December 2022

Helping Mothers Survive

Prolonged & Obstructed Labor

Flip Chart - Part 1 of 2: Assessment

NOTE: *All providers must complete the modules on "Essential Care for Labor & Birth (ECL&B)" before attempting this module.*

FIGO International Federation of Gynecology and Obstetrics — the Global Voice for Women's Health

International Confederation of Midwives — Strengthening Midwifery Globally

UNFPA

American Academy of Pediatrics — DEDICATED TO THE HEALTH OF ALL CHILDREN®

jhpiego — Saving lives. Improving health. Transforming futures.

For the facilitator

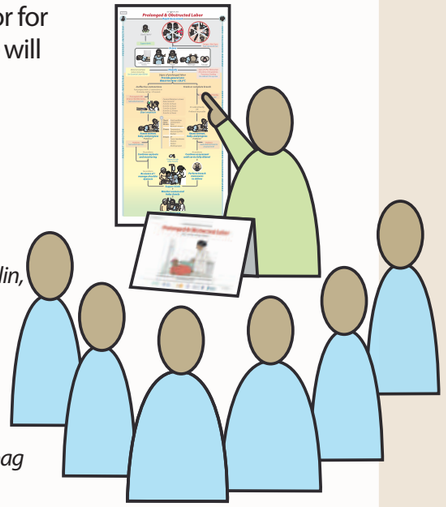
How to facilitate hands on training and ongoing practice

1 *Before the training*

- Plan for training with leadership and local organizers well in advance. Training takes 2 full days but can be broken up into smaller sessions as needed.
- Visit ***www.helpingmotherssurvive.org*** and ***hmbs.org*** to find the tools to help you prepare for and carry out training. You can download learning modules, a preparation checklist, sample agendas and other useful resources.
- Download the ***video chapter book*** (approx. 500 MB) created by Global Health Media Project. You will use the video clips from this video book when you see this icon ▶
- Review service delivery data and documentation practices with facility management so you know the strengths and gaps.

2 *Arrange materials and equipment and put up the Action Plan*

- You will need 1 practice station, facilitator and birthing simulator for every 4 learners. If you can have fewer learners per group, there will be more time for hands-on work.
- Set up video with sound if you are able to use video.
- Ensure you have the following at each practice station:

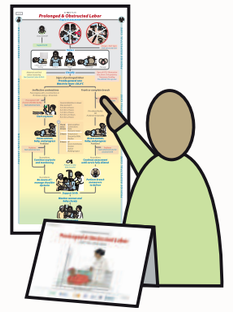


- *Videos and projector/laptop (if using)*
- *Flipchart and markers*
- *Pregnancy wheels or calendars*
- *Pens/pencils, paper, blank partographs and/or client records/labor documentation tool, referral forms*
- *BP machine - 1 per 2 learners*
- *Stethoscope - 1 per 2 learners*
- *Thermometer*
- *Birth simulator with newborn model*
- *Gloves (clean and sterile)*
- *Fetoscope/Doppler and ultrasound gel*
- *Measuring tape*
- *Soap or alcohol based hand rub*
- *Towels, baby hat, and blanket*
- *Scissors or blade*
- *Hemostats, clamps, ties for cord*
- *Basin for placenta*
- *Personal protection for provider*
- *Mock oxytocin, misoprostol, ampicillin, gentamicin, betamimetics, rubbing alcohol, syringes and needles*
- *IV giving set., tourniquet, and fluids (normal saline, Ringer's Lactate, 5% glucose)*
- *IV pump, if available*
- *Indwelling catheter with collection bag*
- *Suction device for baby*
- *Ventilation bag and mask for baby*
- *Clock/watch with second hand*
- *Gauze*

3 *Welcome participants and identify level of knowledge and skills*

- Welcome participants when they arrive.
- Hand out the Knowledge Assessment to be completed.
- Evaluate the participants and give feedback in a way that encourages learning.

4 *Introduce the module and learning objectives*



- Introduce the learning materials, including the Action Plan.
- Follow the content outlined in the Flipchart.
- As you teach, point out where you are on the Action plan. Review how you got to each step to reinforce steps in the Action plan.
- Always emphasize and model respectful care and good communication.

5 *Engage every participant in discussion and practice*

- As you explain and demonstrate, involve participants by inviting discussion. Engage them in skills practice, simulations and role-plays. Encourage them to wear the simulator during practice and guide them to use it.
- Use the "Discuss" questions to identify local problems and find local solutions to achieve the best care possible.

6 *Evaluate participants*

- Use the Knowledge Assessments and OSCEs for each module to check knowledge and skills

7 *Encourage continued practice and quality improvement*

- Help participants plan changes that will improve care in the facility.
- Identify 2 providers at each facility to help their peers practice after training.
- Use the plan for LDHF practice and quality improvement activities found in the back of the Provider's Guide.
- Register your session information - what module, how many participated, where and when at ***www.helpingmotherssurvive.org***

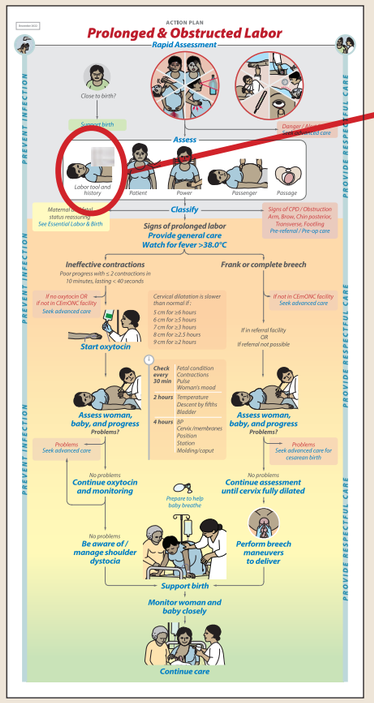
For the facilitator

How to use the course materials

NOTE: All providers must complete the module on "Essential Care for Labor and Birth (ECL&B)" before attempting this module.

Action Plan

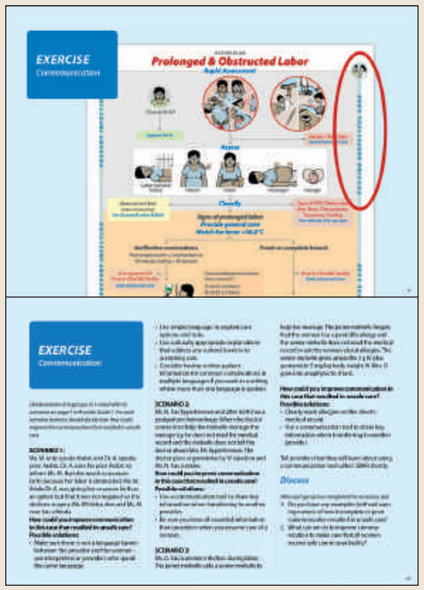
Ask a participant to point out the relevant action.



Flipchart

Use illustrations and text to teach the action.

Practice the sequence of the Action Plan using the practice exercises.



Provider´s guide

Identify, plan for, and address changes that will improve care in the facility.

LDHF practice

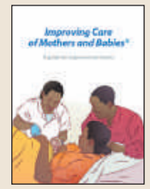
Use the LDHF sessions in the back of the Provider's Guide to ensure ongoing practice in the facility.

Additional resources

IMPAC Managing Complications of Pregnancy and Childbirth>

IMPAC Pregnancy, Childbirth, Postpartum, and Newborn Care>

World Health Organization's Quality of Care Framework>



Survive & Thrive Quality Improvement Workbook>

WHO recommendations Intrapartum care of a positive childbirth experience

Scan QR Code

Use the camera if you have an Iphone, or download the QR Code App to go directly to the Helping Mothers Survive website.

www.helpingmotherssurvive.org

Explain and demonstrate

Explain: "Need to know" information to cover during this session. Involve participants by asking questions.
Demonstrate: Skills will be presented by video. If videos are not shown, give live demonstration as described and proceed to practice or the next section as directed.

Practice

Providers repeat newly learned or refreshed skills with feedback. Spend more time practicing than talking and use the group practices to ensure skills are mastered. Encourage self-reflection, feedback, and review of actions to improve performance (debriefing).

Discuss

Honor providers' experiences by encouraging them to share. Explore what is actually being done in their facility (Is this what you do now? Why or why not?). Identify ways to overcome barriers and put new skills into practice.

Knowledge check

Knowledge checks provide an opportunity to review and reinforce information learned.

You can make a difference

Explain

Start with a story.

Say to learners, ***"Close your eyes and imagine that a woman is referred to your facility because she could not give birth after pushing for hours. You find she is in shock, contractions have stopped, the head is on the perineum, and her uterus has ruptured".*** *(Pause)* ***"She died during surgery."*** *Pause again to allow the learners to reflect.*

Say, ***"Open your eyes. How do you feel? Have you known women who died because a diagnosis was missed or because they did not receive the care they needed?"***

Allow for response. Say, ***"Imagine that another woman is referred to your hospital for prolonged labor. At the health center, the midwife carefully examined the woman, checked the fetal heart rate, and reviewed her labor record. She suspected obstructed labor and referred her for a cesarean birth. She arrived here with an IV in place and all pre-referral care had been given. She had a successful cesarean birth and a healthy baby girl."*** *Pause, then ask,* ***"Now how do you feel? Would anyone like to share?"***

Thank learners and say, ***"Every woman needs a skilled provider caring for her during labor and birth to provide close monitoring and good care. This way she, her baby, and the progress of her labor can be carefully watched and problems can be found and managed quickly. Her life and the life of her baby depend on you. Every one of us can make a difference."***

"Today we are going to review the knowledge, skills and decision-making for when labor is not progressing as we expect or if the fetus is not in the usual position. All of you should have had the Essential Care for Labor & Birth module. Can we confirm that everyone has? Ok, let us get started!"

Helping Mothers and Babies Survive

Helping Mothers Survive (HMS) *and* **Helping Babies Survive (HBS)** *modules build the capacity of all providers to give compassionate, routine and lifesaving care to women and babies; care that honors women's choices.*

HMS learning materials:

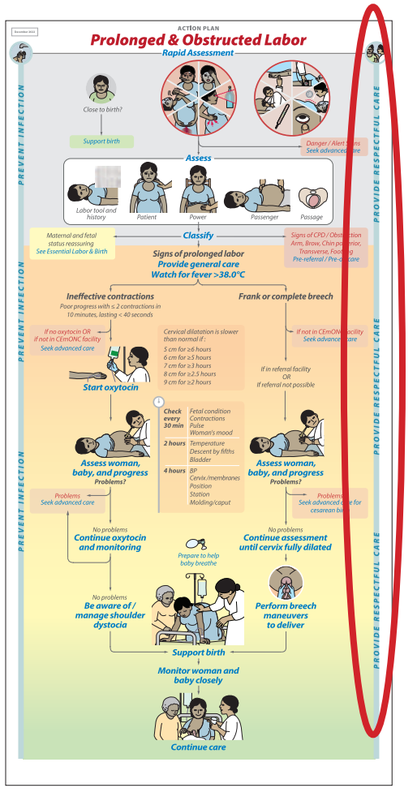
Action Plan: helps identify and manage problems with the process of labor and birth.
Flip Chart: used for instruction
Provider's Guide: includes checklists, more information and help for ongoing practice.
We will use this today for some activities.

Say, ***"We will combine our learning today with online resources and videos. After today's session, you will continue to do short practice sessions and other activities with a peer coordinator from your facility to help keep skills fresh."***

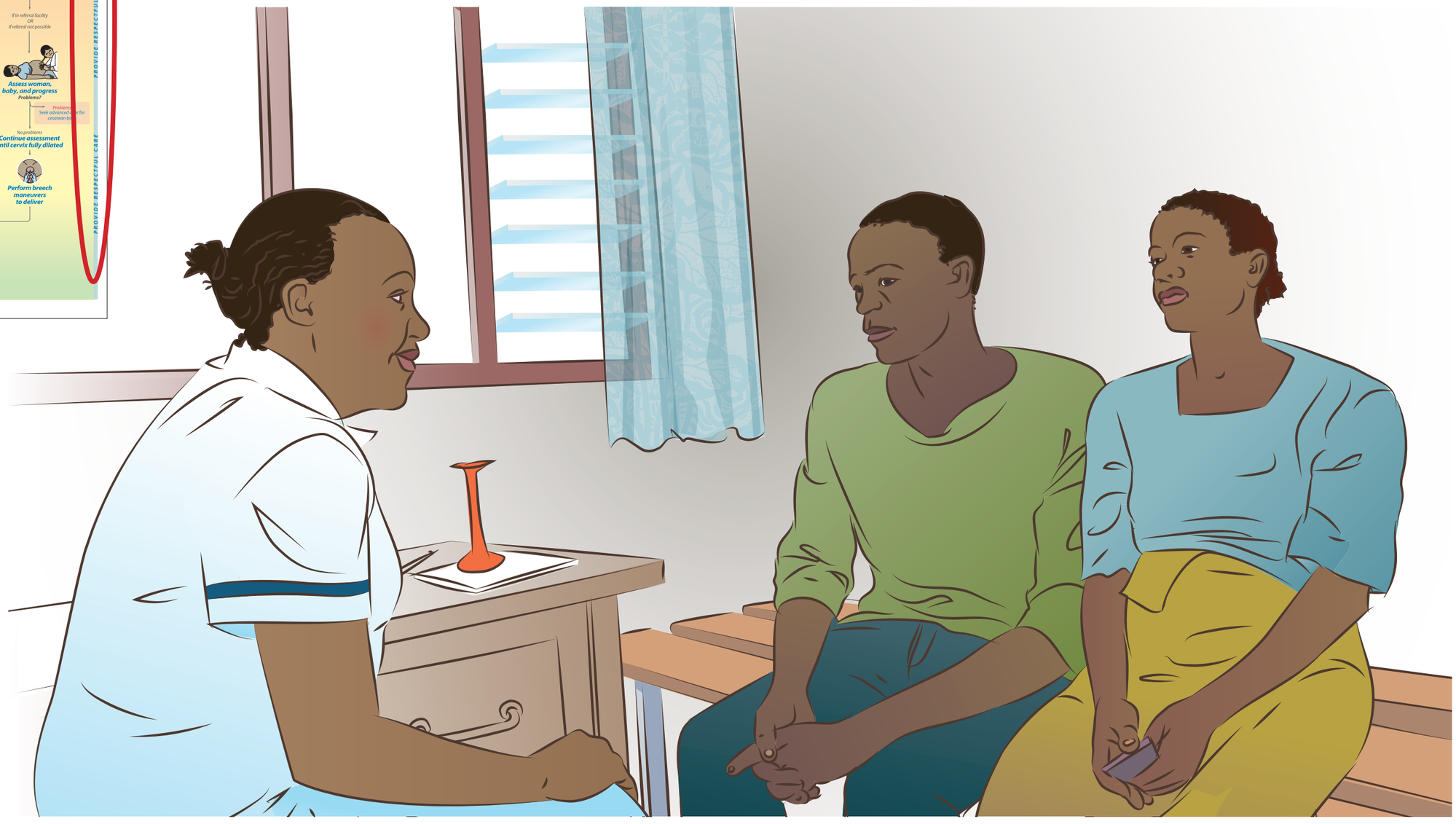
Say, ***"As we go through the day, we will write down any areas for improvement at this facility such as challenges with communication, or being able to closely assess and monitor women with prolonged labor. We will revisit these items together later. Could I ask for a volunteer to please write these for us as they come up?"***

Discuss

Introduce yourself and any other trainers, if you have not done so already. Ask learners to introduce themselves if they do not know each other.



Provide respectful care



Explain

During a complication, RMC includes being a calming presence. Remember to:

- Make eye contact.
- Speak calmly and directly to the woman.
- Validate her experience; she may be very emotional and hard to reach.
- Non-verbal, gentle touch can be reassuring.

Ask; ***"When a woman or her newborn is experiencing a complication, how can you respect the woman's right to information, consent, and respect her choices which may include refusal of medical procedures?"***

- Provide clear, easily understood information about what is happening and what her options are.
- Always obtain oral or written consent before providing care.
- If the woman has declined a procedure for herself or her newborn, make sure she has understood the benefits and risks of declining it. Document this in the record.
- Even when a woman has declined a drug or procedure, continue to provide quality, respectful care.

"How can you make sure to respect a woman's right to privacy and confidentiality when you must transfer her to another facility or provider because of a problem?"

- Only share her information with her consent.
- When giving information to another provider to assure continuity of care, make sure that only those providers needing the information can hear.

