WORKBOOK for TRAINING of MEDICAL OFFICERS

in Pregnancy Care and Management of Common Obstetric Complications

सत्यमेव जयते

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Maternal Health Division
Ministry of Health & Family Welfare
Government of India
August 2009

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PREFACE

The Reproductive and Child Health Programme Phase-II, a flagship programme within National Rural Health Mission, aims to reduce maternal mortality ratio to less than 100 by 2010. **There is a commitment from the Government of India and also from the States and UTs for providing Essential Obstetric Care at all facilities to achieve the goal of universal Skilled Birth Attendance. With this in view, Government of India has planned to operationalize all PHCs and FRUs in handling basic and comprehensive obstetric care, respectively.**

Under the RCH Phase-II, the Government of India envisages that fifty percent of the PHCs and all the CHCs in all the districts would be made operational as 24-hour delivery centres, in a phased manner, by the year 2010. These centres would be responsible for providing Basic and Emergency Obstetric Care and Essential Newborn Care, including Newborn Resuscitation services round the clock. Almost all the States have laid emphasis in providing basic emergency obstetric care and skilled attendance at birth in the Project Implementation Plans (PIP) for RCH Phase-II.

As such, the Medical Officers, who are in-charge of these health facilities, would, therefore, have to be equipped enough to handle the common obstetric emergencies and provide the requisite care such as administration of parenteral oxytocics, antibiotics and anti-convulsant drugs, manual removal of the placenta, the conduction of assisted vaginal deliveries, etc.

Training tool for the training of Medical Officers at PHC on Pregnancy Care and Management of Common Obstetirc Complications have been developed in accordance with the **Guidelines for Pregnancy care and Management of Common Obstetric Complications by Medical Officers** include and Trainers Guide, Handbook and Workbook for the Trainees to manage Essential Obstetric Care. These tools have been prepared by Maternal Health Division in collaboration with Jawaharlal Nehru Medical College, Belgaum with inputs from UNFPA and WHO. I hope the Workbook along with the Guideline's & Handbook will facilitate Medical Officers from Primary Health Centres to build there skills in pregnancy care and management of common obstetric complications and help in ensuring the quality and uniformity in the trainings.

Date: 23.04.08

Shri Naresh Dayal,
Secretary H & FW.
New Delhi, India.

ACKNOWLEDGEMENT

To achieve the goals for reduction of maternal mortality and morbidity, GoI has a commitment under Reproductive and Child Health Program to provide quality Antenatal, Postnatal and Intranatal care during pregnancy and child birth by a Skilled Birth Attendant. Timely identification and management of obstetric complications is the key to the survival of mothers.

To achieve this, Government of India envisages that fifty percent of the Primary Health Centres and all the Community Health Centres should be operationalised as 24-hour delivery centres with proficiency for providing basic and emergency obstetric services. These centres will also be responsible for providing pre-referral emergency care for women who develop complications during delivery. The training tools, i.e., Trainers' Guide, Trainees' Handbook and Workbook will help in imparting knowledge and skills to the MOs, which will help them in providing services to women in labour and obstetric emergencies thereby reducing maternal mortality.

The training package has been designed by the faculty of Jawaharlal Nehru Medical College, Belgaum particularly Dr. B.S. Kodkany, Dr. Kamal Patil, Dr. M.K. Swamy and Mr. Killedar. Inputs have also been taken from professional bodies such as Federation of Obstetric and Gynaecological Societies of India (FOGSI), especially Dr. C.N. Purandere and Dr. Hema Diwakar, UN organizations, particularly Dr. Harish Kumar and Dr. Sonia Trikha of WHO-India and Dr. Dinesh Agarwal of UNFPA-India. I thank them all for their valuable contributions.

I also take this opportunity to acknowledge the contribution of all the experts, especially Dr. Deoki Nandan (Director, NIHFW), Dr. Kamala Ganesh (Ex H.O.D-Ob Gyn, MAMC, Delhi), Dr. (Mrs) N.S. Mahanshetti and faculty of all the Medical Colleges of Karnataka. I also acknowledge the support of WHO in organizing meetings, workshops and providing necessary inputs for accomplishing the preparation of the guidelines.

The sincere and hard work of Dr Narika Namshum, Dr. Himanshu Bhushan, Dr. Manisha Malhotra, Dr. Avani Pathak and Dr. Rajeev Aggarwal from Maternal Health Division, MoHFW needs special mention.

I hope the Handbook along with the Workbook & Guidelines will facilitate medical officers from primary health centres to build their skills in pregnancy care and management of common obstetirc complications and help in ensuring high quality of trainings.

Date: 23.04.08

Aradhana Johri
Joint Secretary, MoHFW
New Delhi, India

FOREWORD

NRHM has a commitment for reduction of maternal & infant mortality/morbidity so as to meet the National and International goals. The reduction of MMR is related to quality of services rendered and also handling of Basic and Comprehensive Obstetric Care services at the health facilities particularly at Primary and Secondary level of the facilities.

National Rural Health Mission has the goal of reducing the maternal mortality ratio to less than 100 per 100,000 live births by 2012 & infant mortality rate to less than 30 per 1000 live births. To achieve these objectives, steps have been taken under NRHM to appropriately strengthen all PHCs and FRUs in handling Basic and Comprehensive Obstetric Care including Care at Birth. However, for the improvement of service delivery, it is important that medical officers are re-oriented on care during pregnancy & childbirth so that facilities can become efficient in handling complications related to pregnancy & care of new born.

