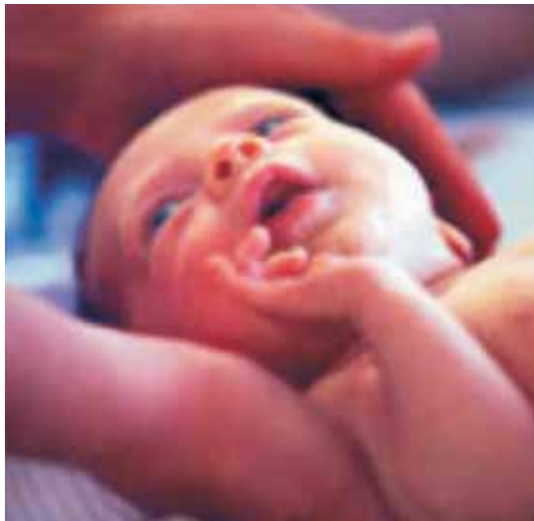
SKILLED BIRTH ATTENDANCE (SBA)

सत्यमेव जयते

# Trainer's Guide for Conducting Training of Auxiliary Nurse Midwives Lady Health Visitors & Staff Nurses 2010



NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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NATIONAL RURAL HEALTH MISSION
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गुलाम नबी आजाद
**Ghulam Nabi Azad**
Union Minister
for Health & Family Welfare

भारत सरकार
स्वास्थ्य और परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110 108

Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi - 110 108

# Health Minister's Message

Women are strong pillars of any vibrant society. Motherhood is an event of joy and celebration for every family. However, high maternal mortality during pregnancy and childbirth is a matter of great concern worldwide. Maternal mortality is a strong indicator for measuring the attention paid to the health care of the women.

The burden of maternal mortality is quite high in India at 254 deaths per 100,000 live births as per the data of Sample Registration System (SRS) for the period 2004-06. However, India is committed to meet the MDG 5 target of less than 100 deaths per 100,000 live births by the year 2015.

GoI's strategy for maternal mortality reduction focuses on building a well functioning Primary Health Care System, which can provide essential obstetric care services with a backbone of skilled birth attendant for every birth, whether it takes place in the facility or at home, which is linked to a well developed referral system with an access to emergency obstetric care for all women who experience complications.

The revised guidelines are meant for orientation and training of our SNs, ANMs, and LHVs who are there at the Primary level of health care and are the first contact of care, particularly for women residing in rural areas. I hope these guidelines will help in knowledge and skill acquisition of all the service providers involved in mid-wifery services and will thus help in reduction of maternal mortality.

I compliment Maternal Health division for bringing out the guidelines along with the training tools.

New Delhi
April 2010

**(Ghulam Nabi Azad)**

**K Sujata Rao**
Secretary
Ministry of Health & Family Welfare

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# Preface

Government of India has a commitment under National Population Policy, NRHM/RCH to ensure universal coverage of all births with skilled attendance both in the institution and at community level and to provide access to emergency obstetric and neonatal care services for women and the new born.

In accordance with the GoI's commitment for universal skilled birth attendance, a policy decision was taken to permit ANMs/LHVs/SNs to give certain injections and undertake interventions for Basic Management of Complications which might develop while providing care during pregnancy and child birth. Accordingly, guidelines for Ante-Natal Care & Skilled Attendance at Birth by ANMs/SNs & LHV as well as training tools were published in the year 2005.

However, based on the evidence of implementation and also due to certain technical advancements, there was a need to revise these guidelines and also the training package.The revised Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs/LHVs/SNs have been updated, which will help the trainees in skill and acquisition of knowledge in various technical interventions.

The Maternal Health Division of the Ministry based on inputs from experts, NGOs and development partners has revised the guidelines accordingly for use by State and District program Officers, Trainers and also ANMs/LHVs/SNs who are involved in practicing midwifery. It is hoped that the revised guidelines would improve the quality of SBA Training in the states and help in providing quality essential obstetric services thereby accelerating the reduction of maternal mortality.

New Delhi
April 2010

**(K Sujatha Rao)**

**P K Pradhan**
AS & MD, NRHM
Ministry of Health & Family Welfare

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# Foreword

NRHM has a commitment for reduction of maternal and infant mortality/morbidity so as to meet the National and Millennium Developmentgoals. The quality of services rendered and also handling of Basic and Comprehensive Obstetric Care services at the health facilities particularly at primary and secondary level has a bearing on reduction of maternal mortality ratio.

To achieve these objectives, steps have been taken under NRHM to appropriately strengthen and operationalise the 24X7 PHCs and designated FRUs in handling Basic and Comprehensive Obstetric Care including Care at Birth. For improvement of service delivery, it is important that the service providers particularly the ANMs/SNs/LHVs are oriented on care during pregnancy & childbirth so that the primary and secondary health facilities can effectively handle complications related to pregnancy and care of new born.

GoI has already launched the guidelines and training package for training of paramedical workers i.e., Nurses; ANMs & LHVs for developing their skills in provision of care during pregnancy and child birth. However, based on the feedback received and due to new technical advancements, there was a need to revise the guidelines and also the training package.

The training guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs/LHVs/SNs have now been updated and revised. This will assist the health personnel involved in midwifery practice particularly at sub-centre and 24x7 PHCs to effectively provide the requisite quality based services for women and newborns nearest to their place of residence.

It is expected that the trainers as well as the trainees will be benefitted in updating their knowledge and skills by using these guidelines along-with the training tools and thus help reducing the maternal mortality and morbidity by early identification and management of basic complications during

New Delhi
April 2010

**(P K Pradhan)**

**Amit Mohan Prasad**
Joint Secretary (RCH)
Ministry of Health & Family Welfare

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# Acknowledgement

National and international evidence indicates that reduction of maternal and infant mortality and morbidity can be accelerated if women are provided skilled care during pregnancy and child birth.

Based on this evidence, the Government of India has taken a policy decision that every birth, both institutional and domiciliary, should be attended by a skilled birth attendant. Accordingly, necessary policy decisions were taken for empowering ANMs/SNs and LHVs for handling basic obstetric care and common complications including Essential Newborn Care and Resuscitation Services. Pre-service and in-service training for these paramedical workers has already been initiated and is being implemented in the states to make them proficient in the provision of care during pregnancy and child birth.

From time to time, there is a need to update the technical knowledge and training tools, these being first published in the year 2005. Maternal Health Division of this Ministry with inputs from development partners like WHO, UNFPA, UNICEF and Professional Bodies like FOGSI, IAP, NNF has now revised the first edition of the guidelines. The revised version has to be now disseminated to the states.

The second edition of the Guidelines would not have been possible without the active interest, and encouragement provided by Ms K. Sujatha Rao, Secretary (H&FW) and Shri Naresh Dayal, Ex Secretary, Ministry of Health & Family Welfare. I also take this opportunity to appreciate the inputs given by development partners specially Dr. Rajesh Mehta, Dr. Sunanda Gupta and Dr. Vinod Anand of WHO- India, Dr Sonia Trikha, UNICEF-India and Dr. Dinesh Aggarwal, UNFPA. Contribution of TNAI, INC, JICA, USAID, DFID and also from states particularly Dr. Ajeesh Desai from Gujarat and Dr. Archana Mishra from Madhya Pradesh is also acknowledged.

I also take this opportunity to thank Dr. Bulbul Sood, Dr. Aparajita Gogoi, Ms. Medha Gandhi, Dr. Annie Mathew of CEDPA India and Dr. Manju Chhugani, Faculty, College of Nursing from Jamia Hamdard University for extending their support while the guidelines and training tools were being drafted. The contributions from FOGSI and other experts particularly Dr. Sudha Salhan & Dr. H.P. Anand from Safdarjung Hospital, Dr. Kamla Ganesh, Ex HOD & Dr. Sagar Trivedi and her team from

Lady Harding Medical College Hospital, Dr. Reva Tripathi from Maulana Medical College hospital also needs special mention.

For achieving the revision of the guidelines, hard-work and untiring efforts of Dr. Himanshu Bhushan, AC(MH), Dr. Manisha Malhotra, AC(MH), Dr. Avani Pathak and Rajeev Agarwal of Maternal Health Division is highly appreciated. The inputs from RCH, Family Planning & Child Health Division helped in firming up various components of these guidelines I hope the guidelines and the training tools will help the states in strengthening the technical interventions and in better implementation of SBA Training.

New Delhi
April 2010

**(Amit Mohan Prasad)**

**Dr. Himanshu Bhushan**
Assistant Commissioner
Maternal Health Division
Ministry of Health & Family Welfare

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# Programme Officer's Message

GoI has a commitment under NRHM/RCH to ensure universal coverage of all births with skilled attendance both in the institution and at community level and to provide access to emergency obstetric and neonatal care services for women and the new born. With this objective in mind, SBA Training for ANMs/LHVs/SNs is presently been undertaken in all the State/UTs to equip Staff Nurses (SNs) and Auxillary Mid-Wives (ANMs) for managing normal deliveries, identify complications, do basic management and then refer at the earliest to higher facilities thereby empowering them to save the life of both the mother and new born.

The earlier Guidelines in the year 2005 for Antenatal Care and Skilled Attendance at Birth by ANMs/LHVs/SNs has been revised and updated based on current scientific evidence and certain technical updates in the field. The revised Guidelines along with the Handbook provides up-to-date, comprehensive, evidence based information and defines and illustrates the skills needed to keep pregnant women, mothers and their newborns healthy, including routine and preventive care as well as early detection and management of life threatening problems. It will require effective training, logistics and supportive supervision to make skilled attendance at every birth in the country, a reality.

I hope that states will adopt the revised training package for effective implementation of the SBA training to enhance the quality. It is suggested that the training centres must be proficient and practicing the technical protocols defined and illustrated in the guideline before they take up the training batches. The first step for this should be the orientation/training of all the health professionals involved in care during pregnancy and child birth at the training centre itself. Timely nomination, Provision of essential supplies such as Partographs, mannequins, drugs and structured monitoring through Quality Assurance Cell at the State, District and Facility level should be the next step. Up-scaling SBA Training by creating more training centres either at the government health facility or through Public-Private Partnership is another important step for achieving our commitment for attending every births by skilled personnel.

I am optimistic that if all the above inputs are implemented in a coordinated manner, the time is not far away for achieving universal coverage of births with skilled attendance both in the institution and at community level. I take this opportunity to thank everyone who has contributed in framing the training package.

New Delhi
April 2010

**(Dr. Himanshu Bhushan)**

# Abbreviations

| | | |
|---|---|---|
| DPMU | : | District Program Management Unit |
| EDD | : | Expected Date of Delivery |
| ENBC | : | Essential New Born Care Unit |
| FH | : | Fundal Height |
| FHR | : | Foetal Heart Rate |
| FHS | : | Foetal Heart Sound |
| FRU | : | First Referral Unit |
| GoI | : | Government of India |
| Hb | : | Haemoglobin |
| HCl | : | Hydrochloric Acid |
| HIV | : | Human Immunodeficiency Virus |
| HLD | : | High Level Disinfection |
| IFA | : | Iron Folic Acid |
| INJ | : | Injection |
| IUCD | : | Intrauterine Contraceptive Device |
| JSY | : | Janani Suraksha Yojana |
| LAM | : | Lactational Amenorrhea Method |
| LHV | : | Lady Health Visitor |
| LLIN | : | Long-Lasting Insecticidal Net |
| LMP | : | Last Menstrual Period |
| LR | : | Labour Room |
| MCH | : | Mother and Child Health |
| MO | : | Medical Officer |
| MoHFW | : | Ministry of Health and Family Welfare |
| MoWCD | : | Ministry of Women and Child Development |
| NRHM | : | National Rural Health Mission |
| NVBDCP | : | National Vector-Borne Disease Control Programme |
| OT | : | Operation Theatre |
| P/V | : | Per Vaginum |
| PHC | : | Primary Health Centre |
| PIH | : | Pregnancy-Induced Hypertension |
| POC | : | Products of Conception |
| PPH | : | Post-Partum Haemorrhage |
| PROM | : | Premature Rupture of Membranes |
| RCH | : | Reproductive and Child Health |
| RDK | : | Rapid Diagnostic Kit |
| RPR | : | Rapid Plasma Reagin |
| RR | : | Respiratory Rate |
| RTI | : | Reproductive Tract Infection |
| SBA | : | Skilled Birth Attendant |
| SC | : | Sub-Centre |
| SN | : | Staff Nurse |
| STI | : | Sexually Transmitted Infection |
| TT | : | Tetanus Toxoid |
| UTI | : | Urinary Tract Infection |
| VDRL | : | Venereal Disease Research Laboratory |

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# 1

# Introduction

Pregnancy and childbirth are normal events in the life of a woman. Though most pregnancies result in normal birth, it is estimated that about 15% may develop complications, which cannot be predicted. Some of these may be life threatening for the mother and/or her baby. The presence of skilled attendants is therefore, crucial for the early detection and also for appropriate and timely management of such complications. The Government of India (GoI) has a commitment under its National Rural Health Mission (NRHM)/Reproductive and Child Health (RCH)-II programme to ensure universal coverage of all births with skilled attendance, both at the institutional and at the community level. The aim is to provide access to emergency obstetric and neonatal care services for women and newborns, and thereby restrict the number of maternal and newborn deaths in the country.

Women below the age of 18 years or above 40 years have greater chances of having pregnancy related complications. Primigravidas and grand multiparas (those who have had four or more pregnancies) are at a higher risk of developing complications during pregnancy and labour. Research shows that women who have spaced their children less than 36 months apart have greater chances of delivering premature and low birth weight babies, thereby increasing risk of infant mortality. An interval of less than two years from the previous pregnancy or less than three months from the previous abortion increases the chances of the mother developing anemia. Since any pregnancy can develop complications at any stage, timely provision of obstetric care services is extremely important for management of such cases and as such, every pregnancy needs to be cared for by a Skilled Birth Attendant (SBA) during pregnancy, childbirth and the post-partum period.

To be called an SBA, the health workers (Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs) and Staff Nurses) must possess the technical competence related to routine care provision, including identification and immediate management of complications arising during pregnancy and childbirth.

In India, 52.3% of births take place at home and of these, just 5.7% of births are attended by a skilled person (District Level Household and Facility Survey [DLHS]-3, 2007–08). These figures highlight that

a high proportion of births in the country are still being undertaken by an unskilled person. In such situations, women who experience life-threatening complications may not receive the required life-saving emergency services. Deliveries conducted by unqualified persons can contribute to large numbers of maternal and neonatal deaths.

More over with the launch of demand promotion schemes, such as the Janani Suraksha Yojana (JSY), the delivery load at the institution level has also increased manifold. This has led to a huge gap between demand and provision of services. Therefore, the presence of an SBA at every delivery, along with the availability of an effective referral system can help reduce maternal morbidity and mortality to a considerable extent.

Maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy (delivery or abortion), irrespective of the duration and site of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not due to accident or incidental causes. As per the reports of the Registrar General of India for 2004–2006, the maternal mortality ratio (MMR) is 254 per 100 000 live births.

The major causes of maternal death have been identified as haemorrhage, sepsis, obstructed labour, toxemia and unsafe abortion. Most of these can be prevented if complications during pregnancy and childbirth can be identified and managed early. This can be achieved only if deliveries at an institution/health facility or in the community are conducted by a skilled birth attendant (SBA). However, as per the DLHS-III, 2007–08, only 52.6% of deliveries are safe deliveries which are attended by SBAs.

The Reproductive and Child Health RCH-II Programme being implemented by Government of India under the umbrella of the National Rural Health Mission (NRHM) aims to strengthen provision of quality services at peripheral and at out-reach level to fulfill the need of clients. To achieve this, reorientation and training of the service providers has been undertaken at all levels for building their capacity to provide quality services.

The key maternal health strategies under the RCH-II (2005–2010) focus on the following:

- Providing essential obstetric care, including quality antenatal care (ANC) and postnatal care (PNC)
- Providing skilled attendance at birth (domiciliary and health facilities)
- Promoting institutional deliveries
- Operationalizing emergency obstetric care
- Strengthening referral systems
- Providing safe abortion services
- Providing services to deal with reproductive tract infections (RTI)/sexually transmitted infections (STI)

# 2

# GoI's Skilled Birth Attendance Initiative

International evidence based practices have demonstrated that the presence of a skilled birth attendant at birth can effectively reduce maternal mortality, and that a package of essential obstetric services provided close to the woman's home in the event of an obstetric emergency is successful in reducing maternal mortality.

An SBA is defined as 'an accredited health professional—such as a midwife, doctor or nurse—who has been educated and trained to achieve proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications in women and newborns'. The GoI considers the SBA as a person who can manage normal pregnancies, childbirth and immediate postpartum care, including care of the newborn, and who can handle common obstetric and neonatal emergencies, recognize when the situation reaches a point beyond his/her capability, and refer the woman or newborn to an FRU/appropriate facility without delay.

In an effort to reduce maternal mortality, the GoI has taken policy initiatives to empower auxiliary nurse midwives (ANMs)/lady health visitors (LHVs)/staff nurses (SNs) and make them competent to take certain life-saving measures. They are permitted to take the following measures:

1. Use uterotonic drugs for the prevention of postpartum hemorrhage (PPH)
2. Use certain drugs in emergency situations to stabilize the patient prior to referral.
3. Perform basic procedures in emergency situations.

The details of the above are at **Annexure-I**. However, there is a need to train these para medical workers in the requisite skills to empower as SBAs.

The following training materials for ANMs/LHVs/SNs were developed in the year 2005 and have now been updated and revised. This is the first critical step towards providing the envisioned skills to these paramedical workers posted at various levels of health care.

1. Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs/LHVs/SNs, which serves as a text for all essential and technical information that is needed to provide skilled attendance at birth
2. Handbook for Antenatal Care and Skilled Birth Attendance by ANMs/LHVs/SNs, which contains step wise check-lists and case studies on the skills that the SBA is expected to master in order to attain proficiency
3. Trainer's Guide, which is designed to support and guide the trainer in conducting training of ANMs/LHVs/SNs in a systematic and methodical manner. This provides step-by-step instructions for the trainer on how to prepare and operationalize the health facility for conducting the SBA Training and also how to proceed with each session, using appropriate teaching aids. The trainer should use this guide in conjunction with the SBA Guidelines and Handbook, as this will help to retain focus on coverage and quality.

3

# Objectives of the SBA Training Programme

The overall objective of SBA training is to enhance the knowledge and skills of the ANMs/LHVs/SNs posted at the outreach centers, sub-centers (SCs) or primary health centers (PHCs)/first referral units (FRUs), so that they are proficient in the skills needed for:

1. Managing normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period.
2. Identifying and managing complications in women and newborns, and making referrals.

## Knowledge-based objectives

By the end of the training, the trainees will be able to understand:

1. The care and importance of the health of the woman and newborn during the antenatal period, labour and postnatal period
2. Essential care of the newborn and its importance for the health of the baby
3. Clinical features and initial management of common obstetric complications during the antenatal period, labour and postnatal period.
4. Importance of the quality of care provided by midwifery services, and the need for a client-centred approach, the use of infection prevention practices, community involvement and provision of a supportive environment for the mother and family.

## Skill-based objectives

By the end of the training, the trainees are expected to be adept at the following skills.

1. Measuring the blood pressure, pulse and foetal heart rate (FHR), checking for pallor and oedema, and determining the fundal height, foetal lie and presentation accurately
2. Performing haemoglobin estimation and testing urine for proteins and sugar
3. Counselling on birth preparedness, complication readiness, diet and rest, infant feeding, sex during pregnancy; domestic violence and contraception
4. Conducting pelvic assessment to determine pelvic adequacy

5. Plotting the partograph and knowing when to refer the woman
6. Conducting safe deliveries, with active management of the third stage of labour (AMTSL), using infection prevention practices
7. Providing essential care and undertaking resuscitation of the newborn
8. Inserting an intravenous line for the management of shock and PPH
9. Inserting a catheter for the management of PPH and convulsions
10. Giving deep intramuscular injection (Magsulph)
11. Preparing sterilized/high-level disinfected (HLD) gloves and instruments
12. Follow infection prevention practices.

# 4

# Components of Trainer's Guide (TG)

The Trainer's Guide is designed to guide and support the trainer who will lead the SBA training programme. It provides all the information and instructions needed to conduct the training programme, including the sessions in the module, in a step-by-step manner. The TG includes information on the following:

## 1. ORIENTATION AND PRE-TRAINING PREPAREDNESS

**A. Orientation to the SBA training:** All staff working for maternal and child health (MCH) care should be oriented in the SBA protocols and it should be ensured that they practice the same. They should also be oriented on the training design and be requested to cooperate with the training team and trainees to ensure that the quality of the training given is of the highest level.

**B. Readiness of the Centre before the start of Training:** It is mandatory that the site selected for the SBA training adheres strictly to protocols such as:

a. Plotting a partograph for monitoring the progress of labour
b. Practice the principle of AMTSL i.e. Use of oxytocins in third stage of labour, CCT and Uterine massage.
c. Practice standard precautions for the prevention of infection.
d. Using Magsulph injection for eclampsia
e. Adopting safe delivery practices and giving care to the newborn.
f. The training site should be strengthened before starting training using the checklist for training site readiness **(Annexure 2)**.

## 2. TRAINER'S PROFILE

The trainer should have worked in the training centre/district hospital in one of the following capacities, and should have received two to three days' orientation training at the State Institute of Health and Family Welfare or at any other site selected by the state/district.

- An Obstetrician–Gynecologist (ObGyn) (MD/Diploma) as master trainer/trainer
- A Pediatrician(MD/diploma) as co-trainer/trainer for sections pertaining to neonatal health or a Medical Officer (MO) trained in emergency newborn care (ENBC) and resuscitation
- MO, nursing teacher or SN of the district hospital/training institute.

## 3. TRAINEES' PROFILE

All ANMs/LHVs/SNs are to be trained as SBAs, giving preference to those who are actively involved in midwifery practices, particularly at SCs and 24-hour PHCs. The trainees should be involved in providing basic care during pregnancy, labour, delivery and the postpartum period; be interested in providing the new/upgraded midwifery services; be willing to attend the residential training; and be interested in learning.

## 4. DURATION OFTRAINING

Trainees have to join on the first day of the training, the duration of which shall be as follows:

a. For staff nurses and LHVs: 2–3 weeks
b. For ANMs: 3–6 weeks

However, it is suggested that the duration of the training be three weeks for all categories, and it should ideally not be extended for more than one week. If proficiency is still not achieved, the trainee can be called back to attend in a subsequent batch, after she has practiced the skills learnt either at the same institution or at her place of work. Such decisions can be taken by the district chief medical officer (CMO) on the recommendation of the master trainers of the institute.

