeding is an important part of postpartum follow-up. **TRUE** Participant Objective 15 (Chapter 4)

**BASIC POSTPARTUM/NEWBORN CARE**

33. Breastfeeding has benefits for the baby only. **FALSE** Participant Objective 16 (Chapter 5)

34. Ensuring that the woman and her family know the maternal and newborn danger signs is an important part of the complication readiness plan for the postpartum period. **TRUE** Participant Objective 16 (Chapter 5)

35. Women who breastfeed exclusively may be protected from becoming pregnant for up to nine months. **FALSE** Participant Objective 16 (Chapter 5)
<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
<th>Answer</th>
<th>Objective</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Hygiene is extremely important to the postpartum woman because she is very vulnerable to infection.</td>
<td>TRUE</td>
<td>Participant Objective 16 (Chapter 5)</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Iron/folate should be discontinued as soon as the woman has given birth.</td>
<td>FALSE</td>
<td>Participant Objective 16 (Chapter 5)</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Delaying the baby’s first bath after birth has no affect on maintaining warmth.</td>
<td>FALSE</td>
<td>Participant Objective 17 (Chapter 5)</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>The baby’s cord should be placed outside the diaper to prevent contamination with urine and feces.</td>
<td>TRUE</td>
<td>Participant Objective 17 (Chapter 5)</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>The only immunization necessary for the newborn is for tuberculosis.</td>
<td>FALSE</td>
<td>Participant Objective 17 (Chapter 5)</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>An infected umbilicus should be cleaned thoroughly with soap and water, dried, and sealed with a clean dressing.</td>
<td>FALSE</td>
<td>Participant Objective 17 (Chapter 5)</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>An atonic uterus is a common cause of immediate postpartum hemorrhage.</td>
<td>TRUE</td>
<td>Participant Objective 18 (Chapter 8)</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Lack of continuous fetal descent is the best measure of unsatisfactory progress in labor.</td>
<td>FALSE</td>
<td>Participant Objective 18 (Chapter 8)</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>A fever of up to 38°C after childbirth is normal.</td>
<td>FALSE</td>
<td>Participant Objective 18 (Chapter 8)</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>If a newborn has pus draining from both eyes, gonococcal infection should be suspected.</td>
<td>TRUE</td>
<td>Participant Objective 18 (Chapter 8)</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>During the procedure of newborn resuscitation, the newborn’s head should be slightly extended.</td>
<td>TRUE</td>
<td>Participant Objective 19 (Chapter 8)</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>After successful resuscitation, the newborn should be taken to the nursery for observation.</td>
<td>FALSE</td>
<td>Participant Objective 19 (Chapter 8)</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>Prophylactic antibiotics should be given before performing manual removal of placenta.</td>
<td>TRUE</td>
<td>Participant Objective 20 (Annex 4)</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td>Source</td>
<td></td>
<td></td>
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<tr>
<td>-------------------------------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>49. Bimanual compression of the uterus may be used to manage bleeding</td>
<td><strong>TRUE</strong></td>
<td>Participant Objective 20 (Annex 4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>associated with an atonic uterus.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50. Interrupted sutures should be used to repair a cervical tear.</td>
<td><strong>FALSE</strong></td>
<td>Participant Objective 20 (Annex 4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
KNOWLEDGE ASSESSMENT QUESTIONNAIRE

USING THE QUESTIONNAIRE

The questionnaire should be administered at the time in the course when all subject areas have been presented. A score of 85% or more correct indicates knowledge-based mastery of material presented in the reference manual. For those participants who score less 85% on their first attempt, the trainer should review the results with the participant individually and guide her/him in using the reference manual to learn the required information. Repeat testing should be done only after the participant has had sufficient time to study the reference manual.
KNOWLEDGE ASSESSMENT QUESTIONNAIRE

Instructions: Write the letter of the single best answer to each question in the blank next to the corresponding number on the attached answer sheet.

FUNDAMENTALS OF BASIC CARE

1. A critical aspect of saving the lives of women and newborns is
   a. the presence of a support person during childbirth and the immediate postpartum/newborn period
   b. the presence of a doctor during childbirth and the immediate postpartum/newborn period
   c. the presence of a skilled caregiver during childbirth and the immediate postpartum/newborn period
   d. for all births to take place in a hospital

2. The steps in the clinical decision making process are
   a. gathering information
   b. interpreting information to form a diagnosis
   c. developing, implementing, and evaluating a care plan
   d. all of the above

3. Good communication skills include
   a. encouraging the woman to ask questions and express her concerns
   b. listening to what the woman has to say
   c. answering the woman in a calm, reassuring manner
   d. all of the above

4. Infection prevention practices
   a. need only be used for clients/patients known to have an infectious disease
   b. should be used for all clients/patients
   c. decrease the risk of transmitting life-threatening diseases
   d. b and c

5. The most practical procedure for preventing the spread of infection is
   a. wearing gloves
   b. wearing a mask
   c. handwashing
   d. all of the above
6. A history of the woman in labor should cover
   a. personal information and information about the present pregnancy, labor, or birth
   b. personal information and information about the present pregnancy, labor, or birth, and obstetric history
   c. personal information and information about the present pregnancy, labor, or birth, and obstetric and medical histories
   d. only information about her condition on admission to the labor ward

7. If the woman’s membranes have ruptured, it is important to ask
   a. when they ruptured
   b. what color the amniotic fluid is/was and whether it smelled foul
   c. whether or not she ever had premature rupture of membranes in a previous pregnancy
   d. a and b

8. Descent assessed by abdominal examination refers to the part of the head
   a. palpable below the symphysis pubis
   b. palpable above the symphysis pubis
   c. palpable below the ischial spines
   d. palpable above the ischial spines

9. The posterior fontanelle is bordered by
   a. The occipital bone and two parietal bones
   b. The two occipital bones
   c. The frontal and two parietal bones
   d. The two occipital bones and the two parietal bones

10. The fetal heart rate should be counted between contractions for
    a. 15 seconds and multiplied by four
    b. 30 seconds and multiplied by two
    c. a complete minute
    d. two complete minutes

11. In the latent phase of the first stage of labor
    a. cervical dilatation is less than 4 cm and there is no progressive descent of the presenting part
    b. cervical dilatation is less than 4 cm and there is progressive descent of the presenting part
    c. cervical dilatation is more than 4 cm and there is no progressive descent of the presenting part
    d. cervical dilatation is more than 4 cm and there is progressive descent of the presenting part
12. In the second stage of labor
   a. cervical dilatation is 4 cm to 9 cm, membranes are usually ruptured, and descent is steady
   b. cervical dilatation is 4 cm to 9 cm, membranes are not usually ruptured, and descent is steady
   c. cervical dilatation is 10 cm, membranes are usually ruptured, and descent is steady
   d. cervical dilatation is 10 cm, membranes are not usually ruptured, and descent is steady

13. If a woman is admitted during the first stage/active phase of labor, cervical dilatation is plotted on the partograph
   a. to the left of the alert line
   b. to the right of the alert line
   c. on the alert line
   d. on the action line

14. During the second stage of labor the fetal heart rate should be monitored every
   a. hour
   b. 30 minutes
   c. 15 minutes
   d. 5 minutes

15. Positions recommended to relieve abdominal (or groin) pain during labor include
   a. sitting or squatting
   b. lying on one side and then the other
   c. getting on hands and knees
   d. all of the above

16. To control the birth of the head
   a. the woman should be asked to pant or give only small pushes with contractions
   b. the birth attendant should place the fingers of one hand gently against the baby’s head to keep it flexed
   c. hold the head very firmly against the perineum
   d. a and b

17. If the cord is around the baby’s neck but is very loose, it should be
   a. clamped in two places and cut
   b. clamped in one place and cut
   c. slipped over the baby’s head
   d. slipped over the baby’s shoulders
18. Before applying controlled cord traction during active management of the third stage of labor
   a. oxytocin is administered intramuscularly and the birth attendant waits for the uterus to contract
   b. the mother is asked to push
   c. pressure is applied to the fundus
   d. all of the above

19. After delivery of the placenta
   a. the placenta should be checked for completeness
   b. the placenta and cord should be checked for completeness
   c. the placenta, cord, and membranes should be checked for completeness
   d. the placenta should be checked for missing pieces

20. Episiotomy should be considered in the case of
   a. complicated vaginal delivery
   b. scarring from female genital mutilation or poorly healed 3rd or 4th degree tears
   c. fetal distress
   d. all of the above

21. Polyglycolic sutures are preferred over chromic catgut for the repair of vaginal and perineal tears because of their
   a. tensile strength
   b. non-allergenic properties and lower probability of infectious complications
   c. cost effectiveness
   d. a and b

22. Vigilant monitoring of the postpartum woman is vital to
   a. ensure good mother-baby bonding
   b. ensure the establishment of early breastfeeding
   c. avert maternal death from postpartum hemorrhage
   d. detect a rise in temperature

23. Antimicrobials suitable for newborn eye treatment are
   a. polyvidone-iodine solution 2.5%, silver nitrate solution 1%, or tetracycline ointment 1%
   b. polyvidone-iodine solution 1.5%, silver nitrate solution 1%, or tetracycline ointment 1%
   c. polyvidone-iodine solution 2.5%, silver nitrate solution 2%, or tetracycline ointment 1%
   d. polyvidone-iodine solution 2.5%, silver nitrate solution 1%, or tetracycline ointment 2.5%
24. A normal newborn’s head may
   a. be symmetrical in shape at birth
   b. have an edematous swelling at birth, over the part of the head that came first
   c. have a misshapen head for up to one week after birth
   d. a and b

25. A common discomfort in the 4th stage of labor is
   a. numbness of fingers and toes
   b. quivering, shivering
   c. hyperventilation/shortness of breath
   d. heart palpitations

26. The usual anatomic/physiologic basis for dizziness or fainting during the 1st to 3rd stage of labor include
   a. a drop in blood pressure caused by changes in position
   b. hormonal changes
   c. lack of food and fluid
   d. all of the above

27. If a woman who is HIV positive chooses to breastfeed, she should be advised that
   a. breastfeeding should be delayed for two weeks following the birth
   b. breastfeeding should be exclusive and not alternated with replacement feeds
   c. breastfeeding should be alternated with replacement feeds
   d. breastfeeding should be continued indefinitely

28. The needs of the pregnant adolescent may be related to
   a. lack of access to basic health services and care during labor and birth
   b. lack of a support system and resources
   c. feelings of powerlessness
   d. all of the above

29. On days 5 to 14 postpartum, the color of lochia is usually
   a. dark red or brownish
   b. pinkish brown
   c. creamy white/yellow
   d. clear and watery
30. The postpartum woman should be

a. asked which family planning methods she has used and whether she wants to use a method in the future
b. told that family planning is not necessary during the immediate postpartum period
c. told that she must begin using a family planning method immediately if she is not fully breastfeeding
d. all of the above

31. Following the birth, the fundus

a. decreases about 3 cm/day for the first 9–10 days
b. decreases about 2 cm/day for the first 9–10 days
c. decreases about 1 cm/day for the first 9–10 days
d. increases the first two days and then decreases

32. Assessment of breastfeeding includes observing

a. positioning, attachment, and effectiveness of suckling
b. attachment and effectiveness of suckling
c. effectiveness of suckling
d. whether the mother has a sufficient supply of breast milk

33. Breastfeeding

a. is sufficient if the baby urinates four times per day
b. is sufficient if the baby urinates six times per day
c. should continue exclusively for eight months only
d. should continue exclusively for four months only

34. Newborn danger signs include

a. difficulty breathing
b. convulsions
c. cyanosis
d. all of the above

35. Women who rely on lactational amenorrhrea as a method of family planning should be advised that

a. there is little risk of becoming pregnant for as long as breastfeeding is continued
b. there is no risk of becoming pregnant for as long as breastfeeding is continued
c. there is no risk of becoming pregnant if the baby is given drinks/food other than breast milk
d. there is a risk of ovulating and becoming pregnant if the baby is given drinks/food other than breast milk
36. Key messages on hygiene for the woman during the postpartum period include
   a. washing hands before and after washing the genitals and changing perineal pads/cloths at least six times a day
   b. douching at least twice daily
   c. using a sitz bath at least twice daily
   d. taking a shower at least twice daily

37. For the prevention of anemia in the postpartum period
   a. iron 60 mg + folate 400 mcg should be taken by mouth once daily for one month
   b. iron 60 mg + folate 400 mcg should be taken by mouth once daily for two months
   c. iron 60 mg + folate 400 mcg should be taken by mouth once daily for three months
   d. iron 60 mg should be taken by mouth once daily for three months

38. To maintain warmth, the newborn should not be bathed
   a. unless hot water is readily available
   b. for at least two hours after birth
   c. for at least four hours after birth
   d. for at least six hours after birth

39. Newborn cord care includes
   a. applying a dry dressing to the cord stump daily
   b. applying alcohol to the cord stump four times daily
   c. applying gentian violet to the cord stump three times daily
   d. applying nothing to the cord stump

40. The recommended newborn immunizations are
   a. BCG
   b. BCG and OPV-0
   c. OPV-0 and HB-1
   d. BCG, OPV-0, and HB-1

41. Treatment of a mildly red cord stump, in the absence of other signs of infection, involves
   a. washing the umbilicus using an antiseptic solution and painting it with an antiseptic solution four times a day
   b. washing the umbilicus using an antiseptic solution and painting it with an antiseptic solution eight times a day
   c. washing the umbilicus using an antiseptic solution and applying a dry dressing
   d. applying a dry dressing and leaving it in place for three days
42. Management of postpartum hemorrhage caused by an atonic uterus involves
   a. massaging the uterus through the abdominal wall to expel clots and cause uterine
      contraction
   b. helping the woman to urinate or catheterizing the bladder
   c. giving an oxytocic drug
   d. all of the above

43. Findings suggesting unsatisfactory progress in the active phase of the first stage of labor
    include
   a. infrequent contractions
   b. irregular contractions
   c. cervical dilatation that does not progress at the rate of at least 1 cm/hour
   d. none of the above

44. Possible causes of a fever of 38°C or more in the postpartum period include
   a. amnionitis
   b. pyelonephritis
   c. endometritis
   d. all of the above

45. A newborn who has pus draining from both eyes may have
   a. ophthalmia neonatorum
   b. chlamydial or staphylococcal conjunctivitis
   c. red eye
   d. a and b

46. During resuscitation, the newborn’s neck should be
   a. slightly extended
   b. moderately extended
   c. slightly flexed
   d. supported by a small but firm pillow

47. Following successful resuscitation, the newborn should be
   a. taken to the newborn nursery for observation
   b. taken to the intensive care unit for observation
   c. placed in skin-to-skin contact with the mother
   d. given oxygen for at least three hours
48. Before manual removal of placenta
   a. a single dose of prophylactic antibiotics should be given orally
   b. a single dose of prophylactic antibiotics should be given intravenously
   c. two doses of prophylactic antibiotics should be given orally, four hours apart
   d. two doses of prophylactic antibiotics should be given intravenously, four hours apart

49. The first step in the management of atonic uterus is
   a. bimanual compression of the uterus
   b. compression of the abdominal aorta
   c. manual removal of the placenta
   d. massage of the uterus through the abdominal wall

50. A cervical tear should be repaired using
   a. continuous 0 chromic catgut suture starting at the upper edge of the tear
   b. continuous 0 chromic catgut suture staring at the lower edge of the tear
   c. continuous 0 chromic catgut suture staring at the center of the tear
   d. interrupted sutures
KNOWLEDGE ASSESSMENT QUESTIONNAIRE ANSWER SHEET