GoI has already launched the training of paramedical workers i.e., Nurses, ANMs & LHVs for making them skilled in provision of care during pregnancy & child birth but the medical officers in rural primary care facilities have not been reoriented in these skills. These medical officers are also supposed to be the supervisors & trainers for the SBA training of Nurses, ANMs & LHVs. Therefore the PHC MOs need to up-grade their skills & knowledge in order to manage & support their team in skill birth attendance.

To achieve this, GoI has developed training tools & guidelines for Medical Officers at primary health facilities. It includes Trainers Guide Handbook and Workbook for the Trainees to manage Essential Obstetric Care. These have been prepared by Maternal Health Division of this Ministry with inputs from experts, professionals, development partners& leaders in the field.

I hope these training tools will facilitate the trainers in orienting the medical officers from primary health facilities in proficient use of essential procedures described in training manual. Similarly, trainees will also be benefitted by the handbook and workbook which has been prepared in line with the Guidelines for Pregnancy care and Management of Common Obstetric Complications by Medical Officers". I hope this will help in reducing the risk & trauma of pregnancy & child birth in community.

Date: 28.08.09

(Amit Mohan Prasad)
Joint Secretary H& FW
Government of India

PROGRAM OFFICER'S MESSAGE

With the launch of National Rural Health Mission, many positive changes have taken place in public health, infrastructure and service delivery but still there is a scope for improvement in the quality of services being rendered. Reduction of maternal and infant mortality is linked with the quality of care during pregnancy and child birth. Skilled attendance in every pregnancy and during birth is a proven strategy for ensuring quality of services and for reducing maternal mortality. Training of midwifes and orientation of doctors is the key step which will help in providing skilled attendance during every pregnancy and birth taking place at public health facilities.

To improve skills of providers, training of ANMs/LHVs/SNs as Skilled Birth Attendant has already been in place but the Medical officers who are also the supervisors of this training need to be re-oriented on the skills. A guideline on Pregnancy Care and Management of Common Obstetric Complications for Medical officers working at PHC and CHC level was prepared for this purpose in the year 2005. However, states could not implement it because the training tools were not available. As such, with the help of the experts and development partners, we have now developed three books i.e. Trainers Guide, Trainees Handbook and Workbook as a training tool for the medical officers.

There was some delay in bringing these books to the final shape because certain technical strategies like Use of Oxytocin at all the health facilities and updated package of Essential New Born Care and Resuscitation etc. were being firmed up. A 10 days' package for Medical officers is now in place but the guidelines are a facilitating tool. Objectives of the guidelines will only be achieved if there is a proper coordination, planning and decision making among all the key stakeholders within the state for conducting this training and utilizing the trained doctors at proper place.

I hope these training tools will facilitate both the trainers and trainees in reorientation of knowledge and skills for care during pregnancy and child birth and will help in reducing the risk & trauma of pregnancy & child birth in community. I take this opportunity to thank everyone who has contributed in framing the training package.

Date: 02.09.09

(**Dr. Himanshu Bhushan**)
Assistant Commissioner
Maternal Health Division
MOHFW
New-Delhi, INDIA

ABBREVIATIONS AND UNITS

@	At the rate of
%	Per cent
AMTSL	Active Management of Third Stage of Labour.
ANC	Ante-natal Care
ANM	Auxiliary Nurse-midwife
APH	Antepartum Haemorrhage
ASHA	Accredited Social Health Activist
BP	Blood Pressure
BPM	Beats Per Minute
c/o	Complaint of
CCT	Controlled Cord Traction
CHC	Community Health Centre
CPD	Cephalopelvic Disproportion
D&C	Dilation and Curettage
e.g.	For example
EDD	Expected Date of Delivery
ENBC	Essential New Born Care
Etc.	Etcetra
FHR	Foetal Heart Rate
FHS	Foetal Heart Sound
FTD	Full Term Delivery
FOGSI	Federation of Obstetrics and Gynecological Societies of India
FRU	First Referral Unit
G(no.) P(no.) A(no.) L(no.)	Gravida (no.) Para (no.) Abortion (no.) Live Birth (no.)
GoI	Government of India
GPE	General Physical Examination
h/o	History of
Hb	Haemoglobin
Hg	Mercury
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
i.e.	That is
IFA	Iron Folic Acid
I/o	Input/output

IM	Intramuscular
ICTC	Integrated Counselling and Testing Center
Inj.	Injection
IUD	Intrauterine Death
IUGR	Intrauterine Growth Retardation
IV	Intravenous
LLIN	Long Lasting Insectide Treated Bednets
LBW	Low Birth Weight
LMP	Last Menstrual Period
LR	Labour Room
MMR	Maternal Mortality Ratio
MOS	Medical Officers
MoHFW	Ministry of Health and Family Welfare
MRP	Manual Removal of Placenta
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
N/A	Not Applicable
NBC	New Born Care
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Disease Control Programme
NSAID	Non-steroidal Anti-inflammatory Drug
O/E	On Examination
OPD	Out Patient Department
OT	Operation Theater
P/A	Per Abdomen
P/S	Per Speculum
P/V	Per Vaginum
P(no.) L(no.) A(no.)	Pregnancy (no.) Live-birth (no.) Abortion (no.)
PHC	Primary Health Centre
PIH	Pregnancy Induced Hypertension
PIP	Project Implementation Plan
PNC	Postnatal Care
PPH	Postpartum Haemorrhage