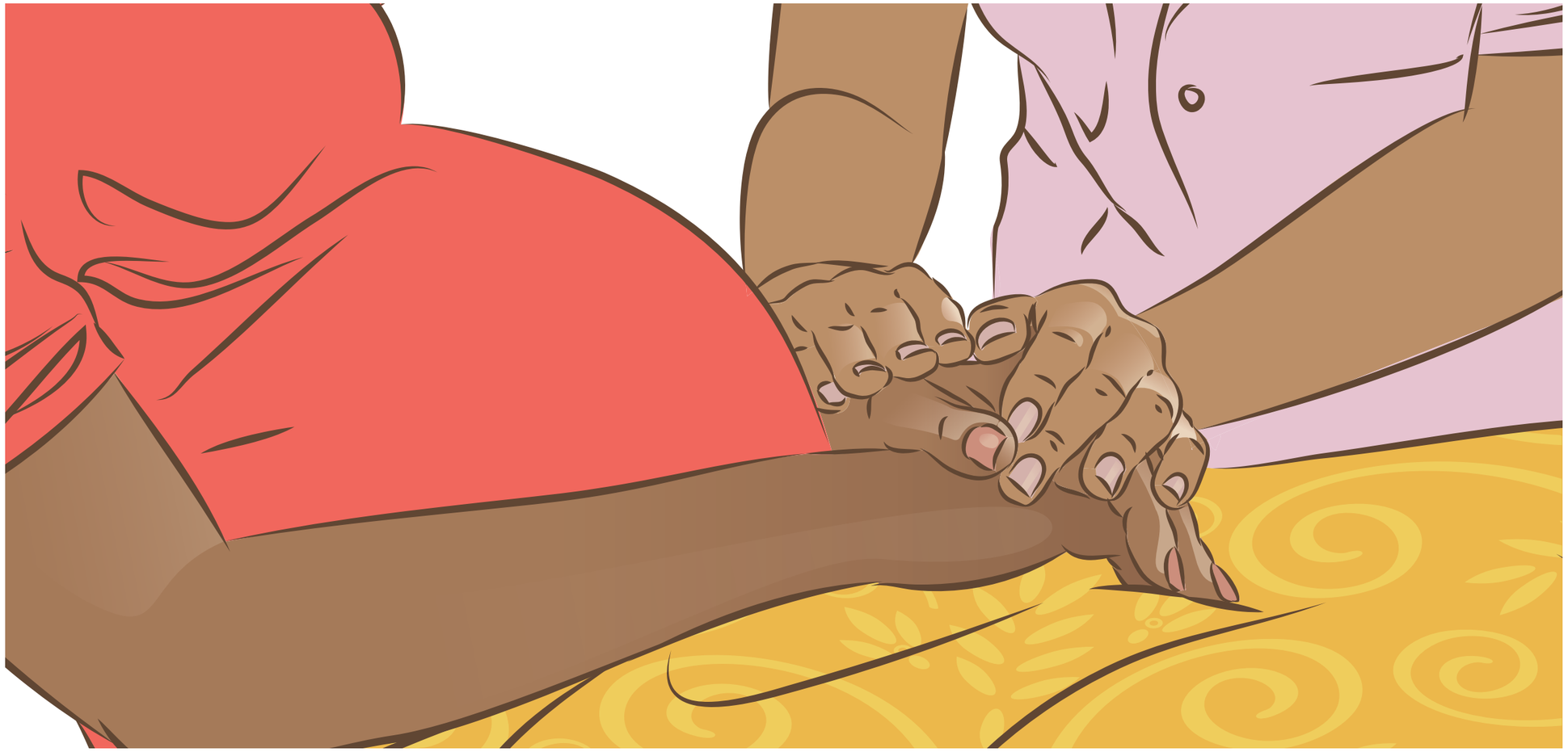
"How can you protect a newborn's right to be with the parents or guardians?"

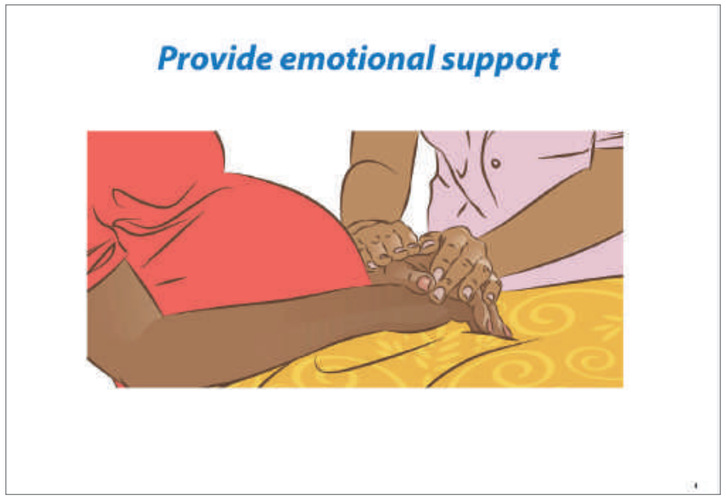
- Keep the woman and her baby together at all times.
- Do not take the newborn from the mother without her consent.
- Monitor and provide care for the baby in the presence of the mother, even during skin-to-skin if possible.
- If the newborn is small or premature, keep the baby with the mother at all times unless he needs care in a special care nursery.
- If the baby is in a special care nursery, make sure the woman can visit her baby.

Discuss

1. What have you done since you completed the module on "Essential Care for Labor & Birth" to make sure that women receive respectful care at your facility?
2. What challenges did you have when you tried to implement any changes? How did you address these challenges?

Provide emotional support





Explain

Women who are having complications may find it hard to talk and explain the problem. It is the responsibility of the entire team to speak with the woman respectfully and put her at ease.

When a woman, her fetus, or her newborn have a complication:

- Listen to her and her family and encourage them to express their concerns; try not to interrupt.
- Respect the woman's sense of privacy and modesty by closing the door or curtains.
- Let the woman know that you are listening carefully.
- Answer the woman's questions directly and calmly. Reassure her. Tell the woman and her family as much as you can about what is happening. Often a simple explanation of what is happening and what to expect can calm their fears and prepare them for what will happen next.
- Be honest. Do not hesitate to admit what you do not know. Maintaining trust matters more than appearing knowledgeable.
- Make sure the woman and her companion understand the information you have provided and ask if they have any further questions.

Practice

In groups of three, practice providing information to a woman who is being referred for obstructed labor.
One will play the role of the provider, the second person will be the pregnant woman, and the third person will be the companion. Read the following information to the learners:

Provider:
You are working at a health center. You identified a Bandl's ring and are preparing to refer the woman for a cesarean birth before the uterus ruptures.

Woman:
You are in pain and scared.
Companion:
You are scared and anxious.

Discuss

1. What are the medical cultural practices in your country around informing people about "bad news" and complications?
2. How does this differ from what we have discussed?
3. How hard will it be for you to change how you talk to women about complications and help support them?

Communication

Explain

Effective communication is important at any time, and even more important when there are complications.

Good communication helps build and maintain strong relationships between providers and clients, providers and colleagues, and between supervisors and staff.

When providers are not communicating effectively, patient safety is at risk because:

- critical information may not be shared
- information may not be understood
- orders may be unclear
- the right care may not be given
- changes in status may be missed

We will be using a communication tool called "SBAR" later today to improve our communication skills.

You will need to communicate with:

- clients and family about admission, complications, treatment, and self-care instructions
- providers regarding patient management, resuscitation and emergency care and during hand overs
- other departments such as pharmacy, laboratory, imaging, operating theater, and intensive care unit
- providers at other facilities when a client is transferred.

Women are more likely to have a positive experience, regardless of outcome if they:

- feel free to make their own choices, even when there are problems
- feel safe and cared for
- feel connected to providers, family and their babies
- feel they are being treated with respect
- understand what happened
- understand that they cannot always control what happens during labor and birth and that complications are not their fault

When there is a problem, communicate quickly with team members.

- Always communicate with respect.
- Communicate confidently and clearly - do not assume others know what you are thinking.
- Provide clear, concise information about the woman's condition.
- Identify team members, including team lead, and a clear role for each member.
- Know who to call if you need a medical consultation or transfer.
- Communicate with the hospital before transporting the woman to reduce wait times and assure safe care.

Discuss

What are some of the challenges at your facility with communicating with:

1. Referral facilities or with facilities who have referred patients to your facility?
2. Providers who are replacing you when your shift ends?

EXERCISE
Commmunication

ACTION PLAN

Prolonged & Obstructed Labor

PREVENT INFECTION

PROVIDE RESPECTFUL CARE

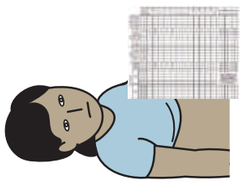
Rapid Assessment

Close to birth?

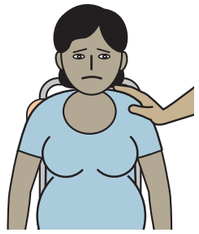
Support birth

Danger / Alert Signs
Seek advanced care

Assess



Labor tool and history



Patient

Power

Passenger

Passage

Classify

Maternal and fetal status reassuring
See Essential Labor & Birth

Signs of CPD / Obstruction
Arm, Brow, Chin posterior, Transverse, Footling
Pre-referral / Pre-op care

Signs of prolonged labor
Provide general care
Watch for fever >38.0°C

Ineffective contractions

Poor progress with ≤ 2 contractions in 10 minutes, lasting < 40 seconds

If no oxytocin OR if not in CEmONC facility
Seek advanced care

Cervical dilatation is slower than normal if :

5 cm for ≥6 hours
6 cm for ≥5 hours
7 cm for ≥3 hours

Frank or complete breech

If not in CEmONC facility
Seek advanced care

EXERCISE
Commmunication

Divide learners into groups of 3-4 and refer to scenarios on page 5 in Provider Guide 1. For each scenario, learners should decide how they could improve the communication that resulted in unsafe care.

SCENARIO 1:
Ms. M. only speaks Arabic and Dr. A. speaks poor Arabic. Dr. A. uses his poor Arabic to inform Ms. M. that she needs a cesarean birth because her labor is obstructed. Ms. M. thinks Dr A. was giving her cesarean birth as an option but that it was not required so she declines surgery. Ms. M's fetus dies and Ms. M. now has a fistula.

How could you improve communication in this case that resulted in unsafe care?
Possible solutions:

- Make sure there is not a language barrier between the provider and the woman – use interpreters or providers who speak the same language.
- Use simple language to explain care options and risks.
- Use culturally appropriate explanations that address any cultural barriers to accepting care.
- Consider having written patient information for common complications in multiple languages if you work in a setting where more than one language is spoken.

SCENARIO 2:
Ms. N. has hypertension and after birth has a postpartum hemorrhage. When the doctor comes in to help the midwife manage the emergency, he does not read the medical record and the midwife does not tell the doctor about Mrs. N's hypertension. The doctor gives ergometrine by IV injection and Ms. N. has a stroke.

How could you improve communication in this case that resulted in unsafe care?
Possible solutions:

- Use a communication tool to share key information when transferring to another provider.
- Be sure you have all essential information from providers when you assume care of a woman.

SCENARIO 3:
Ms. O. has a uterine infection during labor. The junior midwife calls a senior midwife to help her manage. The junior midwife forgets that the woman has a penicillin allergy and the senior midwife does not read the medical record or ask the woman about allergies. The senior midwife gives ampicillin 2 g IV plus gentamicin 5 mg/kg body weight IV. Mrs. O goes into anaphylactic shock.

How could you improve communication in this case that resulted in unsafe care?
Possible solutions:

- Clearly mark allergies on the client's medical record.
- Use a communication tool to share key information when transferring to another provider.

Tell providers that they will learn about using a communictation tool called SBAR shortly.

Discuss

After each group has completed the scenarios, ask:

1. Do you have any examples (without naming names) of how incomplete or poor communication resulted in unsafe care?
2. What can we do to improve communication to make sure that all women receive safe care in your facility?

Actively make decisions to quickly manage problems

Explain

While caring for a woman in labor, you must actively make decisions to quickly manage problems and improve outcomes. Point to the yellow circle on the front page and explain the steps. Each time you assess or ***check*** the woman, fetus, and labor progress you will need to ***record*** your findings, ***compare to alert values*****,** and then develop a care ***plan*** based on findings and shared decisions with the woman.

After you check a woman during routine monitoring or when she presents with a problem, you must record findings and compare them to alert values to help you decide:

- Which signs or symptoms are not normal?
- If findings are not normal, what is the most likely diagnosis? Infection, pre-eclampsia, anxiety, other?

After comparing findings with alert values, explain to the woman and her companion what care you think she needs:

- **Emergency care?**
- **What care does she need, both right now and ongoing?**
- If you can manage her care in your facility but need help:
  - Who do you need to call?
  - When will help arrive?

- If you need to transfer her:
  - Where will you send her?
  - How long will it take to get her there?
  - What do you need to do so you can transport her there safely?
  - What do you need so you can continue monitoring her and manage her problem during transport?
  - Can you safely transfer her before she gives birth?

Discuss

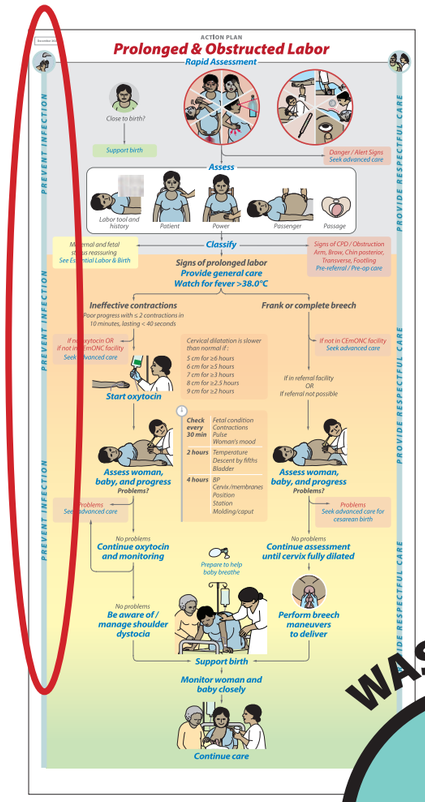
1. What is advanced care in this facility?
2. Who do you call if you have a problem you cannot manage?

Advanced Care Note

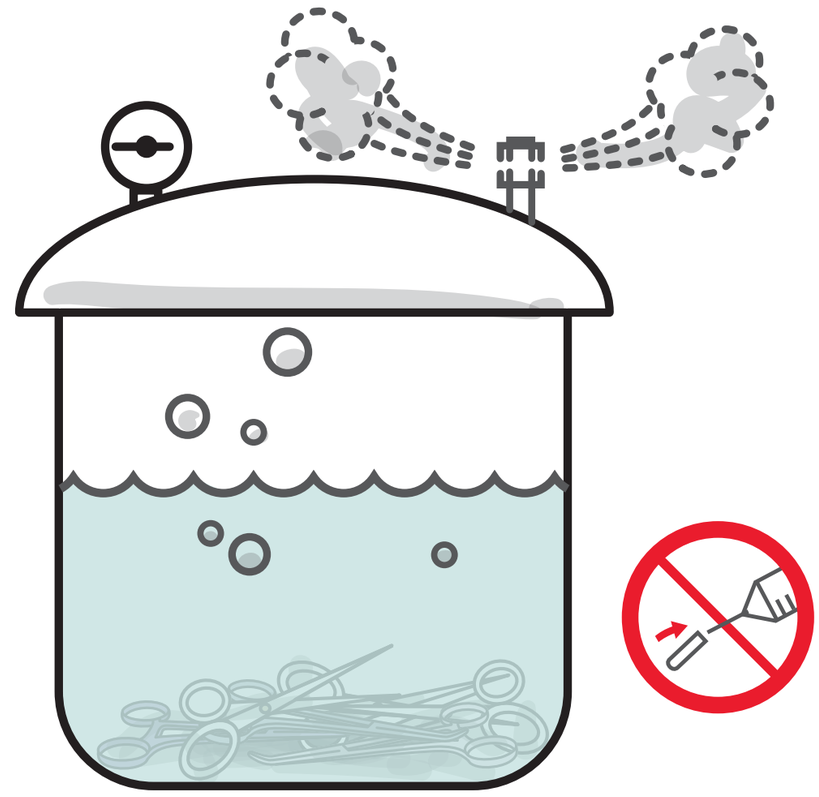
In facilities without the ability to do cesarean delivery or give advanced care, women who are unlikely to give birth vaginally or who have complications should be referred to a facility where the right care is available.

In facilities where advanced care is available, midwives and nurses should consult with physicians or other senior providers to refer or co-manage the woman's care.

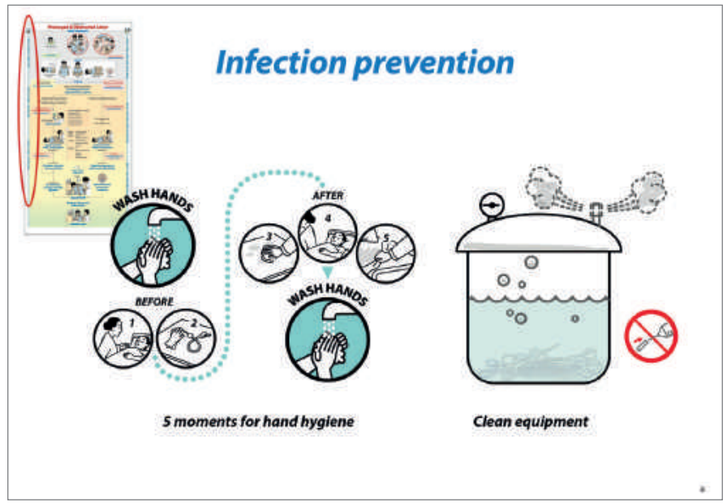
Infection prevention



5 moments for hand hygiene



Clean equipment



Explain

We reviewed infection prevention for all women during Essential Care for Labor & Birth training. However, preventing infection is even more important when caring for women with prolonged or obstructed labor. Both the woman and her baby are at higher risk of infection because women may:

- Have interventions that increase the risk of infection such as multiple vaginal exams, IV or IM injections, catheterization, cesarean birth or instrumental birth
- Have had ruptured membranes for a long time
- Be more exposed to bacteria on the labor ward because they are in labor longer
- Be exhausted and less able to fight infection

Ask, ***"Does anyone remember what the single most important thing is for preventing infection?"***
Answer - ***Handwashing!***

Demonstrate

Preventing Infection through handwashing

▶ *Preventing Infection*

Discuss

1. What steps have you taken since completing the "Essential Care for Labor & Birth" module to improve infection prevention at your facility?
2. Did you have any challenges? If so, how did you address them?
3. What more do you think needs to be done to improve infection prevention practices at your facility?