## 5. RESIDENTIALTRAINING

The SBA training is a residential training. Hence, arrangements for accommodation/payment for hiring of accommodation should be made in coordination with the district officials. Approval/funds for the same can be taken from the District Health Society. Arrangements for stay should be made as close to the training site as possible, if accommodation is not available in the hospital premises.

## 6. TRAINING SCHEDULE

Since this is a residential training with a focus on the acquisition of skills, trainees should not be permitted to join late. Irregularity in attendance by the trainee should not be permitted, and any irregularity should be communicated to the MS/CMO for taking appropriate action. The following training schedule **(Annexure- 3)** must be adhered to:

- The training duration is of 21 working days
- The first three days of training will consist of modular teaching and will solely have classroom sessions.
- From day 4 to day 6, the trainee will attend classes and also visit clinical areas, as per the schedule.

- From day 7 to day 21, all trainees will be posted in the labour ward, ObGyn OPD, postnatal ward and laboratory by rotation, to enable them to have hands-on experience of history-taking, antenatal check-ups, intra-natal care, care of the newborn, postpartum care, management of complications and infection prevention practices.

## 7. BATCH SIZE

The size of a batch will depend upon the case load and number of trainers at the training site. Optimal utilization of the training should be ensured by posting an adequate number of trainees, in accordance with the delivery load. The size of a batch can be increased only if there are a higher number of deliveries, i.e. after the initial 250 deliveries, for every additional 50 deliveries an extra trainee can be inducted. If the prescribed ratio of trainees versus deliveries is not adhered to, the quality of training in terms of skill practice will be affected. The following are the prescribed ratios.

| Number of deliveries per month | Recommended batch size |
|---|---|
| 150 | 2 |
| 150–250 | 3 |
| >250 | 4 |

## 8. TRAINING MATERIAL

Ensure that training manuals such as the Guidelines, Handbook, Trainer's Guide and teaching materials/supplies required for the training are available both to the trainer as well as the trainees before the start of the training.

- The teaching materials, such as the presentations required for each topic, are mentioned under the relevant sections.
- The trainer should prepare well in advance, photocopies of the materials required for individual as well as group work including case studies, scripts for role play, attendance sheet etc, along with adequate photocopy of the "Trainees Experience Record" **(Annexure 4)**, "Pre-/post-test questionnaire" **(Annexure 7G)**, "Log Sheet of practice on clients/models" **(Annexure 5)** should be available well before the training batch is scheduled to commence.
- Ensure that the television, video player and all session-related presentation CDs/tapes are in working condition, and that there are adequate plug points. It is advisable to have power back-up, such as a generator, in case of power failure.

## 9. ROLES AND RESPONSIBILITIES OF TRAINERS

The success of SBA training depends mainly on the trainer's training skills as he/she has tremendous influence on the trainees. The trainer needs to ensure that the environment is conducive for training and also that the quality of the training is maintained. The trainer should be able:

- To ready the training site for the training i.e. orientation of staff on SBA protocols, inform the concerned authorities regarding the training, strengthening the training centre as per requisite standards indicated at **Annexure-2**.

- To ensure that the training institute consistently follows SBA protocols
- To prepare the training schedule as per the GoI guidelines and to ensure that the training is conducted as per the schedule.
- To coordinate and liaise with other trainers.
- To hold weekly review meetings with other trainers to ensure improvements in the quality of the training.
- To give hands-on training, so that trainees are able to practice on mannequins and clients.
- To create a positive atmosphere for learning
- To ensure that trainees practices adequate number of skills as mentioned in recommended client practice and is recorded as per the log book.
- Enter the no. of skills performed in Log sheet of the trainee.
- To follow the certification procedure for assessing the competency of the trainee.
- To manage problems, if any, during the training

  - The trainer should prepare 'ground rules' and present them before the training. Punctuality should be emphasized. The trainer should ask the trainees to talk one at a time and not together; not to interrupt when someone is speaking; not to laugh at or make fun of others when they are answering or asking a question; and not to talk among themselves when training is in progress.
  - Mobile phones are to be switched off during the sessions and skills practice.
  - The trainer should ask the trainees for their feedback on the accommodation, food, transport, etc. He/she should listen to their problems and discuss the possible solutions with them.
  - At the end of each day, the trainer should discuss the day's proceedings and plan for the next day.
  - If a conflict arises, the trainer should identify the issue, listen to both sides and resolve the matter objectively.
  - Silent trainees should be encouraged to express themselves.

## 10. TRAINING METHODOLOGY

The first three days of the training will focus on theoretical issues, while from the fourth day onwards; the focus will be on hands-on practice on models/mannequins and bed side examination\teaching. The trainers can draw a schedule from 7th day onward as per the case load in LR Wards, ANC\PNC rooms. Any further theory classes can be taken as and when the need arises, priority should be given to the bed side teaching. The trainer should provide immediate constructive feedback to the trainees as and when required to encourage correct learning.

### During Classroom Sessions

- The trainer should prepare for session, well in advance and update herself\himself with the relevant teaching material for the session.
- Teaching should be interactive and trainees should be encouraged to speak about the practices being followed at their facilities on the topic of the session. This helps the participants in better understanding of the gaps for implementation of the quality protocols.

- The content should be taught using various audio-visual aids that have been prepared for the SBA training
- The trainer should demonstrate how to use models, charts, flip books, etc. for the management of normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and the identification, management and referral of complications in women and newborns.
- The relevant activities should be conducted during each session. These include video viewing, group discussions, role-plays and case studies.

### During clinical sessions/bedside examination

The trainer should spend time with the trainees at the clinical training sites to guide and support them during practice of skills. This will involve demonstrating particular skills with clients/patients, supervising the trainees to perform these skills and assessing their competency with the help of the relevant skills check-lists. At the end of every clinical session feedback should be taken from the trainees on the sessions conducted.

When in the clinical area, the trainer should also guide the trainees:

- To be accountable for their actions
- To recognize and respect the privacy and dignity of the women to whom they provide care
- To use appropriate interpersonal communication skills when providing care
- To apply recommended infection prevention practices.

### During interactive sessions

#### Role-Play:

a. All the material needed for role-play, e.g. the requisite script, a pelvic model or a baby doll with an attached placenta etc., should be made available to the trainees.

b. Ask for volunteers who would perform the role play or randomly select the participants among the trainees.

c. Instruct the group to use the local language and make the role-play interesting.

d. Instruct them to focus on the topic, speak loudly and clearly, face the audience while making their presentation and set a time limit for the presentation.

e. Allow the group time to prepare.

f. Begin by introducing the trainees to the roles they are supposed to play and stating the situation. For example, you may need to describe the age of the woman, her history, the assessment results and/or any treatment she may have taken earlier.

g. Interrupt if the players are having tremendous difficulty or have strayed from the purpose of the role-play.

h. Points which have to be observed and emphasized have been given in relevant role plays. Trainer has to ensure that relevant points have been highlighted.

i. At the end of the role-play, thank the players. Ensure that the feedback offered by the rest of the group is supportive. First discuss the aspects that were tackled well. Then discuss those which could be improved.

j. Try to get all the members of the group involved in the discussion after the role-play.

k. Ask the trainees to summarize what they have learned from the role-play.

### Case study discussion

a. The case studies can be completed in small groups or individually, in the classroom, at the clinical site or as take-home assignments.

b. The case studies given under the relevant sessions of the trainers guide contains the actual exercise and the "likely" answers to the case studies.

c. The teacher should be thoroughly familiar with the case studies and the likely responses before introducing them to the learners.

d. While introducing the discussion on a case study, the trainees should always be informed about the purpose of the discussion.

e. The trainees should refer to the Handbook for the relevant case study and answer the questions asked in the case study.

f. The trainer should ask each group/trainee for their answers and explain and discuss the right answers.

g. When a trainee gets the answers wrong, the reason why they were wrong should be explained to her in a cordial manner, without embarrassing the trainee.

h. The trainer should always summarize, or ask a trainee to summarize, the correct answers.

### Skill practice on models/mannequins

Practising skills directly on clients is unethical. Trainees should acquire adequate knowledge and skills before they provide the requisite service to the clients. This can be achieved by practising on mannequins.

a. Permit the trainees to handle the mannequins and explain how to use the mannequin to them.
b. Explain to them that the mannequins/models are of the same size as a real person.
c. Use the mannequins to demonstrate clinical skills during the role-plays and case study discussions. Ask one of the trainees to read out the steps of the clinical skill, as given in the checklist of the handbook, while you are demonstrating the same on mannequin. This will enable the trainees to link checklist in the handbook with actual practice and they will be comfortable and more confident while handling real cases.

| Tips for the trainers on the DO's and DON'T's during the training | |
|---|---|
| **DO's** | |
| • Prepare in advance. | • Position visuals so everyone can see them. |
| • Maintain good eye contact. | • Avoid distracting mannerisms and distractions in the room. |
| • Involve trainees and encourage questions | • Be aware of the trainees' body language. |
| • Speak clearly and loudly. | • Keep the group focused on the task. |
| • Write clearly and boldly. | • Check to see if your instructions are understood. |
| • Demonstrate skills on clients/models and ask trainees for a return demonstration. | • Make sure the topics are sequenced logically. |
| • Use checklists to observe trainees as they practice skills and provide constructive feedback. | • Evaluate as you go along. |
| • Be particular about good time management. | • Give feedback. |
| • Keep it simple and provide clear instructions. | • Allow trainees to practice skills using checklists. |
| • Keep the mobile phone in silent mode. | • Be patient. |
| | • Recapitulate at the end of each session. |
| **DON'T's** | |
| • Don't talk to the flip chart or the blackboard. | • Don't ignore the trainees' comments and feedback (verbal and non-verbal). |
| • Don't block visual aids. | • Don't read from the curriculum. |
| • Don't stand at one spot. Move around in the room. | • Don't shout at trainees. |
| • Don't leave a skill practice on models only; follow it by practice on clients | • Don't leave the session in the mid of the activity. |

## 11. RECORD KEEPING BY THE TRAINERS

Trainers will have to keep a record of following:

- Skill practice done by the trainee.
- Attendance sheet of the trainee.

For recording skill practice being done by the candidate, a sample log sheet as in **Annexure 5** has been given in this guide. This log sheet contains tabulated information on requisite number of skills to be observed/assisted/performed by the trainee as per the standard "recommended client practice". Trainers should keep a separate log sheet for each candidate. While the training is

ongoing, trainer should mark the skill of the trainee as "O", "A", "P" i.e. "Observed", "Assisted" and "Performed" respectively depending upon the activity done by the trainee. Trainer has to ensure that trainee observes/assists/performs the requisite number of skills, as mentioned in the log sheet. These filled in sheets duly signed will have to be submitted by the trainer to District CMO, at the end of the training. A copy of the same has to be maintained at the training institute also.

## 12. SESSION PLAN

The teaching aids and preparation required for the sessions, objectives of the sessions, and step-by-step training methodology, including the critical skills to be imparted, are explained in detail under each session plan.

## 13. BUDGET

- The budget shall be based on the number of days for which the training is planned, i.e. 21 days. The amount can be calculated as per the budget indicated in **Annexure 6**.
- District CMO\Civil Surgeon of the district will place adequate funds in advance to the training centers as per the approved training plan.
- The training institutes will maintain\incur the expenses for the logistics of the training.
- The travel allowance/dearness allowance of the participants should be distributed in time.
- The training institute will submit the statement of expenditure to the district immediately after the expenditure is incurred.

## 14. PRE- AND POST-TEST ASSESSMENT

A pre and post test assessment is to be carried out by the trainers to assess the knowledge and skills gained during the training **Annexure 7**. The score obtained in the post-test assessment shall be considered in the final evaluation sheet placed at **Annexure 7A**.

## 15. CERTIFICATION AND ASSESSMENT OF TRAINEES

A formal assessment **(Annexure 7A)** of the trainees is to be undertaken as competent/incompetent before certifying them as a "Skilled Birth Attendant". The process of assessment is to be followed as per the formats placed from **Annexure 7A** to **Annexure 7G**: The assessment will have focus on two aspects:

**A. Knowledge based skills:** At the end of training, trainees have to be assessed for their knowledge on Ante-natal, intra-natal and post natal care including new born care and neo-natal resuscitation, management of complications and infection prevention practices. For this the trainers can use any method used for theoretical assessment like multiple choice questions **(Annexure 7E)** and post test questionnaire as at **Annexure 7G.**
***To be qualified, trainees have to score a minimum of 70% in a knowledge based assessment.***

**B. Skill based:** Trainees will be assessed for the critical skills acquired during the training eriod. It will be carried out through out the training period, once they start to perform skills independently. For this assessment checklist for evaluation have been given in this guide **(Annexure 7A)**.

**To be qualified trainees have to score a minimum of 70% in the skill based assessment.**

## Instructions for trainers on how to use competency checklists

Checklists at **Annexure 7B, 7C, 7D** and **7F** have been given for ante natal, intra-partum, post partum, new born care and infection prevention practices. **Annexure 7E** gives a list of indicative questions for preparing a questionnaire based on knowledge acquired skills.

- For each of the above mentioned skills, critical components have been identified in the checklist. Assessment will be done on these components when the trainee is performing the skill independently.
- Score of "1" will be given if the trainee performs the skill as per the standards mentioned in the guidelines and if not, a score of "0" will be given.
- For each trainee, 5 independent practices will be scored by trainers. For trainee to be certified as competent, he/she has to score minimum of 70% in at least 3 of the 5 skill practice observed by the trainer.

## Certification of Trainees

For the trainee to be certified in SBA skills, he/she will have to be competent i.e. will have to score a minimum of 70% both in knowledge based and in all the skill based assessment. **Annexure 7A** is the final sheet of assessment. Trainers will have to submit a duly signed copy of this sheet to District CMO at the end of the training. A copy of the same should be maintained at the training institute also.

# Annexures 1-7

## Annexure I

## PROCEDURES AND DRUGS PERMITTED FOR USE BY SKILLED BIRTH ATTENDANTS

| S.No. | CONDITION | |
|---|---|---|
| 1. | Active Management of third stage of labor | SBA should be proficient in AMTSL:<br>• Administration of Uterotonics (Injection Oxytocin/Tablet Misoprostol)<br>• Controlled Cord Traction.<br>• Uterine massage. |
| 2. | Diagnosis of prolonged labor | Plotting a partograph for every woman in labour |
| 3. | Prevention of PPH | Active management of the third stage of labour<br>• Administering oxytocin injection (10 IU, intramuscular) for deliveries at SC/PHC/FRU/health facility<br>OR<br>Giving misoprostol tablet (3 tablets of 200 mcg each, orally; total of 600 mcg) for home deliveries<br>• Providing controlled cord traction<br>• Conducting uterine massage |
| 4. | Management of PPH | • Administering oxytocin injection (10 IU, intramuscular). (if not given during AMTSL)<br>• Administering 20 IU oxytocin in 500 ml of Ringer lactate, intravenous, at the rate of 60 drops per minute.<br>• Referring to FRU (if intravenous cannot be given, refer after administering oxytocin injection (10 IU, intramuscular) |
| 5. | Management of eclampsia | Giving one dose of Inj. magnesium sulphate (10 ml) of 5 g, deep intramuscular, in each buttock<br>• Referring to FRU |
| 6. | Vaginal or perineal tears | • Identifying different degrees of tears<br>• Managing first-degree tears by applying pad and pressure<br>• Referring for second- and third-degree tears |
| 7. | Management of puerperal infections/PROM/ Delayed (Secondary) PPH | Giving first dose of the following antibiotics and referring<br>• Gentamycin injection (80 mg, intramuscular)<br>• Ampicilin capsule (1000 mg, orally)<br>• Metronidazole tablet (400 mg, orally) |
| 8. | Incomplete abortion with bleeding P/V | Digital removal of retained products of conception |

## Annexure 2

## CHECKLIST FOR TRAINING SITE READINESS

Name of training site: _____

District and state: _____

Date of assessment: _____

Name and designation of assessor: _____

| | ITEM | OBSERVATION:YES/NO | REMARKS |
|---|---|---|---|
| **A.** | **Ensure readiness of the training site as per GoI guidelines for SBA training**<br>• Monitoring labour using partograph<br>• AMTSL<br>• Use of Magsulph for eclampsia | | |
| **B.** | **Place and furniture (especially in the labour room)** | | |
| | 1. Privacy maintained—curtains/screen | | |
| | 2. Adequate light to visualize cervix | | |
| | 3. Electricity supply with back-up facility (generator with POL) | | |
| | 4. Attached toilet facilities | | |
| | 5. Delivery table with mattress and macintosh and Kelly pad | | |
| | 6. Area marked for care and resuscitation of newborn | | |
| | 7. 1 table and 3 chairs in the side room of the labour room | | |
| **C.** | **Infection prevention equipment** | | |
| | 1. 10 litre bucket with tap or running water | | |
| | 2. Plain plastic tub, 12” at base, for 0.5% chlorine solution | | |
| | 3. Autoclave/boiler | | |
| | 4. Stove in working condition (used for boiling) | | |
| | 5. Plastic mug (1 litre) | | |
| | 6. Teaspoon for measuring bleaching powder | | |
| | 7. Surgical gloves (No. 7) | | |
| | 8. Utility gloves (thick rubber) | | |
| | 9. Soap in a covered soap dish | | |
| | 10. Puncture-proof container/hub cutter and needle destroyer | | |
| | 11. Plastic apron, shoes, mask, cap, goggles | | |

| | ITEM | OBSERVATION:YES/NO | REMARKS |
|---|---|---|---|
| | 12. Dustbin—colour-coded, based on biomedical waste management | | |
| **D.** | **Emergency drug tray** | | |
| | 1. Injection Oxytocin | | |
| | 2. Injection Diazepam | | |
| | 3. Tablet Nifedipine | | |
| | 4. Injection Magnesium Sulphate | | |
| | 5. Injection Lignocaine Hydrochloride | | |
| | 6. Tablet Misoprostol | | |
| | 7. Sterilized cotton and gauze | | |
| | 8. At least 2 pairs of gloves | | |
| | 9. Sterile syringes and needles (different sizes) | | |
| | 10. At least 2 sterile intravenous sets | | |
| | 11. Intravenous fluids | | |
| | 12. Intravenous cannula and drip set | | |
| **E.** | **Equipment, supplies and other drugs** | | |
| | 1. Delivery kits for normal deliveries | | |
| | 2. Cheatle forceps in a dry bottle | | |
| | 3. Foetal stethoscope | | |
| | 4. Baby weighing scale | | |
| | 5. Radiant warmer | | |
| | 6. Table lamp with 200 watt bulb | | |
| | 7. Phototherapy unit | | |
| | 8. Self-inflating bag and mask (neonatal size) | | |
| | 9. Oxygen hood (neonatal) | | |
| | 10. Laryngoscope and endotracheal tubes | | |
| | 11. Mucus extractor with suction tube and foot-operated suction machine | | |
| | 12. Feeding tubes | | |
| | 13. Blankets | | |
| | 14. Clean towels | | |
| | 15. Baby feeding cup | | |
| | 16. Blood pressure apparatus and stethoscope | | |
| | 17. Sterile/clean pads | | |
| | 18. Bleaching powder | | |
| | 19. Povidone iodine | | |
| | 20. Methylated spirit | | |

| | ITEM | OBSERVATION:YES/NO | REMARKS |
|---|---|---|---|
| | 21. Digital thermometer | | |
| | 22. Micropore tape | | |
| | 23. MCH card | | |
| | 24. Partograph | | |
| | 25. Gentamicin injection | | |
| | 26. Ampicillin injection | | |
| | 27. Metronidazole Tablets | | |
| | 28. Foley and plain catheters and uro bag | | |

## Annexure 3

## TRAINING SCHEDULE

| DAY | SESSION | TOPIC | TIME REQUIRED | PREFERRED TRAINER | METHODOLOGY |
|---|---|---|---|---|---|
| 1. | 1. | Registration<br>Welcome<br>Introduction of trainers and trainees<br>Trainees' expectations<br>Pre-test questionnaire<br>Goals and objectives<br>Introduction to SBA training package | 2 hours 15 min | Master Trainer of the Training Centre. | Introduction through games; flip charts for participants to indicate expectations; presentation 1a for goals and objectives and introduction to training package |
| | 1a. | i) Overview of maternal health scenario in India | 30 min | CMO/CDHO | Presentation 1a |
| | | ii) Procedures and drugs permitted by GoI for use by SBAs | 15 min | SN/Sister tutor | Presentation 1a |
| | 1b. | Infection prevention | 3 hours | SN/Sister tutor | Presentation 1b; checklists 5.1 and 5.2; refer to Guidelines Module 1: Introduction, and Module 3; demonstration of chlorine preparation; video on infection prevention; posters on biomedical waste disposal; demonstration of preparation of bleach solution and hand-washing |
| | | Tour of facility: logistics and wrap-up | 30 min | Master Trainer of the Training Centre. | Visit facility with team leader |
| 2. | 2. | Recapitulation of Day 1 | 15 min | Trainee | |
| | 2a. | ANC | 30 min | SN/Sister tutor | Presentations 2a, b, c and d; checklists 1.1, 1.2 and 1.3; refer to Guidelines Module 1: Antenatal care; demonstration; exercises; use of dummies/models; CD; poster on abdominal palpation and fundal height measurement |
| | 2b. | ANC—History-Taking | 1 hour 30 min | SN/Sister tutor | |
| | 2c. | ANC—General Examination | 2 hours | OB/GYN | |
| | 2d. | ANC—Abdominal Examination | 2 hours | OB/GYN | |
| | | Wrap-up and assigning of tasks | 15 min | Master Trainer of the Training Centre | |

| DAY | SESSION | TOPIC | TIME REQUIRED | PREFERRED TRAINER | METHODOLOGY |
|---|---|---|---|---|---|
| 3. | 3. | Recapitulation of Day 2 | 15 min | Trainee | |
| | 3a. | ANC—laboratory investigations; estimating haemoglobin; testing urine for sugar and proteins | 1 h 15 min | SN/Sister tutor and laboratory in-charge | Presentations 3a, b, c and d; checklists 1.4, 1.5, 2.1 and 2.2; refer to Guidelines Module 1: Antenatal care; demonstration; exercises; role-plays; use of dummies/models; visit to the laboratory; poster on diet and nutrition |
| | 3b. | ANC—interventions: IFA, TT, malaria | 45 min | SN/Sister tutor | |
| | 3c. | i) Counselling | 1 h 30 min | SN/Sister tutor | |
| | | ii) Preparation for discharge | 1 h 30 min | OB/GYN | |
| | | | | | |
| | 3d. | Care during labour—assessment, supportive care and vaginal examination of woman in labour | 45 min | SN/Sister tutor | |
| | | Wrap-up and assigning of tasks | 15 min | Master Trainer of the Training Centre | |
| 4. | 4. | Recapitulation of Day 3 | 15 min | Trainee | |
| | 4a. | Care during labour and delivery:<br>i) True and false labour pains | 15 min<br><br>3 h 45 min | SN/Sister tutor<br><br>OB/GYN<br><br>OB/GYN | Presentation 4a; checklists 2.3 and 2.4; refer to Guidelines Module 1: Care during labour and delivery; demonstration; case studies for plotting of partograph; use of dummies/models; CD; poster on partograph |
| | | ii) Stages of labour—monitoring and management of first stage of labour, partograph | 2 h | | |
| | | Clinic teaching and visits to the respective departments will be held simultaneously | | | Visit to labour room |
| | | | | | |

| DAY | SESSION | TOPIC | TIME REQUIRED | PREFERRED TRAINER | METHODOLOGY |
|---|---|---|---|---|---|
| | | Wrap-up and assigning of tasks | 15 min | Master Trainer of the Training Centre | |
| 5. | 5. | Recapitulation of Day 4 | 15 min | Trainee | |
| | 5a. | i) Monitoring and management of third stage of labour | 1 h | OB/GYN<br><br>OB/GYN | Presentations 5a, b and c; checklists 2.5, 2.6, 2.7, 3.1 and 3.2; refer to Guidelines Module 1: Management of third and fourth stages of labour and Newborn resuscitation and care after delivery—postpartum care; demonstration; use of dummies/models; CD; poster on resuscitation flowchart<br><br>Visit to labour room, newborn unit and postnatal ward |
| | | ii) Monitoring and management of fourth stage of | 2 h | OB/GYN | |
| | 5b. | i) Resuscitation of newborn | 2 h | Pediatrician | |
| | | ii) Preparation for discharge | 30 min | Pediatrician | |
| | 5c. | Care after delivery—postpartum care | 45 min | SN/Sister tutor | |
| | | Clinic teaching and visits to the respective departments will be held simultaneously | | | |
| 6. | 6. | Recapitulation of Day 5 | 15 min | Trainee | |
| | 6a. | Management of complications during pregnancy, labour and postpartum period | 5 hours | OB/GYN | Presentation 6a; checklists 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7 and 4.8; refer to Guidelines Module 2: Management of complications; demonstration; use of dummies/models; CD; poster on immediate PPH—management |
| | 6b. | Ensuring quality of care | 1 hour | OB/GYN | Presentation 6b; refer to Guidelines Module 3: Ensuring quality of care |
| | | Clinic teaching and visits to the respective departments will be held simultaneously | | | Visit to ANC outpatient department and ward, labour room, newborn unit and postnatal ward |
| | | | | | |

| DAY | SESSION | TOPIC | TIME REQUIRED | PREFERRED TRAINER | METHODOLOGY |
|---|---|---|---|---|---|
| | | Wrap-up and discussion of schedule for Days 7-21 | 15 min | | |

**Note:**

1. There will be a lunch break of one hour and two tea breaks of 15 min each on all training days.
2. An assessment of the trainee will be carried out at the end of the training.