PROM	Premature or Prelabour Rupture of Membranes
RL	Ringer Lactate
RCH	Reproductive and Child Health
RR	Respiratory Rate
RPR	Rapid Plasma Reagin
RTI	Reproductive Tract Infection
SBA	Skilled Birth Attendant
STI	Sexually Transmitted Infection
Tab	Tablet
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UIP	Universal Immunization Programme
UTI	Urinary Tract Infection
UNFPA	United Nation Population Fund Agency
VDRL	Venereal Disease Research Laboratory
vs	Versus
WHO	World Health Organization
°C	Degree Centigrade
mg/mcg	Milligram/Microgram
cc	Cubic Centimetre
cm	Centimetre
dl	Decilitre
gm	Gram
IU	International Units
kcal	Kilocalories
kg	Kilogram
L	Litre
Lb	Pound
mg	Milligram
ml	Millilitre
mm	Millimetre
U	Units

Name of the Medical Officer	
Name of work place	
Taluka and District	
Name of Training Institute	
Names of the Trainers	1. 2. 3. 4.
Training Duration	w.e.f. _____ to _____
Dates of Joining	
Assessment (Tick any)	Satisfactory/Needs re-orientation
Name and Designation of Supervisor	
Signature with date	

General Instructions to Trainees

This workbook is a compulsory component of your training. You are required to maintain record of all your learning activities and other tasks that you perform during the course. These activities are to be performed under the supervision of the supervisor initially, whose remarks will guide you in improving your skills while practising independently.

The workbook would enable your trainers to have the first hand information about various tasks performed by you and help in assessing the practical hands-on experience gained by you. This would also be very useful to you for planning your activities in advance of the actual performance of the task. This record will also be given due weightage for your final assessment. You should keep this document with you whenever you are practising a skill, complete it and show it to your supervisor for his/her remarks and suggestions.

You are expected to keep the records in this workbook whenever you carry out any procedure under the supervision of the designated supervisor. You may add more items after discussion with your supervisor, whenever required. You must show the record to your supervisor after he/she has observed the procedure and request him/her to give the remarks and suggestions regarding where you need to improve your competencies. Please be honest in completing this workbook, since this is meant to help you acquire competencies. It is very important that you know your weak areas and improve upon them during the training period.

We have also given case studies in your handbook to stimulate your analytic and decision-making skills in relation to selected essential and emergency obstetric care and newborn care which you are likely to face in the field settings. Please go through these and also discuss these with your supervisors. Please keep the workbook even after you finish your training. This would be handy in your practice later on.

Wish you the best of luck

TRAINING SESSION

Day	Session	Topic	Time
1	1a	Registration, Welcome and Introduction to problems of Maternal Health –Maternal Mortality and objectives of Medical Officers Training, Pre-test questionnaire, Orientation to the services and facilities available in hospital	2 hours
	1b	Care during pregnancy – Antenatal Care	1 hour
2	2a	Intrapartum care and partograph	2 hours
	2b	Active Management of Third Stage of Labour (AMTSL)	1 hour
3	3a	Instrumental delivery	1 hour
	3b	Postpartum hemorrhage and shock	1 hour
4	4	Essential newborn care a) Care of baby at the time of birth b) Care of New Born in post natal ward	2 hours
5	5a	Hypertension in pregnancy	1 hour
	5b	Eclampsia	1 hour
6	6a	Postpartum care	1 hour
	6b	Puerperal sepsis	1 hour
7	7a	Anemia	1 hour
	7b	Other problems during pregnancy • Urinary tract infection • Hyperemesis gravidum • Retention of urine • Premature or prelabour rupture of membranes	1 hour
8	8a	Abortion	1 hour
	8b	Antepartum hemorrhage	1 hour
9	9a	Other problems during labour and delivery • Prolonged and obstructed labour and partograph • Preterm labour • Foetal distress • Prolapsed cord • Twins	2 hour
	9b	Other problems during postpartum period • Inversion of uterus • Problems with breast feeding	1 hour
10	10a	Prevention of infection	1 hour
	10b	Revision of 9 days' sessions Post-test questionnaire and feedback from trainees	2 hours

- Monitoring and assessment will be on a daily basis
- Final certification will be done on the last day of training

Recommended Client Practice by Trainee

	Activity	Observe	Perform Independently
1.	Antenatal check-up	5	20
2.	Identification and Management of different complications of pregnancy	5	5
3.	Preparing delivery trolley/equipment	5	-
4.	Perform PV examination	2	5
5.	Monitor labour, plot and interpret partograph	2	5
6.	a) Conduct normal delivery	2	5
	b) Active Management of 3rd stage of labour	2	5
	c) Examination of placenta, membranes, Umbilical Cord	2	5
7.	ENBC procedures and assess and provide NBC including resuscitation of *new born and check weight.	2	5
8.	Assist the mother to initiate and continue BF	2	5
9.	Management of PPH*	2	1
10.	Removal of products of conception/clots under supervision*	2	2
11.	Identification and Management of perineal tears	2	2
12.	Emergency management of eclampsia*	1	1
13.	Identification and Management of other complications of labour	3	-
14.	Postnatal checkup	2	5
15.	Identification and Management of complications of post partum period	2	3
16.	Identification and Management of danger signs in neonate	2	2
17	Emergency obstetric procedure Forceps delivery/Vacuum extraction*	2	2

- **The trainers will ensure practising of these skills by trainees and monitor quality.**
- **Trainee should keep a daily signed Cumulative Client Practice Record.**
- **This record will be utilized by Trainer for certification.**

* **Note:** In case there is no client/patient available on whom any of the above skills can be performed, the trainer should use models and innovative approaches to enable the trainees perform the requisite skills.