When video is not available

Ask the following questions to review information from Essential Care for Labor & Birth:

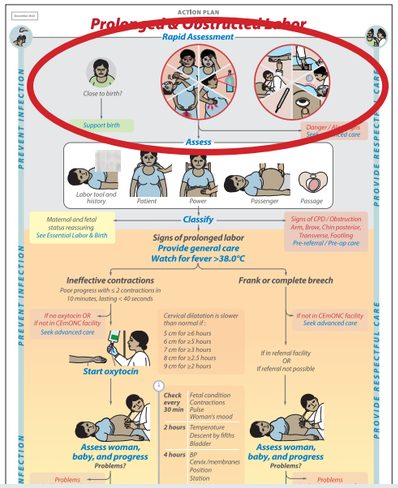
What are the WHO's 5 moments for hand hygiene?:

1. Before touching clients/putting on gloves
2. Before "clean"/ aseptic procedures
3. After exposure to body fluids
4. After touching clients/ removing gloves
5. After contact with client surroundings

How should you clean hands that are not visibly soiled?
Rub hands for 20 - 30 seconds using an alcohol-based hand rub.

How should you clean visibly soiled hands?
Wash visibly soiled hands with soap and water for 40 - 60 seconds.

How should you process equipment and instruments after use?
After use, put all instruments in closed, leak and puncture-proof containers. Wash in soapy water, rinse, dry, and either sterilize or HLD before reuse.

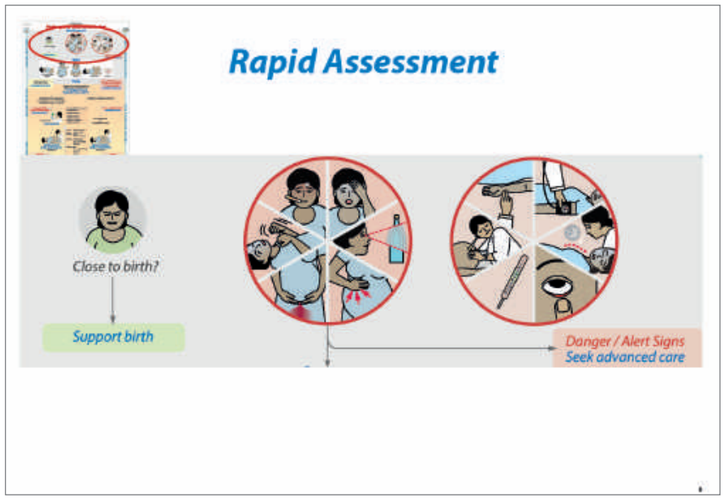


Rapid Assessment

Close to birth?

Support birth

Danger / Alert Signs
Seek advanced care



Explain

Quickly do a rapid assessment to identify problems and decide if a woman needs urgent care or additional assessments. Remember, a woman may have several problems and you must manage all of them.

Do a rapid assessment if:

- you receive a woman from another facility
  OR
- you think a woman is having a problem
  OR
- you are taking over care of a woman from another provider.

Greet her, listen carefully to the report given by the referring provider, and rapidly assess her to see if she needs emergency treatment.

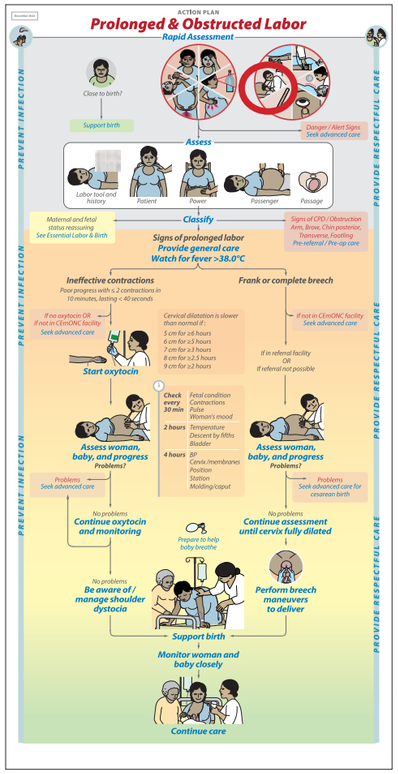
Demonstrate

Wear the simulator and ask a learner to conduct a rapid assessment, using the checklist on page 8 in Provider Guide 1.

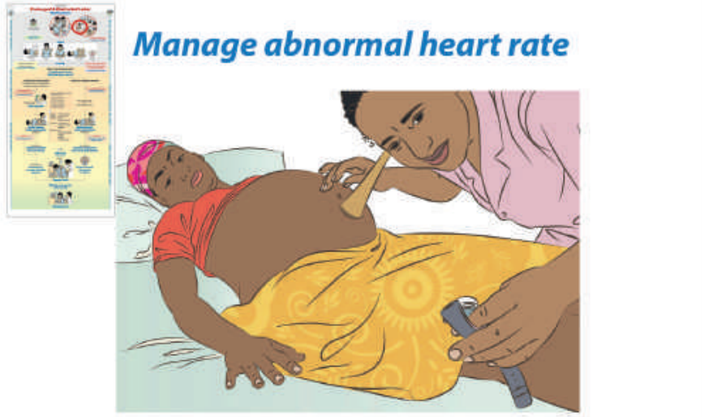
- Welcome the woman and her companion and introduce yourrself.
- Explain that you will check her vital signs and ask if she has concerns and problems.
- Wash your hands or use hand rub.
- Ensure privacy and confidentiality.
- Check if she is close to birth.
- Check how she is coping.
- Check if she has any danger signs. Point to the circles on the front page.
- Check if her vital signs are normal and see if there are signs of shock:
  - Normal pulse is 60-100 beats per minute (shock: pulse **110 beats per minute or more**)
  - Normal temperature less than or equal to 38 °C (shock: **cold and clammy skin)**
  - Normal systolic BP (sBP) is 90–139 mmHg and diastolic BP (dBP) is 60–89 mmHg (shock: **sBP less than 90 mmHg**)
  - Normal respirations between 12 and 20 breaths per minute (shock: **30 breaths per minute or more**)
- Check if she has signs of anemia:
  - Look at her conjunctiva and palms for pallor suggestive of anemia.
- Check if she appears dehydrated:
  - Look for sunken eyes and dry mouth.
  - Pinch the skin of her forearm to see if it goes back slowly.
  - If she has signs of dehydration, check for acetone ++ or more in the urine.
- Check the fetal heart rate for a minimum of 1 minute. Listen during a contraction and continue for at least 30 seconds after the contraction. Normal is 110-159 bpm
- Based on findings, decide if:
  - Birth is close? - Prepare for birth.
  - Any danger or alert signs that need urgent care?
  - Any additional assessments you need to do?
  - Does she need advanced care?
- Share findings with the woman and her companion.
- Address her concerns.

Discuss

1. Do you do rapid assessments if a woman comes to you with problems? Why or why not?
2. How might we ensure that a rapid assessment is done for every woman who may have a problem?



Manage abnormal heart rate



Explain

Recognizing early that the FHR is too high or too low can save lives.

- A normal FHR may slow during a contraction but will recover to normal as soon as the contraction is done.
- A very slow FHR in the absence of contractions or persisting after contractions may mean fetal distress.
- Causes for a slow FHR include head compression during rapid descent and pushing, hypoxia, acidosis, hyperstimulation, fetal heart block, or umbilical cord compression. At the end of second stage, the FHR may drop during pushing.

Demonstrate

Listening to the Baby's Heart

Remind learners that women should be as covered and not flat on their backs.

When video is not available

Ask learners to refer to page 10 in the Provider Guide 1 to follow the demonstration with the checklist. With a volunteer wearing the birth simulator, demonstrate assessment when the FHR is less than 110 or more than 159 beats per minute - you must act quickly!

Make sure you have an accurate measurement of FHR:

- Prop up the woman or place her on her left side.
- Stop oxytocin if it is being given.
- Give oxygen 4–6 L.
- Give fluids by mouth or IV.
- Confirm gestational age of the fetus. A preterm fetus may have a higher FHR.

Check for a maternal cause and treat any identified conditions:

- If a maternal cause is not identified, perform a vaginal examination to check for prolapsed cord or imminent birth.

After 5 minutes, recheck FHR for a full minute during a contraction and for 30 seconds after the contraction ends to evaluate if your management has helped.

- **If no improvement**, seek advanced care at a facility capable of performing a cesarean birth.
- **If improvement**, continue the same treatment, continue to evaluate the FHR, and complete assessment of the woman.

Inform the woman of your findings and address her concerns.

Advanced Care Note

Refer the woman to a facility that can perform a cesarean birth and care for a baby with problems if:

- The FHR remains abnormal for 10 minutes or longer
  OR
- The FHR does not improve after maternal position change / maternal interventions
  OR
- The FHR drops below 100 during a contraction and remains low for one minute after the contraction

Guidance should be adapted based on local protocols.

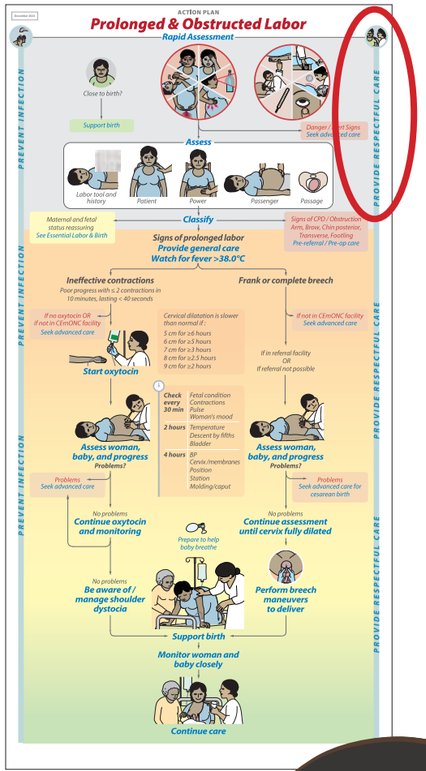
Knowledge check

The FHR was 115 bpm during a contraction and 148 bpm for one minute after the contraction passed. Is this FHR normal? Why?

Yes. A normal FHR may slow during a contraction.

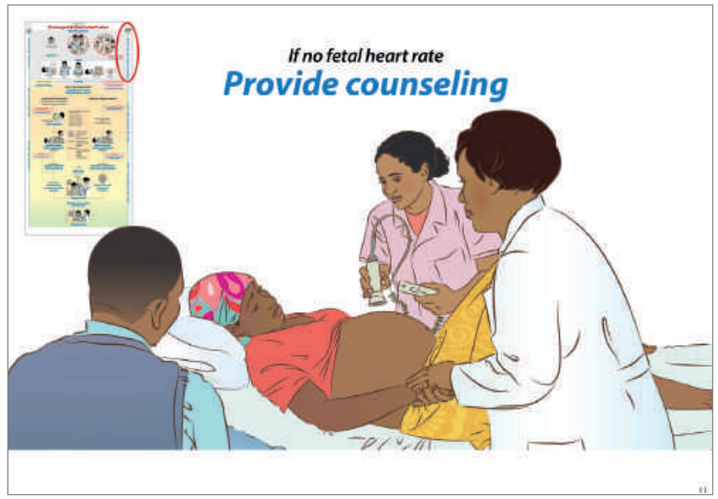
The FHR was 78-90 bpm between 3 contractions. Is this FHR normal? What could be the cause?

No. Possible causes: fetal head compression, uterus not relaxing between contractions or hyperstimulation, fetal hypoxia, fetal acidosis, umbilical cord compression, fetal heart block, or hearing maternal pulse



If no fetal heart rate

Provide counseling



Explain

Almost half of late fetal deaths occur in pregnancies that seemed to be normal.

- **Antepartum fetal death:**
  Death before labor starts
- **Intrapartum fetal death:**
  Death after labor starts, but before birth

If you cannot hear the fetal heart:

- Ask others to listen.
- Use a Doppler stethoscope, if available.
- Confirm fetal death by ultrasound, if available.

If fetal death is confirmed:

- Provide counseling and information in clear and simple language. You may need to repeat it.

Ask learners to refer to page 11 in Provider Guide 1. Ask volunteers to read the counseling points under each of the bullets below out loud:

- ***At the time of diagnosis***
- ***At birth and immediately postpartum***
- ***Postpartum***

Explain

- After birth, examine the baby and placenta and explain the findings to the parents. If the cause of death is known, provide clear information on cause. Do NOT guess!
- Treat the baby with respect. If there are malformations, explain them to the parents and make the baby as presentable as you can.
- **NOTE:** Make it clear that there is nothing the woman ate, did, or did not do that caused the fetal death.
- Respect the parents' preferences about seeing and holding the baby. Seeing the stillborn is proof of the baby's birth, existence, and death. Holding the baby helps in the grieving process but do not force them.
- **NOTE:** If the parents choose to hold the baby, give them time alone with the baby.
- Place a symbol or marker on the door, bed or curtain to signal that the parents have lost their baby. If your facility does not do this, have your volunteer add this to the list of items to discuss later.
- Help the parents collect items that may help with grief such as photographs, hand and footprints, locks of hair, hospital wrist or foot band.

Discuss

In your facility:

1. How do you diagnose intrapartum fetal death?
2. How do you give this news to the parents? Is this a challenge? What can make this easier?
3. What services are available for parents whose babies were stillborn? Is there anything you could do to offer additional support?

Knowledge check

When should you counsel women whose baby has died?

At the time of diagnosis
At birth and immediately postpartum
Postpartum

EXERCISE

Rapid Assessment

ACTION PLAN

Prolonged & Obstructed Labor

PREVENT INFECTION

PROVIDE RESPECTFUL CARE

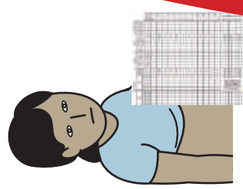
Rapid Assessment

Close to birth?

Support birth

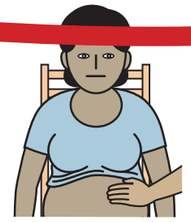
Danger / Alert Signs
Seek advanced ca

Assess



Labor tool and history

Patient



Power

Passenger

Passage

Classify

Maternal and fetal status reassuring
See Essential Labor & Birth

Signs of CPD / Obstruction
Arm, Brow, Chin posterior, Transverse, Footling
Pre-referral / Pre-op care

Signs of prolonged labor
Provide general care
Watch for fever >38.0°C

Ineffective contractions

Poor progress with ≤ 2 contractions in 10 minutes, lasting < 40 seconds

If no oxytocin OR if not in CEmONC facility
Seek advanced care

Cervical dilatation is slower than normal if :

5 cm for ≥6 hours
6 cm for ≥5 hours
7 cm for ≥3 hours
8 cm for ≥2.5 hours

Frank or complete breech

If not in CEmONC facility
Seek advanced care

If in referral facility
OR

EXERCISE

Rapid Assessment

Divide learners into groups of four or fewer.
As the facilitator, wear the simulator and take the role of the woman. Two learners will be the provider and your companion.

Ask learners to follow the checklist on page 8 of Provider Guide 1 and practice conducting the rapid assessment. Refer them to page 12 for management of identified problems.

Read scenario 1 and ask providers to begin care. Only give providers answers to questions they ask or assessments they perform, but do not volunteer information.

SCENARIO 1:
"I am Ms. B, a 28 year old in my 5th pregnancy. I had 3 term births. I think I am in labor but I am not feeling well. I am 39 weeks by last menstrual period. I can talk during contractions and I do not have the urge to push. Please begin care of me."

Membranes:
Not ruptured

Danger signs:
- Complaining of fever and chills

Concerns:
- Say, "I do not feel well."

Vital signs:
- Pulse 108 b/min
- Temp. 39.8°C
- BP 112/72
- Respirations 18 breaths/minute

Conjunctiva:
Pale

Signs of dehydration:
- Mouth is moist
- Skin returns quickly to normal when pinched

FHR:
- 180-188 bpm (listended for a full minute) between 3 contractions

When these assessments are done, ask the group,
"Does Ms. B have any danger signs?"
High fever - T 39.8°C
FHR 180-188 bpm between 3 contractions

"Any other abnormal findings?"
- Conjunctiva: Pale
- Pulse 108

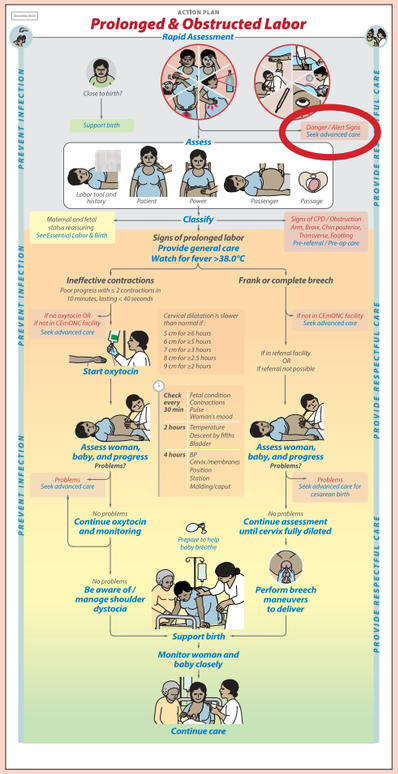
"Does she have signs of shock?"
No

"What is the most likely cause of the rapid FHR?"
- The rapid FHR may be a response to maternal fever or anemia. Because of the rapid maternal heart rate and fever, the rapid FHR is most likely not a sign of fetal distress.