PARTICIPANT'S NAME: ____________________________________________

1. _____ Learning Objective 1 (Section 1: Chapter 1)
2. _____ Learning Objective 2 (Section 1: Chapter 3)
3. _____ Learning Objective 3 (Section 1: Chapter 3)
4. _____ Learning Objective 4 (Section 1: Chapter 3)
5. _____ Learning Objective 4 (Section 1: Chapter 3)
6. _____ Learning Objective 5 (Section 2: Chapter 6)
7. _____ Learning Objective 5 (Section 2: Chapter 6)
8. _____ Learning Objective 6 (Section 2: Chapter 6)
9. _____ Learning Objective 6 (Section 2: Chapter 6)
10. _____ Learning Objective 6 (Section 2: Chapter 6)
11. _____ Learning Objective 6 (Section 2: Chapter 6)
12. _____ Learning Objective 6 (Section 2: Chapter 6)
13. _____ Learning Objective 6 (Section 2: Chapter 6)
14. _____ Learning Objective 6 (Section 2: Chapter 6)
15. _____ Learning Objective 6 (Section 2: Chapter 6)
16. _____ Learning Objective 8 (Section 2: Chapter 6)
17. _____ Learning Objective 8 (Section 2: Chapter 6)
18. _____ Learning Objective 8 (Section 2: Chapter 6)
19. _____ Learning Objective 8 (Section 2: Chapter 6)
20. _____ Learning Objective 9 (Section 4: Annex 4)
21. _____ Learning Objective 9 (Section 4: Annex 4)
22. _____ Learning Objective 10 (Section 2: Chapter 6)
23. _____ Learning Objective 10 (Section 2: Chapter 6)
24. _____ Learning Objective 11 (Section 2: Chapter 8)
25. _____ Learning Objective 12 (Section 3: Chapter 9)
26. _____ Learning Objective 12 (Section 3: Chapter 9)
27. _____ Learning Objective 12 (Section 3: Chapter 10)
28. _____ Learning Objective 12 (Section 3: Chapter 10)
29. _____ Learning Objective 13 (Section 2: Chapter 7)
30. _____ Learning Objective 13 (Section 2: Chapter 7)
31. _____ Learning Objective 13 (Section 2: Chapter 7)
32. _____ Learning Objective 14 or 15 (Section 2: Chapter 7 or 8)
33. _____ Learning Objective 15 (Section 2: Chapter 8)
34. _____ Learning Objective 15 (Section 2: Chapter 8)
35. _____ Learning Objective 14 (Section 2: Chapter 7)
36. _____ Learning Objective 14 (Section 2: Chapter 7)
37. _____ Learning Objective 14 (Section 2: Chapter 7)
38. _____ Learning Objective 15 (Section 2: Chapter 8)
39. _____ Learning Objective 15 (Section 2: Chapter 8)
40. _____ Learning Objective 15 (Section 2: Chapter 8)
41. _____ Learning Objective 17 (Section 3: Chapter 11)
42. _____ Learning Objective 17 (Section 3: Chapter 11)
43. _____ Learning Objective 17 (Section 3: Chapter 11)
44. _____ Learning Objective 17 (Section 3: Chapter 11)
45. _____ Learning Objective 17 (Section 3: Chapter 11)
46. _____ Learning Objective 18 (Section 3: Chapter 11)
47. _____ Learning Objective 18 (Section 3: Chapter 11)
48. _____ Learning Objective 19 (Section 4: Annex 4)
49. _____ Learning Objective 19 (Section 4: Annex 4)
50. _____ Learning Objective 19 (Section 4: Annex 4)
KNOWLEDGE ASSESSMENT QUESTIONNAIRE ANSWER KEY

FUNDAMENTALS OF BASIC CARE

1. A critical aspect of saving the lives of women and newborns is
   a. the presence of a support person during childbirth and the immediate postpartum/newborn period
   b. the presence of a doctor during childbirth and the immediate postpartum/newborn period
   C. THE PRESENCE OF A SKILLED CAREGIVER DURING CHILDBIRTH AND THE IMMEDIATE POSTPARTUM/NEWBORN PERIOD
   d. for all births to take place in a hospital

2. The steps in the clinical decision making process are
   a. gathering information
   b. interpreting information to form a diagnosis
   c. developing, implementing, and evaluating a care plan
   D. ALL OF THE ABOVE

3. Good communication skills include
   a. encouraging the woman to ask questions and express her concerns
   b. listening to what the woman has to say
   c. answering the woman in a calm, reassuring manner
   D. ALL OF THE ABOVE

4. Infection prevention practices
   a. need only be used for clients/patients known to have an infectious disease
   b. should be used for all clients/patients
   c. decrease the risk of transmitting life-threatening diseases
   D. B AND C

5. The most practical procedure for preventing the spread of infection is
   a. wearing gloves
   b. wearing a mask
   C. HANDWASHING
   d. all of the above
6. A history of the woman in labor should cover
   a. personal information and information about the present pregnancy, labor, or birth
   b. personal information and information about the present pregnancy, labor, or birth, and obstetric history
   C. PERSONAL INFORMATION AND INFORMATION ABOUT THE PRESENT PREGNANCY, LABOR, OR BIRTH, AND OBSTETRIC AND MEDICAL HISTORIES
   d. only information about her condition on admission to the labor ward

7. If the woman’s membranes have ruptured, it is important to ask
   a. when they ruptured
   b. what color the amniotic fluid is/was and whether it smelled foul
   c. whether or not she ever had premature rupture of membranes in a previous pregnancy
   D. A AND B

8. Descent assessed by abdominal examination refers to the part of the head
   a. palpable below the symphysis pubis
   B. PALPABLE ABOVE THE SYMPHYSIS PUBIS
   c. palpable below the ischial spines
   d. palpable above the ischial spines

9. The posterior fontanelle is bordered by
   A. THE OCCIPITAL BONE AND TWO PARIETAL BONES
   b. The two occipital bones
   c. The frontal and two parietal bones
   d. The two occipital bones and the two parietal bones

10. The fetal heart rate should be counted between contractions for
   a. 15 seconds and multiplied by four
   b. 30 second and multiplied by two
   C. A COMPLETE MINUTE
   d. two complete minutes

11. In the latent phase of the first stage of labor
   A. CERVICAL DILATATION IS LESS THAN 4 CM AND THERE IS NO PROGRESSIVE DESCENT OF THE PRESENTING PART
   b. cervical dilatation is less than 4 cm and there is progressive descent of the presenting part
   c. cervical dilatation is more than 4 cm and there is no progressive descent of the presenting part
   d. cervical dilatation is more than 4 cm and there is progressive descent of the presenting part
12. In the second stage of labor
   a. cervical dilatation is 4 cm to 9 cm, membranes are usually ruptured, and descent is steady
   b. cervical dilatation is 4 cm to 9 cm, membranes are not usually ruptured, and descent is steady
   C. CERVICAL DILATATION IS 10 CM, MEMBRANES ARE USUALLY RUPTURED, AND DESCENT IS STEADY
   d. cervical dilatation is 10 cm, membranes are not usually ruptured, and descent is steady

13. If a woman is admitted during the first stage/active phase of labor, cervical dilatation is plotted on the partograph
   a. to the left of the alert line
   b. to the right of the alert line
   C. ON THE ALERT LINE
   d. on the action line

14. During the second stage of labor the fetal heart rate should be monitored every
   a. hour
   b. 30 minutes
   c. 15 minutes
   D. 5 MINUTES

15. Positions recommended to relieve abdominal (or groin) pain during labor include
   a. sitting or squatting
   b. lying on one side and then the other
   c. getting on hands and knees
   D. ALL OF THE ABOVE

16. To control the birth of the head
   a. the woman should be asked to pant or give only small pushes with contractions
   b. the birth attendant should place the fingers of one hand gently against the baby’s head to keep it flexed
   c. hold the head very firmly against the perineum
   D. A AND B

17. If the cord is around the baby’s neck but is very loose, it should be
   a. clamped in two places and cut
   b. clamped in one place and cut
   C. SLIPPED OVER THE BABY’S HEAD
   d. slipped over the baby’s shoulders
18. Before applying controlled cord traction during active management of the third stage of labor

   A. OXYTOCIN IS ADMINISTERED INTRAMUSCULARLY AND THE BIRTH ATTENDANT WAITS FOR THE UTERUS TO CONTRACT
   b. the mother is asked to push
   c. pressure is applied to the fundus
   d. all of the above

19. After delivery of the placenta

   a. the placenta should be checked for completeness
   b. the placenta and cord should be checked for completeness
   C. THE PLACENTA, CORD, AND MEMBRANES SHOULD BE CHECKED FOR COMPLETENESS
   d. the placenta should be checked for missing pieces

20. Episiotomy should be considered in the case of

   a. complicated vaginal delivery
   b. scarring from female genital mutilation or poorly healed 3rd or 4th degree tears
   c. fetal distress
   D. ALL OF THE ABOVE

21. Polyglycolic sutures are preferred over chromic catgut for the repair of vaginal and perineal tears because of their

   a. tensile strength
   b. non-allergenic properties and lower probability of infectious complications
   c. cost effectiveness
   D. A AND B

22. Vigilant monitoring of the postpartum woman is vital to

   a. ensure good mother-baby bonding
   b. ensure the establishment of early breastfeeding
   C. AVOID MATERNAL DEATH FROM POSTPARTUM HEMORRHAGE
   d. detect a rise in temperature

23. Antimicrobials suitable for newborn eye treatment are

   A. POLYVIDONE-IODINE SOLUTION 2.5%, SILVER NITRATE SOLUTION 1%, OR TETRACYCLINE OINTMENT 1%
   b. polyvidone-iodine solution 1.5%, silver nitrate solution 1%, or tetracycline ointment 1%
   c. polyvidone-iodine solution 2.5%, silver nitrate solution 2%, or tetracycline ointment 1%
   d. polyvidone-iodine solution 2.5%, silver nitrate solution 1%, or tetracycline ointment 2.5%
24. A normal newborn’s head may
   a. Be symmetrical in shape at birth
   b. Have an edematous swelling at birth, over the part of the head that came first
   c. Have a misshapen head for up to one week after birth
   D. A AND B

25. A common discomfort in the 4th stage of labor is
   a. numbness of fingers and toes
   B. QUIVERING, SHIVERING
   c. hyperventilation/shortness of breath
   d. heart palpitations

26. The usual anatomic/physiologic basis for dizziness or fainting during the 1st to 3rd stage of labor include
   A. A DROP IN BLOOD PRESSURE CAUSED BY CHANGES IN POSITION
   b. hormonal changes
   c. lack of food and fluid
   d. all of the above

27. If a woman who is HIV positive chooses to breastfeed, she should be advised that
   a. breastfeeding should be delayed for two weeks following the birth
   B. BREASTFEEDING SHOULD BE EXCLUSIVE AND NOT ALTERNATED WITH REPLACEMENT FEEDS
   c. breastfeeding should be alternated with replacement feeds
   d. breastfeeding should be continued indefinitely

28. The needs of the pregnant adolescent may be related to
   a. lack of access to basic health services and care during labor and birth
   b. lack of a support system and resources
   c. feelings of powerlessness
   D. ALL OF THE ABOVE

29. On days 5 to 14 postpartum, the color of lochia is usually
   a. dark red or brownish
   B. PINKISH BROWN
   c. creamy white/yellow
   d. clear and watery
30. The postpartum woman should be

A. ASKED WHICH FAMILY PLANNING METHODS SHE HAS USED AND WHETHER SHE WANTS TO USE A METHOD IN THE FUTURE
b. told that family planning is not necessary during the immediate postpartum period
c. told that she must begin using a family planning method immediately if she is not fully breastfeeding
d. all of the above

31. Following the birth, the fundus

a. decreases about 3 cm/day for the first 9–10 days
b. decreases about 2 cm/day for the first 9–10 days
C. DECREASES ABOUT 1 CM/DAY FOR THE FIRST 9–10 DAYS
d. increases the first two days and then decreases

32. Assessment of breastfeeding includes observing

A. POSITIONING, ATTACHMENT, AND EFFECTIVENESS OF SUCKLING
b. attachment and effectiveness of suckling
c. effectiveness of suckling
d. whether the mother has a sufficient supply of breast milk

33. Breastfeeding

a. is sufficient if the baby urinates four times per day
B. IS SUFFICIENT IF THE BABY URINATES SIX TIMES PER DAY
c. should continue exclusively for eight months only
d. should continue exclusively for four months only

34. Newborn danger signs include

a. difficulty breathing
b. convulsions
c. cyanosis
D. ALL OF THE ABOVE

35. Women who rely on lactational amenorrhea as a method of family planning should be advised that

a. there is little risk of becoming pregnant for as long as breastfeeding is continued
b. there is no risk of becoming pregnant for as long as breastfeeding is continued
c. there is no risk of becoming pregnant if the baby is given drinks/food other than breast milk
D. THERE IS A RISK OF OVULATING AND BECOMING PREGNANT IF THE BABY IS GIVEN DRINKS/FOOD OTHER THAN BREAST MILK
36. Key messages on hygiene for the woman during the postpartum period include

A. WASHING HANDS BEFORE AND AFTER WASHING THE GENITALS AND CHANGING PERINEAL PADS/CLOTHS AT LEAST SIX TIMES A DAY
   b. douching at least twice daily
   c. using a sitz bath at least twice daily
   d. taking a shower at least twice daily

37. For the prevention of anemia in the postpartum period

a. iron 60 mg + folate 400 mcg should be taken by mouth once daily for one month
b. iron 60 mg + folate 400 mcg should be taken by mouth once daily for two months
C. IRON 60 MG + FOLATE 400 MCG SHOULD BE TAKEN BY MOUTH ONCE DAILY FOR THREE MONTHS
d. iron 60 mg should be taken by mouth once daily for three months

38. To maintain warmth, the newborn should not be bathed

a. unless hot water is readily available
b. for at least two hours after birth
c. for at least four hours after birth
D. FOR AT LEAST SIX HOURS AFTER BIRTH

39. Newborn cord care includes

a. applying a dry dressing to the cord stump daily
b. applying alcohol to the cord stump four times daily
c. applying gentian violet to the cord stump three times daily
D. APPLYING NOTHING TO THE CORD STUMP

40. The recommended newborn immunizations are

a. BCG
b. BCG and OPV-0
c. OPV-0 and HB-1
D. BCG, OPV-0, AND HB-1

41. Treatment of a mildly red cord stump, in the absence of other signs of infection, involves

a. washing the umbilicus using an antiseptic solution and painting it with an antiseptic solution four times a day
B. WASHING THE UMBILICUS USING AN ANTISEPTIC SOLUTION AND PAINTING IT WITH AN ANTISEPTIC SOLUTION EIGHT TIMES A DAY
c. washing the umbilicus using an antiseptic solution and applying a dry dressing
d. applying a dry dressing and leaving it in place for three days
42. Management of postpartum hemorrhage caused by an atonic uterus involves
   a. massaging the uterus through the abdominal wall to expel clots and cause uterine contraction
   b. helping the woman to urinate or catheterizing the bladder
   c. giving an oxytocic drug
   **D. ALL OF THE ABOVE**

43. Findings suggesting unsatisfactory progress in the active phase of the first stage of labor include
   a. infrequent contractions
   b. irregular contractions
   **C. CERVICAL DILATATION THAT DOES NOT PROGRESS AT THE RATE OF AT LEAST 1 CM/HOUR**
   d. none of the above

44. Possible causes of a fever of 38°C or more in the postpartum period include
   a. amnionitis
   b. pyelonephritis
   c. endometritis
   **D. ALL OF THE ABOVE**

45. A newborn who has pus draining from both eyes may have
   a. ophthalmia neonatorum
   b. chlamydial or staphylococcal conjunctivitis
   c. red eye
   **D. A AND B**

46. During resuscitation, the newborn’s neck should be
   **A. SLIGHTLY EXTENDED**
   b. moderately extended
   c. slightly flexed
   d. supported by a small but firm pillow

47. Following successful resuscitation, the newborn should be
   a. taken to the newborn nursery for observation
   b. taken to the intensive care unit for observation
   **C. PLACED IN SKIN-TO-SKIN CONTACT WITH THE MOTHER**
   d. given oxygen for at least three hours
48. Before manual removal of placenta

   a. a single dose of prophylactic antibiotics should be given orally
   B. A SINGLE DOSE OF PROPHYLACTIC ANTIBIOTICS SHOULD BE GIVEN INTRAVENOUSLY
   c. two doses of prophylactic antibiotics should be given orally, four hours apart
   d. two doses of prophylactic antibiotics should be given intravenously, four hours apart

49. The first step in the management of atonic uterus is

   a. bimanual compression of the uterus
   b. compression of the abdominal aorta
   c. manual removal of the placenta
   D. MASSAGE OF THE UTERUS THROUGH THE ABDOMINAL WALL

50. A cervical tear should be repaired using

   A. CONTINUOUS 0 CHROMIC CATGUT SUTURE STARTING AT THE UPPER EDGE OF THE TEAR
   b. continuous 0 chromic catgut suture staring at the lower edge of the tear
   c. continuous 0 chromic catgut suture staring at the center of the tear
   d. interrupted sutures
ROLE PLAY AND EXERCISE ANSWER KEY

ROLE PLAY 1: REASSURING THE WOMAN IN LABOR
ANSWER KEY

DIRECTIONS

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

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

PARTICIPANT ROLES

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

Woman in labor: Mrs. A is 16 years old. This is her first pregnancy.