Record/Assessment Form for the Trainee

Recommended Client Practice by Trainee

	Activity	Observe	Perform Independently	Grading by Trainer Satisfactory/ Unsatisfactory
1.	Antenatal check-up			
2.	Identification and Management of different complications of pregnancy			
3.	Preparing delivery trolley/equipment			
4.	Perform PV examination			
5.	Monitor labour, plot and interpret partograph			
6.	a) Conduct normal delivery			
	b) Active Management of 3rd stage of labour			
	c) Examination of placenta, membranes, umbilical cord			
7.	ENBC procedures and assess and provide NBC including Resuscitation of new born and check weight.			
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13.	Identification and Management of other complications of labour			
14.	Postnatal checkup			
15.	Identification and Management of complications of post partum period			
16.	Identification and Management of danger signs in neonate			
17	Emergency obstetric procedure Forceps delivery/Vacuum extraction			

Remarks: _____

Grading: **Satisfactory/Needs re-orientation**

Name and Signature: _____

Date: _____

Note: In the Trainers' guide there is same form for filling and keeping record by the trainer.

ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History : G P A L

Order of delivery	Mode of delivery	Complication	Outcome of the pregnancy
1			
2			
3			
4			

Contraceptive History :

Past History :

Family History :

CASE SHEET: ANTENATAL CARE

GPE

Weight	
Pulse	Pallor
Blood Pressure	Oedema
RR	Jaundice
Temperature	Breasts
	Nipples: Normal/Inverted

Systemic Examination

CVS

RS

Per Abdomen	:	Fundal Height
		Lie
		Presentation
		FHS
		Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis :

Investigations	:	Hb
(*__Optional__)		Blood Group & Rh typing
		Urine Routine Examination:
		RPR/VDRL*
		HIV*
		HBsAg*
		USG*

Prophylaxis : Tab I F A

Inj. TT 1st Dose ☐ 2nd Dose ☐

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

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- Blood Group & Rh typing
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- USG*

Prophylaxis :

- Tab I F A
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Any other treatment given :

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History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History : G P A L

Order of delivery	Mode of delivery	Complication	Outcome of the pregnancy
1			
2			
3			
4			

Contraceptive History :

Past History :

Family History :

CASE SHEET: ANTENATAL CARE

GPE

Weight	
Pulse	Pallor
Blood Pressure	Oedema
RR	Jaundice
Temperature	Breasts
	Nipples: Normal/Inverted

Systemic Examination

CVS

RS

Per Abdomen	:	Fundal Height
		Lie
		Presentation
		FHS
		Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis :

Investigations	:	Hb
(*Optional)		Blood Group & Rh typing
		Urine Routine Examination:
		RPR/VDRL*
		HIV*
		HBsAg*
		USG*

Prophylaxis : Tab I F A

Inj. TT 1st Dose ☐ 2nd Dose ☐

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

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CASE SHEET: ANTENATAL CARE

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Pulse	Pallor
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CVS

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Per Abdomen :

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- Presentation
- FHS
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Vaginal Examination (if necessary)

Provisional Diagnosis :

Investigations : (*__Optional__)

- Hb
- Blood Group & Rh typing
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- RPR/VDRL*
- HIV*
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Prophylaxis :

- Tab I F A
- Inj. TT 1st Dose ☐ 2nd Dose ☐

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

ANTENATAL CASE RECORD

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History of Amenorrhoea : months days

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LMP

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CASE SHEET: ANTENATAL CARE

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Pulse	Pallor
Blood Pressure	Oedema
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Investigations : (*__Optional__)

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Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

ANTENATAL CASE RECORD

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Family History :

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ANTENATAL CASE RECORD

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Provisional Diagnosis :

Investigations : (*__Optional__)

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- HIV*
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Prophylaxis :

- Tab I F A
- Inj. TT 1st Dose ☐ 2nd Dose ☐

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

ANTENATAL CASE RECORD

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History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History : G P A L

Order of delivery	Mode of delivery	Complication	Outcome of the pregnancy
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Past History :

Family History :

CASE SHEET: ANTENATAL CARE

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- Lie
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Provisional Diagnosis :

Investigations : (*__Optional__)

- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
- RPR/VDRL*
- HIV*
- HBsAg*
- USG*

Prophylaxis :

- Tab I F A
- Inj. TT 1st Dose ☐ 2nd Dose ☐

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

ANTENATAL CASE RECORD

Name : Registration No:

Age : Date of Examination:

Address :

History of Amenorrhoea : months days

Any complaints :

Menstrual History : Regular/Irregular Cycles

LMP

EDD

Obstetric History : G P A L

Order of delivery	Mode of delivery	Complication	Outcome of the pregnancy
1			
2			
3			
4			

Contraceptive History :

Past History :

Family History :

CASE SHEET: ANTENATAL CARE

GPE

Weight	
Pulse	Pallor
Blood Pressure	Oedema
RR	Jaundice
Temperature	Breasts
	Nipples: Normal/Inverted

Systemic Examination

CVS

RS

Per Abdomen :

- Fundal Height
- Lie
- Presentation
- FHS
- Previous Scar/any other observation

Vaginal Examination (if necessary)

Provisional Diagnosis :

Investigations : (*__Optional__)

- Hb
- Blood Group & Rh typing
- Urine Routine Examination:
- RPR/VDRL*
- HIV*
- HBsAg*
- USG*

Prophylaxis :

- Tab I F A
- Inj. TT 1st Dose ☐ 2nd Dose ☐

Any other treatment given :

Counselling :

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

INTRAPARTUM RECORD

Name: Age: Registration No.