Ask learners to use the "Interventions for abnormal findings" table on page 12 of the PG to answer the following questions:
"What additional assessments will you do?"
- Assess for the cause of maternal fever

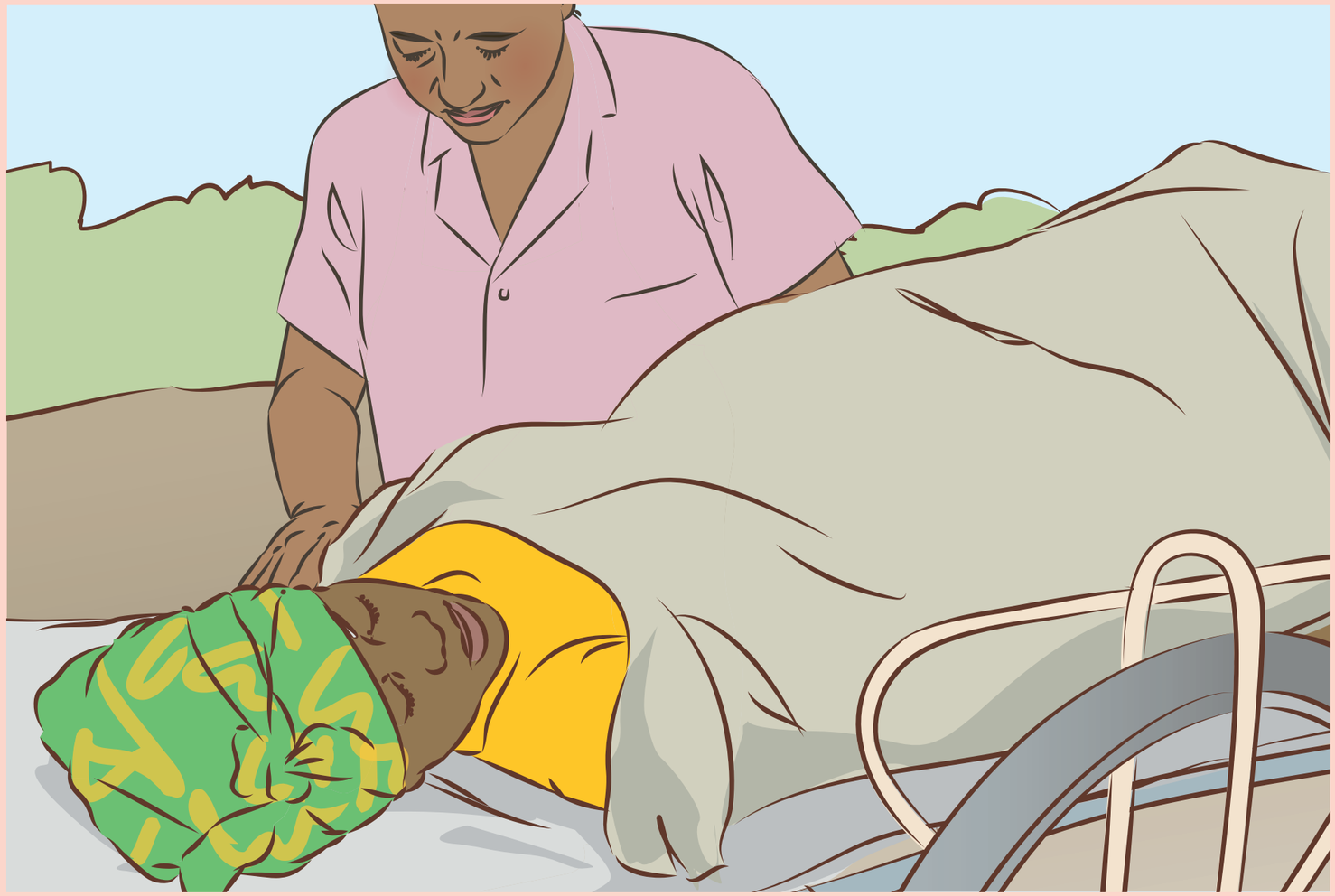
"What actions should you take immediately?"
- Manage elevated FHR
- Give paracetamol for fever
- Manage the cause of elevated temperature

"Does she need advanced care?"
- Not at this time



If you identify a Danger or Alert sign

Seek advanced care



Explain

During rapid assessment, if you identify a danger sign or complication you cannot manage, seek advanced care.

- Give urgent care until the woman can receive advanced care. Provide treatments such as oxygen, MgSO4, antibiotics, IV fluids etc. depending on the problem.
- Remember to give emotional support!
- Call the senior provider, if you are in a facility that provides advanced care.
- Begin your referral plan if not in an advanced care facility and complete the referral form. NOTE: If you think birth is near, do not transport her.

Communicate all findings about a patient's condition to other team members using the **S**ituation-**B**ackground-**A**ssessment-**R**ecommendation or "SBAR" technique.

Ask learners to refer to the SBAR tool on pages 17-18 in Provider Guide 1 and explain each element of the tool.

- Make sure that the provider you are reporting to has understood what you have told them. If they ask you to do something, repeat what they have asked you to do, particularly with medication orders. This is called "closed loop" communication.

Demonstration

Ask learners to refer to the SBAR tool as you read aloud, ***"Ms. X., a 32 y/o G3P2, 38 weeks' GA by LMP, arrived in labor, complaining of heavy vaginal bleeding. Findings on rapid assessment: BP 102/58, pulse 102 bpm, respirations 28 breaths per minute, temperature 37.5°C, and FHR 90-100 bpm between 3 contractions. Actions taken: sent blood for hemoglobin and type/cross-match, gave oxygen, and started an IV with normal saline running at 1L in 1 hour."***

Now, as facilitator, pretend to call your consultant on the phone and give the elements of SBAR below for Ms. X.:

S = Situation: "I am (name) from the labor ward of (facility) caring for Ms. X who came to the hospital in labor because she was bleeding."

B = Background: "Ms. X. is a 32 yo G3P2. On admission, her vital signs were: BP 102/58, pulse 102 bpm, respirations 28 breaths per minute, temperature 37.5, and FHR 90-100 bpm between 3 contractions. Her gestational age is 38 weeks by LMP and her clothes are blood stained. We sent blood for hemoglobin and type/cross-match, are giving oxygen, and started an IV with normal saline running at 1L in 1 hour."

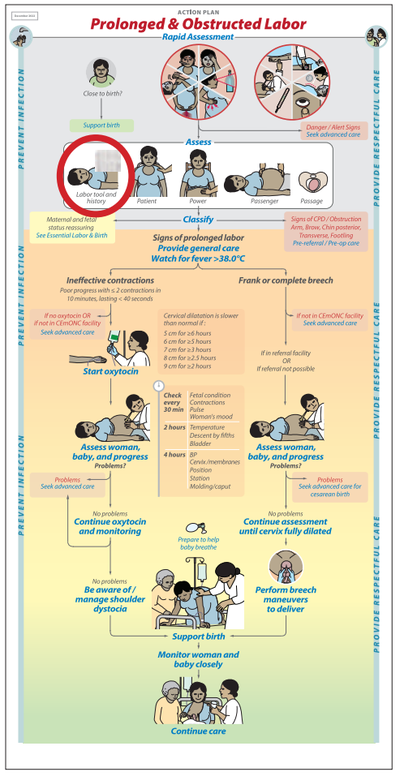
A = Assessment: "I think she has placenta previa or an abruption with fetal distress."

R = Recommendation: "I think Ms. X needs a cesarean. Is there anything you would like me to do until you arrive?"

Practice

After you have done the demonstration, ask learners to work in pairs and prepare an SBAR communication about the practice case of Ms. Z. on page 16, the SBAR tool on page 17 and use the worksheet on page 18 all in Provider Guide 1.

Ask one pair of learners to present their SBAR communication. Facilitate a supportive debrief with the group.



Assess

Labor documentation tool and history

Explain

- Once you have done a rapid assessment and know the woman does not have any danger or alert signs and that birth is not close, take a complete history and review her records. This will help you identify problems early.
- If the woman was referred to you from another facility or provider, try to speak directly to the referring provider to understand her care so far.

Discuss

Ask learners to refer to the checklist on taking a history on page 19 of Provider Guide 1 to respond to the questions below.

"What existing or potential problems can you identify by reviewing the history of this labor?"

- Current problems, treatment and response. You may need to change treatment
- Problems or complications that were not addressed
- CPD or obstruction: Poor progress with good contractions, swollen cervix, caput 3+ and/or molding 3+, maternal and/or fetal distress
- Poor labor progress
- Fetal distress: history of FHR, liquor
- Infection: temperature, signs/symptoms, state of liquor or discharge
- Woman is not coping
- Malposition or malpresentation

"How will information on the history of past pregnancies help you identify existing or potential problems with this labor or birth?"

- Parity can affect duration of labor
- If there was history of operative or cesarean birth, the reason may affect this labor and childbirth
- If she had pregnancy-related problems in previous pregnancies, she may be at risk during this labor.
- If she had a previous complication or intrapartum stillbirth, she may be anxious.

"Why do you need to review her medical history?"

- Labor may make some chronic medical problems worse.
- If she has a chronic medical problem, you may need to consult with a specialist to help with managing the problem.

"How will information on the history of this pregnancy help you identify any existing or potential problems with this labor?"

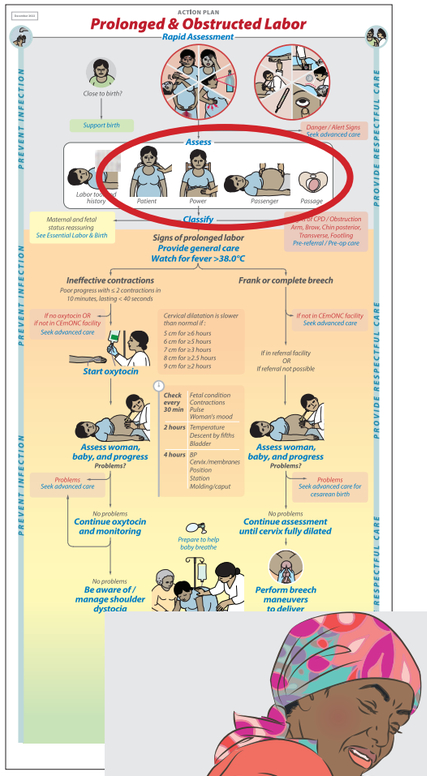
- If the baby is premature or very overdue, they will need special care.
- Are there problems, complications, infections that were not addressed?
- If she is anemic, she is at greater risk of infection and exhaustion and will need careful monitoring.

Learning activity

Ask learners to refer to the exercise on page 20 in Provider Guide 1. After they have done the exercise, ask, ***"What potential problems have you identified?"***

- Labor for 12 hours; early newborn death; history of shoulder dystocia.

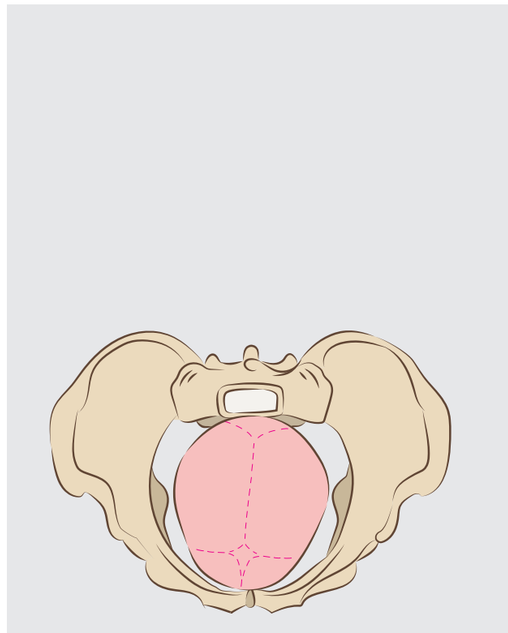
Assess the four “P”s



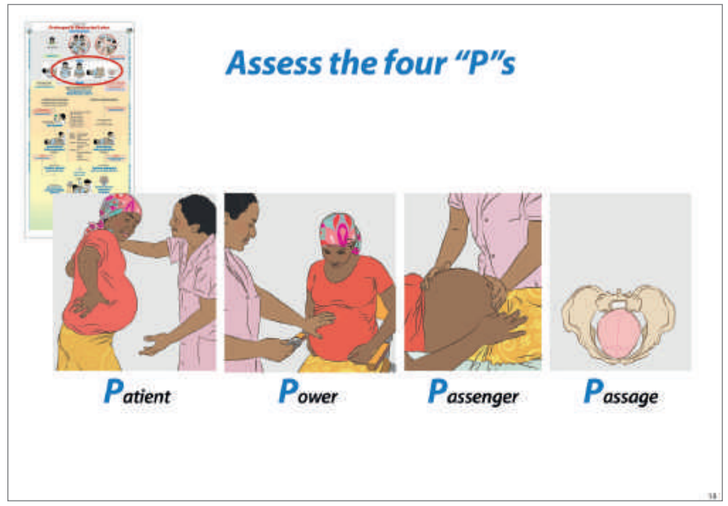
Patient

Power

Passenger



Passage



Explain

If labor is not progressing, quickly decide if labor is **prolonged** due to ineffective contractions or if it is prolonged because of **obstruction.** Management is very different for each, but both require that you act quickly! Also, both can increase the risk of exhaustion, infection, postpartum hemorrhage (PPH), shoulder dystocia, asphyxia, and maternal and fetal death.

To understand why labor is prolonged and to know if it is obstructed, carefully assess the **four "P"s:**

- **P**atient: Coping, exhaustion, dehydration, anxiety, distress, full bladder, and position
- **P**ower: Length and frequency of contractions with progressive cervical dilatation
- **P**assenger: Fetal position, presentation, and size
- **P**assage: Relation of fetal size, presentation, and position to the pelvis

Remember, the active phase of 1st stage of labor is from 5 cm until full dilatation. This usually lasts 12 hours or less in first labors and 10 hours or less in subsequent labors. If the woman and fetus are doing well, do not intervene.

Prolonged active phase of 1st stage of labor is diagnosed when :

- The active phase of 1st stage of labour lasts 12 hours or more in first labours and 10 hours or more in subsequent labours (Remember, if the woman and fetus are doing well, do not intervene) **OR**
- There is secondary arrest of cervical dilatation and descent of the presenting part.

Prolonged 2nd stage of labor is diagnosed when:

- The woman has been in second stage for 3 hours in first labors or 2 hours in subsequent labors and birth has not yet occurred **OR**
- The cervix is fully dilated, the woman has the urge to push, but there is no fetal descent.

Ask, ***"What are causes of prolonged labor without obstruction?"***

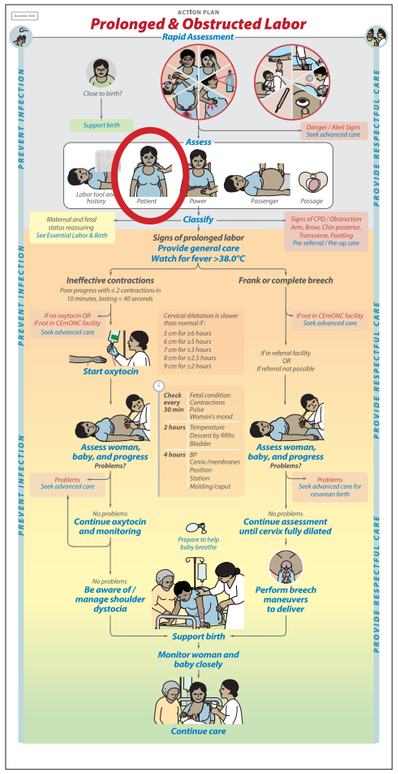
Responses should include: Anxiety, exhaustion, dehydration, ineffective uterine contractions, poor maternal positioning such as supine, infection, malposition/malpresentation.

Obstructed labor can occur in the 1st or 2nd stage s of labor when the fetus cannot pass through the pelvis because it is blocked and the baby's head or body cannot pass through the pelvis. This is called **cephalopelvic disproportion (CPD) or fetopelvic disproportion (FDP).**

- Signs of obstruction include any of the following: 3+ caput, 3+ molding, presenting part poorly applied to the cervix, swelling of cervix, bulging lower portion of uterus, presence of a constriction band or ring often called Bandl's ring.
- There may be secondary arrest of cervical dilatation and descent of the presenting part meaning there has been no change in cervical dilation for at least 2 hours with good contractions.

Ask, ***"What are causes of obstructed labor?"***

Causes of obstructed labor include:
A very large baby, a baby with a birth defect, or a baby in malposition or malpresentation.
From the maternal side, a small or deformed pelvis, a birth canal obstruction such as a narrow vagina, female genital mutilation or tumors.
If obstructed labor is confirmed, this is an emergency and requires a cesarean birth!