SITUATION

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

FOCUS OF THE ROLE PLAY

The focus of the role play is the interpersonal interaction between the midwife and Mrs. A and the appropriateness of the midwife’s verbal and non-verbal communication skills.

DISCUSSION QUESTIONS

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

1. How did the midwife demonstrate respect and kindness during her interaction with Mrs. A?

2. How did the midwife provide emotional support and reassurance to Mrs. A?

3. What non-verbal behaviors did the midwife use to encourage interaction between herself and Mrs. A?

ANSWERS
The following answers should be used by the trainer to guide discussion after the role play. Although these are “likely” answers, other answers provided by participants during the discussion may be equally acceptable.

1. The midwife should speak in a calm, reassuring manner and hold Mrs. A’s hand or rub her back until the contraction has finished. The midwife should speak in a culturally appropriate way and involve any family member that Mrs. A. wants brought into the interaction.

2. When Mrs. A’s contraction has finished, the midwife should make her as comfortable as possible and explain that she is having labor pains and what is likely to happen next, and what she can do to improve outcome. Helping Mrs. A understand what is happening should help to reassure her and reduce her anxiety. Mrs. A should be encouraged to ask questions and the midwife should use the same calm, reassuring manner to answer them. The midwife should also identify and mention anything that Mrs. A. is doing well.

3. Supportive nonverbal behaviors, such as nodding and smiling, should be used to let Mrs. A know that she is being listened to and understood. If culturally appropriate, the midwife can touch the patient gently on her shoulder, arm, hand, and abdomen.
ROLE PLAY 2: PARENT EDUCATION AND SUPPORT FOR CARE OF THE NEWBORN
ANSWER KEY

DIRECTIONS

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

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

PARTICIPANT ROLES

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

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

SITUATION

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

FOCUS OF THE ROLE PLAY

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

DISCUSSION QUESTIONS

1. How did the healthcare provider demonstrate respect and kindness during her interaction with Mrs. B?

2. What key health messages related to hygiene and cord care did the healthcare provider discuss with Mrs. B?

3. What did the healthcare provider do to ensure that Mrs. B understood the health messages?
ANSWERS

The following answers should be used by the trainer to guide discussion after the role play. Although these are “likely” answers, other answers provided by participants during the discussion may be equally acceptable.

1. The healthcare provider should speak in a calm reassuring manner, using simple, clear, and locally understand language and terminology. Mrs. B should be encouraged to ask questions and listened to carefully; the healthcare provider should avoid interrupting Mrs. B while she is speaking and use the same calm, reassuring manner to answer her questions. Supportive nonverbal behaviors, such as nodding and smiling, should be used to let Mrs. B know that she is being listened to and understood. It is very important not to express judgment about Mrs. B’s care of her baby; the healthcare provider should instead show interest, concern, and friendliness.

2. The healthcare provider should discuss hygiene and cord care with Mrs. B, covering the following points: clean clothing; handwashing; bathing the baby on the second or third day after birth; washing the buttocks after each bowel movement; leaving the cord uncovered and washing it with clean water and soap if it becomes soiled, avoidance of applying substances to the cord; and observance of danger signs, such as skin pustules or rashes, discharge from the umbilicus, and discharge from the eyes. During the discussion, the healthcare provider should periodically ask Mrs. B, using a friendly, encouraging tone of voice, to repeat the key points to ensure her understanding.

3. She encouraged Mrs. B to repeat the key points, and gave positive re-enforcement when she repeated them correctly.
EXERCISE 1: USING THE PARTOGRAPH

ANSWER KEY

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

INSTRUCTIONS

The trainer should review the partograph form with participants before beginning the exercise.

Each participant should be three blank partograph forms, one for each the following cases.

- **Case 1**: The trainer should read each step to the class, plot the information on the poster-size laminated partograph, and ask the questions included in each of the steps. At the same time, participants should plot the information on one of their partograph forms.

- **Case 2**: The trainer should read each step to the class and have participants plot the information on another of their partograph forms. The questions included in each step should be asked as they arise.

- **Case 3**: The trainer should read each step to the class and have participants plot the information on the third of their partograph forms. The questions should then be asked when the partograph is completed.

Throughout the exercise, the trainer should ensure that participants have completed their partograph forms correctly.

The trainer should provide participants with the three completed partograph forms from the Answer Key and have them compare these with the partograph forms they have completed. The trainer should discuss and resolve any differences between the partographs completed by participants and those in the Answer Key.

RESOURCES

- Partograph forms (three for each participant)
- Poster-size laminated partograph
- Exercise: Using the Partograph Answer Key
CASE 1

- Step 1—see partograph
- Step 2—see partograph
  - Steps: Inform Mrs. A and her family of the findings and what to expect; encourage her to ask questions; provide her comfort measures, hydration, and nutrition
  - Advice: Assume position of choice; drink plenty of fluids and eat as desired
- Expect at 13.00: Progress to at least 9 cm dilation
- Step 3—see partograph
  - Steps: Prepare for birth
  - Advice: Push only when urge to push
  - Expect: Spontaneous vaginal birth
- Step 4
  - 1\textsuperscript{st} stage of active labor: 5 hours (4 hrs plotted [09.00 to 13.00] plus estimated 1 hour for dilation from 4–5 cm)
  - 2\textsuperscript{nd} stage of active labor: 20 minutes
CASE 2

- Step 1—see partograph
- Diagnosis: Active labor
- Action: Inform Mrs. B and her family about findings and what to expect; give continual opportunity to ask questions; encourage Mrs. B to walk around and to drink and eat as desired
• Step 2—see partograph
  • Diagnosis: Prolonged active phase; less than 3 contractions per 10 minutes, each lasting less than 40 seconds; good fetal and maternal condition
  • Action: The facilitator should take the opportunity to open a discussion about using oxytocin for augmenting labor based on the clinical setting. For instance, is the woman being cared for at a health post that is 4 hours away from a district hospital where an oxytocin drip can be started? Or if she is being cared for in a district hospital, can other measures be used (such as hydration, ambulation) before oxytocin is started?

• Step 3
  • Diagnosis: Prolonged active phase; less than 3 contractions per 10 minutes, each lasting less than 40 seconds; good maternal and fetal condition
  • Action: Augment labor with oxytocin and artificial rupture of membranes; inform Mrs. B and her family of the findings and what to expect; reassure; answer questions; encourage drinks; encourage Mrs. B to assume position of choice

• Step 4
  • Steps: Continue to augment labor (maintain oxytocin infusion rate at 50 dpm), provide comfort (psychological and physical); encourage drinks and nutrition

• Step 5—see partograph

• Step 6—see partograph

• Step 7
  • 1st stage of labor: 9 hours
  • 2nd stage of labor: 1 hour 10 minutes
  • Why augment: Less than 3 contractions in 10 minutes, each lasting less than 40 seconds (lack of progress)
CASE 3

- Step 1—see partograph
- Step 2—see partograph
- Step 3—see partograph
- Step 4—see partograph
- Final diagnosis: Obstructed labor with fetal head 3/5 palpable above the symphysis pubis
- Cesarean section because Mrs. C is already in secondary arrest of dilatation and descent despite at least 3 contractions in 10 minutes, each lasting more than 40 seconds
- 15.00 action: Continue emotional and physical support, including hydration (because Mrs. C and her family may become discouraged with lack of progress and emotionally and physically exhausted); continue attentive monitoring of maternal and fetal condition; have crossed alert line; blood-stained amniotic fluid
- Decision to perform caesarean section: Correct because fetal condition deteriorating, failure to progress despite at least 3 contractions in 10 minutes, each lasting more than 40 seconds, acetone in urine, rising maternal pulse
- Problems expected in newborn: asphyxia, meconium aspiration
CASE STUDIES

USING THE CASE STUDIES

The purpose of the case studies is to help participants develop and practice clinical decision-making skills. While it is suggested in the course outline that the case studies be completed in small groups in the classroom, they can also be completed individually in the classroom or at the clinical site or as homework assignments.

There are six case studies in this course:

- **Case Study 1: Childbirth Assessment and Care** (Support in Labor)
- **Case Study 2: Childbirth Assessment and Care** (Support in Childbirth)
- **Case Study 3: Postpartum Assessment and Care** (Family Planning)
- **Case Study 4: Postpartum Assessment and Care** (Breastfeeding Difficulty)
- **Case Study 5: Newborn Assessment and Care** (Cord Infection)
- **Case Study 6: Newborn Assessment and Care** (Skin Rash due to Lack of Hygiene)

The case studies follow the clinical decision-making framework presented in Section 1: Chapter 3 of the reference manual used for the course. The technical content of the case studies is taken from Section 2: Chapters 6 to 8, Section 3: Chapters 9 to 11, and Section 4: Annex 5. Each case study has a key containing the expected responses. The trainer should be thoroughly familiar with these responses before introducing the case studies to participants. Although the keys contain “likely” responses, other responses provided by participants may be equally acceptable.
CASE STUDY 1: CHILDBIRTH ASSESSMENT AND CARE
(SUPPORT IN LABOR)
ANSWER KEY

DIRECTIONS

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

CLIENT PROFILE

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

PRE-ASSESSMENT

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

- Mrs. A should be greeted respectfully and with kindness and offered a seat to help her feel
  comfortable and welcome, establish rapport, and build trust. A good relationship helps to
  ensure that the client will adhere to the care plan and return for continued care.

- Ascertain, from other staff or from records, whether or not Mrs. A has had a Quick Check. If
  she has not, you should conduct a Quick Check now. The Quick Check detects
  signs/symptoms of life-threatening complications and of advanced labor (e.g., strong regular
  contractions, urge to push, fluid leaking from vagina, grunting or moaning) so that a woman
  receives the urgent care she requires before receiving routine assessment/care.

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

2. What history will you include in your assessment of Mrs. A and why?

- If she is not in advanced labor, you should take a complete history (i.e., personal information,
  estimated date of childbirth/menstrual history, history of present pregnancy and labor
  childbirth, obstetric history, medical history) to guide further assessment and help
  individualize care provision. Some responses may help determine whether she is in labor as
  well as stage/phase of labor, or may indicate a special need/condition that requires
  additional care or a life-threatening complication that requires immediate attention.
• When asking about the history of the current labor, note whether her contractions are increasing in intensity, frequency, and duration.

• When asking about her living situation, previous labors and childbirths, and the current pregnancy, note any stressful experiences that may explain her extreme anxiety.

3. What physical examination will you include in your assessment of Mrs. A and why?

• If she is not in advanced labor, you should perform a complete physical examination (i.e., well-being, vital signs, breasts, abdomen [fundal height, lie, presentation, fetal heart rate], genital examination, and cervical examination) to guide further assessment and help individualize care provision. Some findings may help determine whether she is in labor as well as stage/phase of labor, or may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.

• Assessment of general well-being, including gait and movements, behavior and vocalizations, help to assess her degree of anxiety.

• Mrs. A’s respirations, blood pressure, temperature, and pulse should be measured to rule out any physical problems or abnormalities that might explain her feelings of anxiety.

• During abdominal examination special attention should be given to:
  - Fundal height, which will help confirm gestational age or indicate size-date discrepancy
  - Descent of the presenting part, which would help in evaluating progress of labor
  - Fetal heart tones, which will help indicate fetal condition
  - Frequency and duration of contractions to determine quality of contractions and help determine stage/phase of labor, as well as evaluate progress of labor

• Cervical examination should include assessment of:
  - Dilation of the cervix to help determine stage and phase of labor, as well as evaluate progress of labor
  - Membranes and amniotic fluid to determine whether the membranes have ruptured and to help assess fetal condition
  - Presentation to determine if there is any abnormality that will affect the birth
  - Molding to help determine fetal condition and indicate possible obstruction of labor (fetal-pelvic disproportion)

4. What laboratory tests will you include in your assessment of Mrs. A and why?

• You should conduct all routine laboratory tests if available and as needed (i.e., RPR for syphilis, HIV [if she does not “opt out”), and Rh factor and blood group) to guide further assessment and help individualize care provision. Some findings may indicate a special
need/condition that requires additional care or a life-threatening complication that requires immediate attention.

**DIAGNOSIS (interpreting information to identify problems/needs)**

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

**History:**

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

**Physical Examination:**

- Mrs. A kneels to the floor and cries out with each contraction.
- On measurement of vital signs: Respirations are 18 per minute, BP is 120/82, Pulse is 88 beats per minute, temperature is 37.8°C.
- On abdominal examination:
  - Fundal height is 33 cm
  - Presenting part is four-fifths above the pelvic brim
  - Fetal heart tones are 124 beats per minute
  - Contractions are irregular every 8-10 minutes and last 14-18 seconds
- On cervical examination:
  - Dilation of the cervix is 3 cm
  - Membranes are intact
  - Presentation is vertex and there is no molding
- Her physical exam reveals no abnormal findings.

**Testing:**

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

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

- Mrs. A is in the latent phase of the first stage of labor.
● She is anxious and agitated during contractions, possibly because she remembers her first labor and delivery as being more painful than she had anticipated.

CARE PROVISION (implementing plan of care and interventions)

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

● A supportive, encouraging atmosphere that is respectful of Mrs. A's wishes should be established to help allay anxiety and provide emotional support.

● Mrs. should receive ongoing assessment (e.g., vital signs, fetal heart tones, descent, contractions) as needed, at least every 4 hours, to ensure that any problems or abnormalities in the condition of mother or baby or progress of labor are detected early for immediate attention; and to provide reassurance to Mrs. A and her family that her care is continuous.

● A partograph should be started when she reaches 4 cm.

● She should receive ongoing supportive care:
  ● Her mother-in-law should be encouraged to stay with her to help allay anxiety and provide continuous emotional support.
  ● She should be given a back rub or massage and be taught to breath out more slowly than usual during contractions and relax with each breath—this should help to relieve her anxiety.
  ● Mrs. A should be allowed to remain active, as she desires; rest and sleep should also be encouraged as she desires so that she will be well rested when active labor begins.
  ● Food should be encouraged as tolerated and no restrictions should be placed on intake as long as Mrs. A has no nausea and/or vomiting. She should be provided with nutritious drinks to maintain hydration (2 liters of oral fluids/24 hours minimum) and to meet caloric/energy needs.
  ● Mrs. A should be encouraged to empty her bladder every 2 hours and empty her bowels as needed for her comfort, to prevent urinary retention and to allow descent of the fetal head. She should not be given an enema as this does not prevent soiling or infection and is uncomfortable and unpleasant for the mother.
  ● To maintain cleanliness, Mrs. A should be encouraged to bathe before active labor begins; the genital area should be cleansed before each examination to prevent introduction/entry of organisms into the vagina.