## Annexure 4

## EXPERIENCE RECORD OF TRAINEES PRIOR TO SBA TRAINING

1. Name: _____

2. Designation (ANM/LHV/SN): _____

3. Age: _____ years

4. Place and area of posting: _____

5. Educational qualification with year of passing out: _____

6. Duration of work experience after initial training: _____

7. Have you received refresher midwifery training? Yes/No If yes, then how many?

8. Have you received orientation training on basic SBA skills by your MO in charge? Yes/No

8. Current job responsibilities: Clinical/Training/Supervision

9. Approximate number of deliveries conducted independently: _____

10. Approximate number of deliveries that were complicated: _____

11. Do you practice the following in your work? (Encircle the correct answer):

| | | | | | |
|---|---|---|---|---|---|
| a | Starting intravenous fluids | Yes | | No | |
| b | Hb estimation of the pregnant women | Yes | | No | |
| c | TT administration to the pregnant women | Yes | | No | |
| d | Inj. Magsulph to pregnant woman who have an attack of eclampsia | Yes | | No | |
| e | Manually removing the placenta. | Yes | | No | |
| f | Using Misoprostol to prevent PPH | Yes | | No | |
| g | Using a partograph to monitor labour | Yes | | No | |
| h | Giving enema during labour | Yes | | No | |
| i | Shaving the perineum | Yes | | No | |
| j. | Catheterization | Yes | | No | |

## Annexure 5

## RECOMMENDED PRACTICE AND LOG SHEET FOR TRAINEES ON CLIENTS/DUMMY

**NAME OF TRAINEE**

**TRAINING PERIOD FROM TO**

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Antenatal care | | | | | | | | | | | | | | | |
| History | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| General Examination (wt, BP, pallor, oedema) | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Abdominal Examination including FHS | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Lab Invest. (Hb, urine for sugar and albumin) | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Labour and delivery | | | | | | | | | | | | | | | |
| Monitor labour (using partograph and P/V to assess cervical dilatation) | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Conduct delivery with active management of labour | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Examination of placenta, membranes and umbilical cord | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Provide New Born Care, including assisting in breastfeeding | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | P | P | P | P | P |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Provide New Born resuscitation—perform suction, maintain airway and establish breathing | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | A | P | P | P | P | P | | | | | |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Complication | | | | | | | | | | | | | | | |
| Administer deep IM injection (magsulph) | | | | | | | | | | | | | | | |
| Performance (Tick) | O | O | A | A | P | P | P | P | P | P | | | | | |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Remove Products Of Conception/clots | | | | | | | | | | | | | | | |
| Performance (Tick) | O | A | A | P | P | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Establish IV line | | | | | | | | | | | | | | | |
| Performance (Tick) | O | A | A | P | P | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |
| Catheterization | | | | | | | | | | | | | | | |
| Performance (Tick) | O | A | A | P | P | | | | | | | | | | |
| Date | | | | | | | | | | | | | | | |
| Sign of the trainer | | | | | | | | | | | | | | | |

**Note:**

- The trainer will sign, with date, the category in which he/she has supervised the trainee, i.e. O/A/P.
- This log sheet contains tabulated information on requisite number of skills to be observed/assisted/performed by the trainee as per the standard "recommended client practice".
- Trainers should keep a separate log sheet for each candidate.
- While the training is ongoing, trainer should mark the skill of the trainee as "O", "A", "P" i.e. "Observed", "Assisted" and "Performed" respectively depending upon the activity done by the trainee.
- Trainer has to ensure that trainee observes/assists/performs the requisite number of skills, as mentioned in the log sheet.
- These filled in sheets duly signed will have to be submitted by the trainer to District CMO, at the end of the training.
- A copy of the same has to be maintained at the training institute also.

## Annexure 6

## ILLUSTRATED BUDGET PER BATCH FOR TRAINING OF SKILLED BIRTH ATTENDANTS

| HEADS OF EXPENDITURE/BATCH SIZE | 1 (TRAINEE) | 2 (TRAINEE) | 3 (TRAINEE) | 4 (TRAINEE) |
|---|---|---|---|---|
| *DA (Rate x No. of days x No. of participants) (Rs 400 x 21 x No. of participants) | 400 x 21 x 1 = Rs 8400 | 400 x 21 x 2 = Rs 16 800 | 400 x 21x 3 = Rs 25 200 | 400 x 21x4 = Rs 33 600 |
| **Honorarium (In-house faculty) (Rate x Days of training x No. of trainers) (Rs 200 x 21 x No. of trainers) | 200 x 21 x 2 = Rs 8400 | 200 x 21 x 4 = Rs 16,800 | 200 x 21 x 4 = Rs 16,800 | 200 x 21 x 4 = Rs 16,800 |
| Incidental expenditure, such as study material, course material, photocopying, job aids, flip charts and LCD (Rate x Days of training x No. of trainees) (Rs 250 x 21 x No. of trainees) | 250 x 21 x 1 = Rs 5250 | 250 x 21 x 2 = Rs 10 500 | 250 x 21 x 3 = Rs 15 750 | 250 x 21 x 4 = Rs 21 000 |
| Working lunch, tea and snacks (Rate x Days of training x No. of trainees) (Rs 200 x 21 x No of trainees) | 200 x 21 x 1 = Rs 4200 | 200 x 21 x 2 = Rs 8400 | 200 x 21 x 3 = Rs 12 600 | 200 x 21 x 4 = Rs 16 800 |
| a. Sub-total | Rs 26 250/- | Rs 52 500/- | Rs 70 350/- | Rs 88 200/- |
| b. IOH @15% of sub-total | Rs 3938/- | Rs 7875/- | Rs 10 553/- | Rs 13 230/- |
| c. Total | Rs 30 188/- | Rs 60 375/- | Rs 80 903/- | Rs 101 430/- |
| d. Venue hiring charges | Rs 8000–10 000 | | | |
| e. TA | As per State Rules | | | |

**Note: *The trainees DA incude their accommodation**

- One time grant of Rs 40,000/ shall be given to each identified training centre for purchase of computer, printer, UPS etc.
- Funds for establishment of the training cells shall be provided @ Rs 15,000/ per centre (one time) to District and Sub-District training institutions for procuring stationeries, different monitoring forms, Partograph and other day to day required items for establishing cell and shall be released by the State Health Society/SCOVA to the District Health Societies, which in turn will place the funds at the disposal of the training institutions.
- This grant shall be released by the State Health Society/SCOVA to the District health societies, which in turn will place the funds at the disposal of the training institutions for conducting training of ANMs/LHVs/SNs.

**** Honorarium to the trainers:**

- Rs 200 per day for 4 persons x actual duration of the training
  - Suggested honorarium plan for the trainers:
  - 1 OBG (master trainer)
  - 1 nursing personnel in charge of labour room/on-duty supervisor at labour room
  - 2 x co-trainers such as pediatrician/MO/nursing tutor/any other trainer, as per the sessions conducted

- Funds for conducting 2–3 days' training of trainers (travel, stay, training material, DA) at State Institutes for Health and Family Welfare (SIHFWs) /districts and also for monitoring of training programmes in districts shall be provided to the concerned SIHFW/district from the RCH flexi funds placed with the state/district health society/SCOVA. The norms of RCH training shall be followed for this.
- The entire cost of SBA training shall be met from the RCH flexible pool placed at the disposal of the states and this should also be reflected in the states' programme implementation plan.
- The national-level orientation training at the National Institute of Health and Family Welfare (NIHFW) will be met out of RCH training funds.
- In case of extension of the duration of training for some trainees, the honorarium (for the trainee only) along with expenditure on lunch/tea for the added days can be calculated accordingly. Ideally, there should not be an extension of more than one week.
- Ensuring timely release of funds to the training centers for the implementation of the training programmes and training site maintenance shall be the responsibility of the respective CMO/district training officer/DPM.
- The DPMU is to look after the logistics of the training and ensure that the TA/DA of the participants is distributed in time.

# Annexure 7

## CERTIFICATION

## Annexure 7A

Name of Trainee:
Designation: ANM/LHV/SN
Duration of training: From……. To ……..

### FINAL ASSESSMENT SHEET FOR CERTIFICATION

| | CORE SKILLS | EVALUATION COMPETENT/INCOMPETENT | FINAL EVALUATION |
|---|---|---|---|
| 1. | Core skills Antenatal care **(As per Annexure-B)** | | Competent / Incompetent (Tick as applicable) |
| 2. | Intranatal care, including care of newborn **(As per Annexure-C)** | | |
| 3. | Postpartum care **(As per Annexure-D)** | | |
| 4. | Complication identification and management (knowledge-based) **(As per Annexure-E)** | | |
| 5. | Infection prevention practices **(As per Annexure-F)** | | |
| 6. | Knowledge based/Theoretical Assessment/ Post-test questionnaire scores **(As per Annexure-G)** | | |

**Note:**

- Criteria for competency:
  - For skill based assessment: Trainee has to achieve a score of 70% in 3 of the 5 skill practice observed by the trainer.
  - For knowledge based assessment: Trainee has to achieve a minimum of 70% in theoretical assessment.
- For certifying a trainee as SBA, he/she has to be competent in all the above mentioned skills.

Name, designation and signature of all trainers:

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

4. ..... 5. .....

## Annexure 7B

## CHECKLIST FOR ANTE NATAL CARE

| | | (TRAINEE 1) | | | | | (TRAINEE 2) | | | | | (TRAINEE 3) | | | | | (TRAINEE 4) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NAME OF TRAINEE** | | | | | | | | | | | | | | | | | | | | | |
| | Skills supervised on patients | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| **A.** | **ANTENATAL HISTORY-TAKING:** | | | | | | | | | | | | | | | | | | | | |
| 1. | Calculating expected date of delivery (EDD) | | | | | | | | | | | | | | | | | | | | |
| 2. | Taking obstetric history, history of systemic illnesses and drug allergies | | | | | | | | | | | | | | | | | | | | |
| **B.** | **GENERAL PHYSICAL EXAMINATION** | | | | | | | | | | | | | | | | | | | | |
| 3. | Checking blood pressure | | | | | | | | | | | | | | | | | | | | |
| 4. | Checking for pallor | | | | | | | | | | | | | | | | | | | | |
| 5. | Looking for oedema | | | | | | | | | | | | | | | | | | | | |
| 6. | Recording weight | | | | | | | | | | | | | | | | | | | | |
| **C.** | **ABDOMINAL EXAMINATION** | | | | | | | | | | | | | | | | | | | | |
| 7. | Determining fundal height | | | | | | | | | | | | | | | | | | | | |
| 8. | Determining foetal lie | | | | | | | | | | | | | | | | | | | | |
| 9. | Determining presentation (3rd trimester) | | | | | | | | | | | | | | | | | | | | |
| 10. | Counting FHR | | | | | | | | | | | | | | | | | | | | |
| 11. | Identifying complications | | | | | | | | | | | | | | | | | | | | |
| **D.** | **LABORATORY INVESTIGATIONS** | | | | | | | | | | | | | | | | | | | | |
| 12. | Estimating haemoglobin | | | | | | | | | | | | | | | | | | | | |
| 13. | Testing urine for albumin and sugar | | | | | | | | | | | | | | | | | | | | |
| **E.** | **INTERVENTIONS** | | | | | | | | | | | | | | | | | | | | |
| 14. | Administering tetanus toxoid (TT) injections (2 one month apart) | | | | | | | | | | | | | | | | | | | | |
| 15. | Giving iron and folic acid (IFA) tablets | | | | | | | | | | | | | | | | | | | | |
| | **Total Score (out of 15):** | | | | | | | | | | | | | | | | | | | | |
| | **No. of Cases in which a score > 11 is achieved** | | | | | | | | | | | | | | | | | | | | |
| | Competency (Competent / | | | | | | | | | | | | | | | | | | | | |
| | Incompetent)** | | | | | | | | | | | | | | | | | | | | |

**Note:**

- This sheet evaluates four trainees.
- Score of "1" will be given if the trainee performs the skill as per the standards mentioned in the guidelines and if not, a score of "0" will be given.
- For each trainee, 5 independent practices will be scored by trainers.
- ** For trainee to be certified as competent, he/she has to score minimum of 70% (i.e. a score of 11/15) in at least 3 of the 5 skill practice observed by the trainer.

## Annexure 7C

## CHECKLIST FOR INTRA NATAL CARE AND CARE OF NEWBORN

| | | (TRAINEE 1) | | | | | (TRAINEE 2) | | | | | (TRAINEE 3) | | | | | (TRAINEE 4) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NAME OF TRAINEE** | | | | | | | | | | | | | | | | | | | | | |
| | Skills supervised on patients | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| **A.** | **MANAGEMENT OF FIRST STAGE OF LABOUR USING PARTOGRAPH** | | | | | | | | | | | | | | | | | | | | |
| 1. | Plots partograph correctly | | | | | | | | | | | | | | | | | | | | |
| 2. | Knows when to refer on basis of partograph | | | | | | | | | | | | | | | | | | | | |
| **B.** | **MANAGEMENT OF SECOND STAGE OF LABOUR** | | | | | | | | | | | | | | | | | | | | |
| 3. | Takes correct steps for delivering the foetus | | | | | | | | | | | | | | | | | | | | |
| **C.** | **ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR** | | | | | | | | | | | | | | | | | | | | |
| 4. | Performs AMTSL correctly | | | | | | | | | | | | | | | | | | | | |
| 5. | Examines vagina and perineum for tears | | | | | | | | | | | | | | | | | | | | |
| **D.** | **MANAGEMENT OF FOURTH STAGE, INCLUDING ESSENTIAL CARE OF NEWBORN** | | | | | | | | | | | | | | | | | | | | |
| 6. | Checks for vaginal bleeding | | | | | | | | | | | | | | | | | | | | |
| 7. | Checks uterine behaviour (contracted or relaxed) | | | | | | | | | | | | | | | | | | | | |
| 8. | Provides baby warmth | | | | | | | | | | | | | | | | | | | | |
| 9. | Initiates breastfeeding, including colostrum-feeding | | | | | | | | | | | | | | | | | | | | |
| **E.** | **RESUSCITATION OF NEWBORN** | | | | | | | | | | | | | | | | | | | | |
| 10. | Provides warmth | | | | | | | | | | | | | | | | | | | | |
| 11. | Position's baby's head | | | | | | | | | | | | | | | | | | | | |
| 12. | Clears airway | | | | | | | | | | | | | | | | | | | | |
| 13. | Position's bag and mask, begins ventilation | | | | | | | | | | | | | | | | | | | | |
| 14. | Knows when to refer | | | | | | | | | | | | | | | | | | | | |
| | **Total Score (out of 14):** | | | | | | | | | | | | | | | | | | | | |
| | Competency (Competent/ Incompetent)** | | | | | | | | | | | | | | | | | | | | |

**Note:**

- This sheet evaluates four trainees.
- Score of "1" will be given if the trainee performs the skill as per the standards mentioned in the guidelines and if not, a score of "0" will be given.
- For each trainee, 5 independent practices will be scored by trainers.
- ** For trainee to be certified as competent, he/she has to score minimum of 70% (i.e. a score of 10/14) in at least 3 of the 5 skill practice observed by the trainer.

## Annexure 7D

## CHECKLIST FOR POSTNATAL CARE OF MOTHER AND CARE OF NEWBORN (POST PARTUM CARE)

| | (TRAINEE 1) | | | | | (TRAINEE 2) | | | | | (TRAINEE 3) | | | | | (TRAINEE 4) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NAME OF TRAINEE** | | | | | | | | | | | | | | | | | | | | |
| Skills supervised on patients | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| **A. CARE OF THE MOTHER AND BABY** | | | | | | | | | | | | | | | | | | | | |
| 1. Advises mother on colostrum-feeding and exclusive breastfeeding | | | | | | | | | | | | | | | | | | | | |
| 2. Observes and informs mother about correct position for breastfeeding. | | | | | | | | | | | | | | | | | | | | |
| 3. Checks baby's umbilicus, skin and eyes | | | | | | | | | | | | | | | | | | | | |
| 4. Screens for danger signs in baby | | | | | | | | | | | | | | | | | | | | |
| 5. Advises mother and family members on family planning, immunization and neonatal care | | | | | | | | | | | | | | | | | | | | |
| **Score (out of 5):** | | | | | | | | | | | | | | | | | | | | |
| Competency (Competent / Incompetent)** | | | | | | | | | | | | | | | | | | | | |

**Note:**

- This sheet evaluates four trainees.
- Score of "1" will be given if the trainee performs the skill as per the standards mentioned in the guidelines and if not, a score of "0" will be given.
- For each trainee, 5 independent practices will be scored by trainers.
- ** For trainee to be certified as competent, he/she has to score minimum of 70% (i.e. a score of 3/5) in at least 3 of the 5 skill practice observed by the trainer.

## Annexure 7E

## IDENTIFICATION AND MANAGEMENT OF COMPLICATIONS (KNOWLEDGE-BASED) (INDICATIVE QUESTIONS FOR PREPARING A QUESTIONNAIRE)

**TICK TRUE OR FALSE. EACH QUESTION CARRIES ONE MARK.**

| | | | |
|---|---|---|---|
| 1. | In threatened abortion, when a woman complains of light bleeding and lower abdominal pain, the os is found to be open on vaginal examination. | True | False |
| 2. | A vaginal examination should not be performed in women who have bleeding during pregnancy beyond 12 weeks. | True | False |
| 3. | In cases of secondary PPH, in addition to 20 IU of oxytocin in 500 ml of Ringer lactate, the first dose of antibiotics should be given. | True | False |
| 5. | A catheter should be used to empty the urinary bladder to manage a case of PPH. | True | False |
| 6. | If the blood pressure is more than 140/90 mmHg and there are proteins in the woman's urine, it is a case of pre-eclampsia | True | False |
| 7. | A woman with pre-eclampsia should be advised to restrict her intake of salt and fluid. | True | False |
| 8. | To manage a convulsion during eclampsia, one should administer a magnesium sulphate injection (5 g, deep intramuscular), in each buttock. | True | False |
| 9. | A pregnant woman with anaemia must not be given the therapeutic dosage of IFA in the postpartum period. | True | False |
| 10. | You should suspect urinary tract infection if the pregnant woman complains of fever and /or a burning sensation during micturition. | True | False |
| 11. | Foetal distress is diagnosed if the FHR is less than 120 or more than 160 per minute. | True | False |

**Note:**

For a trainee to be certified as competent, she has to score 70%. Otherwise she will be certified as incompetent.

## Annexure 7F

## CHECKLIST FOR INFECTION PREVENTION PRACTICES

| | | TRAINEE 1 | | | | | TRAINEE 2 | | | | | TRAINEE 3 | | | | | TRAINEE 4 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NAME OF TRAINEE** | | | | | | | | | | | | | | | | | | | | | |
| | Skills supervised on patients | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| **A.** | **CARE OF THE MOTHER AND BABY** | | | | | | | | | | | | | | | | | | | | |
| 1. | Demonstrates proper hand-washing techniques | | | | | | | | | | | | | | | | | | | | |
| 2. | Prepares 0.5% bleach solution correctly | | | | | | | | | | | | | | | | | | | | |
| 3. | Processes instruments (decontamination, cleaning, sterilization/HLD and storage) | | | | | | | | | | | | | | | | | | | | |
| 4. | Prepares clean/HLD gloves | | | | | | | | | | | | | | | | | | | | |
| 5. | Disposes of biomedical waste appropriately | | | | | | | | | | | | | | | | | | | | |
| | **Score (out of 5):** | | | | | | | | | | | | | | | | | | | | |
| | Competency (Competent/ Incompetent)** | | | | | | | | | | | | | | | | | | | | |

Note:

- This sheet evaluates four trainees.
- Score of "1" will be given if the trainee performs the skill as per the standards mentioned in the guidelines and if not, a score of "0" will be given.
- For each trainee, 5 independent practices will be scored by trainers.
- ** For trainee to be certified as competent, he/she has to score minimum of 70% (i.e. a score of 3/5) in at least 3 of the 5 skill practice observed by the trainer.