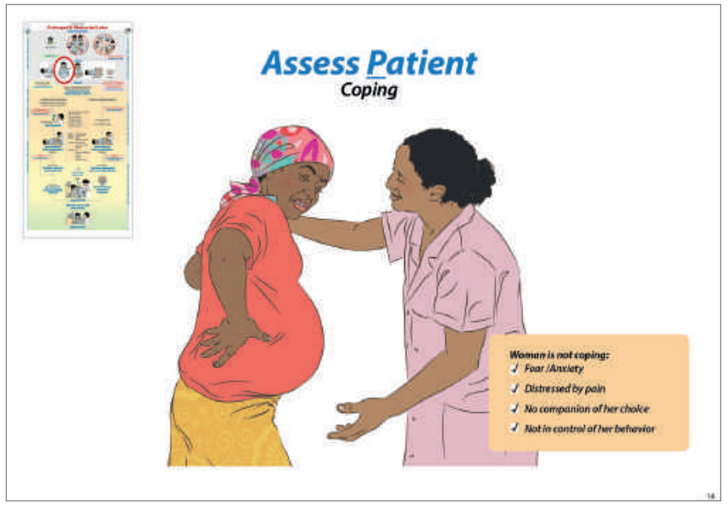


Assess Patient

Coping

Woman is not coping:

- ✓ *Fear /Anxiety*
- ✓ *Distressed by pain*
- ✓ *No companion of her choice*
- ✓ *Not in control of her behavior*



Explain

- If a woman is afraid, it may slow her labor progress. Fear can also increase her pain.

When labor is not progressing normally, check to see what may be causing poor progress:

- Is she coping? Or is she afraid, anxious, in distress, or not in control of her behavior?
- Is she accompanied by a person of her choice? If so, help guide the companion to offer comfort and support.
- Is she receiving pain relief?
- Help the woman as soon as you notice she is not coping well or is distressed by pain.

Discuss

Ask learners to refer to Provider Guide 1 on page 22 and review what to assess and how to respond if the woman is not coping. Ask volunteers to read each bullet under each problem:

To prevent and manage anxiety and fear:

- Ensure privacy.
- Explain the labor process, her progress, what to expect and care options.
- Praise, encourage, and reassure her.
- Listen to her and be sensitive to her feelings.
- Provide her with support, encouragement, and respectful care to help her cope.

If she is needing help to cope with pain:

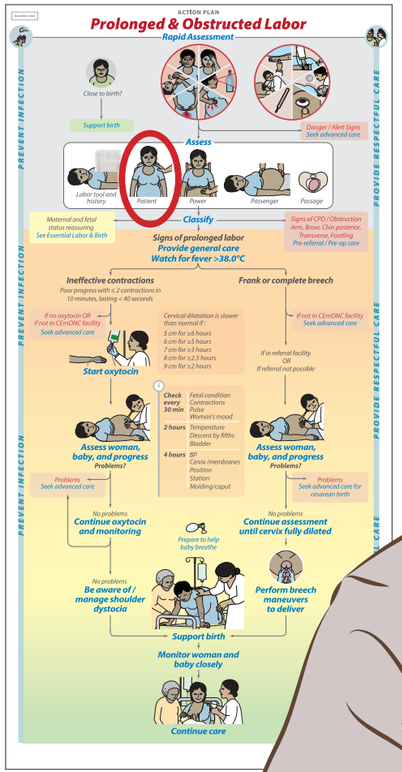
- Suggest a change of position.
- Encourage her to move and walk.
- Encourage her companion to massage her back, sponge her face or place a cool cloth at the back of her neck.
- Explain to her how to use breathing techniques.
- Encourage her to take a warm bath or shower if available.
- Offer other pain management options according to woman's preferences, national guidelines, availability and provider's experience (epidural or opioid analgesia).
- If she does not have a companion of her choice, offer to call someone she chooses.
- If she does have a companion of her choice, make sure the companion knows how to support her and knows when and how to call for help.

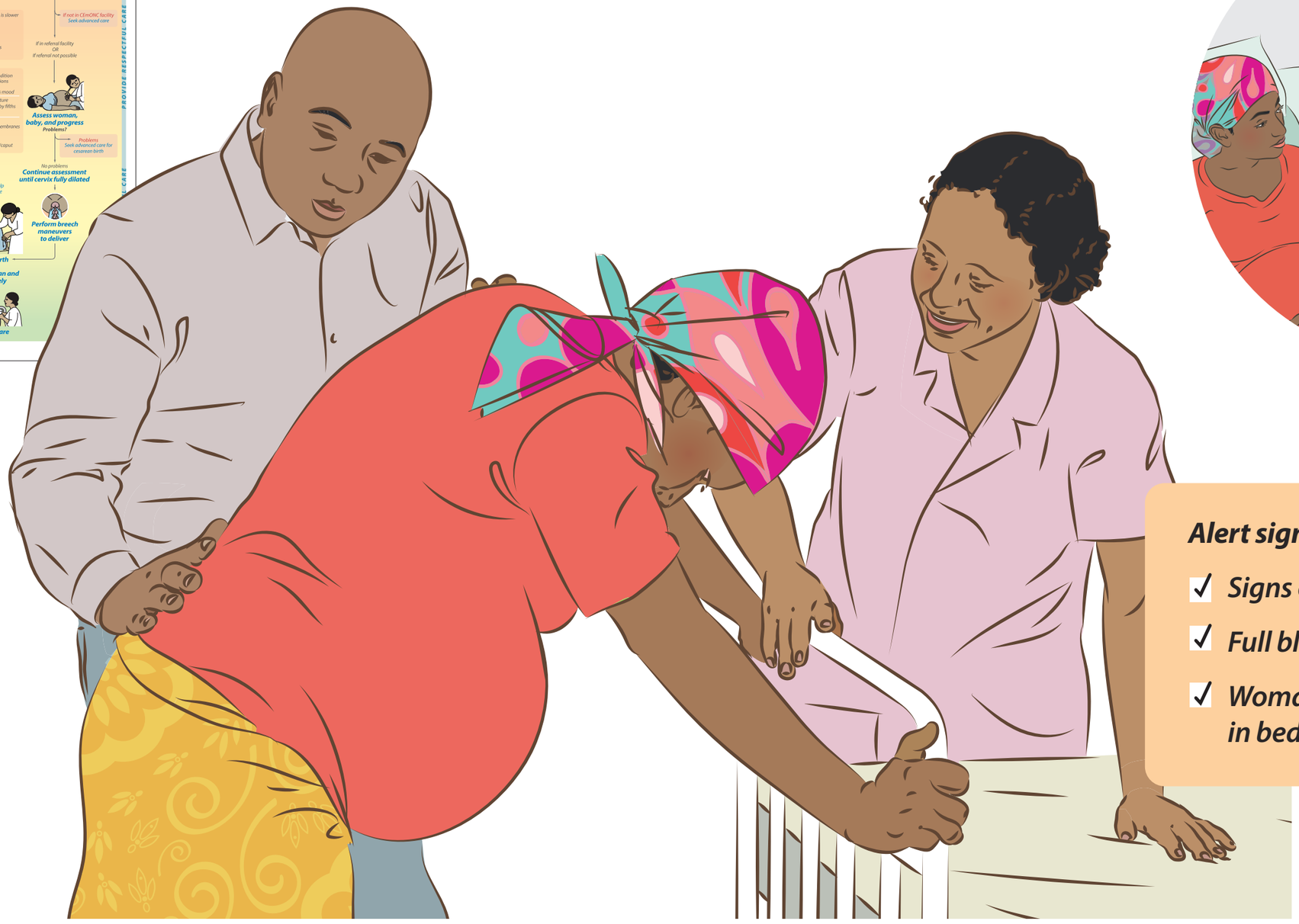
Practice

Have learners turn to page 22 in Provider Guide 1 and work in groups of 2 or 3. One will role play the provider, one a distressed woman, and one the companion. Circulate between the groups to make sure that they are giving good care and support.

Assess Patient

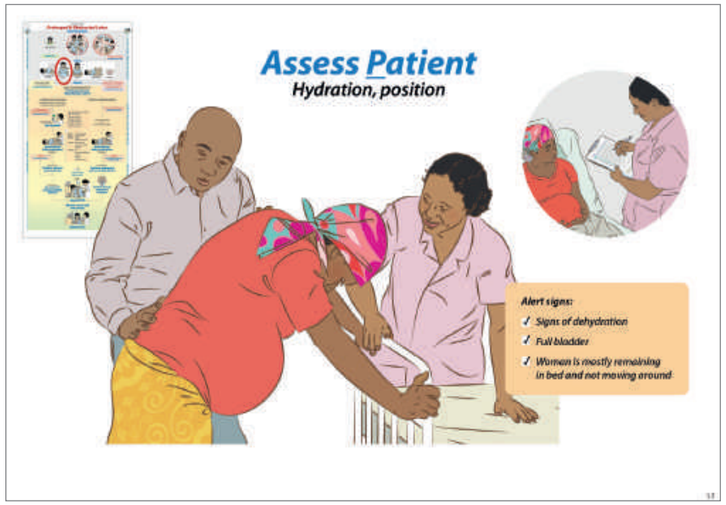
Hydration, position





Alert signs:

- ✓ *Signs of dehydration*
- ✓ *Full bladder*
- ✓ *Woman is mostly remaining in bed and not moving around*



Explain

It is important to encourage all laboring women to:

- drink fluids that they choose
- be mobile if they choose
- keep their bladder empty

If a woman in labor is dehydrated, it may prolong labor and lead to exhaustion. If she is not mobile or cannot choose a position of comfort, labor may be prolonged. A full bladder may weaken her contractions, prevent a baby from moving into a good position, and cause pain and injury to the bladder.

Discuss

Ask, ***"How can you help women stay hydrated and have energy during labor?"***

Responses should include:

- Every time you check on a woman, see what she is drinking. If it is less than 1 glass of fluid an hour, offer to bring her something.
- Make sure she has sweetened fluids such as juice, sweetened tea, or soft drinks.
- Allow her to eat if she likes.
- Check frequently for dehydration: Is her mouth dry? Are her eyes' sunken? Is her urine dark or is the acetone in it ++ or more? Is she extremely tired, or is she dizzy or confused?
- If she is dehydrated and cannot drink, give a 500 mL IV bolus over 30 minutes. Evaluate her after the bolus. You can give up to 4 boluses for a total of 2L.

Ask, ***"What will you do to prevent a full bladder?"***

Responses should include:

- Check to see if her bladder is full and ask if she is urinating regularly.
- Encourage her to empty her bladder often.
- If her bladder is full and she cannot empty it, use a catheter to empty it.

Ask, ***"What position should the woman adopt during labor and birth?"***

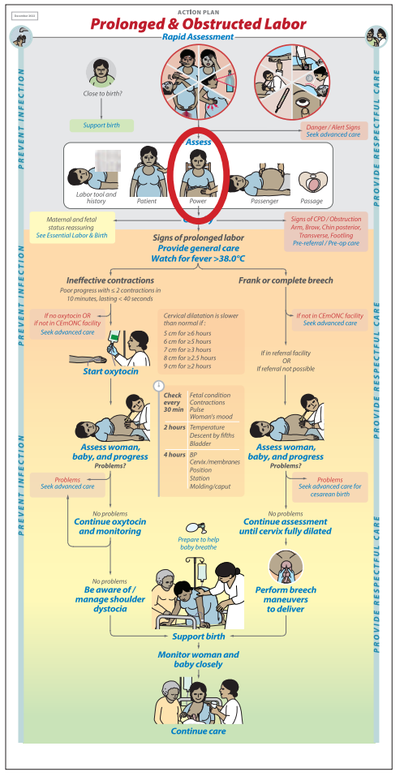
Responses should include:

- Any position she prefers! Every time you check on a woman, encourage her to be mobile if she can.
- Encourage upright positions as much possible. However, let her choose her position and take periodic rest periods to avoid exhaustion.

Knowledge check

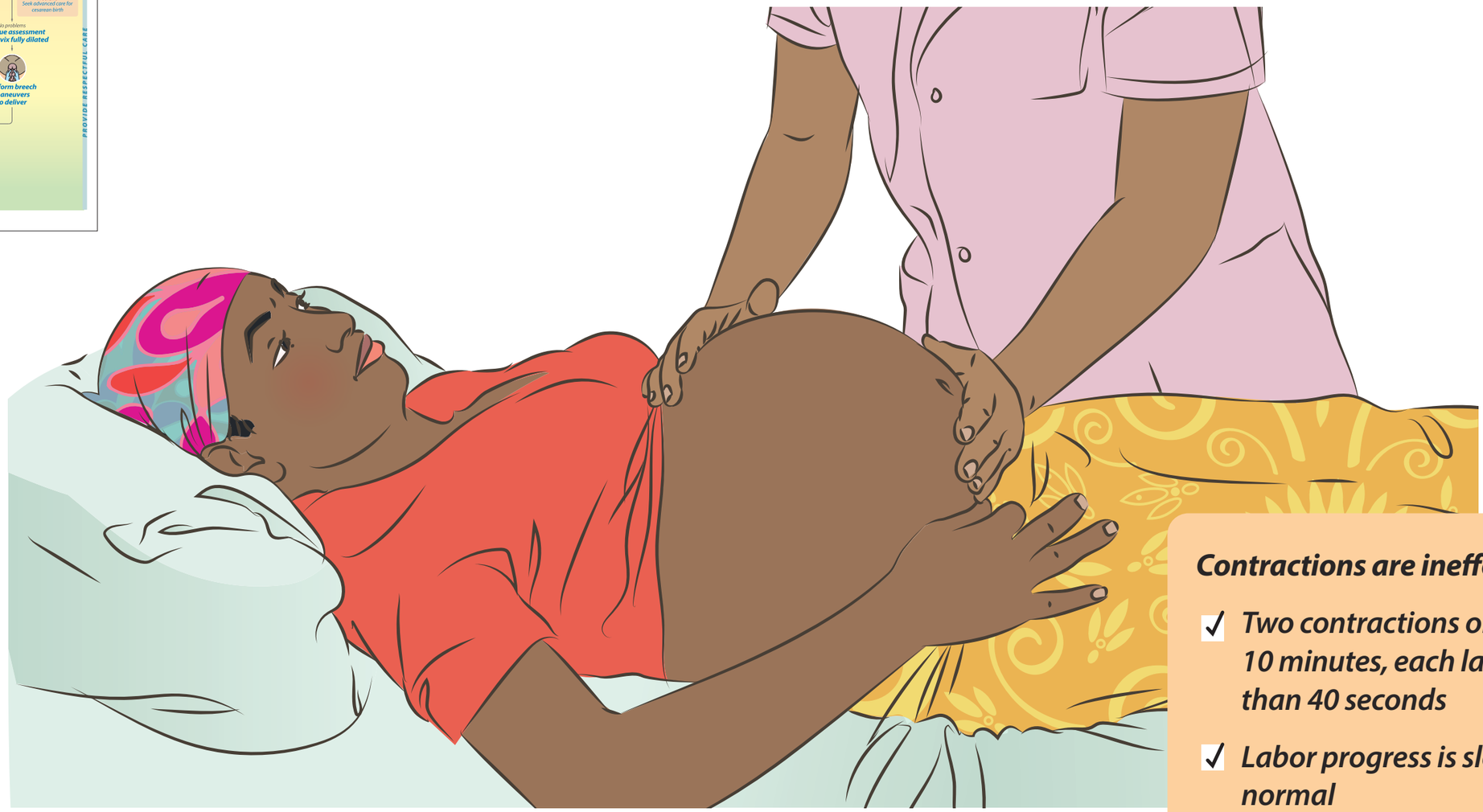
How will you assess a woman to see if she is dehydrated?

- *Check to see if her mouth and tongue are dry or if her eyes are sunken.*
- *Pinch the skin of her forearm to see if it goes back slowly.*
- *Check for dark-colored urine and presence of ++ acetone in the urine.*
- *Does she seem confused?*
- *Ask if she is dizzy.*



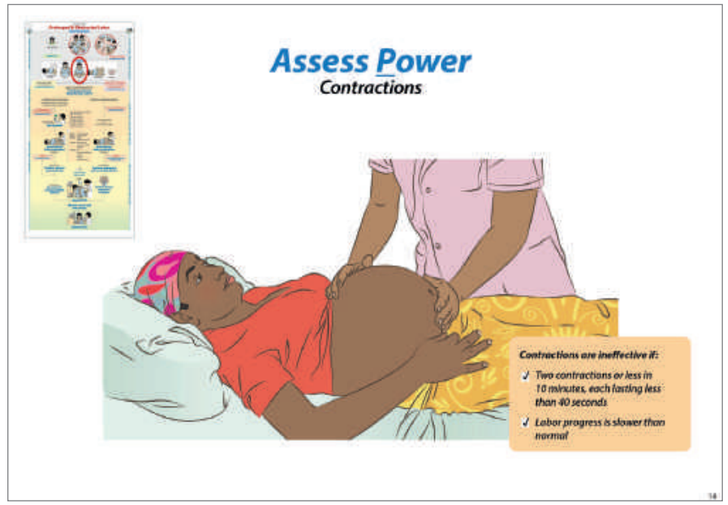
Assess Power

Contractions



Contractions are ineffective if:

- ✓ *Two contractions or less in 10 minutes, each lasting less than 40 seconds*
- ✓ *Labor progress is slower than normal*



Explain

If labor is not progressing well, assess the frequency and duration of her contractions.

Contractions are effective if:

- The woman is having three or more contractions in 10 minutes, each lasting more than 40 seconds.
- At 5cm to 10cm the contractions result in progressive dilatation of the cervix no matter how frequent.
- In second stage, contractions result in progressive descent of the presenting part.

Act fast! Provide emergency care if you find any of these danger signs!