EVALUATION

● Mrs. A continues to have regular contractions; by 2 hours after admission, she is having 2 contractions in 10 minutes, each lasting 20–40 seconds.

● Maternal pulse remains between 80 and 88 beats per minute; fetal heart rate remains between 150 and 160 beats per minute.
Mrs. A's level of anxiety remains high and she continues to become agitated during contractions.

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

- Care should continue as outlined above for reasons given above.
- Breathing techniques should be explained again to Mrs. A, emphasizing the importance of breathing out more slowly than usual and relaxing with each expiration to encourage relaxation and conservation of energy.
- Praise, reassurance, and encouragement should be given to Mrs. A to allay anxiety and provide the extra emotional support that is needed as labor progresses.
- Information on the process of labor and her progress should be provided to Mrs. A to help allay anxiety and provide some feeling of “control” and participation in her labor.
- Care must be taken to ensure that a birth companion is always with Mrs. A. so that she is not left alone.

REFERENCES

BMNC—Section 1, Chapter 3, Interpersonal Skills; Section Two: Core Components of Basic Care, Chapters 4 and 6
CASE STUDY 2: CHILDBIRTH ASSESSMENT AND CARE
(SUPPORT IN CHILDBIRTH)
ANSWER KEY

DIRECTIONS

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

CLIENT PROFILE

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

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

1. What history will you include in your assessment of Mrs. B and why?
   • Because there are signs of advanced labor, there is no time to do a complete history. Mrs. B’s antenatal records should be quickly checked for history of present pregnancy, as well as obstetric and medical histories, with particular attention to problems and treatments.

2. What physical examination will you include in your assessment of Mrs. B and why?
   • You should perform the following elements of examination to guide further assessment and help individualize care provision. Some findings may help determine stage/phase of labor, or may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.
     • Mrs. B’s respirations, blood pressure, temperature, and pulse should be measured to ensure normalcy/normal progress, and detect abnormal signs/symptoms
     • Abdominal examination including assessment of:
       • Surface of abdomen for presence of scars, which might indicate a previous C-section or other uterine surgery
       • Uterine shape, which may indicate lie and/or uterine abnormality
       • Fundal height, which will helps confirm gestational age or indicate size-date discrepancy
       • Fetal parts (and movement), which may indicate multiple pregnancy
• Fetal lie and presentation, which, if abnormal, would indicate the need for urgent referral/transfer
• Descent of the presenting part, which would help in evaluating progress of labor
• Fetal heart tones, which will help indicate fetal condition
• Bladder, which may indicate urinary retention
• Frequency and duration of contractions to determine quality of contractions and help determine stage/phase of labor, as well as evaluate progress of labor

• Genital examination including vaginal opening, skin, labia, and vaginal secretions to rule out infection; any fetal part or cord protruding from vaginal opening, which would require immediate attention; female genital cutting or any other abnormality that might affect the birth.

• Cervical examination including assessment of:
  • Dilation of the cervix to help determine stage and phase of labor, as well as evaluate progress of labor
  • Membranes and amniotic fluid to determine whether the membranes have ruptured and to help assess fetal condition
  • Presentation to determine if there is any abnormality that will affect the birth
  • Molding to help determine fetal condition and indicate possible obstruction of labor (fetal-pelvic disproportion)

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

• You should rapidly draw blood to send to laboratory for RPR for syphilis, HIV [if she does not “opt out”], and blood group and Rh factor, if available, to guide further assessment and help individualize care provision. Some findings may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

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

Physical Examination:

• Vital signs are as follows: Respiration are 20 per minute, BP is 130/82, Pulse is 88 beats per minute, Temperature is 37.8°C.
On abdominal examination:
- No scars are noted and uterus is oval-shaped
- Fundal height is 34 cm
- One set of fetal parts are palpable
- Fetus is longitudinal in lie and cephalic presentation
- Presenting part is not palpable above the symphysis
- Fetal heart tones are 148 per minute
- Bladder is not palpable
- Contractions are 3 per 10 minutes, 40-50 seconds in duration each

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

Testing:
- Test results not yet back at this stage

4. Based on these findings, what is Mrs. X’s diagnosis (problem/need) and why?
- Mrs. B has reached the second stage of labor, indicated by full dilatation and effacement of the cervix.

CARE PROVISION (implementing plan of care and interventions)

5. Based on your diagnosis (problem/need identification), what is your plan of care for Mrs. B and why?
- Mrs. B must not be left alone.
- She should receive ongoing assessment (e.g., maternal pulse and contractions every 30 minutes, fetal heart rate every 5 minutes) to ensure that any problems or abnormalities in the condition of mother or baby or progress of labor are detected early for immediate attention.
- She should receive ongoing supportive care:
  - A supportive, encouraging atmosphere that is respectful of Mrs. B's wishes should be established to provide emotional support.
  - Mrs. B should be made comfortable and encouraged to adopt a position for pushing that is comfortable for her and aids in the descent of the fetus: semi-sitting/reclining, squatting, hands and knees, or lying on side.
Mrs. B should be encouraged to follow her own tendency to push: the intensity of her contractions should regulate her efforts to push. She should be encouraged not to hold her breath or push hard for a long time, pushing for 5-10 seconds and then taking several breaths before pushing again helps to ensure that the baby gets plenty of oxygen.

After each contraction, Mrs. B should be encouraged to take a deep breath and let it out slowly, relaxing her entire body. She should be praised, encouraged, and reassured regarding her progress.

She should be offered cool, sweetened fluids between contractions.

**EVALUATION**

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

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

- Immediate newborn care should be provided:
  - Thoroughly dry baby and cover in clean, warm cloth.
  - Clamp/tie and cut cord.
  - Place baby in skin-to-skin contact on the mother's abdomen; encourage breastfeeding.

- Once Mrs. B’s abdomen is palpated to rule out the presence of an additional baby, the placenta should be delivered using active management of third stage of labor:
  - Administer oxytocin 10 units IM.
  - Perform controlled cord traction.
  - Deliver and examine the placenta
  - Placenta, cord, and membranes should be checked for completeness.
  - Massage the uterus through the abdomen until firmly contracted (Mrs. B should also be shown how to massage her fundus to maintain the contraction).
  - Examine the vagina and perineum for lacerations or tears.

- Mrs. B should be made comfortable (e.g., cleanse perineum, change bed linens).

- She and the baby should receive ongoing assessment every 15 minutes for first 2 hours following birth (e.g., mother: blood pressure, pulse, fundus [for firmness], and vaginal bleeding; newborn: respiration, warmth, color to ensure that any problems or abnormalities in the condition of mother or baby are detected early for immediate attention.

**REFERENCES**

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 6
CASE STUDY 3: POSTPARTUM ASSESSMENT AND CARE
(FAMILY PLANNING)
ANSWER KEY

DIRECTIONS

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

CLIENT PROFILE

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

PRE-ASSESSMENT

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

- Mrs. C should be greeted respectfully and with kindness and offered a seat to help her feel comfortable and welcome, establish rapport, and build trust. A good relationship helps to ensure that the client will adhere to the care plan and return for continued care.

- Ascertain, from other staff or from records, whether or not Mrs. C. has had a Quick Check. If she has not, you should conduct a Quick Check now. The Quick Check detects signs/symptoms of life-threatening complications so that a woman receives the urgent care she requires before receiving routine assessment/care.

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

2. What history will you include in your assessment of Mrs. C and why?

- Because this is Mrs. C's first postpartum visit, you should take a complete history (i.e., personal information, daily habits and lifestyle, history of present pregnancy and labor childbirth, present postpartum, period, obstetric history, contraceptive history/plans, medical history) to guide further assessment and help individualize care provision. Some responses may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.
Information about how the baby is doing should also be obtained, with particular emphasis on feeding—this could have an impact on return of fertility, about which she has expressed concerns.

Special attention should be given to her contraceptive history/plans.

3. **What physical examination will you include in your assessment of Mrs. C and why?**

Because this is Mrs. C's first postpartum visit, you should perform a complete physical examination (i.e., general well-being, vital signs, breast inspection and palpation, abdomen [uterus/involution, bladder], leg examination, and genital examination [lochia, perineum]) to guide further assessment and help individualize care provision. Some findings may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.

4. **What laboratory tests will you include in your assessment of Mrs. C and why?**

You should conduct an HIV test if available and as needed (if status is unknown and she does not “opt out”), to guide further assessment and help individualize care provision. A positive result would indicate a special need/condition that requires additional care.

**DIAGNOSIS (interpreting information to identify problems/needs)**

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

**History:**

- Mrs. C is feeling well.
- Mrs. C reports no complications or problems during this pregnancy, labor/childbirth, or postpartum period. Her medical history is not significant: she is taking no medications, nor does she have any chronic conditions or illnesses.
- Mrs. C’s first child is well and was breastfed for 6 months.
- She is exclusively breastfeeding her baby and intends to do so for at least 6 months.
- She wants to know whether she should start using contraception now, as she does not want to become pregnant again for at least 2 years.
- All other aspects of her history are normal or without significance.

**Physical Examination:**

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

Testing:

HIV test is negative.

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

- Mrs. C needs advice/counseling about family planning. Because she intends to fully breastfeed her baby for at least 6 months, she does not yet need to take an oral contraceptive.

CARE PROVISION (implementing plan of care and interventions)

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

- Mrs. C should receive basic care provision (i.e., breastfeeding and breast care, complication readiness plan, nutritional support, support for mother-baby-family relationships, self-care and other healthy practices, HIV counseling, immunizations, and other preventive measures, as well as about newborn care), which will help support and maintain a healthy postpartum/newborn period. The following special emphasis should also be given:
  - Mrs. C should be counseled about lactational amenorrhea (LAM), as it is effective for women who are exclusively or nearly exclusively breastfeeding, have not had return of menses, and are less than 6 months postpartum.
  - The meaning of "on demand" and “exclusive” breastfeeding should be explained to Mrs. C: that is, feeding the baby whenever s/he desires (at least every 4 hours during the day and every 6 hours at night) and not giving the baby any other food or fluids
  - Mrs. C should be advised that another method of contraception should be chosen if any of the following occur:
    - Menses resume
    - Baby does not breastfeed frequently enough (at least every 4 hours during the day and every 6 hours at night)
    - Regular supplementary feedings (replacing a breastfeeding meal) are added to the baby's diet
    - The baby is 6 months of age
  - Mrs. C should be counseled about other contraceptive options that may be used when LAM is no longer an appropriate method.
  - Mrs. C should be asked to come back for a follow-up visit at 6 weeks postpartum, but told that she can return before then if she has a problem or concern. She should be counseled to bring her newborn to her 6-week checkup or earlier if needed.
EVALUATION

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

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

- Mrs. A should be provided family planning counseling, including the availability and accessibility of family planning services and methods, to enable her to make an informed choice about a method of contraception.

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 7; Section Four: Annexes, Annex 5
CASE STUDY 4: POSTPARTUM ASSESSMENT AND CARE (BREASTFEEDING DIFFICULTY)
ANSWER KEY

DIRECTIONS

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

CLIENT PROFILE

Mrs. A is 18 years of age and gave birth to her first baby at home 10 days ago. Her pregnancy, labor, and birth were uncomplicated. The midwife who attended the birth checked Mrs. A and her baby the day after the birth. She has not seen a healthcare provider since then. This is her first postpartum clinic visit. Mrs. A has come to the clinic because she has sore, red nipples. Her baby is with her.

PRE-ASSESSMENT

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

- Mrs. A should be greeted respectfully and with kindness and offered a seat to help her feel comfortable and welcome, establish rapport, and build trust. Her baby should also be warmly acknowledged. A good relationship helps to ensure that the client will adhere to the care plan and return for continued care.

- Ascertain, from other staff or from records, whether or not Mrs. C. and her baby have had a Quick Check. If not, you should conduct a Quick Check now. The Quick Check detects signs/symptoms of life-threatening complications so that a woman or newborn receives the urgent care required before receiving routine assessment/care.

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

2. What history will you include in your assessment of Mrs. A and why?

- Because this is Mrs. A's first postpartum visit, you should take a complete history (i.e., personal information, daily habits and lifestyle, history of present pregnancy and labor childbirth, present postpartum, period, obstetric history, contraceptive history/plans, medical history) to guide further assessment and help individualize care provision. Some responses may help determine whether point toward reasons for her sore, red nipples, and/or indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.
Special emphasis should be given to obtaining information about how the baby is doing and how breastfeeding is going, because she is complaining of breast problems.

3. **What physical examination will you include in your assessment of Mrs. A and why?**

- Because this is Mrs. A's first postpartum visit, you should perform a complete physical examination (i.e., general well-being, vital signs, breast inspection and palpation, abdomen [uterus/involution, bladder], leg examination, and genital examination [lochia, perineum]) to guide further assessment and help individualize care provision. Some findings may help determine whether point toward reasons for her sore, red nipples, and/or indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.

- Special attention should be given to the examination of Mrs. A’s breasts to determine possible causes of her discomfort.

- Mrs. B should be observed breastfeeding her baby to check positioning, attachment and suckling, and her comfort during breastfeeding.

- Mrs. C’s baby should also be examined (e.g., overall appearance/well-being; head, face and mouth, eyes; chest, abdomen, cord stump, external genitalia, and anus; back and limbs; breastfeeding; and mother-baby bonding) to assess for potential problems.

4. **What laboratory tests will you include in your assessment of Mrs. A and why?**

You should conduct an HIV test if available and as needed (if status is unknown and she does not “opt out”), to guide further assessment and help individualize care provision. A positive result would indicate a special need/condition that requires additional care.

**DIAGNOSIS (interpreting information to identify problems/needs)**

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

**History:**

- Mrs. A is feeling well but has sore, red nipples.
- She reports that the baby breastfeeds approximately every 2 hours.
- All other aspects of her history are normal or without significance.

**Physical Examination:**

- Mrs. A generally appears well.
- Vital signs are as follows: BP is 110/72, Pulse is 76 beats per minute; Temperature is 37.6°C.
- There is no redness, tenderness, streaking, or masses palpable in the breast tissue; however, during observation of breastfeeding, it was found that the baby was not attaching well to the breast.
● All findings on examination of the baby are within normal range and without significance.
● All other aspects of her physical examination are within normal range and without significance.

Testing:

HIV test is negative.

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

● Mrs. A has sore, red nipples related to difficulty attaching the baby to the breast. This is her first baby and her first experience with breastfeeding.

**CARE PROVISION (implementing plan of care and interventions)**

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

● Mrs. A should receive basic care provision (i.e., breastfeeding and breast care, complication readiness plan, nutritional support, support for mother-baby-family relationships, self-care and other healthy practices, HIV counseling, immunizations and other preventive measures as well as about newborn care), which will help support and maintain a healthy postpartum/newborn period. The following emphases should be included:
  ● Mrs. A should be encouraged and reassured about practicing exclusive breastfeeding on demand.
  ● Additional counseling and support should be provided on attachment and positioning for breastfeeding. Mrs. A should be able to help her baby attach to the breast correctly before leaving the clinic.
  ● Mrs. A should be asked to return to the clinic in 2 days so that attachment and positioning for breastfeeding can be checked again, and additional support and encouragement provided.

**EVALUATION**

● Mrs. A returns to the clinic in 2 days.
● You find that her nipples are less sore and red, and attachment has improved, although the problem has not fully resolved.
● Mrs. A is very eager to continue breastfeeding

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

● Mrs. A should again be encouraged and reassured about continuing exclusive breastfeeding on demand to prevent discouragement or discontinuation of breastfeeding.
● Breastfeeding should be observed and Mrs. A should be counseled again about attachment and positioning at the breast to ensure continued success at breastfeeding.
- The baby should be weighed to ensure adequate intake.
- Mrs. A should be asked to return to the clinic every 2 days until the problem has fully resolved.
- Once the problem is resolved, she should be asked to return for follow-up 6 weeks postpartum, or before then if she has questions or concerns.