## Annexure 7G

## PRE-/POST-TEST QUESTIONNAIRE

**Name of participant:** **Present place of posting:**
**Taluka:** **District:**
**Duration of training course: From** **To**
**Total Marks: 30** **Marks obtained:**
**Time: 30 minutes**

Tick ( ✔ ) the correct answer. (Each question carries 1 mark.)

1. Susheela is 24 years old. She comes to you in March and tells you that she is 5 months' pregnant. She says that her last period started a day before Diwali (October 18). Her due date is:

   a) July 17
   b) July 23
   c) July 24
   d) July 25

2. Which of the following is essential for every pregnant woman?

   a) Two doses of tetanus toxoid injection one month apart
   b) Four antenatal check-ups
   c) Early registration
   d) Administration of 100 tablets of IFA
   e) All of the above

3. Which of the following MUST be done for a pregnant woman during every antenatal visit?

   a) Measuring blood pressure, estimating haemoglobin, checking for oedema, stool examination
   b) Measuring blood pressure, estimating haemoglobin, taking weight, checking for oedema, routine urine examination
   c) Measuring blood pressure, estimating haemoglobin, measuring pulse, testing urine for proteins

4. In which of the following conditions MUST a woman be referred to an FRU?

   a) Eclampsia, obstructed labour, foetal distress, severe anaemia, previous Caesarean section
   b) Hypertension, constipation, obstructed labour, bleeding/spotting, severe anaemia
   c) Fever, constipation, breathlessness, nausea and vomiting, severe anaemia

5. Which of the following is the sign of the start of labour?

   a) Feeling of fullness in the abdomen
   b) Bloody/sticky discharge P/V and painful uterine contractions
   c) Bag of waters has not ruptured yet
   d) Bag of waters has ruptured

6. The second stage of labour begins with and ends with:

   a) Onset of labour pains and half dilatation of cervix
   b) Onset of labour pains and full dilatation of cervix
   c) Full dilatation of cervix and delivery of baby
   d) Full dilatation of cervix and delivery of placenta

7. A simplified partograph provides information on:

   a) Pelvic adequacy
   b) Foetal and maternal well-being and progress of labour
   c) Medicines given to the woman and her newborn
   d) Station of the head

8. In active management of the third stage of labour, which uterotonic agent should be used?

   a) Methergine injection, 2 mg
   b) Oxytocin injection/misoprostol tablet
   c) Drotin tablet
   d) Magnesium sulphate injection

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

   a) 20 IU, intramuscular stat
   b) 15 IU in 500 ml of Ringer lactate intravenously
   c) 5 IU, intramuscular stat
   d) 20 IU in 500 ml of Ringer lactate, intravenously

10. What are the dose and route of magnesium sulphate injection for the initial management of eclampsia?

    a) 5 ml (2.5 g), deep intramuscular in each buttock
    b) 10 ml (5 g), deep intramuscular in each buttock
    c) 15 ml (7.5 g), deep intramuscular in each buttock
    d) 20 ml (10 g), deep intramuscular in each buttock

11. Tick True or False. (20 marks)

| | | | | |
|---|---|---|---|---|
| 1. A woman should gain 9–11 kg during her pregnancy. | True | | False | |
| 2. In premature rupture of membranes and puerperal sepsis, the ANM should give the first dose of antibiotics before referral. | True | | False | |
| 3. If the blood pressure of a pregnant woman is more than 140/90 mmHg, check again after 4 hours to confirm hypertension. | True | | False | |
| 4. In case of secondary PPH, in addition to 20 IU of oxytocin in 500 ml of Ringer Lactate, give the first dose of antibiotics. | True | | False | |
| 5. The normal foetal heart rate is between 80–120 beats per minute. | True | | False | |
| 6. The fundal height indicates the progress of the pregnancy and foetal growth. | True | | False | |
| 7. If there is bleeding P/V before 20 weeks, one of the most probable diagnoses is threatened abortion. | True | | False | |
| 8. A pregnant woman with anaemia should receive only 100 tablets of IFA. | True | | False | |
| 9. Constipation and passage of dark stools indicate that the IFA tablets should be immediately stopped as they are not suiting the pregnant woman. | True | | False | |
| 10. If a woman has received TT injections during her previous pregnancy, a single dose of TT is sufficient in the present pregnancy if the interval between the two consecutive pregnancies is less than 3 years. | True | | False | |
| 11. Pre-term labour is defined as labour prior to 40 weeks of gestation. | True | | False | |

| | | | |
|---|---|---|---|
| 12. | The left lateral position is the best position for pregnant women when lying down. | True | False |
| 13. | A mother's first breast milk, called colostrum, should be discarded as it can harm the baby. | True | False |
| 14. | Immediately after the baby is born, it should be bathed with soap and warm water to keep it clean. | True | False |
| 15. | Normally, 6–7 cm dilatation of the cervix is considered full dilatation. | True | False |
| 16. | In the active stage of labour, a vaginal examination must be done every hour. | True | False |
| 17. | The JSY cash benefit scheme is for the mother and the ANM. | True | False |
| 18. | An important element of essential care of the newborn is to maintain a clear airway and breathing. | True | False |
| 19. | Oxytocin injection is the preferred option for the initial management of PPH. | True | False |

**Note:**

For a trainee to be certified as competent, she has to score 70%. Otherwise she will be certified as incompetent.

## ANSWER KEY TO PRE-/POST-TEST QUESTIONNAIRE

| Q.No | Answer |
|---|---|
| 1. | c) July 24 |
| 2. | e) All of the above |
| 3. | b) Measuring blood pressure, estimating haemoglobin, taking weight, checking for oedema, routine urine examination |
| 4. | a) Eclampsia, obstructed labour, foetal distress, severe anaemia, previous caesarean section |
| 5. | b) Bloody/sticky discharge P/V and painful uterine contractions |
| 6. | c) Full dilatation of cervix and delivery of baby |
| 7. | b) Foetal and maternal well-being and progress of labour |
| 8. | b) Oxytocin injection/misoprostol tablet |
| 9. | d) 20 IU in 500 ml of Ringer lactate intravenously |
| 10. | b) 10 ml (5 g), deep intramuscular in each buttock |
| 11.1 | True |
| 11.2 | True |
| 11.3 | True |
| 11.4 | True |
| 11.5 | False |
| 11.6 | True |
| 11.7 | True |
| 11.8 | False |
| 11.9 | False |
| 11.10 | True |
| 11.11 | False |
| 11.12 | True |
| 11.13 | False |
| 11.14 | False |
| 11.15 | False |
| 11.16 | False |
| 11.17 | True |
| 11.18 | True |
| 11.19 | True |
| 11.20 | True |

# SESSION PLANS

## DAY 1

| SESSION 1 |
|---|
| 1. Welcome and Introduction to SBA training package |
| 1.a OVERVIEW OF MATERNAL HEALTH SCENARIO IN INDIA |
| 1.b INFECTION PREVENTION |

**DURATION: 6 h 30 min**

**PREPARATION**

Keep the following ready:

- *Attendance register
- Pretest training questionnaire
- Material for trainees' introductory game
- Folders with notebook, pen, agenda and training package (Guidelines and Handbook) and experience record form, for each trainee
- *Flip charts, markers, tape, adhesive, clips, staplers and eraser
- Plastic bucket/tub, mug, bleaching powder in a closed plastic container, wooden stirrer, teaspoon, 1 litre water, apron and utility gloves
- Cheatle forceps, toothbrush, detergent powder, syringe and needle, gloves, mask, apron, cap, eye wear/goggles, leggings/footwear, antiseptic solution, puncture-proof box, hub cutter and needle destroyer, soap, soap dish, towel, chalk powder, kidney tray and scissors

* These items are required every day during the training.

**Reference:**

- Read the Guidelines (Introduction and Infection Prevention in Module 3) and Handbook (Checklists 5.1 and 5.2) thoroughly before you take the session.

**Logistics:**

- Co-ordinate in advance with the District CMO/DPMU regarding the accommodation of trainees and same may be provided to the trainee on their arrival. Inform the officials and concerned hospital department about the training schedule and their role in the training programme.

## SESSION 1: WELCOME AND INTRODUCTION TO SBA TRAINING PACKAGE

**Venue: Lecture room**

### Step 1

#### Activity 1

- Welcome the trainees to the training facility. Introduce yourself, your co-trainers and support staff. Introduce the trainees to each other, using a warm-up exercise. Even if the trainees know each other, the trainers need to become acquainted with them.
- In order to facilitate informal introductions, split the group into pairs. Pair up the trainers/organizers, too. Tell the pairs that they will be given three minutes to find out the following about each other:
  - Name
  - Place of work
  - Number of years of work
  - Hobby
  - To start the process of introduction, introduce your partner. Allow the members of every pair to introduce their partners very briefly. Use the flip chart to note down and add up the number of years of experience of all the trainees as they introduce themselves.
  - After the introductions, encourage the trainees by saying that they have a wealth of experience between them. Mention the total number of years of experience that all the trainees together have. Tell them that clearly there is much that every individual can share with and learn from others in the group.
- Explain that participation is crucial to the success of the training. Each trainee is expected to be on time and participate actively in all the sessions. Through exercises, role-plays and practical teaching, the trainees will have the opportunity to try out and improve their skills. They should consider each other as well as the trainers as resource persons.
- Distribute the folder containing the course material. Ask the trainees to fill the experience record form **(Annexure-4)**, which is in their folder, and return it to you. Ask them to sign the attendance register.

### Step 2

#### Trainees' expectations

- Ask what the trainees think they will learn. Write down their needs and expectations on a flip chart and paste it on the wall. The flip chart can be referred to periodically and at the end of the training to see if the trainees' needs have been met.
- Identify the expectations that will not be met during the training. Do not spend more than five minutes discussing expectations which are unrelated to the training programme.

### Step 3

#### Activity 2

#### Pre-test questionnaire

- Tell the trainees that they will be required to answer a pre-test questionnaire which will help them as well as the trainers gauge the level of their knowledge prior to training
- Explain that it will also help the trainers to identify the areas that would need reinforcement during the sessions.
- Tell them that they will undergo a similar assessment at the end of the training, which will be used to gauge their gain in knowledge through the training.

## SESSION Ia: OVERVIEW OF MATERNAL HEALTH SCENARIO IN INDIA

### Venue: Lecture room

**Step I**

- Project the presentation for **Session I.a titled:"Maternal Health Scenario in India"**.
- Discuss with the trainees contents of presentation regarding:
  - Maternal mortality-facts, causes and delays.
  - Identify the factors that lead to maternal deaths.
  - Sensitize the trainees on their role as SBAs in prevention of maternal mortality.
- Inform the trainees on the GoI's policy decision, empowering the ANMs by permitting them to undertake certain life saving measures, drugs, procedures etc after this training.
- Interact with them on the presented matter.

## SESSION Ib: INFECTION PREVENTION

### Venue: Lecture room

| PURPOSE / OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| • At the end of session, trainee is expected to be aware of common sources of infection, principles and methods of infection prevention. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 1b).<br>• Demonstration of<br>▪ Steps of washing hands and wearing clean gloves<br>▪ Preparation of 0.5% chlorine<br>▪ Decontamination, cleaning, autoclaving and HLD<br>▪ Handling of sharps<br>• Supervised practice at the teaching site. | • Module 3 "Infection prevention" of the SBA guidelines.<br>• Skill checklist 5.a and 5.b, as given in trainee's handbook.<br>• Demonstration material:<br>▪ Plastic bucket/tub, mug, bleaching powder in a closed plastic container, wooden stirrer, teaspoon, 1 litre water, apron and utility gloves<br>▪ Cheatle forceps, toothbrush, detergent powder, syringe and needle, gloves, mask, apron, cap, eye wear/goggles, leggings/ footwear, antiseptic solution, puncture-proof box, hub cutter, and needle destroyer, soap, soap dish, towel, chalk powder, kidney tray and scissors |

**Step 1:**

- **Inform the trainee's objectives of this session, as given in Box-1.b.1.**

**Box-1.b.1**

**OBJECTIVES:** By the end of this session, the trainee will be able:

- To enumerate the sources of infection.
- To explain why infection should be prevented.
- To enumerate the principles of prevention of infection.
- To explain standard precautions.
- To demonstrate how to prepare 0.5% chlorine solution.
- To demonstrate how to prepare clean and HLD instruments/gloves.
- To explain how to dispose of biomedical waste.
- To demonstrate how to properly handle contaminated waste including sharps.

**Step 2:**

- Project the presentation titled **"Session 1b: Infection Prevention practices"** for the trainees.
- Generate a discussion among trainees, on infection prevention knowledge and practices adopted by them, on the points given below (Box 1.b.2). The same have also been given in the presentation. Note down the responses on the flip chart.

**Box 1.b.2**

- Common Sources of Infection.
- Importance of Infection prevention practices.
- What are the general infection prevention practices adopted by them especially in regard to Labor Room and OT, at their health facility.

- Give an introduction to infection prevention and explain the sources of infection, principles of prevention and standard precautions. Utilize the presentation 1b for the same.

**Step 3:**

**Demonstration and Practice**

- Demonstrate the following skills using **Guidelines, Skill Checklist 5.a and 5.b as in the handbook,** Pictures/Posters regarding infection prevention, Videos (if available).
  - Steps of washing hands and wearing clean gloves
  - Preparation of 0.5% chlorine
  - Decontamination, cleaning, autoclaving and HLD
  - Handling of sharps
- Ask the trainees to come forward and perform the above mentioned infection prevention practices as demonstrated by you. Remember:
  - Ask the trainees (who are not performing the skill) to carefully observe their colleagues performing the procedures. After a trainee has finished performing a procedure, ask for comments/suggestions.
  - Encourage involvement in skill practice by all the trainees.
  - Congratulate the trainees on their performance; correct their mistakes by re-demonstrating the correct steps using checklists 5.1 and 5.2 in the Handbook.

**Step 4:**

**Simulation exercise (Box 1.b.3)**

**Box 1.b.3**

**Exercise:**

- Preparation: Mix various types of waste from hospital, such as cotton, needles, syringes, blood-stained gauze and cotton, cigarettes and fruit peels. Give the trainees three colour-coded bins (blue, red, yellow).
- Ask the trainees to separate the waste into infected and non-infected waste.

- The exercise will demonstrate that nearly 90% of waste from hospitals is non-infected and only 10% is infected. It is, therefore, important to segregate the waste in the appropriate bins at the point of generation of the waste.

**Step 5:**

**End of the session.**

- Emphasize the following key messages and ensure that trainees have understood the steps for performing the critical skills as given below in box 1.b.4:

**Box: 1.b.4**

**Key Messages:**

- Hand-washing is essential for preventing infections.
- Always wear gloves especially where there is a risk of touching blood, body fluids, secretions, excretions or contaminated items.
- Decontamination : 0.5% bleach solution is the least expensive and the most rapid acting and effective agent to use for decontamination.
- Proper handling of contaminated waste minimizes the spread of infection to healthcare personnel and to the local community.
- Proper handling means:
  - Wearing utility gloves
  - Transporting solid contaminated waste to the disposal site in covered containers
  - Disposing of all sharp items in puncture-resistant containers
  - Carefully pouring liquid waste down a drain or flushable toilet
  - Burning or burying contaminated solid waste
  - Washing containers, gloves and hands after disposal of infectious waste

Critical Skills:

- Demonstrates the proper technique of washing hands.
- Prepares 0.5% bleach solution correctly.
- Processes instruments (decontamination, cleaning, sterilization /HLD and storage).
- Prepares clean/HLD gloves.
- Disposes of biomedical waste appropriately.

- At end of discussion/presentation discuss the area of improvement in infection prevention and waste management at their health facility and also ask them if they have any query and solve the same.
- Assign one of the trainees the task of summarizing the first day's session, on the next day.
- Tell the trainees to read and come prepared for the next day's session, as per the agenda.
- Lastly, discuss the logistics, accommodation and meal arrangements and take the trainees on a tour of the facility and labor-room.

| SESSION II | |
|---|---|
| II. | Recapitulation of Day-1 |
| II.a | ANC |
| II.b | ANC- History Taking |
| II.c | ANC- General Examination |
| II.d | ANC- Abdominal examination Wrap up and assigning of tasks |

**DURATION: 6 h 30 min**

## SESSION 11.a: INTRODUCTION TO ANC

### Venue: Lecture room

| PURPOSE / OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To explain the importance of an antenatal check-up and the components of quality ANC<br>• To explain the need for early registration of pregnancy<br>• To demonstrate the use of the pregnancy detection kit<br>• To describe the number and timing of antenatal check-ups<br>• To estimate the number of pregnancies in a year in their work areas<br>• To describe how they would track all pregnant women along with web based tracking.<br>• To fill the Maternal and Child Protection Card.<br>• Record keeping at the SCs in their ANC register.<br>• Preparations for an ANC. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 2.a).<br>• Demonstration on "how to use pregnancy detection kit".<br>• Supervised practice at the teaching site.<br>• Calculation regarding "estimation of pregnancy".<br>• Estimation of duration of pregnancy and EDD. | • Module 1 "Antenatal Care" of the SBA guidelines.<br>• Skill checklist 1.1, as given in trainee's handbook.<br>• Demonstration material:<br>▪ Urine sample of pregnant women.<br>▪ Urine sample of non pregnant women.<br>▪ Pregnancy detection kit.<br>▪ Dropper.<br>• Maternal and Child Protection Card.<br>• Formats of Web based Tracking of Pregnancy. |

**Step 1**

- Ask the trainee who has been assigned the task of summarizing the previous day's session to come forward and present the summary in 15 minutes.
- Ask the others to mention anything that has been left out in the summary.
- Compliment and thank the trainee who summarized the session.

**Step 2**

- Assess the trainees on Antenatal care by generating a discussion on antenatal care points as given in box 2.a.1. Note down the responses on the flip chart.

**Box 2.a.1**

Ask the trainees what they understand/or practice on:

- Importance of Antenatal Care.
- Quality parameters during ANC.
- When do they usually get to know the presence of pregnant woman in their work area and register the same?
- Preparation for an Ante natal Check up.
- Ask the trainees how many pregnant women they usually register in a month/year.
- How do they detect pregnancy in their area and have they used pregnancy detection kit.
- Tracking of missed and left out cases of ANC.

- Give an introduction to the importance of ANC. Emphasize quality ANC, early registration, detection of pregnancy and preparations needed to be made before hand for an ANC examination. Speak about the estimation of the number of pregnancies in an area, and the importance of tracking missed and left out cases of ANC. **(Use presentation 2a and refer to Guidelines Module 1:Antenatal care).**
- Points to emphasize:
  - Inform them that according to the GoI guidelines, every pregnant woman should make at least four visits for ANC. This includes the first visit /registration.
  - Importance of early registration of pregnancy and the timing of the first visit.
  - Emphasize that "complications can develop in any pregnancy and as such all pregnancy needs proper check up as laid down in the guidelines. For this reason, ANMs must register and follow up all pregnant women in their work areas as early as possible.
  - Essential and desirable components of ANC.
  - Estimation of total no. of pregnancy in their areas.
  - How community workers, such as anganwadi workers (AWWs) and accredited social health activists (ASHAs) can help the trainee in identifying and tracking of pregnant women in her work area.
  - Preparation needed to make before getting ready for an ANC examination.

**Step 3**

**Exercise for estimation of the number of pregnancies and deliveries annually**

- Instructions to the trainers:
  - Divide the trainees into two groups and read the exercise, as given in Box 2.a.2 to each group.
  - Ask each group to solve the exercise on calculation of the expected number of pregnant women.
  - Give each group 5 minutes time to solve each exercise.
  - Facilitate the groups while they are making the calculations.
  - After 5 min, ask the groups their response. The correct response is given at the end of each exercise.
  - Discuss the response and method of estimation of pregnancy with the trainees.

**Box 2.a.2**

**Group 1:**

Exercise: If the population of your SC is 6000 and the birth rate of your district is 25, what will be the expected number of pregnancies in your SC in a year?

Answer: Birth rate 25/1000 population/year
Population under your SC is 6000
Therefore, expected no. of live births = 25* 6000/1000=150 births.
Correction factor is 10% of 150 = 15
Therefore, expected no. of pregnancies in a year = 150 + 15 = 165.

**Group 2:**

Exercise: If the population of your SC is 7000 and the birth rate of your district is 25, what will be the expected number of pregnancies in your SC in a year?

Answer: Birth rate 25/1000 population/year
Population under your SC is 7000
Therefore, expected no. of live births = 25* 7000/1000=175 births.
Correction factor is 10% of 150 = 17
Therefore, expected no. of pregnancies in a year = 175 + 17 = 192.

**Step 4**

**Demonstration on "Steps for detection of pregnancy using Pregnancy Test Kits"**

- Show the trainees "Pregnancy detection kit".
- Demonstrate the detection of pregnancy by using the kit and urine samples of pregnant and non pregnant woman. Use checklist 1.4 of SBA handbook for demonstrating use of pregnancy detection kit.
- Ask one or two of the trainees to come forward and demonstrate.
- After 1-2 trainees have demonstrated the use of the kit, congratulate them and correct them if they have made any mistakes.

**Step 5**

**Tracking of all pregnant women**

In step 4, we learnt how to estimate the number of pregnancies likely to occur in the catchment area of the sub-centre and give an idea of the workload that an ANM can expect during the year. In Step 5, the technique for detection of pregnancy was explained. It is important for the health provider to ensure that the pregnant woman receives all the ANC check-ups, prior to the expected date of delivery. In this direction, and to ensure a better coverage, the Government of India has put in place a name based tracking system whereby all the pregnant women and children can be tracked and followed-up for their ANCs and immunization. The system envisages that all pregnant women are registered within 12 weeks and get the first Ante- Natal Care. Subsequently, the women should also receive their other ante-natal care check-ups (ANCs) before institutional delivery. The system also envisages tracking of post-natal care (PNCs) check-ups along-with receiving of complete immunization of the children as per the National Immunization Schedule. The information on the services rendered along with identification and contact details of pregnant women and children etc is to be recorded in the relevant registers and reported in the specified format given at **Annexure -7** in the hand-book. This information is to be reported on a monthly basis to the block headquarters/block PHC from where it will be transmitted to the district headquarters. You may also refer to the operational guidelines for further details on the Web- Portal. To further strengthen the tracking a web based system is being developed that will generate a work plan for the ANM and also assist in tracking the drop-outs in ANC, PNC during pregnancy and after the child birth along with immunization for children.