Date of Admission :

Address :

Registered/Unregistered :

Complaints : Amenorrhea months days

Pain Abdomen since:

Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
EDD:

Obstetric History : G P A L

Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy- live birth/stillbirth
1			
2			
3			

Past Medical History:

Family History:

GPE

Pulse
Blood Pressure
RR
Temp

Pallor
Oedema
Icterus

CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

Per Abdomen	:	Fundal Height
		Presentation
		Uterine Contractions
		FHS
		Any other observation
Vaginal Examination	:	Cervical effacement
		Cervical dilation
		Status of membranes Absent ☐ Present ☐
		Station of presenting part:
		Colour of liquor
Pelvic Assessment	:	Adequate/not adequate
Diagnosis	:	
Investigations	:	Hb
		Urine
		Blood Group & Rh
		Any other

In Latent Phase:

Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).

PARTOGRAPH

Name: W/o: Age: Parity: Reg. No:

Date & Time of Admission Date & Time of ROM:

A) Foetal Condition

Foetal heart rate

200
190
180
170
160
150
140
130
120
110
100
90
80

Amniotic fluid

B) Labour

Cervix (cm) [Plot X]

10
9
8
7
6
5
4

Alert

Action

Hours Time

1 2 3 4 5 6 7 8 9 10 11 12

Contrac-tions per 10 min

5
4
3
2
1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP

180
170
160
150
140
130
120
110
100
90
80
70
60

Temp (°C)

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).

Needs referral to FRU for (if applicable) :

Date and time of delivery :

Delivery Notes

Mother :

Mode of delivery: Normal ☐ Assisted ☐ LSCS ☐

Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL :

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse

BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes : Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

Meconium : Passed/not passed

Congenital anomalies : Yes/No

If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

INTRAPARTUM RECORD

Name: Age: Registration No.

Date of Admission :

Address :

Registered/Unregistered :

Complaints : Amenorrhea months days

Pain Abdomen since:

Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
EDD:

Obstetric History : G P A L

Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy- live birth/stillbirth
1			
2			
3			

Past Medical History:

Family History:

GPE

Pulse
Blood Pressure
RR
Temp

Pallor
Oedema
Icterus

CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

Per Abdomen	:	Fundal Height
		Presentation
		Uterine Contractions
		FHS
		Any other observation
Vaginal Examination	:	Cervical effacement
		Cervical dilation
		Status of membranes Absent ☐ Present ☐
		Station of presenting part:
		Colour of liquor
Pelvic Assessment	:	Adequate/not adequate
Diagnosis	:	
Investigations	:	Hb
		Urine
		Blood Group & Rh
		Any other

In Latent Phase:

Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).

PARTOGRAPH

Name: W/o: Age: Parity: Reg. No:

Date & Time of Admission Date & Time of ROM:

A) Foetal Condition

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200
190
180
170
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120
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Amniotic fluid

B) Labour

Cervix (cm) [Plot X]

10
9
8
7
6
5
4

Alert

Action

1 2 3 4 5 6 7 8 9 10 11 12

Hours Time

Contrac-tions per 10 min

5
4
3
2
1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP

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Temp (°C)

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Date and time of delivery :

Delivery Notes

Mother :

Mode of delivery: Normal ☐ Assisted ☐ LSCS ☐

Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL :

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse

BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes :

Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

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Congenital anomalies : Yes/No

If Yes, specify

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Name and Signature of Trainer/Supervisor:

Date:

INTRAPARTUM RECORD

Name: Age: Registration No.

Date of Admission :

Address :

Registered/Unregistered :

Complaints : Amenorrhea months days

Pain Abdomen since:

Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
EDD:

Obstetric History : G P A L

Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy- live birth/stillbirth
1			
2			
3			

Past Medical History:

Family History:

GPE

Pulse
Blood Pressure
RR
Temp

Pallor
Oedema
Icterus

CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

Per Abdomen	:	Fundal Height
		Presentation
		Uterine Contractions
		FHS
		Any other observation
Vaginal Examination	:	Cervical effacement
		Cervical dilation
		Status of membranes Absent ☐ Present ☐
		Station of presenting part:
		Colour of liquor
Pelvic Assessment	:	Adequate/not adequate
Diagnosis	:	
Investigations	:	Hb
		Urine
		Blood Group & Rh
		Any other

In Latent Phase:

Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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PARTOGRAPH

Name: W/o: Age: Parity: Reg. No:

Date & Time of Admission Date & Time of ROM:

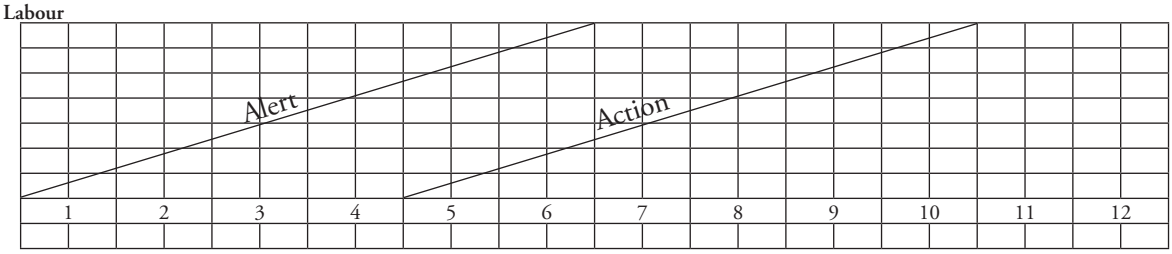
A) Foetal Condition

Foetal heart rate: 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80

Amniotic fluid

B) Labour

Cervix (cm) [Plot X]: 10, 9, 8, 7, 6, 5, 4



Hours Time

Contractions per 10 min: 5, 4, 3, 2, 1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

Temp (°C)

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Delivery Notes

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Date & Time of delivery

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Congenital anomalies : Yes/No

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Name and Signature of Trainer/Supervisor:

Date:

INTRAPARTUM RECORD

Name: Age: Registration No.