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 6; Section Three: Additional Care, Chapter 10; Section Four: Annexes, Annex 5
CASE STUDY 5: NEWBORN ASSESSMENT AND CARE

ANSWER KEY

DIRECTIONS

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

CLIENT PROFILE STUDY

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

PRE-ASSESSMENT

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

   - Mrs. E should be greeted respectfully and with kindness and offered a seat to help her feel comfortable and welcome, establish rapport, and build trust. Baby E should be acknowledged warmly. A good relationship helps to ensure that the client will be satisfied with their care, will adhere to the care plan and return for continued care.

   - Ascertain, from other staff or from records or from the mother, whether or not Baby E has had a Quick Check. If s/he has not, you should conduct a Quick Check now. The Quick Check detects signs/symptoms of life-threatening complications so that a baby receives the urgent care s/he requires before receiving routine assessment/care.

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

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

   - Because this is Baby E’s first visit, you should take a complete history (i.e., mother’s personal information, history of present labor/childbirth, obstetric history, medical history; present newborn period) to guide further assessment and help individualize care provision. Some responses may help determine whether/why the cord is infected, or may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention. The following elements should be emphasized:

     - Information about the birth (including maternal infection, complications that may have caused injury, asphyxia, and birth weight), mother (including chronic conditions and feelings toward the baby), and birth setting/attendant may reveal deviations from normal and other problems. If the birth attendant was not a skilled provider, this may provide
help explain the infected cord.

- History of the newborn period (including breastfeeding, digestive function, vaccines) may reveal deviations from normal and other problems.

- Specific history should be obtained: Because the mother reports a foul smell of cord stump, ask specifically about Baby E’s cord—when the condition developed, whether she has put any substances on the cord (as traditional practices in the community may recommend the application of inappropriate substances to the cord stump), whether it was covered with a bandage—to determine possible cause of condition.

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

- Because this is Baby E’s first visit, you should perform a complete physical examination (e.g., overall appearance/well-being; head, face and mouth, eyes; chest, abdomen, cord stump, external genitalia, and anus; back and limbs; breastfeeding; and mother-baby bonding) to guide further assessment and help individualize care provision. Some findings may help determine whether/why the cord is infected, or may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.

- Because the mother reports a foul smell of cord stump, the following elements should receive special attention:
  - Baby E’s temperature should be taken—high or low temperature could result from sepsis, which can develop from a cord stump infection.
  - Breastfeeding should be carefully observed—poor feeding may be a sign of sepsis.
  - Examine abdomen for distention and cord for draining pus, redness and swelling of the skin extending more than 1 cm beyond umbilicus, skin lesions, or red hard surrounding skin to determine severity of condition.

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

- No laboratory tests are necessary at this point.

**DIAGNOSIS (interpreting information to identify problems/needs)**

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

**Quick Check:**

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

No significant findings nor need for resuscitation.

History:

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

Physical Examination:

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

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

- Baby E has a moist cord stump that has an offensive smell, indicating an umbilical cord infection.

CARE PROVISION (implementing plan of care and interventions)

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

- Baby E should receive basic care provision (breastfeeding, complication readiness, newborn care and other healthy practices [messages for the mother on maintaining warmth, prevention of infection/hygiene, washing and bathing, cord care, sleep and other behaviours/needs], immunizations and other healthy practices]), which will help support and maintain a healthy newborn period. The following emphases may be given:
Mrs. E should be shown how to treat the infected cord, as follows:

- Wash hands with clean water and soap and dry them on a clean towel or piece of cloth
- Clean the cord stump and umbilical area with an antiseptic solution and clean gauze swab or clean piece of cloth
- Paint the cord stump and umbilicus with 0.5% gentian violet solution or 2.5% polyvidone-iodine 4 times/day until odor resolves
- Wash hands thoroughly

Mrs. E should be reminded not to apply any other substances to the cord stump.

Mrs. E should be encouraged to ask questions and responded to in a kind, reassuring manner.

Complication readiness plan, including danger signs, should be reviewed.

She should be asked to return to the health center with her baby in 2 days to check the effectiveness of the treatment or earlier if necessary.

**EVALUATION**

- Mrs. E and Baby E return to the clinic the next day because her mother-in-law has instructed her to not continue the treatment, not wash the cord, and keep the cord bound with a piece of cloth.

- You find that the cord stump and umbilicus have improved only slightly.

- There are no other significant findings or signs of sepsis. The baby continues to feed well and have normal temperature. There is no draining pus, redness and swelling of the skin extending more than 1 cm beyond umbilicus, skin lesions, red hard surrounding skin, or distended abdomen.

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

- Mrs. E should again be shown again how to treat the cord, as indicated above.

- The importance of this treatment should be emphasized. If the mother-in-law is present, you should ask to also speak with her to explain the importance of the treatment.

- She should be asked to return to the health center next day and bring her baby and, if not with her today, to bring her mother-in-law so that the treatment and its importance can be explained.

- If there is no improvement or the infection is worse the next day, begin treatment with antibiotics and urgently refer/transfer baby to appropriate facility.

**REFERENCES**

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 8; Section Three: Additional Care, Chapter 11
CASE STUDY 6: NEWBORN ASSESSMENT AND CARE
ANSWER KEY

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

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

PRE-ASSESSMENT
1. Before beginning your assessment, what should you do for and ask Mrs. F and Baby F?
   - Mrs. F should be greeted respectfully and with kindness and offered a seat to help her feel comfortable and welcome, establish rapport, and build trust. Baby F should be acknowledged warmly. A good relationship helps to ensure that the client will adhere to the care plan and return for continued care.
   - Ascertain, from other staff or from records or from the mother, whether or not Baby F has had a Quick Check. If s/he has not, you should conduct a Quick Check now. The Quick Check detects signs/symptoms of life-threatening complications so that a baby receives the urgent care s/he requires before receiving routine assessment/care.
   - Review records for assessment and care from previous visit.

ASSESSMENT (information gathering through history, physical examination, and testing)
2. What history will you include in your assessment of Baby F and why?
   - Because this is Baby F’s second visit and the 1st visit history was normal or without significance, you should take an interim history (to assess for changes or problems that have occurred since last visit) and history of the present newborn period (to assess for deviations from normal in breastfeeding, digestive function, etc.) to guide further assessment and help individualize care provision. Some responses may help determine the nature and cause of the rash, or may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.
To help determine possible cause and severity of the condition, Mrs. F should be asked

- When Baby F’s skin condition developed and whether she has put any substances on it (as substances can damage the newborn’s tender skin),
- Whether or not the baby has other general signs of sepsis: whether baby is feeding well, is lethargic or drowsy, has felt very hot or cold to touch
- Whether the mother has had a positive test for syphilis

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

- Because this is Baby F’s second visit and the 1st visit physical examination was normal, you should perform a complete physical examination except face/mouth, back, and limbs (e.g., overall appearance/well-being; head and eyes; chest, abdomen, cord stump, external genitalia, and anus; breastfeeding; and mother-baby bonding) to guide further assessment and help individualize care provision. Some findings may help determine the nature and cause of the rash, or may indicate a special need/condition that requires additional care or a life-threatening complication that requires immediate attention.

- Special attention should be given to signs of systemic sepsis, such as whether there is jaundice or pallor, abdominal distension/vomiting, lethargy/drowsiness/floppiness, fever, or profuse runny nose.

- If possible, observe feeding to be sure that baby is feeding well.

- Special attention should be given to the characteristics of the rash: number of lesions; surface covered by the lesions; presence of red or swollen skin/tissue, fluctuant lesions, rash on palms and soles, or generalized edema

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

- No laboratory tests are necessary at this point.

DIAGNOSIS (interpreting information to identify problems/needs)

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

History:

- Record review reveals that Mrs. F has no running water in her home and must carry water for household use from a river that is known to be polluted.
- Mrs. F reports that the rash began 3 days ago.
- She denies putting any substance on the baby’s skin.
- She reports that the baby is feeding well.
- All other aspects of the baby’s history are normal or without significance.

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

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

- Baby F has skin pustules, indicating a skin infection, probably because of poor hygiene.

CARE PROVISION (implementing plan of care and interventions)

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

- Baby F should receive basic care provision (breastfeeding, complication readiness, newborn care and other healthy practices [messages for the mother on maintaining warmth, prevention of infection/hygiene, washing and bathing, cord care, sleep and other behaviours/needs], immunizations and other healthy practices]), which will help support and maintain a healthy newborn period.

- Because clean water is not readily accessible to Mrs. F, possible solutions to this problem should be discussed with her. The principles and importance of boiling water and safe storage of water should be discussed. General hygiene should also be discussed, including the importance of clean clothing and regular washing/hygiene for the baby.

- Mrs. F should be shown how to treat the skin infection, as follows:
  - Wash hands with clean water and soap and dry them on a clean towel or piece of cloth to prevent transmission of infection
  - Gently clean the pustules with an antiseptic solution and a clean gauze swab or clean piece of cloth to destroy and remove organisms present on the skin
  - Apply gentian violet 0.5% solution to the pustules for antisepsis
  - Wash hand thoroughly to prevent transmitting infection from the baby to others

- Mrs. F should be instructed to carry out this treatment four times daily and reminded not to apply any other substances to the skin. This reminder is important because Mrs. F may think, or be told by neighbors or family, that she should apply traditional preparations to the skin, which may exacerbate the infection.
- Mrs. F should be encouraged to ask questions and responded to in a kind, reassuring manner to establish rapport and trust.
• She should be asked to return to the health center with her baby in 2 days to check the effectiveness of the treatment, or earlier if necessary.

EVALUATION

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

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

• Mrs. F should be given praise and encouragement for continuing the treatment and for managing to keep the baby clean.
• The importance of continuing the treatment for an additional 3 days should be emphasized and Mrs. F should be asked to return to the health center then to check that the skin infection has resolved. If she has any other problems or concerns in the meantime, she should bring the baby to the health center.

REFERENCES

BMNC—Section Two: Core Components of Basic Care, Chapters 4 and 8; Section Three: Additional Care, Chapters 9 and 11
SKILLS PRACTICE SESSIONS

CONDUCTING SKILLS PRACTICE SESSIONS

Skills practice sessions provide participants with opportunities to observe and practice clinical skills, either in a simulated setting or at a clinical site. The outline for each skills practice session includes the purpose of the particular session, instructions for the trainer, and the resources needed to conduct the session, such as anatomic models, supplies, equipment, learning guides, and checklists. Before conducting a skills practice session, the trainer should review the session and ensure that she/he can perform the skill or activity. It will also be important to ensure that the necessary resources are available and that an appropriate site has been reserved.

The first step in a skills practice session requires that participants review the relevant learning guide, which contains the individual steps or tasks, in sequence (if necessary), required to perform a skill or activity in a standardized way. The learning guides are designed to help learn the correct steps and the sequence in which they should be performed (skill acquisition), and measure progressive learning in small steps as the participant gains confidence and skill (skill competency).

Next, the trainer demonstrates the steps/tasks, several times if necessary, for the particular skill or activity and then has participants work in groups of two or three to practice the steps/tasks and observe each other’s performance, using the relevant learning guide. The trainer should be available throughout the session to observe the performance of participants and provide guidance. Participants should be able to perform all of the steps/tasks in the learning guide before the trainer assesses skill competency using the relevant checklist.

There are eleven skills practice sessions in the course:

- Skills Practice Session 1: Assessment of the Woman in Labor
- Skills Practice Session 2: Assisting Normal Birth
- Skills Practice Session 3: Episiotomy and Repair
- Skills Practice Session 4: Repair of First and Second Degree Tears
- Skills Practice Session 5: Newborn Physical Examination
- Skills Practice Session 6: Assessment of the Postpartum Woman
- Skills Practice Session 7: Newborn Resuscitation
- Skills Practice Session 8: Manual Removal of Placenta
- Skills Practice Session 9: Bimanual Compression of the Uterus
- Skills Practice Session 10: Compression of Abdominal Aorta
- Skills Practice Session 11: Repair of Cervical Tears
EMERGENCY DRILL

The purpose of a simulated emergency drill is to provide participants with an opportunity to observe and take part in an emergency drill. By the end of the course, they should be able to conduct a drill in their own facility.

Drills can be conducted several times throughout the course, and involve trainers and participants. The steps involved in setting up and conducting a drill are as described below.

First drill

- Trainers decide on a scenario, such as one in which a woman suffers an immediate postpartum hemorrhage. In the first drill, trainers play all roles except the client. Trainers should practice their roles before conducting the drill.

- The roles are as follows:

Role 1: Charge person
- Conduct rapid initial assessment
- Stabilize client (massage uterus, give oxytocin, give directions to others on team)
- Assist skilled provider when s/he arrives

Role 2: Runner
- Telephones skilled provider
- Returns to bedside and assists as needed, e.g., takes vital signs, takes specimens to lab, gathers equipment, etc.
- Follows additional instructions of person in charge

Role 3: Supplier
- Checks emergency tray at beginning of each shift
- Brings emergency tray to bedside during emergency
- Gives needed supplies/medications to skilled provider
- Replenishes supplies/medications after use
Role 4: Assistant

- Cares for infant
- Assists with crowd control
- Escorts family members away from bed; keeps client and family informed of situation

At a pre-designated time a small bell is rung; the participant selected to play the role of client lies down on a table prepared ahead with sheet and pillow; she has an infant model acting as “baby.” Another participant may act as the client’s family. The charge person (Role 1) goes directly to the bedside and begins the rapid initial assessment. The runner (Role 2) telephones the skilled provider and returns to the bedside; the charge person should tell the runner to take vital signs. The supplier (Role 3) brings the emergency tray and assists with giving oxytocin, starting an IV, etc. The assistant (Role 4) takes the baby and tells the family what is happening. All of this is happening simultaneously, as though it were a real situation. The charge person “massages” the woman’s uterus and reports whether it is contracted; the runner takes BP, pulse, and respiration, and reports to the charge person; the assistant “gives” oxytocin if directed, etc. Upon arrival of the skilled provider, the charge person gives him/her a report of the client’s status and follows further directions until the client is stable. After the emergency, the supplies are replenished and equipment is disposed of using correct infection prevention procedures.

Second and Subsequent Drills

- At each subsequent drill, a participant takes one more of the trainers’ roles. At the beginning of the day, one or more participants are assigned a role, and when the bell rings signaling an emergency, roles are assumed and played. By the end of the course, the drill should be run entirely by participants. Different scenarios can be used for each drill.
SECTION THREE: TIPS FOR TRAINERS

BEING AN EFFECTIVE TRAINER IN THE CLASSROOM

Characteristics of an Effective Trainer and Coach ..............................................................1
Skill Transfer and Assessment: The Coaching Process .........................................................2

CREATING A POSITIVE LEARNING ENVIRONMENT IN THE CLASSROOM

Preparing for the Course ......................................................................................................5
Understanding How People Learn ......................................................................................7
Using Effective Presentation Skills ...................................................................................11

CONDUCTING LEARNING ACTIVITIES IN THE CLASSROOM

Delivering Interactive Presentations ..................................................................................13
Facilitating Group Discussions ..........................................................................................17
Facilitating a Brainstorming Session .................................................................................19
Facilitating Small Group Activities ...................................................................................20
Conducting an Effective Clinical Demonstration ..............................................................22

TEACHING CLINICAL DECISION-MAKING .......................................................................25

MANAGING CLINICAL PRACTICE

Performing Clinical Procedures with Clients .......................................................................29
Creating Opportunities for Learning ..................................................................................30
Conducting Pre- and Post-Clinical Practice Meetings ..........................................................33
The Trainer as Supervisor .................................................................................................34
The Trainer as Coach .........................................................................................................36
BEING AN EFFECTIVE TRAINER IN THE CLASSROOM

Health professionals conducting clinical training courses are continually changing roles. They are trainers or instructors when presenting illustrated lectures and giving classroom demonstrations. They act as facilitators when conducting small group discussions and using role plays, case studies, and clinical simulations. Once they have demonstrated a clinical procedure, they then shift to the role of the coach as the participants begin practicing.