**Step 6**

**Instructions for filling of Maternal and Child Protection Card**

Mother and Child Protection Card have been developed jointly by the Ministry of Health and Family Welfare (MoHFW) and Ministry of Women and Child Development (MoWCD) to ensure uniformity in record keeping. This card should be duly completed for every woman registered by the ANMs/ LHVs/ SNs. The case record should be handed over to the woman. She should be instructed to bring this card with her during all subsequent check-ups/visits and also to carry it along with her at the time of delivery. This will also help the service provider to know the details of previous ANCs/PNCs both for routine and emergency care.

Ask the trainees to see Mother and Child Protection Card given at **Annexure - 6** in the handbook. Explain to them how to fill the relevant columns concerning ANC/ PNC, Institutional delivery, Immunization etc. The information contained in the card should also be recorded in the antenatal register.

- At end of discussion/presentation, discuss with the trainees, what are the activity they would like to include/add in their work area and also ask them for their queries and solve the same.

## SESSION 11.b: ANTENATAL HISTORY-TAKING

**Venue: Lecture room**

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To take a detailed history of a pregnant woman—asking for symptoms during the pregnancy; history of the previous pregnancies, family history of systemic illnesses and history of drug intake or allergies. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 2.b).<br>• Calculating "expected date of delivery"<br>• Supervised practice at the teaching site. | • Module 1 "Antenatal Care" of the SBA guidelines.<br>• Skill checklist 1.1, as given in trainee's handbook.<br>• Materials required for an History taking :<br>▪ Maternal and Child protection Card.<br>▪ Calendar |

**Step 1**

- Ask one of the trainees to recall the preparations needed to make before an ANC examination.
- Ask other trainees to add on the points missed by the trainee.
- Explain to the group that before starting an antenatal check-up, it is very important to make preparations in advance so that all the instruments/equipment required for the check-up are ready.
- Emphasize the need for the following during history-taking:
  - Ensuring a calm and quiet atmosphere so that the woman is relaxed and comfortable.
  - Maintaining privacy and confidentiality.
  - Asking questions in such a way that the woman is not alarmed or intimidated.
  - Recording all the facts correctly and neatly in the antenatal card.
  - Highlighting any abnormal findings.
- Remind them that they have to ask the pregnant women and fill all the information as mentioned in the Maternal and Child Protection Card.

**Step 2**

- Ask the trainees what questions they ask a pregnant woman during history-taking and list all of them on the board/flip chart. Discuss the rationale for asking these questions.
- Ask the trainees to list the symptoms that the pregnant women who come to them usually complain of.
- Ask them to name some of the complications that they have encountered.
- Draw a line in the middle of the flip chart and note down the common symptoms mentioned on one side and the complications on the other side.
- Ask the trainees how they calculate a pregnant woman's EDD. Note down their responses on the flip chart.

**Step 3**

- Use module 1 of the guidelines along with the presentation 2 a& 2b, to discuss with the trainees, that during history taking, besides asking for name, age, parity etc., the following should be enquired about. Tell them the reasons why it is important to do so.
  - Age of the woman.
  - Order of pregnancy.
  - Birth interval.

- Symptoms that are normal in a pregnancy.
- Symptoms that indicate complications.
- Obstetric history.
- Medical History.
- Family history.

**Step 4**

- Refer to the points listed on the flipchart and list the points trainees have missed on the board/flip chart and discuss the importance of the questions they have not mentioned. (Refer to Guidelines Module 1: checklist 1.1.

**Step 5**

**Calculating Expected Date of Delivery**

- Instructions to the trainers:
  - Read the exercise, as given in Box 2.b.1 for the trainees.
  - Facilitate them while they are making the calculations. Don't spend more than 5 min on this exercise. Correct answers are given at the end of each exercise.
  - Congratulate those who have got it right. As for those who got it wrong, tell them where they went wrong and ask them to calculate again, explaining while they do so.

**Box 2.b.1**

**Exercise 1:**

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

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

**Exercise 2:**

Laxmi, who is 18 years old, says she got her last period on January 2. She wants to know when she will deliver. Calculate her due date.

**Answer:** 9 calendar months + 7 days, i.e. September 9

**Step 6**

Discuss with the trainees about the "Indications for referral to the PHC for ANC and delivery on the basis of past obstetric and medical history.

**Step 7**

At end of discussion/presentation, discuss with the trainees, what new knowledge have they gained from this session. Note their responses and correct them if required. Also ask them for their query and solve the same.

## SESSION 11.c: GENERAL EXAMINATION

### Venue: Lecture room

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To conduct a general physical examination, including checking for pallor and oedema, measuring the pulse, blood pressure, weight and respiratory rate | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 2.c).<br>• Demonstration<br>• Supervised practice at the teaching site. | • Module 1 "Antenatal Care" of the SBA guidelines.<br>• Skill checklist 1.2, as given in trainee's handbook.<br>• Materials required for a General Examination :<br>▪ Maternal and Child Protection Card.<br>▪ Weighing Scale.<br>▪ Blood Pressure Apparatus.<br>▪ Stethoscope.<br>▪ Dummy. |

**Step 1**

- Inform the trainees the objectives of this session, as listed above.
- Ask the trainees what are general examinations they routinely conduct during an Ante natal Check up. Note their responses on the flip chart.

**Step 2**

**Demonstration**

- Ask volunteers to come forward and demonstrate how they check for pallor and oedema, measure the pulse, blood pressure and weight, conduct a breast examination and check the respiratory rate. Tell them they can demonstrate on themselves, co-trainees or a dummy.
- Observe them carefully and also ask other trainees to observe each other.
- After the volunteers have performed the tasks, trainer should demonstrate the correct way of conducting each examination (using checklist 1.2, from handbook). Also use presentation 2.c for the same.
- Ask the trainees to mention anything that the volunteers have missed. Ask them whether there is any difference between the way the procedures should be performed and the way they have been performing them. Note down their responses.
- Inform the trainees, the importance of filling the findings of general examination in the MCH card.

**Step 3**

**Skill practice**

- Ask other volunteers to conduct a general examination on their co-trainees with the help of checklist 1.2.
- Observe them carefully and help them carry out each procedure correctly, as per the steps defined in the checklist.
- Ask the trainees if they think that the new methods they have learnt will be useful in their practice. Note down their responses. Ask them whether they will have any trouble performing the procedures. Note down their responses and try to solve their problems, if possible.

## SESSION 11.d: ABDOMINAL EXAMINATION

### Venue: Lecture room

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To conduct an abdominal examination on a pregnant woman, i.e. measure the fundal height; determine the foetal lie and presentation, listen to the foetal heart sounds (FHS) and count the FHR, and conduct a breast examination. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 2.d).<br>• Demonstration<br>• Supervised practice at the teaching site. | • Module 1 "Antenatal Care" of the SBA guidelines.<br>• Skill checklist 1.3, as given in trainee's handbook.<br>• Materials required for a general examination :<br>▪ Maternal and Child protection Card.<br>▪ Models/dummies<br>▪ CD;<br>▪ Charts/Poster for Abdominal examination.<br>▪ examination table;<br>▪ stepping stool;<br>▪ screen/curtain;<br>▪ inch tape;<br>▪ foetoscope;<br>▪ thermometer;<br>▪ watch with seconds hand;<br>▪ Sterile gloves; |

**Step 1**

- Inform the trainees the objectives of this session, as listed above.
- Ask the trainees what routine abdominal examinations they routinely conduct during an Ante natal Check up and enumerate the steps. Note their responses on the flip chart.
- Discuss with the trainees, importance of abdominal examination, using presentation 2.d and Module 1 of the guidelines. Emphasize to them:
  - All steps of abdominal examination.
  - How to prepare for conducting an abdominal examination.
  - Importance of measuring Fundal height and reasons for disparity with gestation age.
  - Importance of abdominal grips.
  - Recording of FHS.

**Step 2**

**Demonstration of Fundal Height (FH )**

- Ask volunteers to come forward and demonstrate on the dummy how they would conduct an abdominal examination to determine the following. Observe them carefully.
  - Fundal height
  - Foetal lie and presentation,
  - Foetal Heart Sounds and count the FHR,
  - Determine whether it is a single/multiple pregnancy.

- If they perform the steps correctly, congratulate them. If not, then demonstrate the correct way of performing an abdominal examination, using checklist 1.3 from the handbook. You can demonstrate these steps using a female pelvic model and doll.
- Now ask each trainee to perform the abdominal examination on the dummy, using checklist 1.3. Encourage them as they perform.

**Step 3**

- Inform the trainees, the importance of filling the findings of abdominal examination in the MCH card and how to fill up the same.
- At end of discussion/demonstration, discuss with the trainees, how will the skills learnt during this session, help them during the ANC they normally provide. Also ask them for any query they might be having and solve the same.

**Closure of session 2**

- Wrap up the session and ask the trainees what are the critical skills they have learnt in this session. Ensure that trainees summarize all the skills as mentioned in Box 2.d., given below:

**Box 2.d**

**Critical Skills**

- EDD calculation.
- History taking including obstetric history, and history of systemic illnesses and of drug allergies
- Check the blood pressure, check for pallor and oedema, record weight
- Conducting abdominal examination to determine the fundal height and foetal lie and presentation
- Count the Foetal Heart Rate (FHR)
- Identify foetal complications

- Ask them to read Guidelines Module 1: ANC counseling, laboratory investigations and care during the first and second stages of labour.
- Assign one of the trainees the task of summarizing the second day's session.

## DAY 3

| SESSION |
|---|
| III. Recapitulation of Day-2 |
| III.a ANC- Laboratory Investigations |
| III.b ANC- Interventions |
| III.c Counseling and Symptoms & Signs during pregnancy |
| III d. Care during labor- Assessment, Supportive Care and Vaginal Examination |
| Wrap up and assigning of tasks |

**DURATION: 5 h 45 min**

## SESSION III.a: ANC—LABORATORY INVESTIGATIONS

### Venue: Lecture Room + Laboratory room

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To list the laboratory investigations to be conducted for a pregnant woman.<br>• To demonstrate how to conduct laboratory investigations, such as haemoglobin estimation and testing of urine for sugar and proteins. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 3.a).<br>• Visit to laboratory room.<br>• Demonstration.<br>• Supervised practice at the teaching site. | • Module 1 of SBA guidelines.<br>• Checklist 1.4 from the Handbook.<br>• Laboratory investigations: test-tubes, test-tube holder, burner, reagents—acetic acid and Benedict solution, Uristix and Diastix strips, container to dispose of used reagents, small bottles for urine sample collection, Haemoglobinometer, needles, hub cutter, cotton, spirit swabs, match box. |

**Step 1**

- Ask the trainee who has been assigned the task of summarizing the previous day's session to come forward and present the summary in 15 minutes.
- Ask the others to mention anything that has been left out in the summary.
- Compliment and thank the trainee who summarized the session.
- Discuss with the trainees what laboratory investigations they routinely perform during an Ante natal visit. Also discuss with them, when and how do they perform these investigations and what are its interpretations. Note down their responses on the flip chart.

**Step 2**

- Inform the trainees that they will be visiting the laboratory to see and learn about the different investigations that have to be done for every pregnant woman. Explain the importance of each investigation. (Use presentation 3a and refer to Guidelines Module 1: Laboratory investigations.).

**Step 3**

**Demonstration and practice**

- Explain how urine and blood investigation is conducted. (Use checklist 1.4 and refer to Guidelines Module 1: Laboratory investigations.) Encourage the trainees to clarify any doubts they may have.
- Demonstrate (or ask the laboratory technician to demonstrate) how to carry out hemoglobin estimation and examine the urine for albumin and sugar.
- Discuss with them how the steps of laboratory examination differ from what they routinely perform at their center. Ensure that all their queries are solved.
- Let the trainees practice on samples in the laboratory.
- Emphasize that Hb and urine investigation should be conducted at each ANC visit and explain its importance.

**Step 4**

- Inform the trainees, that they have to fill the results of laboratory investigation in the maternal and child protection card.
- Emphasize to them the importance of filling this information in the MCH card.
- Ask the trainees, if they have any doubts. If yes, then solve the same.
- Ask the trainees to assemble in lecture room for the next session.

## SESSION III.b: ANC—ANC Interventions

### Venue: Lecture room

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To describe the essential interventions to be carried out for every pregnant woman. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 3.b).<br>• Video on ANC | • Module 1 of SBA guidelines.<br>• Skill Checklist 1.5, as given in the handbook.<br>• Posters/ppt on diagnosis of anemia. |

**Step 1**

- Start a discussion on the interventions that must be carried out for a pregnant woman when she comes for her antenatal check-ups. Note down the trainees' responses on a flip chart.
- Find out from the trainees, whether their health center is located in the area endemic for malaria. If so, discuss what prophylactic measures they take during ante natal care of pregnant women.

**Step 2**

- Introduce the essential interventions to be carried out for every pregnant woman. Emphasize that these interventions are important for preventing dangerous conditions, such as anaemia, tetanus and malaria. (Use presentation 3.b.).
- Emphasize and inform the trainees:
  - Importance of giving IFA supplementation and TT injections, to every pregnant woman.
  - Importance of malaria prophylaxis for women residing in areas endemic for malaria.
  - Doses of IFA tablets for prophylaxis and therapeutic treatment of anaemia.
  - Various myths/misconceptions associated with intake of IFA tablets.
  - How they can convince and motivate women to take IFA tablets.
- Discuss with the trainees, how the essential interventions as discussed by you, were different from those they usually practiced.
- Ask the trainees, if they have any doubts. If yes, then solve the same.

## SESSION III.c: COUNSELING AND SIGNS AND SYMPTOMS OF PREGNANCY

**Venue: Lecture room**

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To demonstrate how to counsel a pregnant woman on planning and preparing for birth (birth preparedness), on recognizing danger signs during pregnancy, labour and after delivery/abortion (complication readiness), and on diet, rest, infant feeding, sex during pregnancy, domestic violence and contraception.<br>• To understand symptoms and signs during pregnancy, probable diagnoses and action to be taken at the SCs.<br>• To understand conditions which need referral to PHC/FRUs. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 3.c(i)& 3c(ii).<br>• Role play. | • Module 1 of SBA guidelines.<br>• Skill Checklist 1.5, as given in the handbook.<br>• Role plays<br>• MCH Card.<br>• Models/dummies, CD, examination table, stepping stool, screen/curtain, inch tape, foetoscope, thermometer, watch with seconds hand, sterile gloves, 0.5% bleach solution in a plastic container |

**Step 1**

- Ask the trainees how and on what points they counsel the pregnant women during Ante natal care. Note down the responses given by the trainees on flip chart.
- Explain the importance of counselling on birth preparedness, complication readiness, signs of labour, diet, rest, infant feeding, sex during pregnancy, domestic violence and contraception.
- Emphasize that while counselling a pregnant woman, one should make sure one treats her with respect, and maintains her privacy and confidentiality. (Use presentation 3c(i) and refer to Guidelines Module 1 for Micro birth planning and counseling and Module 3 for Counseling and supportive environment – Rights of a Woman.)

**Step 2**

**Symptoms and signs during pregnancy, probable diagnoses and action to be taken at the SC**

- Ask the trainees what are the usual complaints of the pregnant women, for which they come to them for help. Note down their responses on flip chart.
- Discuss symptoms and signs during pregnancy and the probable diagnoses and action to be taken. (Use presentation 3c(ii) and refer to Guidelines Module 1: Table 1.). Help the trainees; in identifying which signs and symptoms they missed during the discussion.

**Step 3**

- Ask the trainees to list the conditions for which a woman needs referral to a PHC or an FRU. Discuss the conditions which were missed by the trainee and paste it on the wall. **(Use presentation 2b.)**

  **Note:** It is sufficient if the trainees can identify which cases can be managed by them through routine care, which require special care, and which require referral to a higher facility for further investigation and care. Emphasize the importance of identifying cases that need to be referred to a higher facility. This will be covered further when they learn to identify and manage the complications of pregnancy, labour and the postpartum period in later sessions as well.

**Step 4**

- Explain to the trainees that they will practice history-taking and counselling through role-plays. Tell them that while initially, they will carry out these activities through role-plays with their co-trainers in the classroom, later they will have to deal with pregnant women in the clinic and hospital setting.
- Ask for volunteers for role play: one as a pregnant women and other as a health care worker. For the next role play ask for different volunteer.
- Instruct the volunteer:
  - Listen to the role play of the case attentively, so as not to miss any points.
  - They will be given 5 minutes to prepare for role play.
  - To focus on the topic, speak loudly and clearly, use local language and complete the role play within a stipulated time of 10 minute.
  - They can use the relevant checklist, as given in handbook for history taking.
- Instruct rest of the trainees to closely observe the volunteers and list the points missed by the trainees at the end of individual role play.
- Ensure that all the items required for ANC especially MCH card, BP apparatus etc are available to the trainees.
- Interrupt if the players are having tremendous difficulty or have strayed from the purpose of the role-play.
- Points which have to be observed/ emphasized have been given in relevant role plays. Trainer has to ensure that relevant points have been highlighted. Answers to role plays have also been given in the end of role play exercise.
- At the end of the role-play, thank the players. Ensure that the feedback offered by the rest of the group is supportive. First discuss the aspects that were tackled well. Then discuss those which could be improved.
- Ask the trainees, if they have any doubts. If yes, then solve the same.

**ROLE PLAYS**

**Role Play: 1**

- Your name is Babita. You are a 18 year old married girl. You have become pregnant for the first time. You are 5 months' pregnant and have come to the health-care provider for your first antenatal check-up. You have a backache and are feeling very weak. You do not have any other health problem. Your father has high blood pressure. You do not take tobacco or alcohol. You have come to the health-care provider because of the weakness and backache. You also feel some movements in your lower abdomen.
- **Instructions for the volunteer acting as a health worker:** You will have to take history and provide ANC interventions and counselling.

- **Points to be noted and discussed after role play:**
  - How did the health care provider initiate communication with the client?
  - While taking the history and counselling Babita on diet and rest, which relevant points did she elicit and the ones she missed?
  - On the basis of the history, would Babita require routine or specialized ANC and why?
  - What more could be done while counselling Babita?
  - Has the Mother and Child Protection Card been duly filled?

**Answers:** Babita should undergo routine ANC, with special attention to her blood pressure as she is a young primi gravida and her father has h/o hypertension. She should be counseled about diet and rest and taking IFA tablets. The health-care provider should emphasize the importance of regular antenatal check-ups, birth preparedness and complication readiness. As Babita is young primigravida, she should be advised to have her delivery at the health facility.

**Role Play: 2**

- Your name is Lajwanti. You are a 24-year-old married woman. You have become pregnant for the sixth time. You got your last period about 8 months ago. You have painless vaginal bleeding while sleeping. You have two daughters of 8 and 5 years, respectively. You had 2 spontaneous abortions and 1 stillbirth three years ago at home. You do not have any other health problem.

  Lajwanti refuses to go to the health centre for delivery. Counsel her to opt for an institutional delivery.

- **Instructions for the volunteer acting as a health worker:** You will have to take history and provide ANC interventions and counselling.

- **Points to be noted and discussed after role play:**

  - How did the health-care provider initiate communication with the client?
  - While taking the history and counselling Lajwanti, which relevant points did she elicit and or miss?
  - On the basis of the history, would Lajwanti require routine or specialized ANC and why?
  - How would you convince Lajwanti to go for an institutional delivery?
  - Has the Mother and Child Protection Card been duly filled.

**Answers:** Lajwanti needs specialized ANC as she is a multigravida with a bad obstetric history. She should go to the health facility because of the painless vaginal bleeding which is a sign of APH. She should be advised to have all her antenatal check-ups and delivery at the health facility preferably a FRU under the supervision of a MO. Lajwanti should be counselled on birth preparedness and complication readiness for her baby's and her own well-being. She should also be counselled on family planning and taking IFA and good diet. She should have a blood donor identified as she has APH.

**Role Play : 3**

- Your name is Rukhsana. You are a 30-year-old married woman. You have become pregnant for the fifth time. You got your last period about 6 months ago. You feel very weak and have difficulty in breathing. Sometimes you feel as though you are having a blackout and cannot see things properly. You have no live children and have had spontaneous abortions thrice. The last abortion was two years ago. You had a premature birth at home and the baby was very small. He died after 6 days.
- **Instructions for the volunteer acting as a health worker:** You will have to take history and provide ANC interventions and counselling.

- **Points to be noted and discussed after role play:**

  - How did the health-care provider initiate communication with the client?
  - While taking the history and counselling Rukhsana, which relevant points did she elicit or miss?
  - On the basis of the history, would Rukhsana require routine or specialized ANC and why?
  - What could one inform Rukhsana about while counselling her?
  - Has the Mother and Child Protection Card been duly filled?

**Answers:** Rukhsana needs specialized ANC as she is a multigravida with a very bad obstetric history. Since she is also having difficulty breathing and is a multigravida, she may be anaemic too, she should be advised to have her antenatal check-ups regularly and delivery at the FRU. She should be counselled to register herself at the PHC\ FRU and have a complete check-up done. Emphasis should be laid on the appropriate diet and rest, and the need to have an institutional delivery, preferably at a FRU where a neonatal nursery is available.

**Role Play: 4**

Your name is Saraswati. You are a 22-year-old married woman. You have one son, who is 3 years old. The first delivery took place at home. Now you are pregnant for the second time and are expecting the delivery in a month's time. You have come for your fourth check-up. You have no complaints, except increased frequency of urination, constipation and heart burn.

**Instructions for the volunteer acting as a health worker:** You will have to take history and provide ANC interventions and counselling.

- **Points to be noted and discussed after role play:**
  - How did the health-care provider initiate communication with the client?
  - While taking the history and counselling Saraswati, which relevant points did she elicit?
  - On the basis of the history, does Saraswati require routine or specialized ANC and why?
  - What should be told to Saraswati while counselling her?
  - Has the Mother and Child Protection Card been duly filled.

**Answers:** Saraswati should be given routine ANC at the SC. She should be informed that her complaints of increased frequency of urination, constipation and heartburn are normal and she should be advised on how to handle/overcome them (refer to Table 1 in Guidelines). Counsel her to have an institutional delivery Also, counsel her about infant feeding and contraception.