Date of Admission :

Address :

Registered/Unregistered :

Complaints : Amenorrhea months days

Pain Abdomen since:

Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
EDD:

Obstetric History : G P A L

Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy- live birth/stillbirth
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2			
3			

Past Medical History:

Family History:

GPE

Pulse
Blood Pressure
RR
Temp

Pallor
Oedema
Icterus

CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

Per Abdomen	:	Fundal Height
		Presentation
		Uterine Contractions
		FHS
		Any other observation
Vaginal Examination	:	Cervical effacement
		Cervical dilation
		Status of membranes Absent ☐ Present ☐
		Station of presenting part:
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Pelvic Assessment	:	Adequate/not adequate
Diagnosis	:	
Investigations	:	Hb
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Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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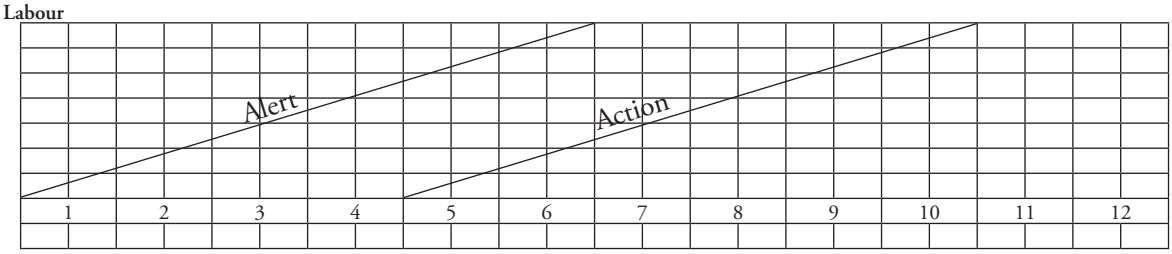
B) Labour

Cervix (cm) [Plot X]: 10, 9, 8, 7, 6, 5, 4



Hours Time

Contractions per 10 min: 5, 4, 3, 2, 1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

Temp (°C)

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).

Needs referral to FRU for (if applicable) :

Date and time of delivery :

Delivery Notes

Mother :

Mode of delivery: Normal ☐ Assisted ☐ LSCS ☐

Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL :

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse

BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes : Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

Meconium : Passed/not passed

Congenital anomalies : Yes/No

If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

INTRAPARTUM RECORD

Name: Age: Registration No.

Date of Admission :

Address :

Registered/Unregistered :

Complaints : Amenorrhea months days

Pain Abdomen since:

Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
EDD:

Obstetric History : G P A L

Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy- live birth/stillbirth
1			
2			
3			

Past Medical History:

Family History:

GPE

Pulse
Blood Pressure
RR
Temp

Pallor
Oedema
Icterus

CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

Per Abdomen	:	Fundal Height
		Presentation
		Uterine Contractions
		FHS
		Any other observation
Vaginal Examination	:	Cervical effacement
		Cervical dilation
		Status of membranes Absent ☐ Present ☐
		Station of presenting part:
		Colour of liquor
Pelvic Assessment	:	Adequate/not adequate
Diagnosis	:	
Investigations	:	Hb
		Urine
		Blood Group & Rh
		Any other

In Latent Phase:

Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

* Plotting of Partograph to be initiated from 4 cm. dilatation onwards (MANDATORY).

PARTOGRAPH

Name: W/o: Age: Parity: Reg. No:

Date & Time of Admission Date & Time of ROM:

A) Foetal Condition

Foetal heart rate

200
190
180
170
160
150
140
130
120
110
100
90
80

Amniotic fluid

B) Labour

Cervix (cm) [Plot X]

10
9
8
7
6
5
4

Alert

Action

1 2 3 4 5 6 7 8 9 10 11 12

Hours Time

Contrac-tions per 10 min

5
4
3
2
1

C) Interventions

Drugs and IV fluids given

D) Maternal Condition

Pulse and BP

180
170
160
150
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Temp (°C)

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Delivery Notes

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Indication in case of Instrumental delivery/LSCS

Date & Time of delivery

AMTSL :

- IM Oxytocin 10 U
- CCT
- Uterine Massage

Pulse

BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes : Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

Meconium : Passed/not passed

Congenital anomalies : Yes/No

If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

INTRAPARTUM RECORD

Name: Age: Registration No.