CHARACTERISTICS OF AN EFFECTIVE TRAINER AND COACH

Coaching is a training technique in which the trainer:

- Describes the skills and client interactions that the participant is expected to learn
- Demonstrates (models) the skill in a clear and effective manner using learning aids such as slide sets, videotapes, and anatomic models
- Provides detailed, specific feedback to participants as they practice the skills and client interactions using the actual instruments in a simulated clinical setting and as they provide services to clients

An effective trainer:

- Is proficient in the skills to be taught
- Encourages participants in learning new skills
- Promotes open (two-way) communication
- Provides immediate feedback:
  - Informs participants whether they are meeting the objectives
  - Does not allow a skill or activity to be performed incorrectly
  - Gives positive feedback as often as possible
  - Avoids negative feedback and instead offers specific suggestions for improvement
Is able to receive feedback:

- **Asks for it.** Find trainers who will be direct with you. Ask them to be specific and descriptive.
- **Directs it.** If you need information to answer a question or pursue a learning goal, ask for it.
- **Accepts it.** Do not defend or justify your behavior. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest.

Recognizes that training can be stressful and knows how to **regulate participant as well as trainer stress:**

- Uses appropriate humor
- Observes participants and watches for signs of stress
- Provides for regular breaks
- Provides for changes in the training routine
- Focuses on participant success as opposed to failure

The characteristics of an **effective coach** are the same as those of an **effective trainer.** Additional characteristics especially important for the coach include:

- Being patient and supportive
- Providing praise and positive reinforcement
- Correcting participant errors while maintaining participant self-esteem
- Listening and observing

**SKILL TRANSFER AND ASSESSMENT: THE COACHING PROCESS**

The process of learning a clinical skill within the coaching process has three basic phases: demonstration, practice and evaluation. These three phases can be broken down further into the following steps:

- First, during interactive classroom presentations, **explaining** the skill or activity to be learned
- Next, using a videotape or slide set, **showing** the skill or activity to be learned
• Following this, **demonstrating** the skill or activity using role play (e.g., counseling demonstration) or clinical simulation

• Then, allowing the participants to **practice** the demonstrated skill or activity in a simulated environment (e.g., role play, clinical simulation) as the trainer functions as a coach

• After this, **reviewing** the practice session and giving constructive feedback

• After adequate practice, **assessing** each participant’s performance of the skill or activity on models or in a **simulated situation**, using the competency-based checklist

• After competence is gained with models or practice in a simulated situation, having participants begin to **practice** the skill or activity with clients under a trainer’s guidance

• Finally, **evaluating** the participant’s ability to perform the skill according to the standardized procedure as outlined in the competency-based checklist

During initial skill acquisition, the trainer demonstrates the skill as the participant observes. As the participant practices the skill, the trainer functions as a coach and observes and assesses performance. When demonstrating skill competency, the participant is now the person performing the skill as the trainer evaluates performance.
CREATING A POSITIVE LEARNING ENVIRONMENT IN THE CLASSROOM

A successful training course does not come about by accident, but rather through careful planning. This planning takes thought, time, preparation and often some study on the part of the trainer. The trainer is responsible for ensuring that the course is carried out essentially as it was designed. The trainer must make sure that the clinical practice sessions, which are an integral part of a clinical skills course, as well as the classroom sessions, are conducted appropriately. In addition to taking responsibility for the organization of the course in general, the trainer must also be able to give presentations and demonstrations and lead other course activities, all of which require prior planning. Well-planned and executed classroom and clinical sessions will help to create a positive learning environment.

PREPARING FOR THE COURSE

To prepare for the course, the following steps are recommended:

- **Review the course syllabus**, including the course description, goals, learning methods, training materials, methods of evaluation, course duration and suggested course composition.

- **Review the course schedule**.

- **Study the course outline**. The course outline provides detailed suggestions regarding the teaching of each objective and the facilitation of each activity. Based on suggestions in the course outline and the trainer’s own ideas, the trainer will gather the necessary equipment, supplies and materials. The trainer should also compare time estimates in the course outline to the schedule to ensure that sufficient time has been allotted for all sessions and activities.

- **Read and study the reference manual** to ensure complete familiarity with the content to be presented during the course.

- **Review the pre- and midcourse questionnaires** and make copies of the questionnaires, matrix and answer sheets if needed.

- **Check all audiovisual equipment** (e.g., overhead projector, video player, flipchart stand).
• **Practice all clinical procedures** using the learning guides and checklists found in the trainer’s notebook and participant’s handbook.

• **Obtain information about the participants who will be attending the course.** It is important for the trainer to know basic information about participants such as:
  
  - The **experience and educational background** of the participants. The trainer should attempt to gather as much information about participants as possible before training. If this is not possible, the trainer should inquire about their backgrounds and expectations during the first day of the course.
  
  - The types of **clinical activities** the participants will perform in their daily work after training. Knowing the exact nature of the work that participants will perform after training is critical for the trainer. The trainer must use appropriate, job-specific examples throughout the course so that participants can draw connections between what is being taught and what they will need to do. This is an excellent way to reinforce the importance of what is being learned.

• **Prepare the classroom and make sure** that:
  
  - Tables arranged in a U-shape or other formation that will allow as many of the participants as possible to see one another and the trainer (this may be difficult in a lecture hall where chairs are attached to the floor).
  
  - A table in the front of the room where the trainers can place their course materials.
  
  - Space for audiovisual equipment (e.g., flipchart, screen, overhead projector, video player, monitor); the trainer should make sure that participants will be able to see the projection screen and other audiovisuals.
  
  - Space for participants to work in small groups (i.e., either arrange chairs in small circles or work around the tables), unless separate breakout rooms (see below) are available.
  
  - Space to set up simulated clinics (e.g., for counseling practice).
  
  - Breakout rooms for small group work (e.g., case studies, role plays, clinical simulations, problem-solving activities) are
available if necessary, and are set up with tables, chairs and any materials that the participants will need.

- The room is properly heated or cooled and ventilated.

- The lighting is adequate, and the room can be darkened enough to show audiovisuals and still permit participants to take notes or follow along in their learning materials.

- There will be adequate electric power throughout the course, and contingency plans have been made in case the power fails.

- Furniture such as tables, chairs and desks is available. The chairs are comfortable and tablecloths are available.

- There is a writing board with chalk or marking pens, as well as an information board available for posting notes and messages for participants.

- There is audiovisual equipment in working order, with spare parts such as bulbs readily available. The video monitor is large enough so that all participants can see it well. There are sufficient electrical connections, and extension cords, electrical adaptors and power strips (multi-plugs) are available, if necessary.

- There are toilet facilities that are adequately maintained.

- Telephones are accessible and in working order, and emergency messages can be taken.

UNDERSTANDING HOW PEOPLE LEARN

Establishing a positive learning climate depends on understanding how adults learn. The trainer must have a clear understanding of what the participants need and expect, and the participants must have a clear understanding of why they are there. Adults who attend courses to acquire new knowledge, attitudes and skills share the characteristics described below:

- Require learning to be relevant. The trainer should offer participants learning experiences that relate directly to their current or future job responsibilities. At the beginning of the course, the objectives should be stated clearly and linked to job performance. The trainer should take time to explain how each
learning experience relates to the successful accomplishment of the course objectives.

- Are highly **motivated** if they believe learning is relevant. People bring **high levels of motivation and interest** to learning. Motivation can be increased and channeled by the trainer who provides clear learning goals and objectives. To make the best use of a high level of participant interest, the trainer should explore ways to incorporate the needs of each participant into the learning sessions. This means that the trainer needs to know quite a bit about the participants, either from studying background information about them or by allowing participants to talk early in the course about their experience and learning needs.

- Need **participation** and **active involvement** in the learning process.

- Few individuals prefer just to sit back and listen. The effective trainer will design learning experiences that **actively involve the participants in the training process**. Examples of how the trainer may involve participants include:
  - Allowing participants to provide input regarding schedules, activities and other events
  - Questioning and feedback
  - Brainstorming and discussions
  - Hands-on work
  - Group and individual projects
  - Classroom activities

- Desire a **variety** of learning experiences.

- Participants attending courses **desire variety**. The trainer should use a variety of learning methods including:
  - Audiovisual aids
  - Illustrated lectures
  - Demonstrations
  - Brainstorming
  - Small group activities
  - Group discussions
  - Role plays, case studies
- Clinical simulations and hands-on skills practice

- Desire positive feedback. Participants need to know how they are doing, particularly in light of the objectives and expectations of the course. Is their progress in learning clinical skills meeting the trainer’s expectations? Is their level of clinical performance meeting the standards established for the procedure? Positive feedback provides this information. Learning experiences should be designed to move from the known to the unknown, or from simple activities to more complex ones. This progression provides positive experiences and feedback for the participant. To maintain positive feedback, the trainer can:

  - Give verbal praise either in front of other participants or in private
  - Use positive responses during questioning
  - Recognize appropriate skills while coaching in a clinical setting
  - Let the participants know how they are progressing toward achieving learning objectives

- Have personal concerns. The trainer must recognize that many participants fear failure and embarrassment in front of their colleagues. Participants often have concerns about their ability to:

  - Fit in with the other participants
  - Get along with the trainer
  - Understand the content of the training
  - Perform the skills being taught

- Need an atmosphere of safety. The trainer should open the course with an introductory activity that will help participants feel at ease. It should communicate an atmosphere of safety so that participants do not judge one another or themselves. For example, a good introductory activity is one that acquaints participants with one another and helps them to associate the names of the other participants with their faces. Such an activity can be followed by learning experiences that support and encourage the participants.

- Need to be recognized as individuals with unique backgrounds, experiences and learning needs. People want to be treated as individuals, each of whom has a unique background, experience and learning needs. A person’s past experiences is a good
foundation upon which the trainer can base new learning. To help ensure that participants feel like individuals, the trainer should:

- Use participant names as often as possible
- Involve all participants as often as possible
- Treat participants with respect
- Allow participants to share information with others during classroom and clinical instruction

- Must maintain their self-esteem. Participants need to maintain high self-esteem to deal with the demands of a clinical training course. Often the clinical methods used in training are different from clinical practices used in the participants’ clinics. It is essential that the trainer show respect for the participants, no matter what practices and beliefs they hold to be correct, and continually support and challenge them. This requires the trainer to:
  - Reinforce those practices and beliefs embodied in the course content
  - Provide corrective feedback when needed, in a way that the participants can accept and use with confidence and satisfaction
  - Provide training that adds to, rather than subtracts from, their sense of competence and self-esteem
  - Recognize participants’ own career accomplishments

- Have high expectations for themselves and their trainer. People attending courses tend to set high expectations both for the trainers and for themselves. Getting to know their trainers is a real and important need. Trainers should be prepared to talk modestly, and within limits, about themselves, their abilities and their backgrounds.

- Have personal needs that must be taken into consideration. All participants have personal needs during training. Taking timely breaks and providing the best possible ventilation, proper lighting and an environment as free from distraction as possible can help to reduce tension and contribute to a positive learning atmosphere.
USING EFFECTIVE PRESENTATION SKILLS

It is also important to use effective presentation skills. Establishing and maintaining a positive learning climate during training depends on how the trainer delivers information because the **trainer sets the tone** for the course. In any course, **how** something is said may be just as important as **what** is said. Some common techniques for effective presentations are listed below:

- **Follow a plan and use trainer’s notes**, which include the session objectives, introduction, body, activity, audiovisual reminders, summary and evaluation.

- **Communicate in a way that is easy to understand.** Many participants will be unfamiliar with the terms, jargon and acronyms of a new subject. The trainer should use familiar words and expressions, explain new language and attempt to relate to the participants during the presentation.

- **Maintain eye contact with participants.** Use eye contact to “read” faces. This is an excellent technique for establishing rapport and getting feedback on how well participants understand the content.

- **Project your voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone and inflection to maintain participants’ attention. Avoid using a monotone voice, which is guaranteed to put participants to sleep!

- **Avoid the use of slang or repetitive words, phrases or gestures** that may become distracting with extended use.

- **Display enthusiasm about the topic and its importance.** Smile, move with energy and interact with participants. The trainer’s enthusiasm and excitement are contagious and directly affect the morale of the participants.

- **Move around the room.** Moving around the room helps ensure that the trainer is close to each participant at some time during the session. Participants are encouraged to interact when the trainer moves toward them and maintains eye contact.

- **Use appropriate audiovisual aids** during the presentation to reinforce key content or help simplify complex concepts.

- **Be sure to ask both simple and more challenging questions.**
- **Provide positive feedback** to participants during the presentation.

- **Use participants’ names as often as possible.** This will foster a positive learning climate and help keep the participants focused on the presenter.

- Display a **positive use of humor** related to the topic (e.g., humorous stories, cartoons on transparency or flipchart, cartoons for which participants are asked to create captions).

- **Provide smooth transitions between topics.** Within a given presentation, a number of separate yet related topics may be discussed. When shifts between topics are abrupt, participants may become confused and lose sight of how the different topics fit together in the bigger picture. Before moving on to the next topic, the trainer can ensure that the transition from one topic to the next is smooth by:
  
  - providing a brief summary,
  - asking a series of questions,
  - relating content to practice, or
  - using an application exercise (case study, role play, etc.).

- **Be an effective role model.** The trainer should be a positive role model in appearance (appropriate dress) and attitude (enthusiasm for the course), and by beginning and ending the session at the scheduled times.
CONDUCTING LEARNING ACTIVITIES IN THE CLASSROOM

Every presentation (training session) should begin with an introduction to capture participant interest and prepare the participant for learning. After the introduction, the trainer may deliver content using an illustrated lecture, demonstration, small group activity or other learning activity. Throughout the presentation, questioning techniques can be used to encourage interaction and maintain participant interest. Finally, the trainer should conclude the presentation with a summary of the key points or steps.

DELIVERING INTERACTIVE PRESENTATIONS

Introducing Presentations

The first few minutes of any presentation are critical. Participants may be thinking about other matters, wondering what the session will be like, or have little interest in the topic. The introduction should:

- Capture the interest of the entire group and prepare participants for the information to follow
- Make participants aware of the trainer’s expectations
- Help foster a positive learning climate

The trainer can select from a number of techniques to provide variety and ensure that participants are not bored. Many introductory techniques are available, including:

- Reviewing the session objectives. Introducing the topic by a simple restatement of the objectives keeps the participant aware of what is expected of her/him.

- Asking a series of questions about the topic. The effective trainer will recognize when participants have prior knowledge concerning the course content and encourage their contributions. The trainer can ask a few key questions, allow participants to respond, discuss answers and comments, and then move into the body of the presentation.

- Relating the topic to previously covered content. When a number of sessions are required to cover one subject, relate each
session to previously covered content. This ensures that participants understand the continuity of the sessions and how each relates to the overall topic. Where possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.

- **Sharing a personal experience.** There are times when the trainer can share a personal experience to create interest, emphasize a point or make a topic more job-related. Participants enjoy hearing these stories as long as they relate to the topic and are used only when appropriate.

- **Relating the topic to real-life experiences.** Many training topics can be related to situations most participants have experienced. This technique not only catches the participants’ attention, but also facilitates learning because people learn best by “anchoring” new information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.

- **Using a case study, clinical simulation or other problem-solving activity.** Problem-solving activities focus attention on a specific situation related to the training topic. Working in small groups generally increases interest in the topic.

- **Using a videotape or other audiovisual aid.** Use of appropriate audiovisuals can be stimulating and generate interest in a topic.