## SESSION III.d: CARE DURING LABOUR- ASSESSMENT, SUPPORTIVE CARE AND VAGINAL EXAMINATION

**Venue: Lecture room**

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able: • To explain how to conduct assessment of a woman in labour.<br>• To provide supportive care during labour.<br>• To conduct a vaginal examination during labour. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session 3.d).<br>• Demonstration.<br>• Video | • Module 1 of SBA guidelines.<br>• Skill Checklist 2.1 and 2.2 as given in the handbook.<br>• Bony pelvis/dummy/model for cervical dilation<br>• Sterile gloves, cotton swab, anti septic lotion. |

**Step 1**

- Ask the trainees, what supporting care they give to women in labor. Note down their responses on flip chart.
- Emphasize the importance of maintaining the woman's privacy and reassuring her throughout labour as indicators of quality services. Stress that a woman in labour must be encouraged to remain mobile in the first stage and change positions in accordance with how she feels comfortable.
- Ask the trainees about their practice regarding giving an enema to women in labour. Listen to them carefully and then explain that an enema should not be given routinely.

**Step 2**

- Discuss with the trainees the importance of assessment and supportive care during the first stage of labour, and of vaginal examination to decide the stage of labour. Also, highlight the importance of their role in the above as SBAs. (Use presentation 3d and refer to Guidelines Module 1: Care during labour and delivery.)

**Step 3**

**Vaginal examination to decide the stage of labour**

- Ask the trainees how they decide the stage of labour through vaginal examination. Note down their responses on the flip chart.
- Discuss with the trainees, what to look for during a vaginal examination to decide the stage of labour. (Use presentation 3d.).
- Explain that vaginal examination during labour is done to assess pelvic adequacy and the progress of labour, and to decide the stage of labour.

**Step 4**

**Demonstration**

- Demonstrate the steps of a vaginal examination on a model of bony pelvis and female dummy pelvis (refer to checklist 2.2 in Handbook).
- Use the bony pelvis to demonstrate the sacral promontory, sacral curve and ischial spines.
- Emphasize that if woman is in active labour, i.e. if cervix is dilated 4 cm or more, plot the findings on a Partograph. Otherwise, use a client record.

- **Stress that vaginal examination should be done once every four hours during labour to check its progress.** Frequent P/V examinations cause vaginal infection and may lead to puerperal sepsis later. Tell the trainees not to carry out vaginal examination if the woman is bleeding.
- Tell the trainees that they will get enough opportunities to perform vaginal examination and assess women in labour. This will enable them to gauge pelvic adequacy and the progress of labour, and to decide the stage of labour.

**Step 5**

**Closure of session 2**

- Wrap up the session and ask the trainees what are the critical skills they have learnt in this session. Ensure that trainees summarizes all the skills as mentioned in Box 3.d.1, given below:

**Box 3.d.1**

- Conduct haemoglobin estimation test.
- Test the urine for albumin and sugar.
- Give 2 TT injections one month apart.
- Provide IFA tablets.
- Counsel women on diet, rest, birth planning, institutional delivery, contraception etc.
- Know when to perform a vaginal examination, how to do so and interpret the same.

- Ask the trainees to read Guidelines Module 1: Care during labour—first and second stages of labour.
- Assign one of the trainees the task of summarizing the day's session.

## DAY 4

| SESSION |
| --- |
| IV. Recapitulation of Day-3 |
| • Care during Labour and Delivery<br>• Wrap-up and assigning of tasks |

**DURATION: 6 h 15 min**

## SESSION IV: CARE DURING LABOUR AND DELIVERY

### Venue: Lecture room + labour room

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To differentiate between true and false labour<br>• To describe the stages of labour<br>• To list the supplies required for a normal delivery<br>• To enumerate the steps of monitoring the first stage of labour using a Partograph.<br>• To conduct and manage the second stage of labour. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Presentation 4).<br>• Demonstration.<br>• Video | • Module 1 of SBA guidelines.<br>• Skill Checklist 2.3 and 2.4, as given in the handbook.<br>• Copies of Partograph.<br>• Dummy pelvis and a doll with a placenta, cord and membranes<br>• Models/dummies and CD, examination table, stepping stool, screen/curtain, inch tape, foetoscope, thermometer, watch with seconds hand, sterile gloves, 0.5% bleach solution in plastic container<br>• Delivery kit (as per Annexure 5 in Guidelines)<br>• Video on normal delivery. |

**Step 1**

- Ask the trainee who has been assigned the task of summarizing the previous day's session to come forward and present the summary in 15 minutes.
- Ask the others to mention anything that has been left out in the summary.
- Compliment and thank the trainee who summarized the session.

**Step 2**

- Assess the trainees on knowledge and practices while conducting the delivery by asking them:
  - What they understand by true and false labour pains and how do they differentiate them.
  - Different stages of labour.
  - How do they monitor and manage "first stage of labour".
  - Have they heard about Partograph? What is its use? Do they use it?
- Note their responses on the flip chart.

**Step 3**

- Discuss the following with the trainees **(Refer to Guidelines Module 1:True labour pains versus false labour pains, Use presentation 4.):**
  - True and False labour pains.
  - Four stages of labour and their duration.
  - Latent and active phases of labour; monitoring of contractions, the FHR, cervical dilatation and vitals at frequent intervals; and the action to be taken at each step
- Emphasize that in true labour:
  - Cervix dilates progressively.
  - If there is no change in cervical dilation and the woman does not have good contractions, it is a matter of concern and she needs care at a PHC/CHC/FRU.

**Step 4**

**Partograph**

- **Tell the trainees what is a Partograph and its utility**
  - The partograph is a graphic recording of the progress of labour and the condition of the mother and foetus. It is a tool which helps assess the need for action and recognize the need for intervention at the appropriate time. This facilitates timely referral to save the life of the mother and foetus.
- **Tell the trainees how to fill the Partograph**
  - Ask the trainees to follow the instructions below carefully while filling the Partograph.
    - **Identification data**—Note down the woman's name and age, parity, date and time of admission, registration number and time of rupture of the membranes.
    - **Foetal condition**
      - Count the FHR every half an hour.
      - Count the FHR for one full minute.
      - The rate should be preferably counted immediately after a uterine contraction.
      - If the FHR is below 120 beats per minute or above 160 beats per minute, it indicates foetal distress. Manage as indicated later under 'Foetal Distress'.
      - Remember that each of the small boxes in the vertical column of the Partograph represents a half-hour interval.
    - Note the condition of the membranes and observe the colour of the amniotic fluid as visible at the vulva or on pad every half an hour.
    - Record in the partograph as follows:
      - Membranes intact (mark 'I')
      - Membranes ruptured
        - Clear liquor (mark 'C')
        - Meconium-stained liquor (mark 'M')

**Labour**

- **Begin plotting on the Partograph only when active labour starts. Active labour starts when the cervical dilatation is 4 cm or more and the woman is having at least two good contractions every 10 minutes.**
- Record the cervical dilatation in centimeters every four hours.
- In this phase, cervical dilatation progresses by approximately 1 cm per hour and is often quicker in multigravidae.
- **Plot the first recording of cervical dilatation on the Alert line. Write the time accordingly in the corresponding row for time. After four hours, conduct a vaginal examination and plot the cervical dilatation in centimeters on the graph.**
- **If the Alert line is crossed (the plotting moves to the right of the Alert line), it indicates prolonged/obstructed labour and you should be alert that something is abnormal with the labour.**
- Note the time when the Alert line is crossed. The woman needs to be referred urgently to the FRU. Please remember to send the partograph along.
- Crossing of the Action line (the plotting moves to the right of the Action line) indicates the need for intervention. There is a difference of four hours between the Alert line and the Action line. By the time the Action line is crossed, the woman should ideally have reached the FRU for the appropriate intervention.
  **Refer as soon as Alert line is crossed and Do not wait for referral till the action line is crossed.**

- Chart the contractions every half an hour; count the number of contractions over 10 minutes and note their duration in seconds.
  - if contractions are Less than 20 seconds, then mark as  in the box
  - if contractions are Between 20 and 40 seconds then mark as  in the box
  - if contractions are More than 40 seconds then mark as  in the box

**Maternal condition**

- Record the maternal pulse on the graph every half an hour and mark with a dot (.).
- Record the woman's blood pressure on the graph every four hours, using a vertical arrow (↕) with the upper end of the arrow signifying the systolic blood pressure and the lower end indicating the diastolic blood pressure.
- Record the temperature every four hours and note it on the temperature graph.

**Interventions**

- Mention any drug that has been administered during labour, including the dosage, route and time of administration. Also include the food items and liquids consumed by the woman during labour.

**Step 5**

**Exercise for plotting of Partograph**

- Tell the trainees that they will practice plotting Partograph using case studies from the Handbook, and will also do so while monitoring women in labour in the hospital during their clinical posting.
- Give each trainee three partographs, one for each case study. Ask them to go through checklist 2.3 in the Handbook and read case study 1 thoroughly. Ask them to plot the findings on one partograph.
- Extra copies of Partographs may be kept for practice
- Go around and observe the trainees as they plot the partograph and help them, when necessary.
- After all the trainees have finished, ask one of them to come forward and explain how she has filled the partograph. The other trainees should not interrupt, but listen carefully.
- Ask the others for their comments one by one. After all have had their say, congratulate the trainee for her efforts.
- Explain how to plot the partograph for case study 1. (Use presentation 4)
- Repeat the same with case studies 2 and 3.

  **Note for the trainers:** Plotting of Partograph is a critical skill to be learnt during this training. As a trainer, you have to ensure that trainee learns correct plotting of Partograph. Also emphasize that a partograph is essential to be plotted during labour in every pregnancy. Help the trainees with the plotting exercise. Check their Partograph and make corrections, if required. Tell them to practice plotting on the Partograph as an assignment as well. Encourage the trainees to ask questions if they have not understood any section of the Partograph. Clarify their doubts. Congratulate them on their efforts.

# THE SIMPLIFIED PARTOGRAPH

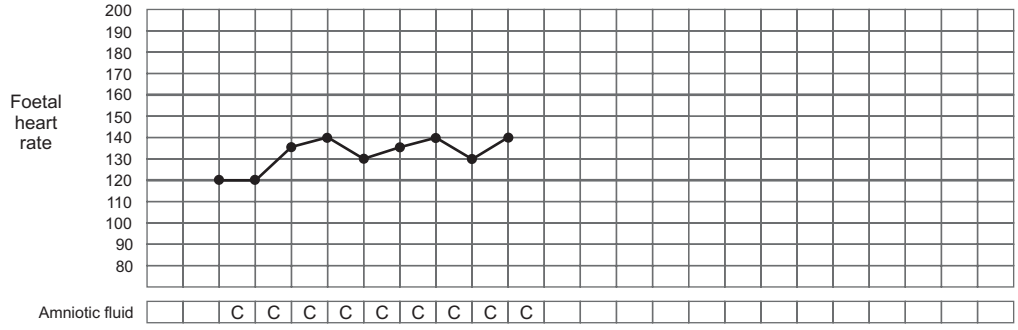
**IDENTIFICATION DATA**

**Name:** Radha **W/e:** Gangaram **Age:** 26 yrs **Parity:** 3rd gravida **Reg. No.:**

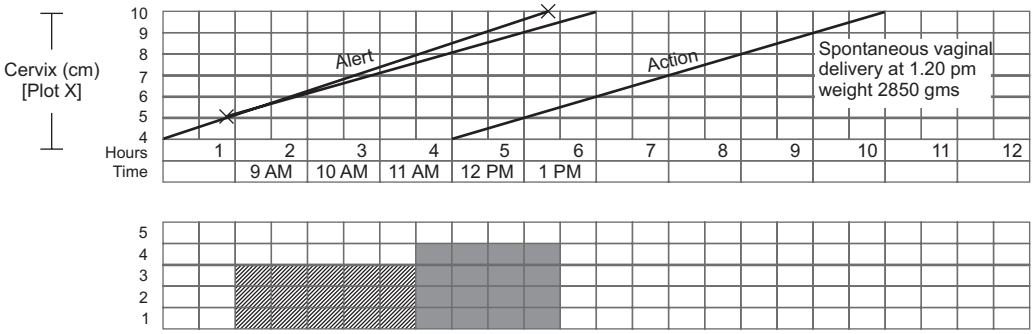
**Date & Time of Admission**
11th June 2009, 5 AM

**Date & Time of ROM:**
11th June 2009, 4 AM

**(A) Foetal Condition**

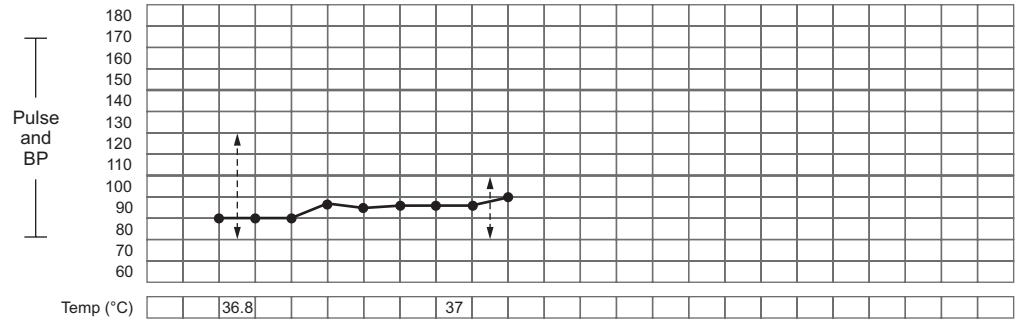



**(B) Labour**




**(C) Interventions**


**(D) Maternal Condition**



## CASE STUDY 1

Radha (wife of Gangaram), 26 years of age, third gravida, was admitted at 5:00 am on 11 June 2009 with the complaint of full term pregnancy with labour pains since 2:00 am. Her membranes ruptured at 4:00 am. She has two children of the ages of 5 and 2 years. On admission, her cervix was dilated 2 cm.

**Plot the following findings on the partograph.**

**At 9:00 am:**

- The cervix was dilated 5 cm.
- She had 3 contractions in 10 minutes, each lasting 20–40 seconds.
- The FHR was 120 beats per minute.
- The membranes had ruptured and the amniotic fluid was clear.
- Her blood pressure was 120/70 mmHg.
- Her temperature was 36.8° C.
- Her pulse was 80 per minute.

**9:30 am:** FHR 120, contractions 3/10 each 30 seconds, pulse 80/minute, amniotic fluid clear
**10:00 am:** FHR 136, contractions 3/10 each 35 seconds, pulse 80/minute, amniotic fluid clear
**10:30 am:** FHR 140, contractions 3/10 each 40 seconds, pulse 88/minute, amniotic fluid clear
**11:00 am:** FHR 130, contractions 3/10 each 40 seconds, pulse 88/minute, amniotic fluid clear
**11:30 am:** FHR 136, contractions 4/10 each 45 seconds, pulse 84/minute, amniotic fluid clear
**12:00 noon:** FHR 140, contractions 4/10 each 45 seconds, pulse 88/minute, amniotic fluid clear
**12:30 pm:** FHR 130, contractions 4/10 each 50 seconds, pulse 88/minute, amniotic fluid clear
**1:00 pm:** FHR 140, contractions 4/10 each 55 seconds, pulse 90/minute, temperature 37° C, blood pressure100/70 mmHg, amniotic fluid clear

**At 1:00 pm:**

- Cervix fully dilated
- Amniotic fluid clear
- Blood pressure 100/70 mmHg

**At 1:20 pm:** Spontaneous birth of a live female infant weighing 2.85 kg

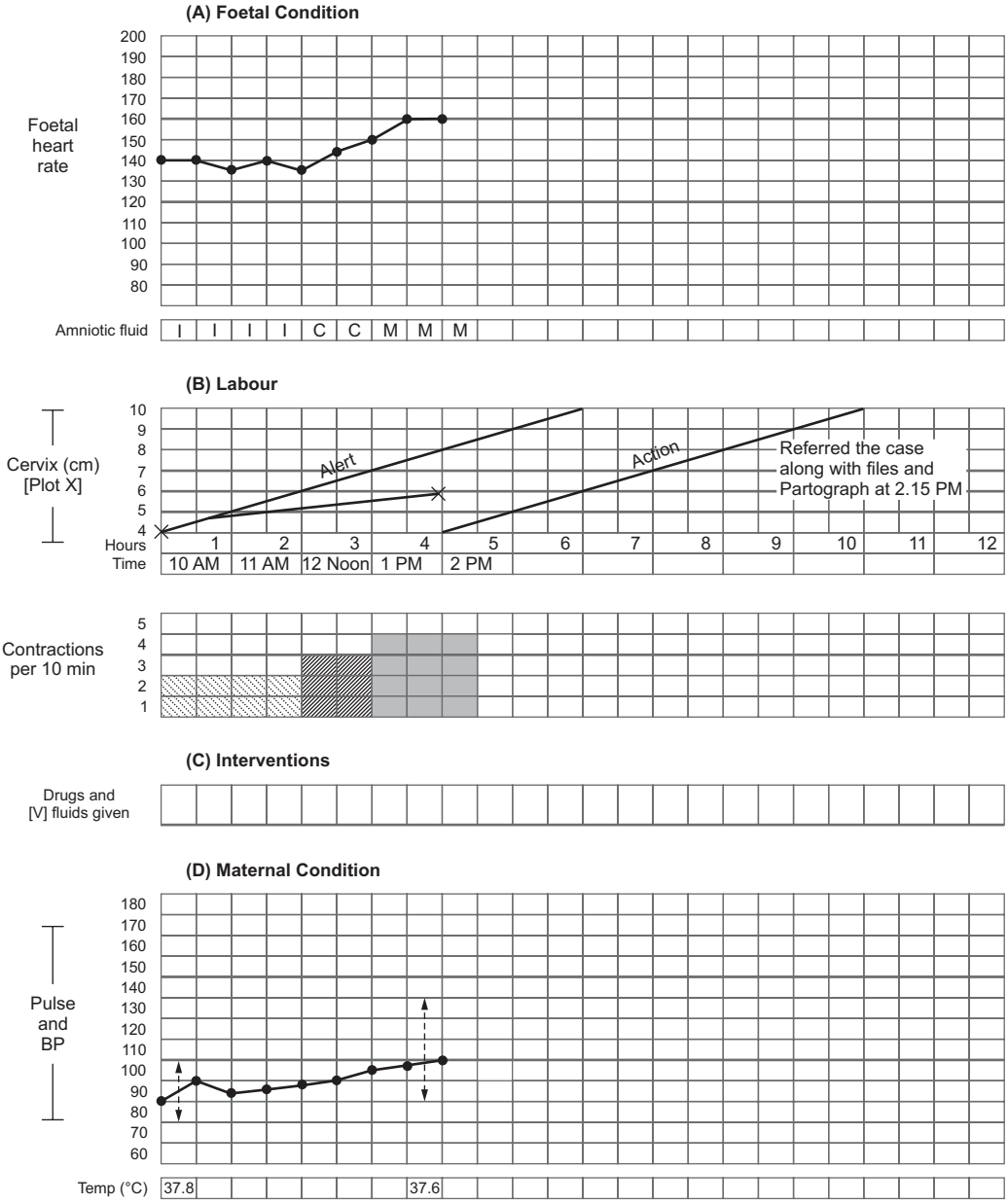
# THE SIMPLIFIED PARTOGRAPH

**IDENTIFICATION DATA**

**Name:** Rani **W/e:** Rambhanaj **Age:** 18 yrs **Parity:** Primigravida **Reg. No.:**

**Date & Time of Admission**
11th June 2009, 10 AM

**Date & Time of ROM:**
11th June 2009, 12 Noon



## CASE STUDY 2

Rani (wife of Rambhajan), 18 years of age, was admitted at 10:00 am on 11 June 2009 with complaints of 39 weeks pregnancy and labour pains since 7:00 am. This is her first pregnancy.

**Plot the following findings on the partograph.**

**At 10:00 am:**

- The cervix was dilated 4 cm.
- She had 2 contractions in 10 minutes, each lasting less than 20 seconds.
- The FHR was 140/minute.
- The membranes were intact.
- Her blood pressure was 100/70 mmHg.
- Her temperature was 37° C.
- Her pulse was 80 per minute.

**10:30 am:** FHR 140, contractions 2/10 each 20 seconds, pulse 90/minute
**11:00 am:** FHR 136, contractions 2/10 each 20 seconds, pulse 88/minute
**11:30 am:** FHR 140, contractions 2/10 each 20 seconds, pulse 84/minute
**12:00 noon:** FHR 136, contractions 3/10 each 30 seconds, pulse 88/minute, membranes ruptured, amniotic fluid clear
**12:30 pm:** FHR 146, contractions 3/10 each 35 seconds, pulse 90/minute, amniotic fluid clear
**1:00 pm:** FHR 150, contractions 4/10 each 40 seconds, pulse 92/minute, amniotic fluid meconium-stained
**1:30 pm:** FHR 160, contractions 4/10 each 45 seconds, pulse 94/minute, amniotic fluid meconium-stained

**At 2:00 pm:**

- Cervix dilated 6 cm
- Amniotic fluid meconium-stained
- Contractions 4/10 each 45 seconds
- FHR 162/minute
- Pulse 100/minute
- Temperature 37.6° C
- Blood pressure 130/80 mmHg

# THE SIMPLIFIED PARTOGRAPH

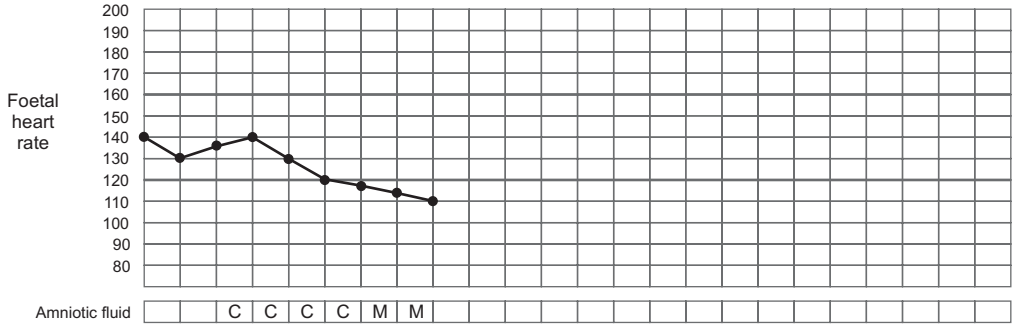
**IDENTIFICATION DATA**

**Name:** Rubina **W/e:** Zarif **Age:** 26 yrs **Parity:** 5th Gravida **Reg. No.:**

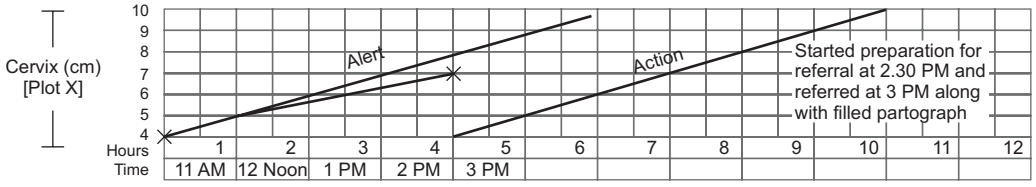
**Date & Time of Admission**
12th June 2009, 11 AM

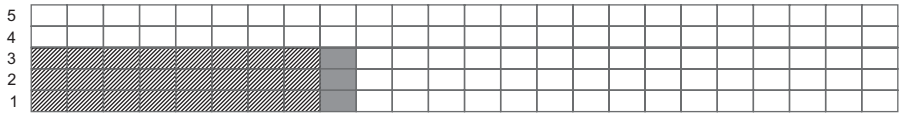
**Date & Time of ROM:**
12th June 2009, 9 AM

**(A) Foetal Condition**



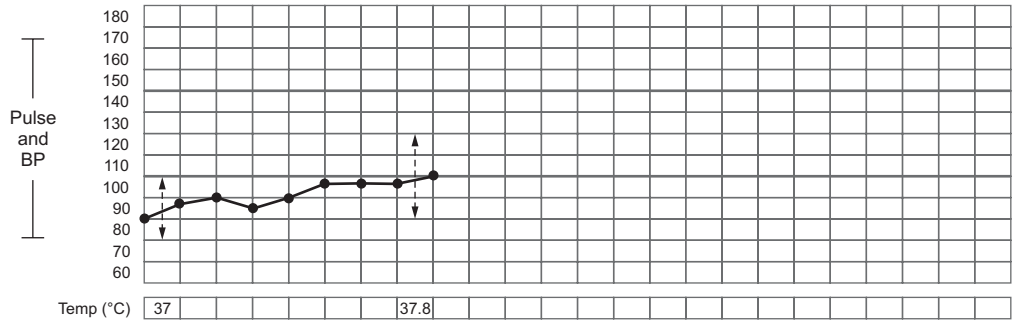

**(B) Labour**




**(C) Interventions**


**(D) Maternal Condition**



## CASE STUDY 3

Rubina (wife of Zarif), age 26 years, was admitted at 11:00 am on 12 June 2009 with the complaint of full term pregnancy with labour pains since 4:00 am. Her membranes ruptured at 9:00 am. She has three children, aged 10, 7 and 3 years. She gave birth to a stillborn baby 4 years back.