- Constant pain that starts suddenly or persists between contractions may be a sign of placental abruption, especially if there is vaginal bleeding.
- Contractions stop suddenly. Check for signs of ruptured uterus. The woman may have continuous pain and vaginal bleeding.
- Hyperstimulation: Any contraction lasts longer than 60 seconds **OR** if there are more than five contractions in 10 minutes **OR** the uterus does not relax between contractions. Quickly manage hyperstimulation of the uterus! We will review this later.

If the woman is having two contractions or less in 10 minutes or they last less than 40 seconds:

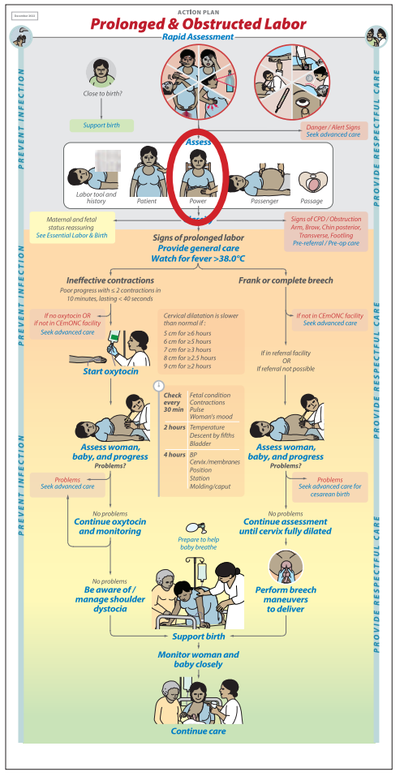
- Evaluate effectiveness by seeing if her cervix is dilating and if there is fetal descent.
- Are there reasons for poor contractions? Check hydration, position and mobility. Look for infection, fear, anxiety or distress with pain.
- Encourage her to move, offer pain relief, and treat dehydration to improve contractions and progress.
- Ensure privacy, companionship and comfort measures.

NOTE: Do not perform amniotomy as the only intervention to augment labor especially in settings with high HIV prevalence.

Advanced Care Note
Refer the woman to a facility that can perform a cesarean birth and care for a baby with problems if you believe the woman has:

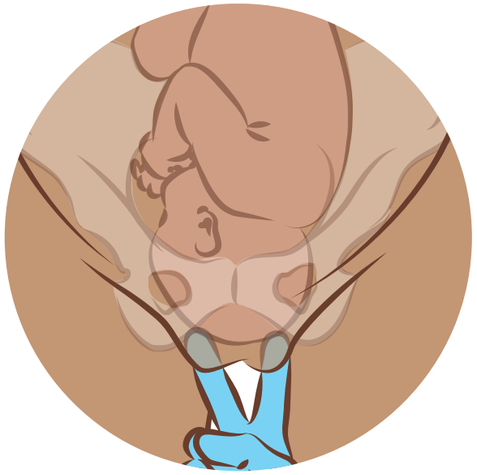
- CPD OR
- Obstruction OR
- Placental abruption OR
- Ruptured uterus

Also refer the woman if she has ineffective contractions but your facility cannot provide augmentation with oxytocin. Guidance should be adapted based on local protocols and standards.



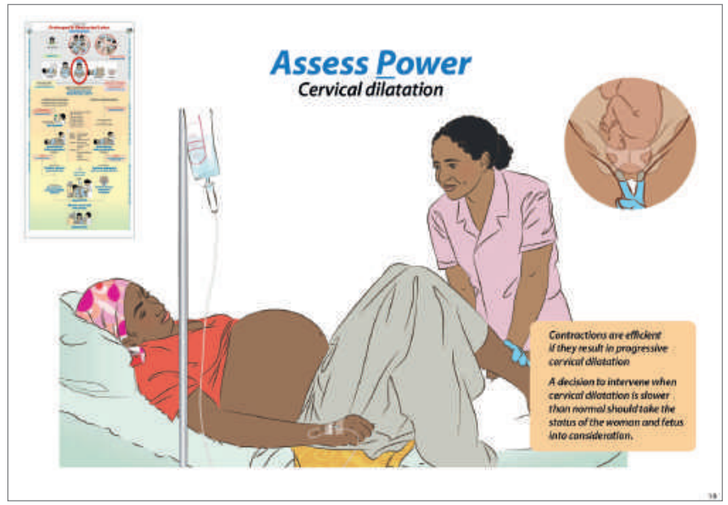
Assess Power

Cervical dilatation



Contractions are efficient if they result in progressive cervical dilatation

A decision to intervene when cervical dilatation is slower than normal should take the status of the woman and fetus into consideration.



Explain

The length and flow of every labor can be very different between women. It can even be different for the same woman from one labor to the next.

Remember, the **duration of the 1st stage of labor from 5 to 10 cm dilatation** is usually not more than 12 hours in first labors, and usually not more than 10 hours in subsequent labors.

Review the woman's record and labor documentation tool to see her rate of cervical dilatation, descent, and her contraction pattern over time.

- Diagnose slower than normal progress if the cervix remains at:
  - 5 cm for 6 hours or more
  - 6 cm for 5 hours or more
  - 7 cm for 3 hours or more
  - 8 cm for 2.5 hours or more
  - 9 cm for 2 hours or more

If fetal and maternal conditions are reassuring, a finding that cervical dilatation slower than 1 cm/hour during active phase of labor **should not be the only reason to try and speed up labor in any way.**

- If still using the partograph, the alert line of the partograph may be used to identify women who may need transfer for advanced care. If not in an advanced care facility, consider transferring the woman if cervical dilatation is slower than 1 cm/hour.

Rule-out CPD, obstruction, malposition or malpresentation if the woman is having three or more contractions in 10 minutes, each lasting 40 -60 seconds **but**:

- Cervical dilatation is slower than normal **in active phase.**
- There is arrest of cervical dilatation **in active phase.**

Knowledge check

What will you assess for during a vaginal examination?

- *Status of the membranes*
- *Color and odor of fluid or discharge*
- *Sores and scars*
- *Position of cervix*
- *Length, effacement, consistency (soft, firm), and dilatation of the cervix. Is it swollen?*
- *Presenting part*
- *Position of presenting part*
- *Presence and degree of molding and caput*

What findings on vaginal examination may indicate obstruction?

- *A swollen cervix*
- *Presenting part not well applied to the cervix*
- *+3 molding - Bones are overlapping and cannot be separated easily with pressure by your finger*
- *+3 caput*
- *Diffuse swelling of the scalp*

If cervical dilatation is slower than 1 cm/hour, what might indicate there is a problem?

- *Fetal and/or maternal conditions are not reassuring and/or*
- *Uterine contractions are effective.*

EXERCISE

Assess power

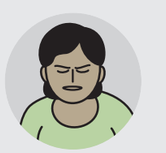
ACTION PLAN

Prolonged & Obstructed Labor

PREVENT INFECTION

PROVIDE RESPECTFUL CARE

Rapid Assessment

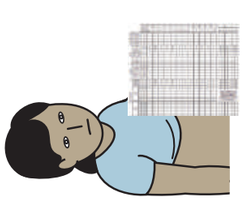


Close to birth?

Support birth

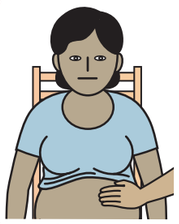
Danger / Alert Signs
Seek advanced care

Assess



Labor tool and history

Patient



Power

Passenger

Passage

Classify

Maternal and fetal status reassuring
See Essential Labor & Birth

Signs of CPD / Obstruction
Arm, Brow, Chin posterior, Transverse, Footling
Pre-referral / Pre-op care

Signs of prolonged labor
Provide general care
Watch for fever >38.0°C

Ineffective contractions

Poor progress with ≤ 2 contractions in 10 minutes, lasting < 40 seconds

If no oxytocin OR if not in CEmONC facility
Seek advanced care

Cervical dilatation is slower than normal if :

5 cm for ≥6 hours
6 cm for ≥5 hours
7 cm for ≥3 hours

Frank or complete breech

If not in CEmONC facility
Seek advanced care

EXERCISE

Assess power

Have learners turn to page 26 in Provider Guide 1. Divide learners into small groups and assign half the groups to scenario 1 and half to scenario 2. Read the cases aloud and ask the groups to answer the questions in the Provider Guide associated with their case.

SCENARIO 1:
Ms. A. is a 21 yo G1P0 at 38 weeks who labored at home for 24 hours without giving birth. She appears comfortable and can talk during contractions. The rapid assessment shows everything is normal so far. Her mother says Ms. A. has had irregular contractions for the past 24 hours and that she is not leaking fluid.
At 21:00 hours: Ms. A is having 3 contractions in 10 minutes lasting 40-50 seconds.

Questions for scenario 1

"Are contractions "effective"?"

- We do not know until we check cervical dilatation and descent over time.
- We also do not know if she is in latent labor, active phase of first stage of labor or how long she has really been in labor.

"What do you need to do to see if her contractions are effective?"

- We need to check cervical dilatation to see what phase of labor she is in and then we need to see dilatation and descent over time.

"Does the woman need advanced care?"

- We cannot determine this until a complete assessment is done

SCENARIO 2:
Ms. B. is a 28 yo G5P3 at 39 weeks who has been laboring at your facility for 8 hours and has been in active phase of first stage labor since 03:00 hours.
At 05:00 hours you are taking over care of Ms. B. and find that she is having 2 contractions/10 minutes lasting 30 seconds.

Questions for scenario 2

"Are contractions "effective"?"

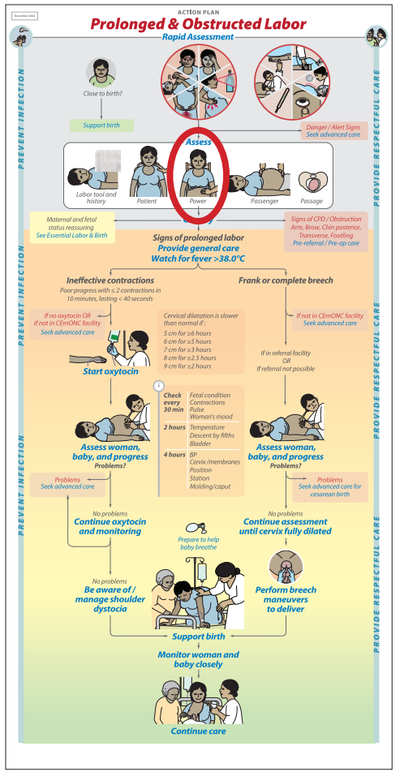
- She is in active phase of labor and contractions are less than 3 / 10 minutes lasting less than 40 seconds, but we cannot tell if they are effective until we review cervical dilatation and descent over time.

"Does the woman need advanced care?"

- We cannot determine this until a complete assessment is done.

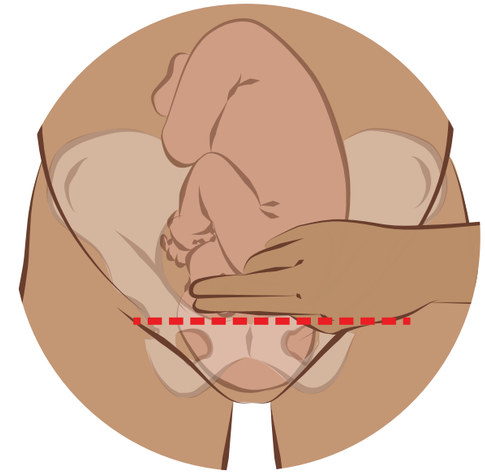
Discuss

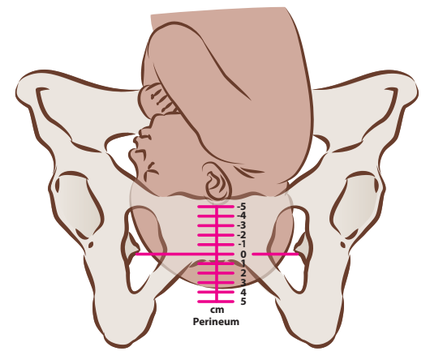
After each group has completed their scenario, ask a volunteer to give the answers they found to the questions for their group. Provide any corrective feedback as needed.

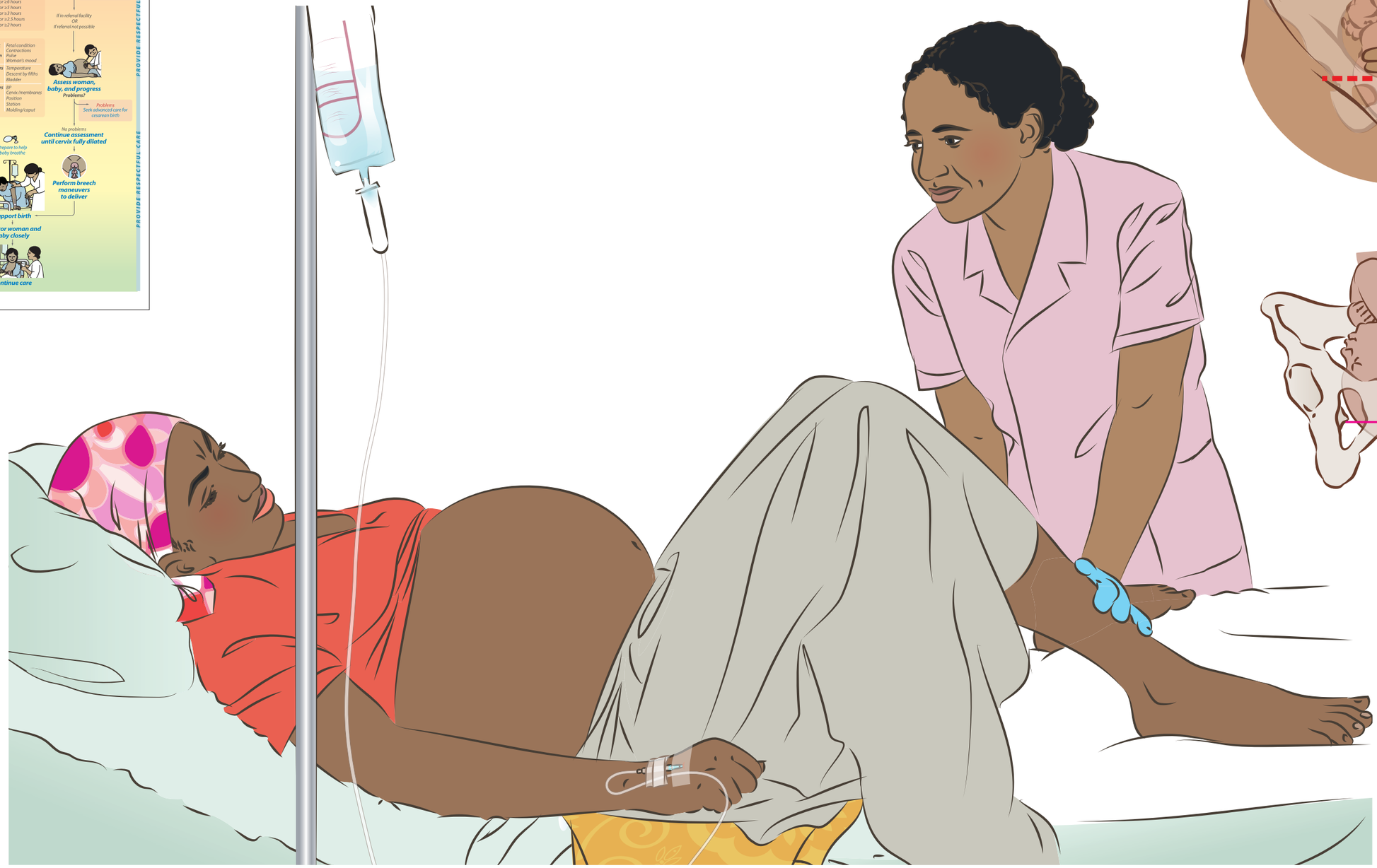


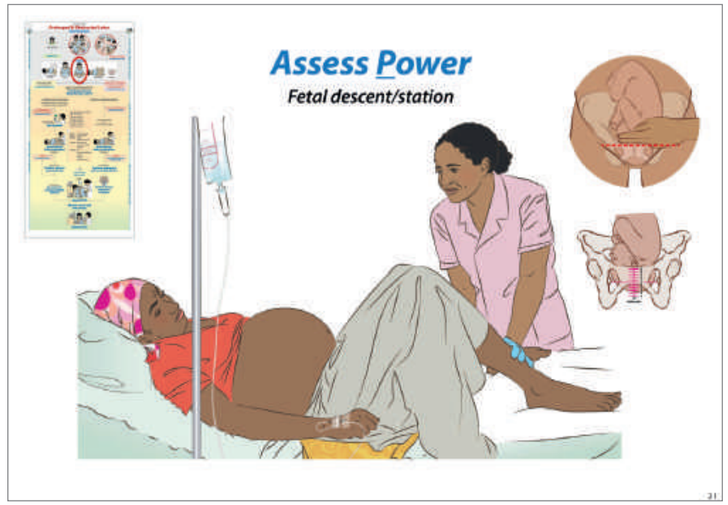
Assess Power

Fetal descent/station









Explain & Demonstrate

- Fetal descent begins during active phase of the first stage of labor. Lack of descent with effective contractions may be a sign of CPD or obstruction.