Date of Admission :

Address :

Registered/Unregistered :

Complaints : Amenorrhea months days

Pain Abdomen since:

Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
EDD:

Obstetric History : G P A L

Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy-live birth/stillbirth
1			
2			
3			

Past Medical History:

Family History:

GPE

Pulse
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Temp

Pallor
Oedema
Icterus

CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

Per Abdomen	:	Fundal Height
		Presentation
		Uterine Contractions
		FHS
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Vaginal Examination	:	Cervical effacement
		Cervical dilation
		Status of membranes Absent ☐ Present ☐
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		Urine
		Blood Group & Rh
		Any other

In Latent Phase:

Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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Amniotic fluid

B) Labour

Cervix (cm) [Plot X]

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Alert

Action

1 2 3 4 5 6 7 8 9 10 11 12

Hours Time

Contrac-tions per 10 min

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Drugs and IV fluids given

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Date & Time of delivery

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BP

Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes :

Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

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If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

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Complaints : Amenorrhea months days

Pain Abdomen since:

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Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
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CASE SHEET: INTRAPARTUM RECORD

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Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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Contrac-tions per 10 min

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Date of Admission :

Address :

Registered/Unregistered :

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Bleeding P/V :

Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
LMP:
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Obstetric History : G P A L

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Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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Uterus Contracted & Retracted

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Baby :

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Watery discharge P/V :

Any other complaints :

Menstrual History : Regular/Irregular Cycles
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Order of delivery	Mode of delivery-normal/ instrumental/LSCS	Complication if any	Outcome of the pregnancy-live birth/stillbirth
1			
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Past Medical History:

Family History:

GPE

Pulse
Blood Pressure
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Pallor
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CASE SHEET: INTRAPARTUM RECORD

Systemic Examination:

CVS

RS

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Investigations	:	Hb
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In Latent Phase:

Date & Time	Pulse	BP	Contractions	FHS	PV	Advice

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PARTOGRAPH

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Date & Time of Admission Date & Time of ROM:

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Foetal heart rate

200
190
180
170
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100
90
80

Amniotic fluid

B) Labour

Cervix (cm) [Plot X]

10
9
8
7
6
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Alert

Action

Hours Time

1 2 3 4 5 6 7 8 9 10 11 12

Contrac-tions per 10 min

5
4
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1

C) Interventions

Drugs and IV fluids given

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Pulse and BP

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Uterus Contracted & Retracted

Bleeding PV

Placenta & Membranes : Complete/Incomplete

Baby :

Sex M ☐ F ☐

Cried immediately/Resuscitation needed

Colour: Pink/Blue/Pale

Tone: Normal/Flaccid

Weight:

Urine : Passed/not passed

Meconium : Passed/not passed

Congenital anomalies : Yes/No

If Yes, specify

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

INSTRUMENTAL DELIVERY

Outlet Forceps Delivery/Ventouse:

Name & Age :

Registration No. :

Indication :

Pre-Requisites :

Outcome of delivery :

Identification and repair of any tears/lacerations :

Post partum notes:

PR

BP

P/A tone of uterus

bleeding PV

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor: Date:

INSTRUMENTAL DELIVERY

Outlet Forceps Delivery/Ventouse:

Name & Age :

Registration No. :

Indication :

Pre-Requisites :

Outcome of delivery :

Identification and repair of any tears/lacerations :

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P/A tone of uterus

bleeding PV

Assessment Grading (Satisfactory/Unsatisfactory)

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Post partum notes:

PR

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P/A tone of uterus

bleeding PV

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor: Date:

INSTRUMENTAL DELIVERY

Outlet Forceps Delivery/Ventouse:

Name & Age :

Registration No. :

Indication :

Pre-Requisites :

Outcome of delivery :

Identification and repair of any tears/lacerations :

Post partum notes:

PR

BP

P/A tone of uterus

bleeding PV

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor: Date:

MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS IN POSTNATAL WARD

Name: _____ **Date of Examination:** _____

Date and time of Birth: _____

Birth Weight: _____ **Temperature:** _____°C/°F

ASK: Does the mother or infant have any problem? _____

ASSESS:

CHECK FOR FEEDING PROBLEM	Observation	Remarks
ASK THE MOTHER • Have you started breast feeding the baby? • Is there any difficulty in feeding the baby? • Do you have any pain while breast feeding? **If yes, then look for:** Flat or inverted nipples or sore nipples Engorged breasts or breast abscess • Have you given any other foods or drinks to the baby? **If Yes, what and how?**		
CHECK FOR DANGER SIGNS		
• Count the breaths in one minute:_____ breaths per minute Repeat if fast, note down _____ breaths per minute		
• Look for severe chest in drawing		
• Look at the umbilicus. Is it red or draining pus?		
• Look for skin pustules. Are there 10 or more pustules or a big boil?		
• Measure axillary temperature (if not possible, feel for fever or low body temperature): ♦ Normal (36.5–37.4° C) ♦ Mild hypothermia (36.0–36.4° C/cold feet) ♦ Moderate hypothermia (32.0° C – 36.0° C/cold feet and abdomen) ♦ Severe hypothermia (< 32° C) ♦ Fever (> 37.4° C/feels hot)		
See if young infant is lethargic or unconscious.		
• Look at young infant's movements. Less than normal?		
• Look for jaundice. Are the palms and soles yellow?		
• Has the infant had convulsions?		

ASSESS BREASTFEEDING		
• Has the infant breastfed in the previous one hour? If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.		
• Is the infant able to attach? To check attachment, look for:		
♦ Chin touching breast Yes____No___ ♦ Mouth wide open Yes____No___ ♦ Lower lip turned outward Yes____No___ ♦ More areola above than below the mouth Yes____No___ • ***Classify***: ♦ ***No attachment at all*** ♦ ***Not well attached*** ♦ ***Good attachment*** • Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)? • ***Classify***: ♦ ***Not suckling at all*** ♦ ***Not suckling effectively*** ♦ ***Suckling effectively***		
• If not suckling well, then look for: ulcers or white patches in the mouth (thrush).		
HAS THE YOUNG INFANT RECIEVED		
♦ Vitamin K ♦ BCG, OPV 0, HEP-B 1		
• **Assess other Problems:**		
• **Advice at**		
• Discharge • Follow Up: • Danger Signs:		