**Plot the following findings on the partograph.**

**At 11:00 am:**

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

**11:30 am:** FHR 130, contractions 3/10 each 35 seconds, pulse 88/minutes, amniotic fluid clear
**12:00 noon:** FHR 136, contractions 3/10 each 40 second, pulse 90/minutes, amniotic fluid clear
**12:30 pm:** FHR 140, contractions 3/10 each 40 seconds, pulse 88/minutes, amniotic fluid clear
**1:00 pm:** FHR 130, contractions 3/10 each 40 seconds, pulse 90/minutes, amniotic fluid clear
**1:30 pm:** FHR 120, contractions 3/10 each 45 seconds, pulse 96/minutes, amniotic fluid clear
**2:00 pm:** FHR 118, contractions 3/10 each 45 seconds, pulse 96/minutes, amniotic fluid clear
**2:30 pm:** FHR 112, contractions 3/10 each 45 seconds, pulse 98/minutes, amniotic fluid meconium-stained

**At 3:00 pm:**

- FHR 100/minute
- Contractions 4/10 each 45 seconds
- Pulse 100/minute
- Amniotic fluid meconium-stained
- Temperature 37.8° C
- Blood pressure 120/80 mmHg
- Cervix dilated 7 cm

**Step 6**

**Monitoring and managing the second stage of labour**

- Ask the trainees the following questions and note down their responses on flip chart.
  - What are the signs of imminent labour?
  - How often do you monitor the frequency and duration of the contractions?
  - What are the different positions the woman can use to make pushing easier, and what positions do women usually use while delivering at the SC or at home?
  - Which precautions would you take while delivering the head, shoulders and the rest of the baby?
  - What immediate care would you provide to the newborn?
- Describe the signs of imminent labour and its management, and how the head, shoulders and rest of the baby's body are to be delivered. (Use presentation 4)
- Co-relate the discussion with viewing of video on normal labour. Discuss each step of the delivery with the trainees.

**Step 7**

**Demonstrating steps of normal delivery**

- Keep a dummy pelvis and a doll with a placenta, cord and membranes ready.
- Ask one trainee at a time to use the dummy pelvis and doll to demonstrate how she would conduct a delivery.
- Instruct rest of the trainees to closely observe the trainee who is demonstrating, and list the points missed by the trainees at the end of demonstrations by all trainees.
- After all the trainees have conducted the demonstration, congratulate everyone. Ensure that the feedback offered by the rest of the group is supportive. Ensure that steps where trainees have performed in an incorrect manner are highlighted and trainees learn the correct steps.
- Then proceed to demonstrate the correct steps of the delivery of the head, shoulders and rest of the body. (Use presentation 4 and checklist 2.4 of Handbook.)
- Discuss the precautions to be kept in mind while delivering the head and shoulders to prevent tearing of the perineum and vaginal wall.
- Ask the trainees if they think that the new methods learnt would be useful in their practice.

**Step 8**

**Closure of session and visit to Labour room**

- Wrap up the session and ask the trainees what are the critical skills they have learnt in this session. Ensure that trainees summarizes all the skills as mentioned in Box 3.d.1, given below:

| **Box 3.d.1** |
|---|
| • Plotting of Partograph.<br>• When to refer a woman on the basis of Partograph findings.<br>• Different stages of labour.<br>• Monitoring and management of 1st stage of labour.<br>• Correct steps for delivering a baby. |

- Ask the trainees to read Guidelines Module 1: Care during labour—third stage, AMTSL; Fourth stage of labour, including care of the mother and newborn; Newborn resuscitation; Preparing for discharge and care after delivery—postpartum care. Tell them to prepare for the next day's training.

- Assign one of the trainees the task of summarizing the day's session.
- Ask for any doubts among the trainees and solve the same.
- Depending on the availability of delivery cases, a visit to the labour room should be scheduled so that the trainees can observe the steps of managing the second stage of labour. (In the morning, inform the labour room staff about the scheduled visit.)

## DAY 5

| SESSION |
| --- |
| V. Recapitulation of Day-4 |
| V.a Management of Third and Fourth Stages of Labor |
| V.b Resuscitation of New-Born |
| V.c Care after delivery- Post-Partum Care |

**DURATION: 6 h 30 min**

## SESSION V.a. MANAGEMENT OF THIRD AND FOURTH STAGES OF LABOUR

**Venue: Lecture room**

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To enumerate the steps of AMTSL.<br>• To describe the care to be provided to the mother and newborn immediately after delivery.<br>• To list the elements of essential care of the newborn. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session V.a).<br>• Demonstration. | • Module 1 of SBA guidelines.<br>• Skill Checklist 2.5 and 2.6, as given in the handbook.<br>• Dummy pelvis and a doll with a placenta, cord and membranes.<br>• Inj Oxytocin/Tab Misoprostol.<br>• Video on AMTSL and ENBC. |

**Step 1**

- Greet the trainees and ask the trainee who was assigned the task of summarizing the previous day's session to present the summary in 15 minutes.
- Ask the others to mention anything that is missing from the summary.
- Compliment and thank the trainee who summarized the session.
- Enquire from the trainees, have they heard about "Active management of third stage of labour". If yes, then ask the details known to them.
- Generate a discussion among the trainees on the points listed below, in box 5.a. Write down their responses on the flip chart.

**Box 5.a.1**

- What are the steps to prevent excessive blood loss during delivery? How do they prevent PPH?
- What are the steps for the delivery of placenta, once the baby is delivered?
- How long does it take?
- What do they do for the mother and the baby once the placenta is delivered.
- What do they do, if the placenta takes a long time to be delivered?
- How do they dispose placenta in their set up.

**Step 2**

- Discuss with the trainees importance of AMTSL in preventing PPH and excessive loss of blood, and how this can save the lives of mothers during delivery. Also discus management of the mother and baby during fourth stage of labour. (Use presentation 5a and checklist 2.5 in Handbook.)

**Box 5.a.2**

Emphasize to the trainees:

- Correct dose as well as time and route of administration of oxytocics.
- Inform the trainees that most common choice of oxytocics at all health facility (including SC) is "Injection Oxytocin". Tab Misoprostol is to be used where refrigeration is not possible during high temperatures.
- Importance of excluding another baby before administering Injection oxytocin / Tablet Misoprostol.
- Importance of management of the fourth stage, i.e. the first two hours after delivery of the placenta, where observing mother and baby is necessary and conditions for which they need to call for help.
- Care for the mother: Examination of perineum, lower vagina and vulva for tears, and cleaning of the woman after the delivery.

- Care for the newborn: How to check the baby's colour and breathing, and cord. Emphasize that the baby should be checked for warmth, skin-to-skin contact with the mother should be provided, and breastfeeding should be started immediately and certainly within an hour.
- Proper way for the disposal of placenta.

**Step 3**

**Demonstration**

- Demonstrate the steps of AMTSL, using checklist 2.5, on the model with the placenta, cord and membranes.
- Make each trainee give a return demonstration. Observe the trainees closely and correct them if they are wrong.
- Explain how to examine the placenta, membranes and the cord.
- Tell the trainees that they will get an opportunity to practice on clients during their hospital posting.

## SESSION Vb. RESUSCITATION OF THE NEWBORN

**Venue: Lecture room**

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To describe the steps of resuscitating a newborn who is not crying or breathing immediately after birth. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session V.b).<br>• Demonstration. | • Module 1 of SBA guidelines.<br>• Skill Checklist 2.7, as given in the handbook.<br>• Dummy pelvis and a doll with a placenta, cord and membranes<br>• Bag and mask equipment—self-inflating bag (volume 250–500 ml), face masks (sizes 0 and 1, cushioned-rim masks preferred)<br>• Suction equipment—mucus extractor, mechanical suction and tubing<br>• Miscellaneous items :<br>▪ radiant warmer<br>▪ firm, padded resuscitation surface<br>▪ warm linen<br>▪ oxygen source with flow meter, if available<br>▪ gloves<br>▪ shoulder roll<br>▪ clock with seconds hand<br>▪ 0.5% bleach solution in plastic container.<br>▪ television, DVD, cassette on resuscitation of newborn |

**Step 1**

- Ask the trainees what they do if the baby does not cry immediately after birth. Also ask the trainees, what steps they keep in mind while discharging the mother and baby post delivery. Listen carefully and note down their responses.

**Step 2**

- Discuss with the trainees, steps of resuscitation of newborns. Use flow chart in Guidelines Module 1: Resuscitation of the newborn, presentation 5b and video on New Born resuscitation.

**Box: 5.b.1**

Emphasize:
- Steps of resuscitation.
- Equipments required for resuscitation.(use checklist 2.7 in the handbook).
- Only 10% of babies require assistance to begin breathing after birth. It is, however, important to keep all the equipment necessary for resuscitation ready at every delivery, so that no time is wasted in an emergency and the life of the newborn can be saved.
- Discharge of mother and the baby.

**Step 3**

**Demonstration**

- Use the resuscitation equipment on a dummy/model to demonstrate the steps of resuscitating newborns.
- Now ask each trainee to demonstrate the method. (Use checklist 2.7.)
- Observe the trainees performing the steps of resuscitation and correct them if they are wrong.
- Ask each trainee to demonstrate the steps of resuscitation on the mannequin This helps to build confidence.

## SESSION Vc CARE AFTER DELIVERY- POST PARTUM CARE

### Venue: Lecture room + Post natal ward

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>• To enumerate the number and timing of postpartum visits to be made to the mother and her baby.<br>• To describe the required history-taking, examination and management/counselling of the mother and examination /management of the baby during the postpartum visits.<br>• To describe the steps to be taken during referral and transfer of the baby. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session V.c).<br>• Demonstration/ Role Play. | • Module 1 of SBA guidelines.<br>• Skill Checklist 3.1, 3.2, as given in the handbook.<br>• Role Play / Baby Doll. |

**Step 1**

- Ask the women about post partum care they provide, on the points highlighted in box 5.c.1. Note down their responses on a flipchart.

**Box 5.c.1**

- Ask them the importance of post partum care.
- Ask the trainees how many postpartum visits they undertake for the women delivered by them. How do they schedule this visit?
- In case woman is delivered at an institution, then how many visits they make to such woman and when?
- Ask the trainees what do they do during these visits? What advices do they give to mother regarding her own health and care of her baby during these visits

**Step 2**

- Discuss with the trainees the importance of post partum care. (Use presentation 5c and refer to Guidelines Module 1: Care after delivery and checklists 3.1 and 3.2 in Handbook.)
- Emphasize on points (as given in Box 5.c.2), during discussion on post natal care.

**Box 5.c.2**

- Importance of post partum care.
- No. and timings of post partum visits.
- Items required to be carried during post partum visits.
- History taking, examination of mother and baby and counselling to be given during the post partum visits.
- Explain that the care provided to the mother and newborn during the first six weeks after delivery is crucial for their health and survival. Stress that the postpartum period is a neglected component of maternal care.

**Step 3**

**Demonstration/ Role play**

- Divide the trainees into pairs. One trainee will play the role of an ANM and the other will play the role of a mother. Give each pair a model of a baby.
- Tell them that the 1st group of trainees will have to demonstrate history-taking, examination and counselling during the postpartum visits, while the other group will observe the demonstration/role play and not if done correctly.
- They should use checklists 3.1 and 3.2 in the Handbook while enacting the role-play.
- Explain that if they observe any abnormality during the examination, they should refer the woman to an FRU after giving her the initial care

**Step 4**

**Closure of session and visit to post partum ward**

- Wrap up the session and ask the trainees what are the critical skills they have learnt in this session. Ensure that trainees summarizes all the skills as mentioned in Box 5.d.1, given below:

**Box 5.c.3**

- Performs AMTSL correctly
- Examines vagina and perineum for tears
- Checks for vaginal bleeding
- Checks for uterine contractions
- Takes corrective steps for resuscitation: provides baby warmth, positions baby's head, clears airway, positions bag and mask correctly, and begins ventilation
- Knows when to refer
- Advises mother on exclusive breastfeeding, including colostrum-feeding
- Observes and informs mother about correct position for breastfeeding
- Checks baby's umbilicus, skin and eyes
- Screens for danger signs in baby
- Advises mother and family members on immunization and neonatal care

- Ask the trainees to read Guidelines Module 2: Complications during pregnancy, labour and delivery and in the postpartum period.
- Ask for any doubts among the trainees and solve the same.
- Take the trainees for a visit to post natal ward to observe the various examinations/interventions/activities carried out for postnatal mothers and newborns.

## DAY 6

| SESSION | |
|---|---|
| VI. | Recapitulation of Day-5 |
| VI.a. | Management of Complications during pregnancy, labor and post-partum period |
| VI.b. | Ensuring quality of Care |
| | Wrap-up and assigning of tasks |

**DURATION: 6 h 15 min**

## VI.a. MANAGEMENT OF COMPLICATIONS DURING PREGNANCY, LABOUR, DELIVERY AND THE POSTPARTUM PERIOD

**Venue: Lecture room**

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| • To list the signs and symptoms of the following obstetric complications before referral<br>• Vaginal bleeding<br>• Convulsions<br>• Hypertension and pre eclampsia<br>• Anaemia<br>• Urinary tract infection (UTI)<br>• Obstructed labour<br>• Pre-term labour<br>• Prolapsed cord<br>• Retained placenta and placental fragments<br>• Vaginal and perineal tears<br>• Puerperal sepsis<br>• Sore and cracked nipples<br>• To demonstrate how to identify and manage the above obstetric complications before referral. | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session VI.a).<br>• Demonstration/ Role Play. | • Module 2 of SBA guidelines.<br>• Model of pelvis, dummy model for IV set, CDs on managing complications, doll, cord with placenta, bowl, thread, cotton rolls<br>• Drip Stand, Intravenous bottles, intravenous set, needles, syringes, hub cutter, bucket with bleach solution, waste disposal bins, tape scissors and spirit swabs.<br>• Magsulph injection, gentamicin injection, ampicillin injection, metronidazole tablet<br>• Handbook checklists 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7 and 4.8 |

**Step I**

- Greet the trainees and ask the trainee who was assigned the task of summarizing the previous day's session to present the summary in 15 minutes.
- Ask the others to mention anything that is missing from the summary.
- Compliment and thank the trainee who summarized the session.
- Introduce the topic of the session. Tell the trainees that in this session, they will discuss obstetric problems which may endanger the life of the woman and her baby.
- Remind the trainees that abnormalities can arise during any of the stages of normal pregnancy, labour and the postpartum period. It is, therefore, important to be alert regarding the condition of the woman during these periods,
- Explain that identifying complications during these periods will help the ANM to manage them accordingly and she will be able to refer the woman to the FRU for specialized care in time.
- Stress the fact that only identification of the problem, its management and referral of the woman/baby are not enough. These can be effective only if the problem is identified early and care provided promptly and appropriately.
- Therefore, the pregnant woman, her family members and community should also be made aware of the danger signs during pregnancy, labour and the postpartum period, as well as of the action that they can take, such as seeking appropriate medical help.

  **(Refer to Guidelines Module 2: Management of complications, and use presentation 6a.)**

**Step 2**

- Ask the trainees to list the problems/complications related to pregnancy, labour and the postpartum period that they have encountered.

- Divide a page in the flip chart into three parts by drawing two vertical lines. In the left column, write down the problems that can occur during pregnancy. The middle column should mention the problems that can occur during labour and delivery, while the last column should mention the problems encountered during the postpartum period.
- Note down the responses of the trainees in the appropriate columns.
- Tick marks the complications once each of these has been dealt with in this session.
- Tell the trainees that the identification and management of each complication will be discussed separately.

## COMPLICATIONS

### 1. Vaginal bleeding

**Step 1**

- Ask the trainees which complication they think is responsible for the maximum number of maternal deaths. Note down their responses.
- Tell the trainees that bleeding related to pregnancy and childbirth is one of the most important causes of maternal mortality. Bleeding may occur during early or late pregnancy; during delivery or after delivery, in the postpartum period.
- Inform them about the types of vaginal bleeding. (Use presentation 6a.)

**Step 2**

**Vaginal bleeding in early pregnancy**
**(Use presentation 6a and checklist 4.1 in Handbook, and refer to Guidelines Module 2.)**

- Explain that in early pregnancy, bleeding can occur any time before 20 weeks of pregnancy.
- Ask the trainees to list the causes of bleeding during early pregnancy. Ask which measures they take to stop the bleeding.
- Note down their responses on the flip chart.
- Tell them about the various causes of vaginal bleeding in early pregnancy. (Use presentation 6a.)
- Discuss the advice that should be given to a woman who has had an abortion regarding when to return for follow-up, self-care and family planning.
- Stress the fact that ANMs and LHVs should inform the woman that she can get pregnant soon after an abortion. Therefore, she must consider using a family planning method. She must come for a check-up or go to the MO of a 24-hour PHC if she does not get her period within 4–6 weeks of abortion. (Use presentation 6a.)

**Step 3**

**Case Study**

- Ask the trainees to complete case study 4 given in their handbook. The answers have been given below for your reference.

## CASE STUDY 4

**Q. Asha is 28 years old. She is 12 weeks pregnant when she comes to the health centre complaining of light vaginal bleeding and abdominal pain. This is her first pregnancy. It is a planned pregnancy, and she has been well until now. On vaginal examination, her cervical os is found to be closed.**

**1. What should your initial assessment consist of?**

**Initial assessment:** Assess the general condition—measure the pulse, blood pressure and temperature, check the respiratory rate, check for pallor, and assess the amount of vaginal bleeding (going by the number of pads soaked).

**Findings:** Asha's vitals are within normal limits, i.e. her general condition is fair, her pulse is 70 per minute, her blood pressure is 110/70 mmHg, there is no pallor, the respiratory rate is 20 breaths per minute and she is afebrile. She has slightly stained one pad in the past 24 hours

**Probable diagnosis:** Since Asha's vital signs are within normal limits, the os is closed and the bleeding is light, it is a case of threatened abortion.

**2. How should you manage Asha?**

Since the vaginal bleeding in Asha's case is light, you need only to explain the facts to her, reassure her and advise her to go home after you have checked her vital signs. Advise her to avoid strenuous exercises/work and to avoid sexual intercourse. Also, advise her to take bed rest.

Send her to the MO with a referral slip for further advice.

**Step 4**

**Vaginal bleeding in late pregnancy—antepartum haemorrhage (APH)**

- Tell the trainees that bleeding that occurs after 20 weeks of pregnancy is called APH and is very dangerous for the mother and the baby.
- Tell them that the ANM should record the vital signs, such as the pulse, blood pressure, temperature and amount of bleeding, as reported by the woman or her relatives, and estimate the amount of blood loss on the basis of the number of pads/cloths soaked since the bleeding began.
- **Emphasize that a P/V should NOT BE DONE in such cases.**
- Explain that if a woman is bleeding heavily or is in shock, it is an emergency and the ANM needs to act quickly to stabilize the woman. She should start the woman on intravenous fluids rapidly, before referring her to a 24-hour PHC or an FRU which has facilities for blood transfusion.
- The woman should be given a referral slip, which should be filled in correctly and completely. It should mention the amount of fluids given.

**Step 5**

**Demonstration**

- Demonstrate how to insert an intravenous line on the dummy arm,
- Ask each trainee to practice on the dummy arm. (Use checklist 4.7.)
- Observe the trainees while they perform and correct them if they are wrong.

**Step 6**

- Explain to the trainees that while the intravenous fluid is being given, the ANM should inform the woman's family members and counsel them to take her to the nearest 24-hour PHC/FRU as soon as possible.
- Tell them that the ANM may send a relative of the woman to call for a means of transport which she may have arranged for in the village in case of emergencies.
- Arrange 1-2 blood donors if she is in shock; however, send the woman to a FRU so that she gets immediate attention; donors can be sent soon after
- During transport, the woman should be kept warm. It will be good if the ANM accompanies the woman as the intravenous line is on. She should carry an extra bottle of Ringer lactate or normal saline with her.

**Step 7**

**Case study**

- Ask the trainees to complete case study 5 given in their handbook. The answers have been given in the next page for your reference.

## CASE STUDY 5

**Q. Deepa is a healthy 20-year-old primigravida. Her pregnancy has been uncomplicated. At 38 weeks of gestation, Deepa comes to the health centre, accompanied by her husband. She appears to be confused and is sweating profusely. She reports that since two hours, she has been having painless vaginal bleeding; the blood is bright red.**

**1. What should your initial assessment of Deepa include and what is the probable diagnosis?**

**Initial assessment:** Assess the general condition—measure the pulse, blood pressure and temperature, check for pallor, check the respiratory rate, and assess the amount of vaginal bleeding (going by the number of pads soaked). A quick abdominal examination should be performed to determine the foetal lie and presentation, and check for uterine tenderness. Count the FHR and remember that vaginal examination should not be done.