Facilitation note: *As you describe descent and station, point to the front of the flipbook.*

- During abdominal examination, assess fetal descent in terms of fifths of fetal head palpable above the symphysis pubis.
- During vaginal examination, assess fetal station by comparing where the largest diameter of the presenting part is in relation to the ischial spines.
- Station of -4 to zero indicates that the presenting part is above the ischial spines.
- Station of 0 to +4 indicate that the presenting part has descended below the ischial spines.
  - At station –4 or –3 the fetal head is still 'floating' and not yet engaged
  - At station –2 or –1 it is descending closer to the ischial spines
  - The baby's head is "engaged" (zero station) when the largest diameter of the fetal head (the biparietal diameter) is aligned with the woman's ischial spines.
  - **Zero station is equivalent to 2/5 of the head being palpable above the symphysis pubis.** The sinciput and part of the occiput are felt.
  - At station +3 the baby's head is crowning, or visible at the vaginal opening even between contractions.

Note: Compare descent by abdominal examination to station determined by vaginal examination. Be aware that if the baby has a large caput or significant molding, it may be difficult to accurately assess station. In this case, assessment of descent by abdominal palpation may be more useful.

Suspect the woman's labor is obstructed or there is CPD and act quickly if the woman is having three or more contractions in 10 minutes, each lasting 40 -60 seconds but:

- The fetal head is not engaged.
- There is secondary arrest of descent of the presenting part.
- The cervix is fully dilated and the woman has the urge to push, but there is no descent.

Knowledge check

If the head is high at more than 2/5 fingerbreadths palpable above the pelvic brim at 8 cm cervical dilatation, what do you need to rule out?

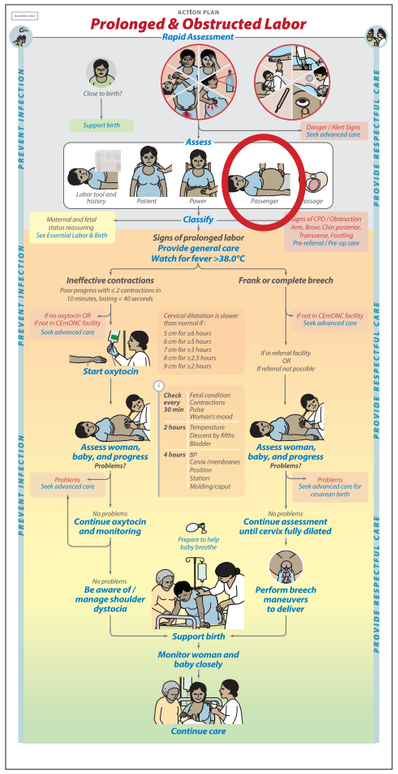
- ***Ineffective contractions, obstruction, or CPD.***

Advanced Care Note

Refer to a facility that can perform a cesarean birth and care for a baby with problems if:

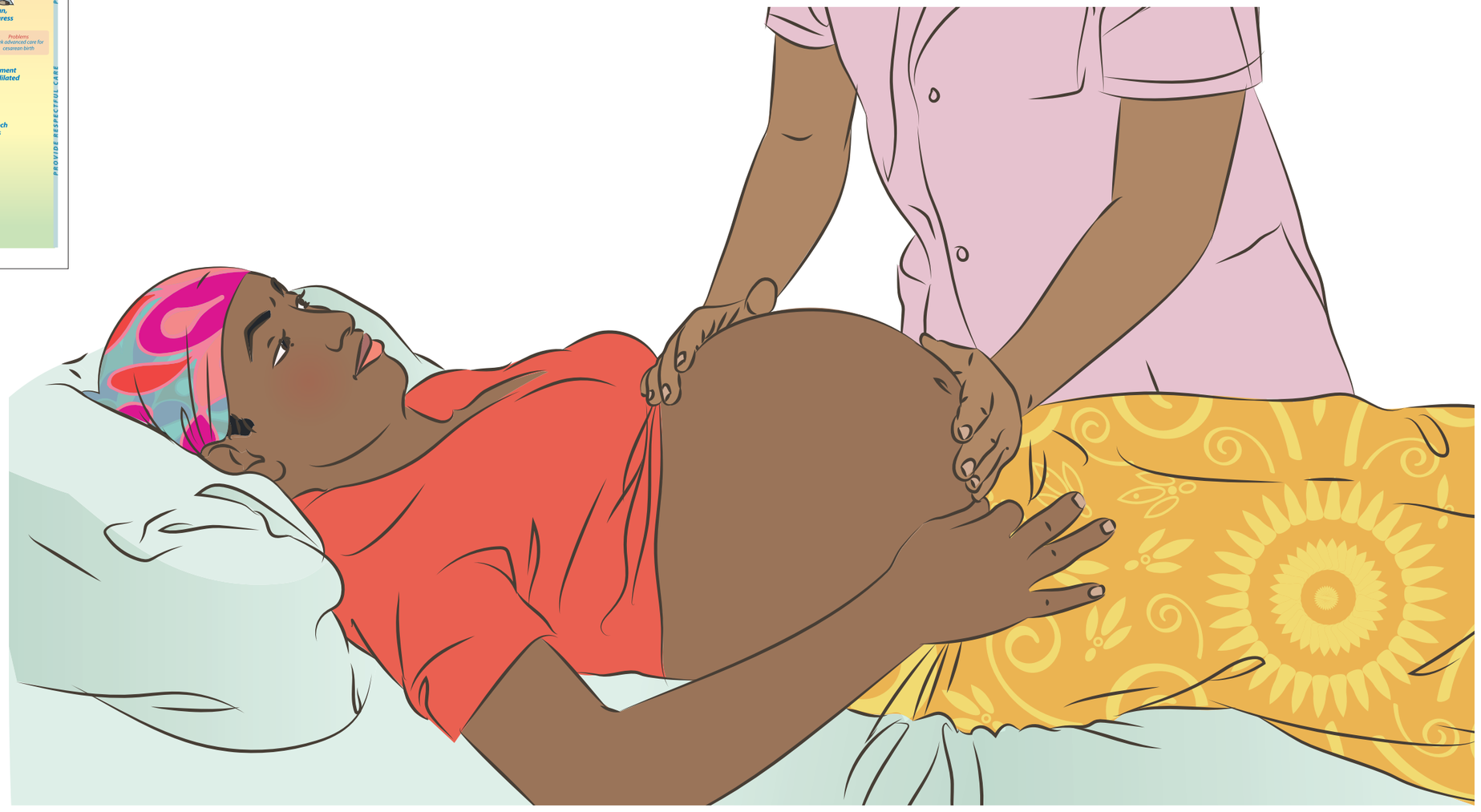
- The cervix is not dilating with effective contractions, is swollen, or the fetal head is not well applied to it. These are all signs of obstruction.
- In active phase of first stage of labor, there is not progressive fetal descent with effective contractions.

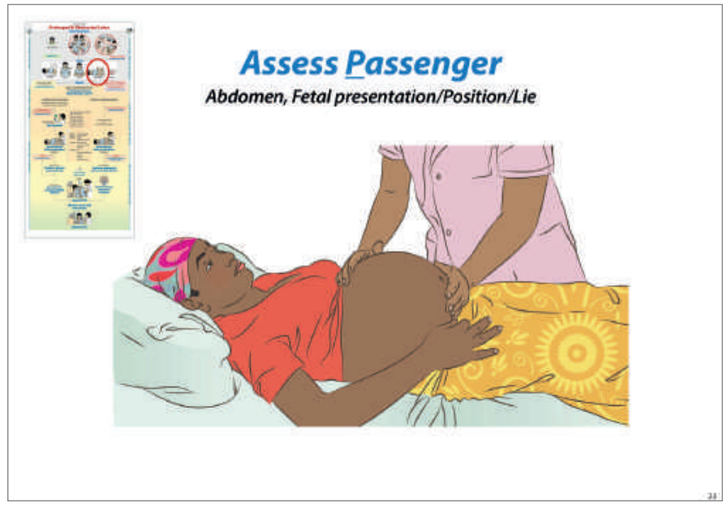
Follow local protocols and standards.



Assess Passenger

Abdomen, Fetal presentation/Position/Lie





Explain

Abnormal presentation, lie, or position or a baby that is too large for the woman's pelvis can prevent labor from progressing normally.

- **Malpresentation:** The fetus is in any presentation other than cephalic and any lie other than longitudinal. This increases the risk for complications such as prolapsed cord or uterine rupture due to obstructed labor.
- **Malposition:** The fetal head is in an abnormal position relative to the woman's pelvis.
- Confirm position and presentation during vaginal examination. Before conducting an exam, review findings from previous exams for comparison.

Practice

Say; ***"Describe what you would find on abdominal examination for each of the following malpresentations or malpositions."***
Complete information with ***text in green.***
For each position, after a volunteer describes findings, ask them to stand and hold the fetal simulator in front of their abdomen in the identified presentation/position to demonstrate. To ease facilitation, you may choose to demonstrate the first malposition.

Occiput posterior (OP) position:
A saucer-shaped depression at or immediately below the umbilicus, a high head with the depression above it that looks like a full bladder.

Brow presentation:
More than half the fetal head is above the symphysis pubis and the occiput is palpable at a higher level than the sinciput.

Face presentation:
A groove felt between the occiput and the back.

Breech presentation:
The head is felt in the upper abdomen and the breech in the pelvic brim.

Transverse lie and shoulder presentation:
Neither the head nor the buttocks are felt at the symphysis pubis and the head is usually felt in the flank.

Multiple pregnancy:
Multiple fetal poles and parts felt on abdominal examination.

Knowledge check

What findings on abdominal exam might be signs of obstructed labor or CPD?

- *A horizontal ridge across the lower abdomen - Bandl's ring – or ballooning of the lower uterine segment.*
- *Slow or arrested descent.*

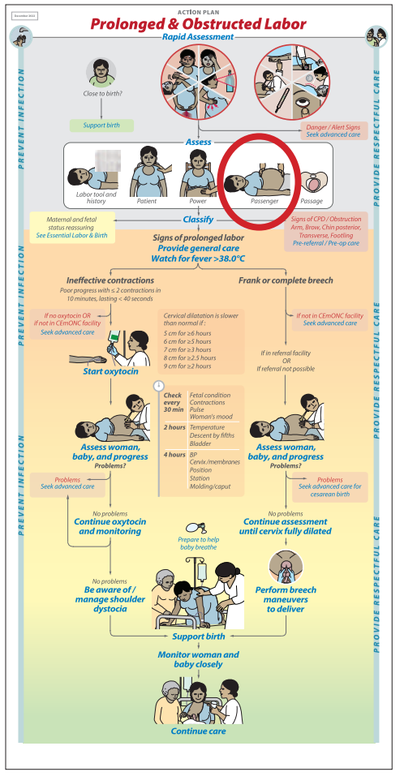
What might be the cause of abdominal or uterine tenderness?

- *Infection, placental abruption, or ruptured uterus.*

Advanced Care Note

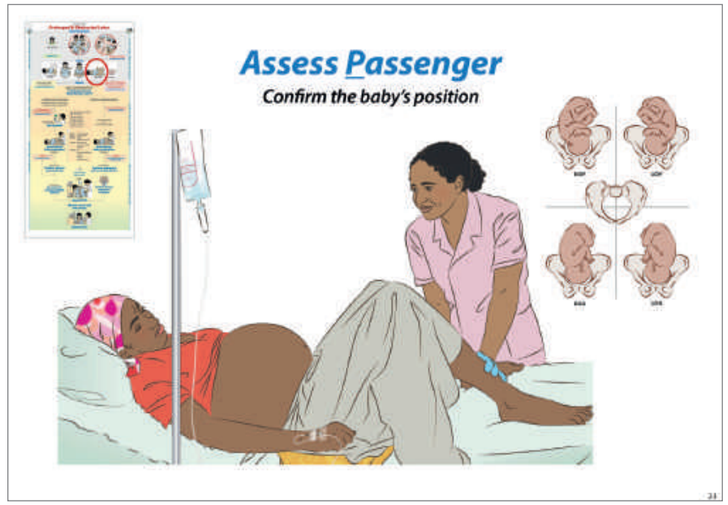
Based on local protocols and standards, refer women with the following findings if your facility cannot perform breech birth OR a cesarean birth OR care for a baby with problems:

- Signs of obstructed labor (ballooning of lower uterine segment, Bandl's ring)
- Breech presentation
- Multiple pregnancy



Assess Passenger

Confirm the baby's position



Explain

During vaginal examination, look for findings that may indicate a problem and confirm fetal position. Compare with abdominal findings. If ultrasound is available, confirm presentation and position using ultrasound.

Practice

Say; ***"Describe what you would find on vaginal examination for each of the following malpresentations or malpositions."***

When learners answer, omplete the information as needed. After they describe findings, ask them to put the fetus in the simulator in the presentation and position and do a vaginal examination to validate answers.

Chin-posterior position:
Examiner's finger enters the mouth easily and the jaw bones are felt. The chin is posterior in relation to the woman's pelvis.
Say, ***"Chin posterior usually requires cesarean birth. Chin anterior position may result in vaginal birth."***

Transverse lie and shoulder presentation:
A shoulder may or may not be felt. An arm may prolapse, and the elbow, arm or hand may be felt in the vagina. NOTE: Transverse lie and shoulder presentation always require advanced care.

Brow:
The anterior fontanelle and the orbits are felt. NOTE: Brow presentation usually requires cesarean birth.

OP:
The posterior fontanelle is towards the sacrum and the anterior fontanelle may be easily felt if the head is not flexed.
NOTE: OP position may prolong labor.

Asynclitic position:
The center of the head is not in the middle of the pelvis when the cervix is ≥5 cm dilated. Cervix may be thicker on one side. NOTE: Asynclitism may prolong labor.

Tell learners that helpful tips for diagnosing malpositions and malpresentations are on page 29 of Provider Guide 1.

Knowledge check

What will you find on vaginal examination if the baby's head is well-flexed?

The fetal occiput is lower in the vagina than the sinciput.

What findings on vaginal exam might be signs of uterine infection?

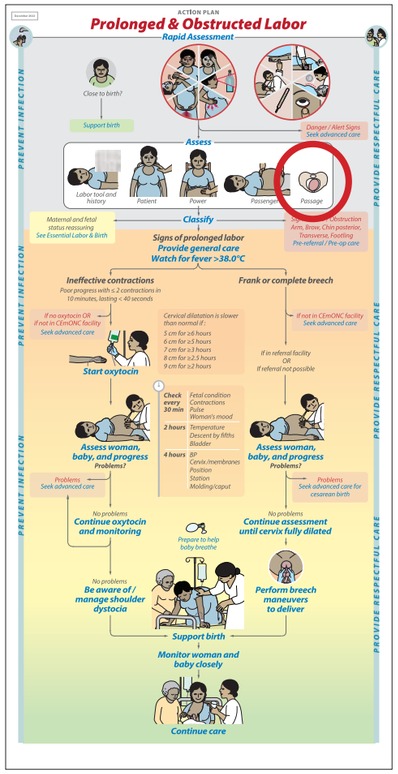
Amniotic fluid that is greenish, purulent, or foul smelling.

Advanced Care Note

Refer women with the following findings if your facility cannot perform a cesarean birth or care for a baby with problems:

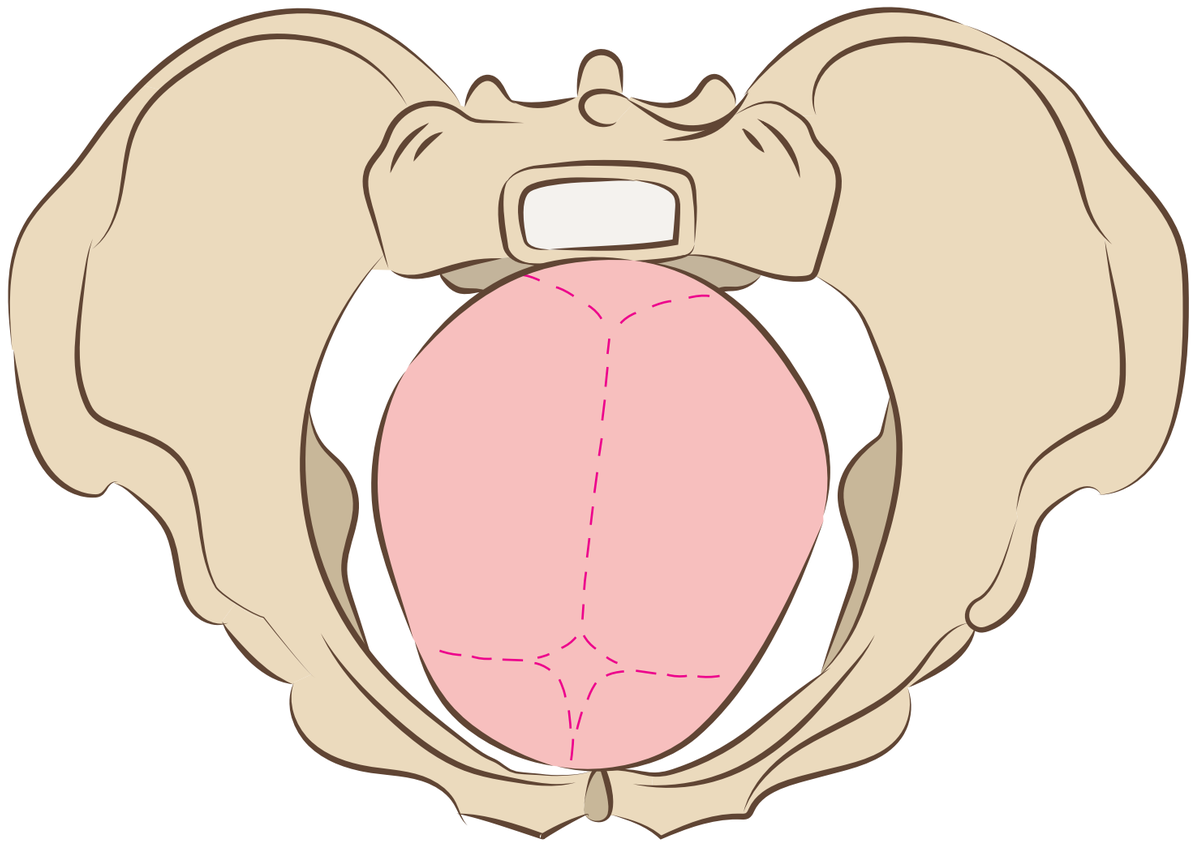
- Transverse lie and shoulder presentation
  OR
- Signs of obstructed labor or CPD
  OR
- Chin-posterior position
  OR
- Brow, footling, arm, shoulder presentation
  OR
- Frank or complete breech with an extended head
  OR
- Asynclitism is not correcting itself spontaneously

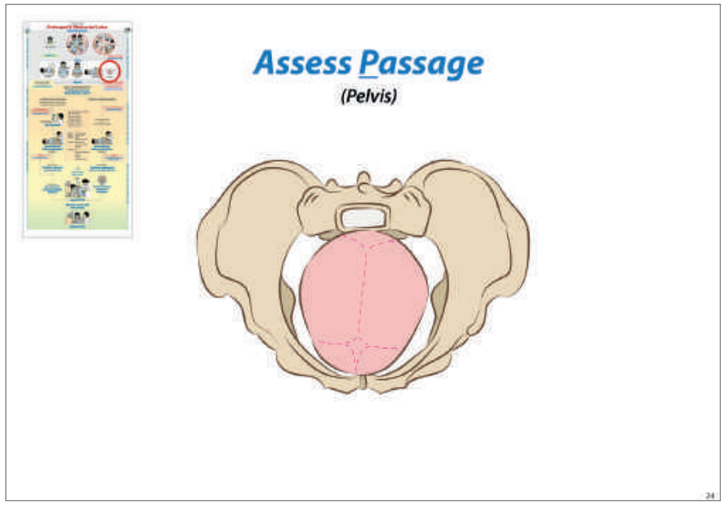
Guidance should be adapted based on local protocols and standards.