- **Giving a classroom demonstration.** Most clinical training courses involve equipment, instruments and techniques that lend themselves to demonstrations, which generally increase participant interest.

- **Using a game, role play or simulation.** Games, role plays and simulations generate tremendous interest through direct participant involvement and therefore are useful for introducing topics.

- **Relating the topic to future work experiences.** Participants’ interest in a topic will increase when they see a relationship between training and their work. The trainer can capitalize on this by relating objectives, content and activities of the course to real work situations.
Using Questioning Techniques

Questions can be used at anytime to:

- Introduce a topic
- Increase the effectiveness of the illustrated lecture
- Promote brainstorming
- Supplement the discussion process

Use a variety of questioning techniques to maintain interest and avoid a repetitive style.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some participants may dominate while others may not participate.

- **Target the question to a specific participant by using her/his name prior to asking the question.** The participant is aware that a question is coming, can concentrate on the question, and respond accordingly. The disadvantage is that once a specific participant is targeted, other participants may not concentrate on the question.

- **State the question, pause and then direct the question to a specific participant.** All participants must listen to the question in the event that they are asked to respond. The primary disadvantage is that the participant receiving the question may be caught off guard and have to ask the trainer to repeat the question.

The key in asking questions is to avoid a pattern. The skilled trainer uses all three of the above techniques to provide variety and maintain the participants’ attention. Other techniques follow:

- **Use participants’ names** during questioning. This is a powerful motivator and also helps ensure that all participants are involved.

- **Repeat a participant’s correct response.** This provides positive reinforcement to the participant and ensures that the rest of the group heard the response.

- **Provide positive reinforcement for correct responses** to keep the participant involved in the topic. Positive reinforcement may take the form of praise, displaying a participant’s work, using a participant as an assistant or using positive facial expressions, nods or other nonverbal actions.
• **When a participant’s response is partially correct,** the trainer should reward the correct portion and then improve the incorrect portion or redirect a related question to that participant or to another participant.

• **When a participant’s response is incorrect,** the trainer should make a noncritical response and restate the question to lead the participant to the correct response.

• **When a participant makes no attempt to respond,** the trainer may wish to follow the above procedure or redirect the question to another participant. Come back to the first participant after receiving the desired response and involve her/him in the discussion.

• **When participants ask questions,** the trainer must determine an appropriate response by drawing upon personal experience and weighing the individual’s needs against those of the group. If the question addresses a topic that is relevant but has not been previously discussed, the trainer can either:
  - answer the question and move on, or
  - respond with another question, thereby beginning a discussion about the topic.

**Summarizing Presentations**

A **summary** is used to reinforce the content of a presentation and provide a review of its main points. The summary should:

• Be **brief**
• Draw together the **main points**
• Involve the participants

Many summary techniques are available to the trainer:

• **Asking the participants for questions** gives participants an opportunity to clarify their understanding of the instructional content. This may result in a lively discussion focusing on those areas that seem to be the most troublesome.
• **Asking the participants questions** that focus on major points of the presentation

• **Administering a practice exercise or test** gives participants an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for a
discussion by asking for correct answers and explaining why each answer is correct.

- Using a game to review main points provides some variety, when time permits. One popular game is to divide participants into two teams, give each team time to develop review questions, and then allow each team to ask questions of the other. The trainer serves as moderator by judging the acceptability of questions, clarifying answers and keeping a record of team scores. This game can be highly motivational and serve as an excellent summary at the same time.

**FACILITATING GROUP DISCUSSIONS**

The group discussion is a learning method in which most of the ideas, thoughts, questions and answers are developed by the participants. The trainer typically serves as the facilitator and guides the participants as the discussion develops.

Group discussion is useful:

- At the conclusion of a presentation
- After viewing a videotape
- Following a clinical demonstration or skills practice session
- After reviewing a case study or clinical simulation
- After a role play
- Any other time when participants have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when participants have limited knowledge or experience with the topic often will result in little or no interaction and thus an ineffective discussion. When participants are familiar with the topic, the ensuing discussion is likely to **arouse participant interest, stimulate thinking** and **encourage active participation**. This interaction affords the facilitator an opportunity to:

- Provide positive feedback
- Stress key points
- Develop critical thinking skills
- Create a positive learning climate

The facilitator must consider a number of factors when selecting group discussion as the learning strategy:
Discussions involving more than 15 to 20 participants may be difficult both to lead and may not give each participant an opportunity to participate.

Discussion requires more time than an illustrated lecture because of extensive interaction among the participants.

A poorly directed discussion may move off target and never reach the objectives established by the facilitator.

If control is not maintained, a few participants may dominate the discussion while others lose interest.

In addition to a group discussion that focuses on the session objectives, there are two other types of discussions that may be used in a training situation:

- General discussion that addresses participant questions about a learning event (e.g., why one type of episiotomy is preferred over another)
- Panel discussion in which a moderator conducts a question and answer session between panel members and participants

Follow these key points to ensure successful group discussion:

- Arrange seating to encourage interaction (e.g., tables and chairs set up in a U-shape or a square or circle so that participants face each other).
- State the topic as part of the introduction.
- Shift the conversation from the facilitator to the participants
- Act as a referee and intercede only when necessary.
  Example: “It is obvious that Alain and Ilka are taking two sides in this discussion. Alain, let me see if I can clarify your position. You seem to feel that....”
- Summarize the key points of the discussion periodically.
  Example: “Let’s stop here for a minute and summarize the main points of our discussion.”
- Ensure that the discussion stays on the topic.
• **Use the contributions of each participant** and provide positive reinforcement.

  Example: “That is an excellent point, Rosminah. Thank you for sharing that with the group.”

• **Minimize arguments** among participants.

• **Encourage all participants to get involved.**

• **Ensure that no one participant dominates the discussion.**

• **Conclude the discussion with a summary** of the main ideas. The facilitator must relate the summary to the objective presented during the introduction.

**FACILITATING A BRAINSTORMING SESSION**

Brainstorming is a learning strategy that **stimulates thought and creativity** and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts or alternative solutions that focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that participants have some background related to the topic.

The following guidelines will facilitate the use of brainstorming:

• **Establish ground rules.**

  Example: “During this brainstorming session we will be following two basic rules. All ideas will be accepted and Alain will write them on the flipchart. Also, at no time will we discuss or criticize any idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not. . . .”

• **Announce the topic or problem.**

  Example: “During the next few minutes we will be brainstorming and will follow our usual rules. Our topic today is ‘Indications for cesarean section.’ I would like each of you to think of at least one indication. Maria will write these on the board so that we can discuss them later. Who would like to be first? Yes, Ilka. . . .”

• **Maintain a written record** of the ideas and suggestions on a flipchart or writing board. This will prevent repetition and keep
participants focused on the topic. In addition, this written record is useful when it is time to discuss each item.

- **Involve the participants and provide positive feedback** in order to encourage more input.

- **Review written ideas and suggestions periodically** to stimulate additional ideas.

- **Conclude brainstorming by reviewing all of the suggestions** and clarifying those that are acceptable.

### FACILITATING SMALL GROUP ACTIVITIES

There are many times during training that the participants will be divided into several *small groups*, which usually consist of four to six participants. Examples of small group activities include:

- **Reacting to a case study**, which may be presented in writing, orally by the trainer or introduced through videotape or slides

- **Preparing a role play** within the small group and presenting it to the entire group as a whole

- **Dealing with a clinical situation/scenario**, such as in a *clinical simulation*, that has been presented by the trainer or another participant

- **Practicing a skill** that has been demonstrated by the trainer

Small group activities offer many advantages including:

- Providing participants an opportunity to **learn from each other**

- **Involving** all participants

- Creating a sense of **teamwork** among members as they get to know each other

- Providing for a **variety of viewpoints**

When small group activities are being conducted, it is important that participants are not in the same group every time. Different ways the trainer can create small groups include:

- **Assigning** participants to groups

- Asking participants to **count off** “1, 2, 3,” etc. and having all the “1s” meet together, all the “2s” meet together, etc.

- Asking participants to **form their own groups**
Asking participants to **draw a group number** (or group name)

The room(s) used for small group activities should be large enough to allow different arrangements of tables, chairs and teaching aids (models, equipment) so that individual groups can work without disturbing one another. The trainer should be able to move easily about the room to visit each group. If available, consider using smaller rooms near the primary training room where small groups can go to work on their problem-solving activity, case studies, clinical simulations or role plays. Note that it will be difficult to conduct more than one clinical simulation at the same time in the same room/area.

Activities assigned to small groups should be **challenging, interesting, relevant**; should require **only a short time to complete**; and should be **appropriate for the background of the participants**. Each small group may be working on the same activity or each group may be taking on a different problem, case study, clinical simulation or role play. Regardless of the type of activity, there is usually a time limit. When this is the case, inform groups when there are 5 minutes left and when their time is up.

Instructions to the groups may be presented:

- In a **handout**
- On a **flipchart**
- On a **transparency**
- **Verbally** by the trainer

Instructions for small group activities typically include:

- **Directions**
- **Time** limit
- A **situation or problem** to discuss, resolve or role play
- Participant **roles** (if a role play)
- **Questions** for a group discussion

Once the groups have completed their activity, the clinical training facilitator will **bring them together** as a large group for a discussion of the activity. This discussion might involve:

- **Reports** from each group
- **Responses** to questions
- **Role plays** developed in each group and presented by participants in the small groups
Recommendations from each group

Discussion of the experience (if a clinical simulation)

It is important that the trainer provide an effective summary discussion following small group activities. This provides closure and ensures that participants understand the point of the activity.

CONDUCTING AN EFFECTIVE CLINICAL DEMONSTRATION

When introducing a new clinical skill, a variety of methods can be used to demonstrate the procedure. For example:

- Show slides or a videotape in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
- Perform role plays in which a participant or surrogate client simulates a client and responds much as a real client would.
- Demonstrate the procedure with clients in the clinical setting (clinic or hospital).

Whatever methods are used to demonstrate the procedure, the trainer should set up the activities using the "whole-part-whole" approach.

- Demonstrate the whole procedure from beginning to end to give the participant a visual image of the entire procedure or activity.
- Isolate or break down the procedure into activities (e.g., pre-operative counseling, getting the client ready, pre-operative tasks, performing the procedure, etc.) and allow practice of the individual activities of the procedure.
- Demonstrate the whole procedure again and then allow participants to practice the procedure from beginning to end.

When planning and giving a demonstration of a clinical procedure (with clients, if appropriate), the trainer should use the following guidelines:

- Before beginning, state the objectives of the demonstration and point out what the participants should do (e.g., interrupt with questions, observe carefully, etc.).
- Make sure that everyone can see the steps involved.
Basic Maternal and Newborn Care: Basic Childbirth, Postpartum, and Newborn Care

JHPIEGO/Maternal and Neonatal Health Program

Section Three: Tips for Trainers - 23

- **Never** demonstrate the skill or activity incorrectly.

- Demonstrate the procedure in as **realistic** a manner as possible, using instruments and materials in a simulated clinical setting.

- Include **all steps** of the procedure in the **proper sequence** according to the approved performance standards. This includes demonstrating “nonclinical” steps such as pre- and postoperative counseling and communication with the client during surgery, use of recommended infection prevention practices, etc.

- During the demonstration, **explain to participants what is being done**, especially any difficult or hard-to-observe steps.

- **Ask questions** of participants to keep them involved.

  Example: “What should I do next?” “What would happen if...?”

- **Encourage** questions and suggestions.

- **Take enough time** so that each step can be observed and understood. Remember that the objective of the demonstration is learning the skills, **not** for the trainer to show her/his dexterity and speed.

- **Use equipment and instruments properly** and make sure participants clearly see how they are handled.

  In addition, participants should use a clinical skills **learning guide** developed specifically for the clinical procedure to observe the trainer’s performance during the initial demonstration. Doing this:

  - Familiarizes the participant with the use of competency-based learning guides

  - Reinforces the standard way of performing the procedure

  - Communicates to participants that the trainer, although very experienced, is not absolutely perfect and can accept constructive feedback on her/his performance
As the role model the participants will follow, the trainer must practice what s/he **demonstrates** (i.e., the approved **standard method** as detailed in the learning guide). Therefore, it is essential that the trainer use the standard method. During the demonstration, the trainer also should provide supportive behavior and cordial, effective communication with **the client** and **staff** to reinforce the desired outcome.
TEACHING CLINICAL DECISION-MAKING

Clinical decision-making is the systematic process by which skilled providers make judgments regarding a patient’s condition, diagnosis and treatment. Despite the importance of sound clinical decision-making to the provision of high quality services, it is not well taught in either preservice education or inservice training. There is so much basic knowledge to be acquired that it leaves little time for complex skills such as clinical decision-making. And even when there is enough time, decision-making is a difficult skill to teach and learn.

Until recently, very little was known about how decisions are made. For experienced providers, decision-making is an intuitive process based on knowledge and experience. Many of the steps necessary to arrive at a decision can be completed rapidly and unconsciously. Such providers are unable to explain how they make decisions, which in turn makes it difficult to teach this skill to others. Nor is it easy for learners to identify how a decision is made when simply observing other providers in action. Consequently, they have nothing to model for developing their own skill.

It is now known, however, that there is a process to clinical decision-making that can be broken down into a series of steps that help the provider to gather the information needed to form accurate judgments, begin appropriate care and evaluate the effectiveness of that care. There are a number of different ways to name these steps, but they describe the same process. Two such approaches are illustrated below.

- **Assessment**, or Gathering information
- **Diagnosis**, or Interpreting the information
- **Planning**, or Developing the care plan
- **Intervention**, or Implementing the care plan
- **Evaluation**, or Evaluating the care plan

An important strategy in teaching clinical decision-making is to be sure that learners are aware of this step-by-step process and what occurs in each step. They also must understand that, although there is a sequence of steps for clinical decision-making, movement through the steps is rarely linear or sequential. Rather, it is an ongoing, circular process, in which the provider moves back and forth between the steps as the clinical situation changes and different needs or problems emerge.
Learners should be introduced to the steps in clinical decision-making early in their education. After that, these steps should receive continual emphasis and be used in a variety of situations. Throughout the curriculum, learners should be given opportunities and appropriate situations in which to apply these steps and practice their decision-making skills. Whether they are actively practicing their own skills or observing more experienced providers, learners should focus on understanding the reasoning and judgment that are the basis for each step in the process. How a decision is made is as important as what decision is made. Explaining how a decision is made usually requires the active involvement of the teacher because the process of decision-making is not easy to observe or identify.

Another key strategy in teaching clinical decision-making is to provide as much experience and practice in decision-making as possible. This experience, together with clinical knowledge, is a key component of successful decision-making. Teachers should:

- Expose learners to as many and as wide a variety of patients as possible.
- Put learners in the clinical setting as early as possible and provide careful guidance as they gain their experience.
- Give learners as much structured independence as possible; they must be given the opportunity and time to draw their own conclusions and consider their own decisions.
- Provide learners with a forum, for example, case reviews or clinical conferences, for comparing their decisions with the decisions made by more experienced providers.

It is important that the teacher discuss the decision-making process with each learner, and that learners share their experiences with one another. By sharing experiences, learners get that many more cases or approaches to the same case to “file away” for future use, even though they may not have been directly involved in the cases themselves.

Finally, the teacher should give learners feedback on how the clinical decision-making process was applied in a given situation. This will strengthen future performance more effectively than focusing on whether or not the “correct answer” was identified. In fact, a wrong answer for the right reason should receive more positive feedback than a right answer for the wrong reason.

Often, it is not possible to give learners experience with all the types of situations they will encounter as independent practitioners. Their
“memory files” of experience can nevertheless be built up in other ways. Extensive use of case studies, role plays and simulations, in which specific clinical situations are acted out, can contribute significantly to learners’ experience. For example, true shoulder dystocia during childbirth is uncommon, but repeated drilling or practice on models of the corrective maneuvers for shoulder dystocia will help learners respond to the emergency when it happens.