**Findings:** Deepa appears confused and pale, and her skin is cold and clammy. Her pulse is 112 per minute, her blood pressure is 90/60 mmHg, her respiratory rate is 32 breaths per minute, and the bleeding is heavy (1 pad is being soaked in 5 minutes). The abdominal examination reveals longitudinal lie, vertex presentation and an FHR of 112 per minute.

**Probable diagnosis:** Deepa is in shock due to bleeding, which may be the result of placenta praevia (APH).

**2. How should you manage Deepa?**

As Deepa is in shock, immediately start intravenous infusion of 500 ml Ringer lactate, at the rate of 60 drops per minute. Raise the foot end of the bed, keep her warm with blankets Fill in a referral slip for her and make arrangements to send her to the FRU as soon as possible. Accompany her to the FRU.

**3. What advice should you give Deepa's husband?**

Advise her husband to keep her covered in a blanket and explain her condition to him. Give him emotional support and reassurance. Explain that Deepa may require blood transfusion and he should be ready to donate blood.

**Step 8**

**Bleeding during and within 24 hours of delivery (immediate PPH)**

(Refer to Guidelines Module 2: 1C Vaginal bleeding during and within 24 hours of delivery—immediate PPH; Figure 3: Flowchart to diagnose the cause of immediate PPH and its management; checklist 4.2; and presentation 6.)

- Ask the trainees if they have seen or heard of a case of PPH in their work area.
- If they say 'yes', ask them how long after the delivery did the woman start bleeding heavily.
- Note down their responses.
- Ask them what happened to the woman, who managed the problem and how it was managed.
- Note down their responses on the flip chart.

**Step 9**

- Discuss PPH and explain how to estimate the amount of blood lost.
- Tell the trainees that PPH may be immediate or delayed, depending on how long after delivery it starts. In immediate PPH, the bleeding starts during or within 24 hours of delivery, while in delayed PPH, it starts after 24 hours of delivery.
- Explain the causes of immediate PPH.
- Tell the trainees that some of these conditions can be partially managed at the domiciliary and SC level, before the woman is referred to an appropriate facility. In other cases, referral to an FRU is necessary after 'general management'.
- Using the flowchart on immediate PPH in Module 2 of the Guidelines, explain and discuss the cause of immediate PPH and its management.
- Inform the trainees about the general steps to be taken to stabilize the woman before referring her to an FRU. (Use presentation 6.)

**Step 10**

**Demonstration**

- Demonstrate on a pelvic model how to perform uterine massage to expel blood clots and 'bimanual compression' if bleeding persists and the uterus remains soft. (Refer to Guidelines Module 2 and presentation 6.)
- Ask each trainee to demonstrate and practice uterine massage and bimanual compression on the pelvic model.

**Step 11**

- After all the trainees have completed the demonstration, stress that the interval from the onset of bleeding to death in PPH is as little as two hours. Hence, it is important to act immediately with appropriate life-saving measures before referral.
- Explain that an intravenous line should be started immediately; 20 IU of oxytocin should be added to 500 ml of Ringer lactate and the drip should be given at the rate of 60 drops per minute.
- The ANM should ensure that the woman reaches the FRU as soon as possible.

**Step 12**

Bleeding 24 hours after delivery (delayed/secondary PPH) (Refer to Guidelines Module 2.: Vaginal bleeding 24 hours after delivery (delayed/secondary PPH); Checklist 4.2; and presentation 6a.)

- Explain that delayed PPH can occur from 24 hours after delivery up to six weeks postpartum. It could be due to infection or due to retained clots or placental fragments.
- PPH due to infection can be managed initially, before referral. (Refer to Guidelines Module 2, checklist 4.5 and presentation 6a.)

- PPH due to retained clots or placental fragments can be managed as described in Guidelines Module 2: retained clots and placental fragments.
- The woman should be referred to the MO at the 24-hour PHC.

**Step 13**

Ask the trainees to complete case study 6 given in their handbook. The answers have been given in the next page for your reference.

## CASE STUDY 6

**Q. Seema is 20 years old. She gave birth to a full-term baby one-and-a-half hours ago at home. Her birth attendant was her grandmother, who has brought Seema to the health centre because she has been bleeding heavily since the birth. The duration of labour was 12 hours, the birth was normal and the placenta was delivered 20 minutes after the birth of the baby.**

1. **What should your initial assessment of Seema include?**

   **Initial assessment:** Assess the general condition—measure the pulse, blood pressure and temperature, check for pallor, check the respiratory rate, conduct an abdominal examination, assess the amount of vaginal bleeding (going by the number of pads soaked), and check for tears.

   **Findings:** Seema appears confused and pale. Her pulse is 108 per minute, her blood pressure is 80/60 mmHg, her respiratory rate is 28 breaths per minute, and the bleeding is heavy (1 pad is being soaked in 5 minutes). A quick abdominal examination reveals a soft and relaxed uterus. There are no vaginal tears.

   **Probable diagnosis:** The probable diagnosis is atonic PPH.

2. **How should you manage Seema?**

   Establish an intravenous line and give Seema 500 ml Ringer lactate with 20 IU of oxytocin, at the rate of 40–60 drops per minute. Simultaneously start a uterine massage. If an intravenous line cannot be established, 10 IU of oxytocin should be administered as an intramuscular injection. Continue the uterine massage.

   If the bleeding persists and the uterus continues to be in the relaxed state (uterus soft), fill in a referral slip for her and make arrangements for transporting her to the FRU. Utilize the intervening time to perform bimanual compression.

   **Arrange for a blood donor immediately.**

3. **What advice should you give Seema's grandmother?**

   Explain Seema's condition to her. Give her emotional support and reassurance. Tell her that Seema may require blood transfusion, and that she should inform/prepare the blood donor.

**2. Pregnancy-induced hypertension (PIH)**

**Step 1**

- Tell the trainees that a woman with a history of hypertension in her previous pregnancies is more prone to high blood pressure than in the present pregnancy.
- Explain that like eclampsia, imminent eclampsia is a life-threatening condition for the mother and the baby during pregnancy and labour.
- Therefore, the woman and her family members should be made aware of the danger signs.
- Discuss PIH, the follow-up care of women with pre-eclampsia, and the danger signs. **(Use presentation 6a and checklists 4.3 and 4.8 in Handbook.)**

**Step 2**

**Ask the trainees to complete case study 7 given in their handbook. The answers have been given in the next page for your reference.**

## CASE STUDY 7

**Q. Uma is 20 years old. She is 30 weeks pregnant and has attended the antenatal clinic thrice. All the findings were within normal limits until her last antenatal visit one week ago. At that visit, it was found that her blood pressure was 150/90 mmHg. Her urine was negative for protein. The foetal heart sounds were normal, the foetus was active and the uterine size was consistent with the date. She has come to the clinic today, as requested, for follow up. She is accompanied by her mother and husband.**

**1. What should your initial assessment of Uma include and what is the diagnosis?**

**Initial assessment:** Assess the general condition—measure the pulse, blood pressure and temperature, check for pallor, check the respiratory rate, conduct a urine examination and carry out a quick abdominal examination.

**Findings:** Uma's pulse is 80 per minute and her blood pressure is 150/90 mmHg, even during the second reading after four hours. Her respiratory rate is 24 breaths per minute and the urine negative for proteins. The abdominal examination reveals that the FHR is 120. It also reveals a cephalic presentation and longitudinal lie. The uterine size is consistent with the date.

**Probable diagnosis:** The probable diagnosis is PIH.

**2. How should you manage Uma?**

She should be referred to the 24-hour PHC/FRU for further management and should be told to follow the advice of the MO. If she is not treated on time, she may end up with other life-threatening complications, including eclampsia. Make sure contact is maintained with Uma or her family, as such cases need to be followed up appropriately by the health worker.

**3. What advice should you give Uma and her family?**

Encourage her to take rest and a normal diet, with no restrictions on salt and fluids. Advise her to have an institutional delivery. Ask her family members to rush her to the PHC/FRU if they see danger signs, such as:

- Headache (increasing in frequency and duration)
- Visual disturbances (blurring, double vision, blindness)
- Oliguria (passing less than 400 ml of urine in 24 hours)
- Upper abdominal pain
- Oedema, especially on the face and lower back

### 3. Convulsions—eclampsia

**Step 1**

**(Refer to Guidelines Module 2: Convulsions, presentation 6a and checklist 4.4 in Handbook.)**

- Ask the trainees if they have dealt with a woman suffering from fits during pregnancy, labour or in the postpartum period.
- If so, what was the outcome of the convulsions and how did the trainees manage them?
- Did they conduct any tests, such as measuring the blood pressure or testing the urine for proteins, immediately?
- Note down the trainees' responses on a flip chart.

**Step 2**

- Explain that if convulsions occur any time during pregnancy, labour or the postpartum period, the woman should be considered to have eclampsia, unless proved otherwise.
- Explain that eclampsia is a dangerous complication for the mother and baby, and is one of the major causes of maternal death.
- Inform the trainees that the fits of eclampsia resemble the fits of epilepsy. Hence, it is always useful to ask the client while taking her history if she suffers from epilepsy. The difference is that eclampsia is characterized by high blood pressure and proteinuria and occurs only during pregnancy, labour or the postpartum period.

**Step 3**

- Discuss the management of a woman with eclampsia. (Refer to Guidelines Module 2, presentation 6a and checklist 4.4 in Handbook.)
- Explain that supportive care is the first step in the management of a woman suffering from fits. Supportive care includes ensuring a clear airway, maintaining proper breathing and checking if the heart is beating.

**Step 4**

**Demonstration**

- Demonstrate how to administer a Magnesium Sulphate injection on a dummy model. (Use checklist 4.6 in Handbook and presentation 6a.)
- Make each trainee demonstrate the same.

**Step 5**

- Stress that Magnesium Sulphate should be administered only as a deep intramuscular injection in the buttocks Inform the trainees about the symptoms which a woman may experience during or after the injection. (Refer to the Guidelines and presentation 6.)
- Stress that the ANM should administer only the first dose of the Magnesium Sulphate injection and then refer the woman to a 24-hour PHC/FRU. If possible, she should accompany the woman to the FRU.
- The woman should reach the FRU within two hours of receiving the first dose of the Magnesium Sulphate injection.

**Step 6**

**Ask the trainees to complete case study 8 given in their handbook. The answers have been given in the next page for your reference.**

## CASE STUDY 8

**Q. Smita is 23 years old. She is 36 weeks' pregnant. For the past two months, she was being treated at the PHC for PIH. Smita has been counselled about the danger signs of PIH and what to do about them. Her mother and husband have brought her to the health centre because she developed a severe headache and blurred vision this morning, and had convulsions on the way to the health centre.**

**1. What should your initial assessment of Smita include and what is the diagnosis?**

**Initial assessment:** Assess the general condition—measure the pulse, blood pressure and temperature, check for pallor, check the respiratory rate, and conduct a urine examination after passing a catheter. Also record her urine output.

**Findings:** Smita's pulse is 100 per minute, her blood pressure is 160/110 mmHg, there is no pallor and her respiratory rate is 24 breaths per minute. The urine examination shows proteinuria 3+. The abdominal examination reveals that the FHR is 100, and it also reveals a cephalic presentation and longitudinal lie.

**Probable diagnosis:** The probable diagnosis is eclampsia.

**2. How should you manage Smita?**

She should be offered supportive care, such as the following.

- Position her on the left lateral side.
- Remove any obstructions and place a mouth gag to prevent tongue bite. (Do not insert the gag during a fit)
- Clean the mouth and nostrils by applying gentle suction, and remove the secretions.
- Administer the first dose of magnesium sulphate (10 ml, i.e. 5 g) by deep intramuscular injection in each buttock.
- Record the vital signs and measures of initial management. Fill in the referral slip and refer her to the FRU as early as possible for further management.
- If delivery is imminent, deliver her in PHC and refer to FRU soon after delivery with referral slip.

**3. What advice should you give Smita's husband/mother?**

Explain her condition and answer their queries. Ask them to remain by Smita's side in order to protect her from a fall or injury

**4. Anaemia**

**Step I**

- Ask the trainees to recall how to identify anaemia and the dangers it poses to the pregnant woman.
- Stress that anaemia during pregnancy is dangerous for the mother and baby, and is dangerous for the mother during labour and the postpartum period as well.
- Ask the trainees to recall the prophylactic and therapeutic doses of IFA.
- Discuss the management of anaemia during pregnancy. (Refer to Guidelines Module 2 and presentation 6a.)

**5. Urinary tract infection**

**Step I**

- Discuss how to identify and manage UTI.
- UTI should be suspected when a woman complains of fever and/or burning on urination and/or pain in the flanks.
- The woman should be referred to the MO for management.
- Explain that it is common for women to have UTI during pregnancy and the postpartum period if proper perineal hygiene is not maintained. (Refer to Guidelines Module 2 and presentation 6a.)

**6. Pre-term labour**

**Step I**

- Ask the trainees what they understand by pre-term labour. Note down their responses.
- Explain the definition of pre-term labour and speak about its management. (Refer to Guidelines Module 2.6 and presentation 6.)
- Tell the trainees that breech presentation is common in pre-term deliveries; hence, it is important to assess foetal presentation accurately.
- Explain that if the delivery is imminent, the baby should be delivered and the woman referred to an FRU which has facilities for neonatal care.
- Tell them that they should always keep the equipment required for resuscitation of the newborn ready in advance, in case it is required after the delivery.

**7. Premature/Pre-labour rupture of membranes (PROM)**

**Step I**

- Ask the trainees what they understand by PROM. Note down their responses.
- Explain how to identify and manage PROM. (Refer to Guidelines Module 2 and presentation 6a.)
- Explain that there is an increased chance of infection travelling up to the uterus and foetus if the membranes rupture before 8 months of pregnancy, or if labour does not start within 8–12 hours of rupture of the membranes.
- Discuss the dose and route of administration of the antibiotics to be given to prevent or control infection in such cases.
- Stress the importance of referring the woman to an FRU as she may need a Caesarean Section or an assisted delivery to save her life and that of the baby.

**8. Foetal distress**

**Step I**

- Ask the trainees to recall the normal range of the FHR (between 120–160 beats per minute).
- Explain that foetal distress is diagnosed if the FHR is either less than 120 or more than 160 beats per minute.
- Foetal distress is also diagnosed if the amniotic fluid is greenish or brownish. Normally, the amniotic fluid should be clear or opaque.
- Start oxygen for the mother if there are signs of fetal distress.
- Explain the steps to be taken if the woman is in early labour and also, if she is in late labour, and delivery is imminent.
  **(Refer to Guidelines Module 2 and presentation 6a.)**

**9. Obstructed labour**

**Step I**

- Explain what is meant by obstructed labour, and describe the symptoms and signs to help diagnose obstructed labour.
- Inform the trainees that obstructed labour is another important cause of maternal death as it may lead to a ruptured uterus. Stress that abnormal presentation, especially transverse lie, is an important cause of obstructed labour.
- Tell them that obstructed labour is an obstetric emergency and requires immediate Caesarean Section.
- Discuss the management of obstructed labour. **(Refer to Guidelines Module 2 and presentation 6a.)**

**10. Prolapsed cord**

**Step I**

- Ask the trainees what they understand by the term prolapsed cord.
- Explain to them that prolapsed cord is a condition in which the umbilical cord lies in the birth canal, below the foetal presenting part, or is visible at the vagina following rupture of the membranes.
- Inform them that a prolapsed cord is associated with foetal distress and may cause foetal death. Hence, it is an emergency and the woman should be referred to the FRU immediately.
- Stress that in cases of foetal distress, the ANM should look for the presence of a prolapsed cord.
- Tell them that when the delivery is imminent, they should be prepared to resuscitate the newborn and to refer the mother and baby to a higher health facility. **(Refer to Guidelines Module 2 and presentation 6a.)**

**11. Retained placenta and placental fragments**

**Step I**

- Ask the trainees whether they have attended a delivery in which the placenta did not deliver within an hour of the delivery of the baby. Note down their responses.
- If they say 'yes', ask them what happened and what they did to help the woman. Note down their responses.
- Ask them how long after the delivery of a baby do they consider the placenta to be retained. Note down their responses.
- Stress the fact that a retained placenta is an important cause of PPH and is dangerous for the woman.
- Hence, immediate steps need to be taken to stabilize and refer the woman to the MO of the 24-hour PHC/FRU.
- Explain that ANMs and LHVs should not be tempted to try to remove the retained placenta or its fragments from the uterus at the domiciliary or SC level.
- However, if the placenta is separated and is lying in the vagina, then you can gently and slowly remove it by inserting a gloved hand into the vagina. (Refer to Guidelines Module 2 and use presentation 6a.)

## 12. Vaginal and perineal tears

**Step 1**

- Ask the trainees if they have encountered tears in the perineum or vagina during the course of conducting deliveries in their clinics/SCs.
- Ask them how they identified the tears and differentiated them from deeper tears. Note down their responses.
- Ask them what they do in such situations to manage the problem. Note down their responses.
- Discuss with the trainees how to identify and manage superficial and deep perineal tears, in which conditions the woman should be referred to the MO PHC at the PHC/FRU, and the steps to be kept in mind before and while transporting the woman.
- Stress that it is not necessary to refer a woman with superficial perineal tears, which can be managed at the domiciliary and SC level. **(Refer to Guidelines Module 2 and use presentation 6a.)**

## 13. Puerperal sepsis

**Step 1**

- Tell the trainees what puerperal sepsis is and what its symptoms and signs are.
- Also, tell them that fever in the postpartum period can be due to causes other than puerperal sepsis, such as UTI, mastitis and other non-obstetric causes.
- Tell them that if the general condition of the woman is fair, she should be given the first dose of antibiotics and referred to a PHC/FRU.
- If the general condition of the woman is poor, intravenous fluids should be started, she should be given the first dose of antibiotics and should be referred to the MO at the PHC for further care.
  **(Refer to Guidelines Module 2, checklist 4.5 in Handbook and presentation 6a.)**

**Step 2**

**Ask the trainees to complete case study 9 given in their handbook. The answers have been given in the next page for your reference.**

## CASE STUDY 9

**Q. Sita is 20 years old. She had a full-term normal delivery a week ago. She complained of intermittent fever and chills during the past 24 hours and thought that she had the flu, which most people in her village have had recently. She also complained of pain in the lower abdomen and foul-smelling vaginal bleeding. Sita comes to the health centre complaining that the fever and chills have continued and that she has developed abdominal pain.**

**1. What should your initial assessment of Sita include?**

**Initial assessment:** Assess the general condition—measure the pulse, blood pressure and temperature, check for pallor, check the respiratory rate, and assess the amount of vaginal bleeding (going by the number of pads soaked).

**Findings:** Sita's pulse is 100 per minute, her blood pressure is 110/70 mmHg, her temperature is is 39° C, and her respiratory rate is 26 breaths per minute. She has foul-smelling vaginal discharge. Abdominal examination reveals tenderness in the lower abdomen and the uterus appears sub-involuted.

**Probable diagnosis:** The probable diagnosis is puerperal sepsis.

**2. How should you manage Sita?**

Sita should be given the first dose of antibiotics, namely:

- Gentamicin injection (80 mg intramuscular stat)
- Ampicillin capsule (1 g orally)
- Metronidazole tablet (400 mg orally)

Refer her to the FRU, with the details of the examination and treatment given written clearly on the referral slip.

**3. What advice should you give Sita and her family?**

Sita's family should be advised to take her to the FRU as soon as possible and strictly follow the MO's instructions.

## 14. Breast conditions

**Step 1 :**

- Ask the trainees which common problems of the breast they have come across in a woman in the postpartum period. Explain that during lactation, the nipples can become sore and cracked and this happens usually because of improper attachment of the baby to the breast.
- Explain that pain in the nipples due to cracks and soreness prevents women from breastfeeding their babies. This leads to breast engorgement and more pain, and is often associated with fever.
- Discuss the signs of proper attachment of the baby to the breast and how to manage cracked nipples. **(Refer to Guidelines Module 2 and use presentation 6a.).**

**Step 2 :**

- Explain the steps to be followed when referring a woman with complications to the FRU/24-hour PHC. **(Use presentation 6a.)**

## SESSION VIb. ENSURING QUALITY OF CARE

### Venue: Lecture room

| OBJECTIVES | ACTIVITY | RESOURCE MATERIAL |
|---|---|---|
| By the end of the session, the trainees will be able:<br>1. To explain the role of partners in the community, such as self-help groups (SHGs), community-based organizations (CBOs) and non-governmental organizations (NGOs), in raising awareness regarding the danger signs during pregnancy, delivery and the postpartum period | • Knowledge assessment.<br>• Lecture/Discussion (use of ppt. Session VI.b).<br>• Demonstration. | • Module 3 of SBA guidelines. |

**Step 1**

- Tell the trainees that this session is on community involvement in improving the health of women and bringing down maternal mortality.
- Generate a discussion on a list of things that they can do as a part of their responsibility to empower the community to improve the state of health of women. **(Refer to Module 3.)**
- Discuss how they can help the community in drawing up an action plan to respond to emergencies.
- Emphasize the importance of making a review of the maternal deaths in one's area.
- Speak about the fact that pregnancy is a time of joy and hence, to prevent all unpleasantness, the trainees, as the health-care providers at the grassroots level, should provide every woman with supportive care. They should also be aware of the rights of every woman.
- Explain the general principles of communication and support.
- Inform them about the JSY. **(Use presentation 6b and Guidelines Module 3: Ensuring Quality.)**

**Step 2**

- Ask the trainees what critical skills they have acquired in this session. Ensure that trainees recall all the critical skills as given in box 6.b.1 below.

**Box 6.b.1**

**Critical Skills**

Knows how to recognize, manage and take corrective measures for complications occurring during pregnancy, labour, delivery and the postpartum period

- Vaginal bleeding
- PIH
- Convulsions—eclampsia
- Anaemia
- UTI
- Pre-term labour
- PROM
- Foetal distress
- Obstructed labour
- Prolapsed cord

- Retained placenta and placental fragments
- Vaginal and perineal tears
- Puerperal sepsis
- Breast conditions

- Wrap up the session by revising the topics covered and ask one of the trainees to prepare a recapitulation of Day 6.
- Plan the schedule for hospital postings with the trainees.

Notes

Notes


Maternal Health Division
Department of Family Welfare
Ministry of Health and Family Welfare
Government of India