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS IN POSTNATAL WARD

Name: _____ **Date of Examination:** _____

Date and time of Birth: _____

Birth Weight: _____ **Temperature:** _____°C/°F

ASK: Does the mother or infant have any problem? _____

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• If not suckling well, then look for: ulcers or white patches in the mouth (thrush).		
HAS THE YOUNG INFANT RECIEVED		
♦ Vitamin K ♦ BCG, OPV 0, HEP-B 1		
• **Assess other Problems:**		
• **Advice at**		
• Discharge • Follow Up: • Danger Signs:		

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS IN POSTNATAL WARD

Name: _____ **Date of Examination:** _____

Date and time of Birth: _____

Birth Weight: _____ **Temperature:** _____°C/°F

ASK: Does the mother or infant have any problem? _____

ASSESS:

CHECK FOR FEEDING PROBLEM	Observation	Remarks
ASK THE MOTHER • Have you started breast feeding the baby? • Is there any difficulty in feeding the baby? • Do you have any pain while breast feeding? **If yes, then look for:** Flat or inverted nipples or sore nipples Engorged breasts or breast abscess • Have you given any other foods or drinks to the baby? **If Yes, what and how?**		
CHECK FOR DANGER SIGNS		
• Count the breaths in one minute:_____ breaths per minute Repeat if fast, note down _____ breaths per minute		
• Look for severe chest in drawing		
• Look at the umbilicus. Is it red or draining pus?		
• Look for skin pustules. Are there 10 or more pustules or a big boil?		
• Measure axillary temperature (if not possible, feel for fever or low body temperature): ♦ Normal (36.5–37.4° C) ♦ Mild hypothermia (36.0–36.4° C/cold feet) ♦ Moderate hypothermia (32.0° C – 36.0° C/cold feet and abdomen) ♦ Severe hypothermia (< 32° C) ♦ Fever (> 37.4° C/feels hot)		
See if young infant is lethargic or unconscious.		
• Look at young infant's movements. Less than normal?		
• Look for jaundice. Are the palms and soles yellow?		
• Has the infant had convulsions?		

ASSESS BREASTFEEDING		
• Has the infant breastfed in the previous one hour? If infant has not fed in the previous hour, ask the mother to put her infant to the breast. Observe the breastfeed for 4 minutes.		
• Is the infant able to attach? To check attachment, look for:		
♦ Chin touching breast Yes____No___ ♦ Mouth wide open Yes____No___ ♦ Lower lip turned outward Yes____No___ ♦ More areola above than below the mouth Yes____No___ • ***Classify***: ♦ ***No attachment at all*** ♦ ***Not well attached*** ♦ ***Good attachment*** • Is the infant suckling effectively (that is, slow deep sucks, sometimes pausing)? • ***Classify***: ♦ ***Not suckling at all*** ♦ ***Not suckling effectively*** ♦ ***Suckling effectively***		
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Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

MANAGEMENT OF THE YOUNG INFANT AGE UP TO 2 MONTHS IN POSTNATAL WARD

Name: _____ **Date of Examination:** _____

Date and time of Birth: _____

Birth Weight: _____ **Temperature:** _____°C/°F

ASK: Does the mother or infant have any problem? _____

ASSESS:

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Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

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Name: _____ **Date of Examination:** _____

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Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Date:

POSTPARTUM CARE

Date and Registration No.	
Name of the Woman & Age	
Address	
Presenting complaints, if any • Fever • Pain in abdomen Type of Delivery Place and Date of Delivery Time of Delivery Time of initiation of Breast Feeding	
Examination: Pallor Pulse rate BP Breast examination Involution of uterus Lochia Perineal care	
Advice	

Assessment Grading (Satisfactory/Unsatisfactory)

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COMPLICATIONS DURING PREGNANCY

(This exercise will help you to develop your skills in diagnosing obstetric complications and their management. The list of questions in history is long and covers different types of complications. By selecting the relevant ones, you will learn what to ask and look for when examining a patient. This can also be used as a 'virtual exercise' if enough cases of complications are not seen during your training period).

History:

During pregnancy:

a. Bleeding P/V- painless/with pain; duration of amenorrhea when first episode occurred; amount of bleeding; treatment taken; any blood transfused; USG done; any other
b. High BP: when first recorded as high; any pre-pregnancy hypertension; headache and blurring of vision; pain in epigastrium; urine protein absent/present; decreased urinary output; edema yes/no;
c. Convulsions yes/no; any convulsions previously and number; treatment taken; previous h/o of epilepsy and treatment taken; unconsciousness yes/no; tongue bite yes/no; involuntary passing urine yes/no; others
d. Breathlessness on exertion yes/no; puffiness of face yes/no; pedal edema yes/no;
e. Any other

During delivery

Prolonged labour
Sudden disappearance of labour pains (s/o uterine rupture)
PPH
Home delivery attended by unskilled personnel/TBA/Relative
Retained placenta
Any fits
Sweating, confusion, low BP; loss of consciousness
Perineal tears

Post-partum

Fever, urinary retention/incontinence; constipation/feacal incontinence; pain abdomen; foul smelling lochia; excessive bleeding p/v; breast engorgement; any other

Examination:

GE:

P/A:

P/V:

Final diagnosis

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

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Final diagnosis

Assessment Grading (Satisfactory/Unsatisfactory)

Name and Signature of Trainer/Supervisor:

Maternal Health Division
Ministry of Health & Family Welfare
Government of India