Tools for teaching clinical decision-making are presented throughout this learning resource package. The case studies and clinical simulations have been designed to facilitate the teaching of decision-making by reinforcing the steps involved in the process. The partograph exercises are also effective tools for decision-making. Their purpose is not simply to help learners plot data on the partograph, but rather to use those data for identifying and responding to problems as soon as, or even before, they occur. The tools alone, however, will not effectively teach clinical decision-making. The teacher must take an active role in discussing, questioning, explaining and challenging the learners about how decisions are being made each time one of these tools is used. And this interaction must continue as the learners move into the clinical area and work with patients.

Clinical decision-making is still a difficult skill to teach. But by beginning early in the curriculum and continually providing practice opportunities and guidance—whether by using the tools included in this learning resource package or through experience with patients—teachers will help learners more fully understand the decision-making process and develop their decision-making skills. As a result, the quality of care received by patients will be improved.
MANAGING CLINICAL PRACTICE

Getting the most out of clinical practice requires that the trainer be well acquainted with the clinical practice sites. Being familiar with the healthcare facility before training begins allows the trainer to develop a relationship with the staff, overcome any inadequacies in the situation, and prepare for the best possible learning experience for participants. Even the best planning, however, is not always enough to ensure a successful clinical practice experience. In the classroom, the trainer is able to control the schedule and activities to a large extent; whereas in the clinic, the trainer must always be alert to unplanned learning opportunities that may arise at any time, and be ready to modify the schedule accordingly.

PERFORMING CLINICAL PROCEDURES WITH CLIENTS

The final stage of clinical skill development involves practicing procedures with clients. Possible and appropriate, participants should be allowed to work with clients only after they have demonstrated skill competency and some degree of skill proficiency in a simulated situation.

The rights of clients should be considered at all times during a clinical training course. The following practices will help ensure that clients’ rights are routinely protected during clinical training.

- The right to bodily privacy must be respected whenever a client is undergoing a physical examination or procedure.

- The confidentiality of any client information obtained during counseling, history taking, physical examinations or procedures must be strictly observed. Clients should be reassured of this confidentiality. Confidentiality can be difficult to maintain when specific cases are used in learning exercises such as case studies and clinical meetings. Such discussions always should take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.

- When receiving counseling, undergoing a physical examination or receiving maternal and neonatal health services, the client should be informed about the role of each person involved (e.g., trainers, individuals undergoing training, support staff, researchers).
• The **client’s permission should be obtained** before having a clinician-in-training observe, assist with or perform any procedures. Understanding the right to refuse care from a clinician-in-training is important for every client. Furthermore, care should not be rescheduled or denied if the client does not permit a clinician-in-training to be present or provide services. In such cases, the trainer or other staff member should perform the procedure.

• The **trainer should be present during any client contact** in a training situation and the client should be made aware of the trainer’s role. Furthermore, the trainer should be ready to intervene if the client’s safety is in jeopardy or if the client is experiencing severe discomfort.

• The **trainer must be careful how coaching and feedback are given** during practice with clients. Corrective feedback in the presence of a client should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.

• **Clients should be chosen carefully** to ensure that they are appropriate for clinical training purposes. For example, participants should not practice with “difficult” clients until they are proficient in performing the procedure.

**CREATING OPPORTUNITIES FOR LEARNING**

**Planning for Learning**

The trainer should **develop a plan for each day spent in the healthcare facility**. The plan will provide a daily focus that is consistent with the learning objectives and help to ensure that all required skills will be adequately addressed. When preparing the plan, the trainer should consider the following points.

• **Clinical practice should progress from basic to more complex skills.** This not only helps ensure the safety and quality of care provided by participants, but also allows them to gain self-confidence as they demonstrate competency in the basic skills.

• **There may be more participants than can be accommodated comfortably in one area of the healthcare facility at the same time.** Generally, three or four participants are the most that a specific area of a facility can absorb without affecting service delivery. If there are more, the trainer should plan a rotation system that allows
each participant to have equal time and opportunity in each clinical area.

- Some clinical experiences, such as obstetrical emergencies (e.g., eclampsia, postpartum hemorrhage, obstructed labor), cannot be planned or predicted. The trainer must be alert to identify appropriate clinical situations and distribute them equally among the participants. Before each day’s practice, the trainer should ask the staff to notify him/her of any clients that may be of particular interest, so that participants can be assigned to work with them.

- In addition to daily practice of specific clinical skills, the trainer’s plan should include other areas of focus such as infection prevention, facility logistics or client flow. Although these topics may not be directly assessed with a checklist or other competency-based assessment tool, they play an important role in the provision of high quality maternal and neonatal health services. To make sure that participants give adequate attention to these topics, the trainer should design and develop activities that address each one, such as:

  - Observing the infection prevention practices used in the facility. Which recommended practices are being used, and which are not? Are they being used consistently and correctly? Why or why not?

  - Reviewing facility records for the past several months to identify the types of obstetrical clients seen. Additional information could be obtained, such as the most common complaints and, in individual cases, course of labor (partograph review), progression of a specific condition, treatment provided, response to treatment, etc.

  - Taking an inventory of the supplies, equipment and drugs available in the service provision area to ensure rapid access when needed.

- Inevitably there will be times when there are few or no clients in the facility. The trainer should have ready additional activities, such as those described above, for the participants. Case studies and role plays also are very useful at such times. Even without clients, learning must continue. Taking extended breaks or leaving the clinical site early is not an acceptable option.
In the Healthcare Facility

As has been mentioned, planning alone is not sufficient to guarantee a successful clinical practice. There are several key strategies that a trainer can use in the healthcare facility to increase the likelihood of success.

- The trainer must actively monitor the skills each participant is able to practice, and with what frequency, so that each participant has adequate opportunities to develop competency. A participant who demonstrates competency in performing a cesarean section operation or in administering spinal anesthesia should not be assigned additional patients requiring this operation or procedure until other participants have had an opportunity to develop such competency.

- It is essential that the trainer be flexible and constantly alert to learning opportunities as they arise. This requires knowing about the healthcare facility—how it is set up and functions, the client population, etc.—as well as having a good working relationship with the staff. The trainer will need to rely on the staff’s cooperation in notifying her/him of unique or unusual clients and allowing participants to provide services to these clients. This relationship is most easily established beforehand, during site preparation and other visits made by the trainer.

- The participants also should be encouraged to watch for such learning opportunities. The trainer may then decide which, and how many, of the participants will be assigned to a particular client. The trainer and participants should remember that clinical experiences need to be shared equally. Therefore, the participant who identifies a case may not be assigned to it if this participant has had a similar case before. It is not appropriate to subject the client to a procedure multiple times simply so that all participants can practice a skill.

- To take advantage of opportunities as they occur may require that the trainer modify the plan for that day and subsequent days, but with as little disruption as possible to the provision of services. Participants should be notified of any changes as soon as possible so that they can be well prepared for each clinical day.

- Rarely will all participants have the opportunity to work with all types of clients. The trainer will need to supplement, with case studies and role plays, the work done with clients. The trainer should rapidly identify important but rare events or conditions, such as severe pre-eclampsia, and prepare activities in advance.
Actual cases seen in the healthcare facility may also serve as the basis for such activities. These can then be used during clinical sessions to expand the participants’ range of experiences.

CONDUCTING PRE- AND POST-CLINICAL PRACTICE MEETINGS

Although every healthcare facility will not have a meeting room, the trainer must make every effort to find a space that:

- Allows free discussion, small group work and practice on models
- Is away from the client care area if possible, so as to not interfere with efficient client care or other staff duties

Pre-Clinical Practice Meetings

The trainer and participants should meet at the beginning of each clinical practice session. The meeting should be brief. Items to be covered include:

- The learning objectives for that day
- Any scheduling changes that may be needed
- Participants’ roles and responsibilities for that day, including the work assignments and rotation schedule if applicable
- Special assignments to be completed that day
- The topic for the post-clinical practice meeting, so that the participants can take special note of anything happening during the day that would contribute to the discussion
- Questions related to that day’s activities or from previous days if they can be answered concisely; if not, they should be deferred until the post-clinical practice meeting

Post-Clinical Practice Meetings

The trainer should end each clinical day with a meeting to review the day’s events and build on them as learning experiences. A minimum of 1 hour is recommended. These meetings are used to:

- Review the day’s learning objectives and assess progress toward their completion
• Present cases seen that day, particularly those that were interesting, unusual or difficult

• Respond to clinical questions concerning situations and clients in the healthcare facility or information in the reference manual

• Plan for the next clinical session, making changes in the schedule as necessary

• Conduct additional practice with models if needed

• Review and discuss case studies, role plays or assignments that have been prepared in advance by the participants. These activities should complement the sessions conducted during the classroom portion of the course, especially when classroom time is limited and clinical experience is necessary to gain a better understanding of the issues to be discussed. Topics for case studies, role plays and assignments include:
  - Quality of care
  - Clinical services provided
  - Preventive care measures
  - Medical barriers to providing high quality services
  - Recommended follow up
  - Assessment, diagnosis, planning, intervention, and evaluation in the care of an individual client

**THE TRAINER AS SUPERVISOR**

In the role of supervisor, the trainer must monitor participant activities in the healthcare facility so that:

• Each participant receives appropriate and adequate opportunities for skill practice,

• Participants do not disrupt the efficient provision of services within the facility or interfere with staff and their duties, and

• The care provided by each participant does not harm clients or place them in an unsafe situation.

**The trainer must always be with participants when they are working with clients**, especially when they are performing clinical procedures. Trainers may have more than one or two participants to
supervise. Because the trainer cannot be with all of them at the same time, other methods of supervision must be used.

- Participants must understand what they can do independently and what requires trainer supervision, so that they can keep busy when the trainer is involved with another participant. Participants should be made responsible for ensuring that they are supervised when necessary. The trainer, however, still holds the ultimate responsibility.

- Additional activities that require no direct supervision will give participants the opportunity to be actively engaged in learning when they are not with clients.

- Clinical staff also can act as supervisors if the trainer is confident of their clinical skills and ability to provide appropriate feedback. The possibility of having clinical staff supervise participants is another reason why the trainer should get to know the staff before the training begins. During clinical site preparation, the trainer can observe the skills of the staff members, and verify that they are competent, if not proficient, service providers. The trainer may also have the opportunity to assess their coaching skills. There may even be time to work with staff members to improve their skills so that they can serve as role models and support participant learning.

- The more participants there are in the facility, the more the trainer relies upon the staff also to act as trainers. Nevertheless, the ultimate responsibility for each participant, including that of final assessment of skill competency, is the trainer’s. For this reason, if multiple clinical sites are used during a course, a trainer must be assigned to each site.

- Because clinical staff may not be involved in the classroom portion of a course, they do not have an opportunity to get to know the participants and their abilities before they arrive at the facility. Therefore, it is a good idea to share such information with the clinical staff whenever they will have to take over a large part of the participant supervision. Clinical staff should also be encouraged to do an initial assessment of participants’ skills before allowing them to work with clients so that they can feel confident that the participants are well prepared.

- Clinical staff should also be aware of the feedback the trainer would like to receive from them about participants.
• Will it be oral, written or both? If written feedback is needed, the trainer should design an instrument or form to guide the clinical staff. The trainer should furnish a sufficient number of copies of the form and instruct the staff in its use. The trainer should develop a form that staff members can complete quickly and easily.

• How frequently will feedback be provided? Daily? Weekly? Only at the end of training?

• Should both positive and corrective feedback be provided?

• Are there appropriate administrative channels through which the feedback should be transmitted? In some clinics, for example, staff members provide their feedback to the individual in charge of the healthcare facility who then prepares a report for the trainer.

• When designing the feedback system, the trainer should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinical staff, who already have a very busy schedule. It is best to keep the system as simple and easy to use as possible.

THE TRAINER AS COACH

One of the most difficult tasks for the trainer, and one with which even experienced trainers struggle, is to be a good coach and provide feedback in the clinical setting. No matter how comfortable a trainer may be in giving feedback in the classroom or while working with models, the situation changes in the facility. The clients, staff and other participants are nearby and the emergency services need to keep running smoothly and efficiently. The trainer often feels pressured to keep things moving because other clients need to be seen and the trainer needs to be available to all the participants. Spending “too much time” with any one client or participant has an impact on everyone.

Feedback Sessions

The feedback sessions before and after practice are often skipped in an effort to save time. These sessions, however, are very important for the continued development of the participant’s psycho-motor or decision-making skills. Without adequate feedback and coaching, the participant may miss an important learning opportunity and take longer to achieve competency. Keep in mind that by this time the
participant has already demonstrated competency on a model and may not need extensive feedback. To minimize disruption of services, the pre- and post-practice feedback sessions can take place in just a few minutes in a location away from the client care areas.

The structure of the feedback session is essentially the same regardless of whether the session takes place before or after practice, and whether it is for a participant’s performance with models or with clients.

- The participant should first identify personal strengths and the areas where improvement is needed.

- Next, the trainer should provide specific, descriptive feedback that includes suggestions of not only what, but also how, to improve.

- Finally, the participant and the trainer should agree on what will be the focus of the practice session, including how they will interact while they are with the client. For example, they may agree that if the trainer places a hand on the participant’s shoulder, it is a signal to stop and wait for further instructions.

The feedback session before practice should be given before entering the room to work with the client. The feedback session after practice can be delayed until the client’s care has been completed or the client is in stable condition so that continuous care is no longer needed. The trainer should try not to delay feedback any longer than necessary. Feedback is always more effective when given as soon after care as possible. This will also allow the participant to use the feedback with the next client for whom services are provided, if appropriate.

**Feedback during a Procedure**

Be sure the client knows that the participant, although already a service provider, is also a learner. Reassure the client that the participant has had extensive practice and mastered the skill on models. The client should expect to hear the trainer talk to the participant and understand that it does not mean that something is wrong. Finally, the client should clearly understand that the trainer is a proficient service provider and is there to ensure that the procedure is completed safely and without delay.

**Positive Feedback**

Positive feedback is often easy to give and can be provided in the presence of the client. Trainers often think that hearing feedback, even positive feedback, will disturb the client. Many clients, however, find it comforting to hear the service provider being given positive feedback.
• Keep the feedback restrained and low-key; overly exuberant praise can be as worrisome to the client as hearing negative comments. Too much praise may cause the client to wonder, “What is being hidden?” “Why is it so surprising that this person is doing a good job?”

• Positive feedback can be conveyed by facial expression and tone of voice rather than words, and still be highly effective.

At the same time, the absence of feedback of any kind can be disturbing to the participant. By this phase of skill development the participant is expected to do a good job even with the first client, and is accustomed to hearing positive comments. Therefore, in order to maintain the participant’s confidence, it is still important to give positive feedback.

**Corrective Feedback**

Corrective feedback is difficult to give under any circumstances, but particularly when a client is present. It is important to keep such feedback low-key and restrained. There are a number of techniques that will make it easier.

• Often a look or hand gesture (e.g., a touch on the shoulder) can be as effective as words and less worrisome to the client.

• Simple suggestions to facilitate the procedure can be made in a quiet, direct manner. Do not go into lengthy explanations of why you are making the suggestion or offering an observation—save that for the post-practice feedback session.

• To help a participant avoid making a mistake, the trainer can calmly ask a simple, straightforward question about the procedure itself. If a step in a procedure is about to be missed, for example, asking the participant to name the next step before doing anything further could help avoid an error. This is not the time to ask hypothetical questions about potential side effects and complications, as this may distract the participant and alarm the client.

• Sometimes, even though they have had extensive practice on models, participants make mistakes that can potentially harm the client. In these instances, the trainer must be prepared to step in and take over the procedure at a moment’s notice. This should be done calmly and with complete control to avoid unnecessarily alarming the client.