Assess Passage

(Pelvis)





Explain

Clinical pelvimetry is used to help identify if the pelvis will allow the fetus to fit through the birth canal.

- CPD exists when the baby's head is too large or a woman's birth canal too small to allow a baby to fit through. This may be due to a small pelvis, a large fetus, an unfavorable position of the fetus, or a combination of these factors.

Remember: A head that is not flexed and that is in an occiput posterior position may have trouble in any pelvis. However a big baby, in a favorable position with a well-flexed head will probably do fine in a normal size pelvis.

- If labor is not progressing normally, experienced and trained providers may use clinical pelvimetry to see if the pelvis is large enough to allow the baby to be born vaginally.
- Women must not be prevented from a trial of labor based on pelvimetry alone.
- Clinical pelvimetry should only be used if labor is not progressing as expected.
- During vaginal examination, look for:
  - Problems with the birth canal that may cause obstruction such as a narrow vagina, female genital cutting or tumors
  - A deformed or narrow pelvis
  - Poor descent in active labor or in second stage with adequate contractions

Knowledge check

What is the position of the baby's head in the illustration?

OP

Advanced Care Note

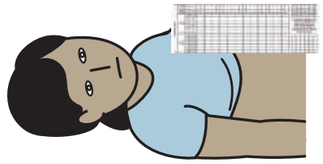
Based on local protocols and standards, seek advanced care immediately if you note any of the following:

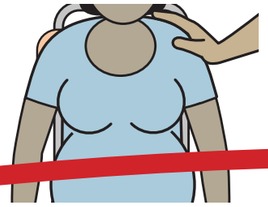
- Signs of CPD: Secondary arrest of cervical dilatation - no change in cervical dilation and/or descent for at least 2 hours with good contractions.
- If labor is not progressing normally and the cause appears to be because the pelvis is too small for this fetus or you feel she may have a pelvic deformity or problems with the birth canal.

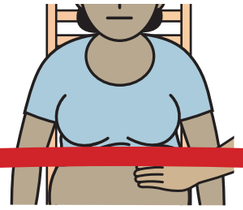
If learners have additional training and authorization to provide advanced care, they should act within their scope of practice.

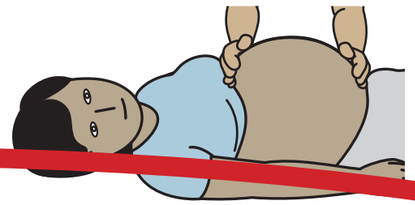
Guidance should be adapted based on local protocols and standards.

Classify









Labor test and history | Patient | Power | Passenger | Passage

Classify

Maternal and fetal status reassuring
See Essential Labor & Birth

Signs of CPD / Obstruction
Arm, Brow, Chin posterior, Transverse, Footling
Pre-referral / Pre-op care

Signs of prolonged labor
Provide general care
Watch for fever >38.0°C

Ineffective contractions

Poor progress with ≤ 2 contractions in 10 minutes, lasting < 40 seconds

If no oxytocin OR if not in CEmONC facility
Seek advanced care

Cervical dilatation is slower than normal if :

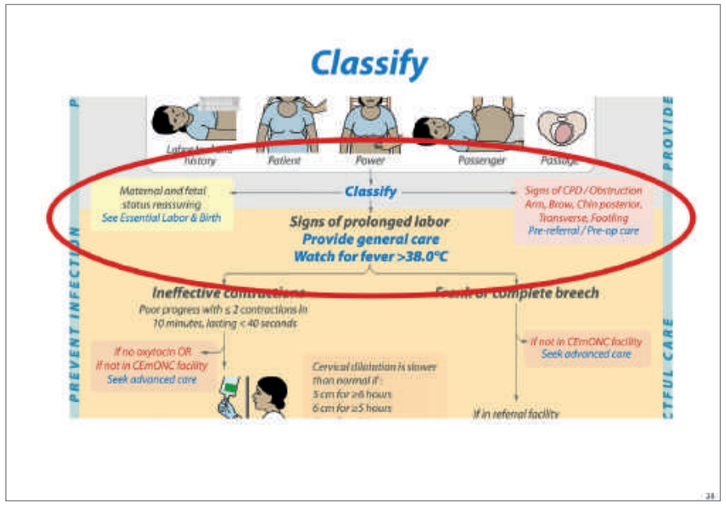
5 cm for ≥6 hours
6 cm for ≥5 hours
7 cm for ≥3 hours

Frank or complete breech

If not in CEmONC facility
Seek advanced care

If in referral facility

PREVENT INFECTION | PROVIDE | TFUL CARE



Explain

Your assessment will allow you to classify if the labor is obstructed, prolonged, or normal. Point providers to the "Classify" section of the Action Plan.

Once you have completed your assessment, decide if:

1. **The woman needs advanced care:**
   - Labor is obstructed OR
   - There are signs of CPD OR
   - She has a complication that you cannot manage at your facility OR
   - There is a malpresentation or malposition that requires a cesarean birth. Ask, ***"Can someone name these?"*** Chin posterior position; transverse lie; shoulder, brow, footling breech, complete or frank breech with a poorly flexed fetal head.

2. **The woman's labor is prolonged and there are no signs of CPD/obstruction.**
   - Manage prolonged labor depending on the cause.
   Ask, ***"Can someone name these?"***
   Anxiety, exhaustion, dehydration, ineffective uterine contractions, poor maternal positioning such as supine, infection, malposition or malpresentation.

3. **The woman's labor is neither prolonged nor obstructed, and maternal and fetal conditions are reassuring.**
   - Provide supportive labor care.
   Say, ***"Remember what we learned in the HMS Essential Care for Labor & Birth? Can someone give some examples of how to support the woman?"***
   Encourage mobility, an empty bladder, drinking sweetened fluids, and help her companion offer comfort. Offer encouragement.

Remember: When labor is prolonged, the most important part of assessment is ruling-out CPD or obstruction. If diagnosis is delayed, the woman and her baby may deteriorate rapidly resulting in severe complications and even death.

Knowledge check

What is the difference between prolonged and obstructed labor?

- *When labor is prolonged, contractions may be ineffective, the woman may be distressed or dehydrated or may have an infection, or the baby may be in a position other than occipital anterior.*
- *When labor is obstructed, contractions are usually effective yet labor does not progress normally.*

What are the risks of prolonged and obstructed labor?

- *Infection, uterine rupture, obstetric fistula, fetal distress, shoulder dystocia, asphyxia, PPH, and maternal and fetal death.*

EXERCISE

Classify

ACTION PLAN

Prolonged & Obstructed Labor

PREVENT INFECTION

PROVIDE RESPECTFUL CARE

Rapid Assessment

Close to birth?

Support birth

Danger / Alert Signs
Seek advanced care

Assess

Maternal and fetal status reassuring
See Essential Labor & Birth

Classify

Signs of CPD / Obstruction
Arm, Brow, Chin posterior, Transverse, Footling
Pre-referral / Pre-op care

Signs of prolonged labor
Provide general care
Watch for fever >38.0°C

Ineffective contractions

Poor progress with ≤ 2 contractions in 10 minutes, lasting < 40 seconds

If no oxytocin OR if not in CEmONC facility
Seek advanced care

Cervical dilatation is slower than normal if :

5 cm for ≥6 hours
6 cm for ≥5 hours
7 cm for ≥3 hours

Frank or complete breech

If not in CEmONC facility
Seek advanced care

EXERCISE

Classify

Practice in groups of 3-4. Wear the simulator with the 6 cm insert in place with the baby in LOP position. Ask for a volunteer to be the provider and another to be your companion. You will give results of any of the assessments from the scenario below only if the learner playing the role of provider has done the assessment.

Say, ***"Ms. A. is 21 years, G1P0 who came from home after having labor pains for 24 hours. On admission she was walking with support from relatives and appeared exhausted. It is 21:00 hours and I am Ms. A. Begin your assessment of me."***

Rapid assessment at 21:00 hours:

- No danger signs and reports positive fetal movements.
- Vital signs: T 37.9°C, Pulse 110 and regular, BP 118/72, Respirations 22.
- FHR: 152/minute between contractions.
- Eyes sunken, mouth dry and skin of her forearm goes back slowly when pinched. She says she is not urinating much.
- Conjunctivae are pink.
- Tolerating contractions and can talk during them.

History and review of labor record:

- No labor record available.
- Irregular contractions for 24 hours, clear fluid leaking for 3-4 hours
- No ANC visits but says LMP was about 9 months ago
- No history of gynecological or obstetric surgery
- Past medical history is unremarkable
- Living with her husband
- No history of chronic disease and no history of smoking, alcohol, or drug use

Examination:

- Fundal height is 37 cm.
- Contractions 2/10 minutes lasting 30 seconds.
- Uterus is not tender.
- The bladder is not distended.
- Presentation: Cephalic
- Level of engagement: 3/5
- Vaginal exam: 6 cm and soft.
- Membranes are ruptured, liquor is clear.
- Position: occiput posterior
- No caput or molding.

After completing the assessment, ask the providers:
"What is the most likely diagnosis?"

- Active labor, fewer than 3 contractions in 10 minutes lasting less than 40 seconds, dehydration, malposition

"Does Ms. A have signs of CPD or obstruction"

- Not at this time

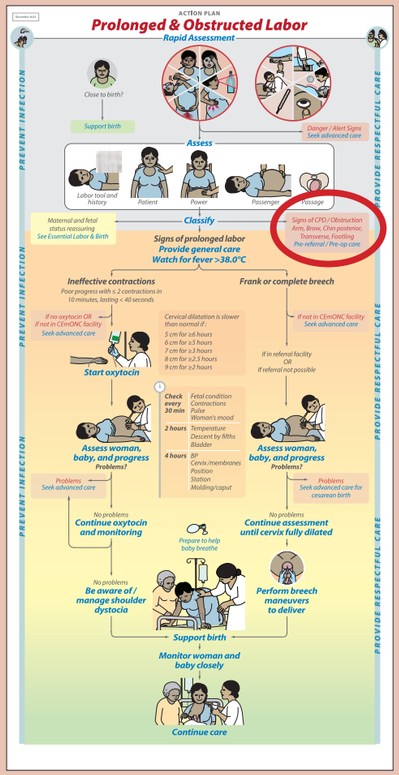
"Does Ms. A need advanced care?"

- Not at this time

Debrief

When finished, debrief with the team. Ask the provider to evaluate his/her performance and then invite comments from others:

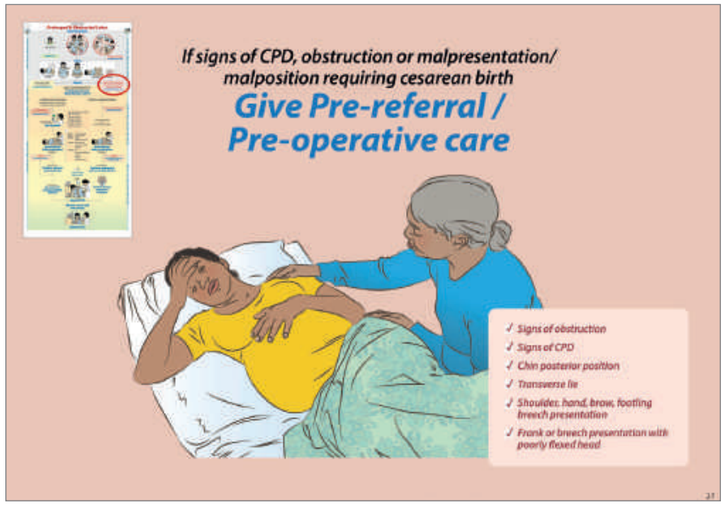
- ***"What did the provider do well? "***
- ***"Is there anything the provider forgot to do?"***
- ***"What additional examinations or labs need to be done?" (ANC laboratory investigations.)***
- ***"Is there additional information that the provider needs to get from the woman?"***



If signs of CPD, obstruction or malpresentation/ malposition requiring cesarean birth

Give Pre-referral / Pre-operative care

- ✓ *Signs of obstruction*
- ✓ *Signs of CPD*
- ✓ *Chin posterior position*
- ✓ *Transverse lie*
- ✓ *Shoulder, hand, brow, footling breech presentation*
- ✓ *Frank or breech presentation with poorly flexed head*



Explain

- **Act quickly and ensure urgent things are done first**. Rapidly stabilize the woman.
- Your assessment will help you decide what care she needs. For example, she will need an IV and may need antibiotics, oxygen, or analgesics depending on your assessment.
- If the baby is dead, the woman and her family need counseling to prepare for a stillborn baby. In some places, a craniotomy may be done to avoid cesarean if the baby is dead.

If you identified CPD or obstruction, a malposition or malpresentation or a complication that you cannot manage at your facility:
Provide pre-referral and / or pre-operative care

- If advanced care is available at your facility, contact the consultant to come and advise you on her care. Put the transport plan into action if she must be referred.
- Until you transfer her care to the operating team:
  - Prepare the woman for advanced care.
  - Provide general labor and emotional support.
  - Monitor the woman, her baby, and the progress of labor very closely.
  - Make sure she has adequate pain relief!
  - Be sure to record all findings on the labor record or partograph, including the position/presentation.

Discuss

Ask learners to turn to the "Key Actions" for pre-referral care on page 37 of Provider Guide 1 to respond to the following questions.

"How will you prepare women for referral or cesarean birth?"

- Explain to the woman and her companion what is happening and why cesarean birth or referral is needed. Answer any questions.
- Give supportive care and labor support. Explain all procedures, gain her consent, discuss any test results with her, listen and be sensitive to her feelings.

"Which women should receive antibiotics?"

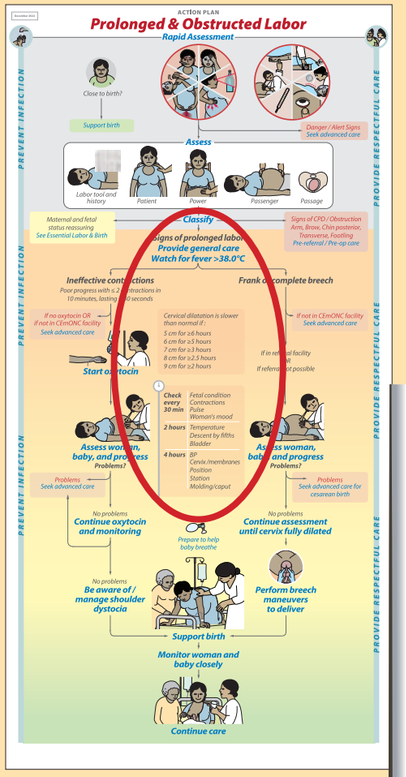
- Give antibiotics if there are signs of infection (temperature >38°C, foul-smelling vaginal discharge, uterine tenderness)
  - ampicillin 2 g IV every six hours PLUS
  - gentamicin 5 mg/kg body weight IV every 24 hours.

"How will you manage her fluids?"

- Start an IV (Ringer's Lactate or normal saline)
- If the woman is in shock or will have a cesarean birth, place an indwelling foley catheter in the bladder to ensure it stays empty and to accurately record output.
- Record all IV fluids infused, oral fluid intake, and all urine output.
- NOTE: Do not give oral fluids to a woman in shock!

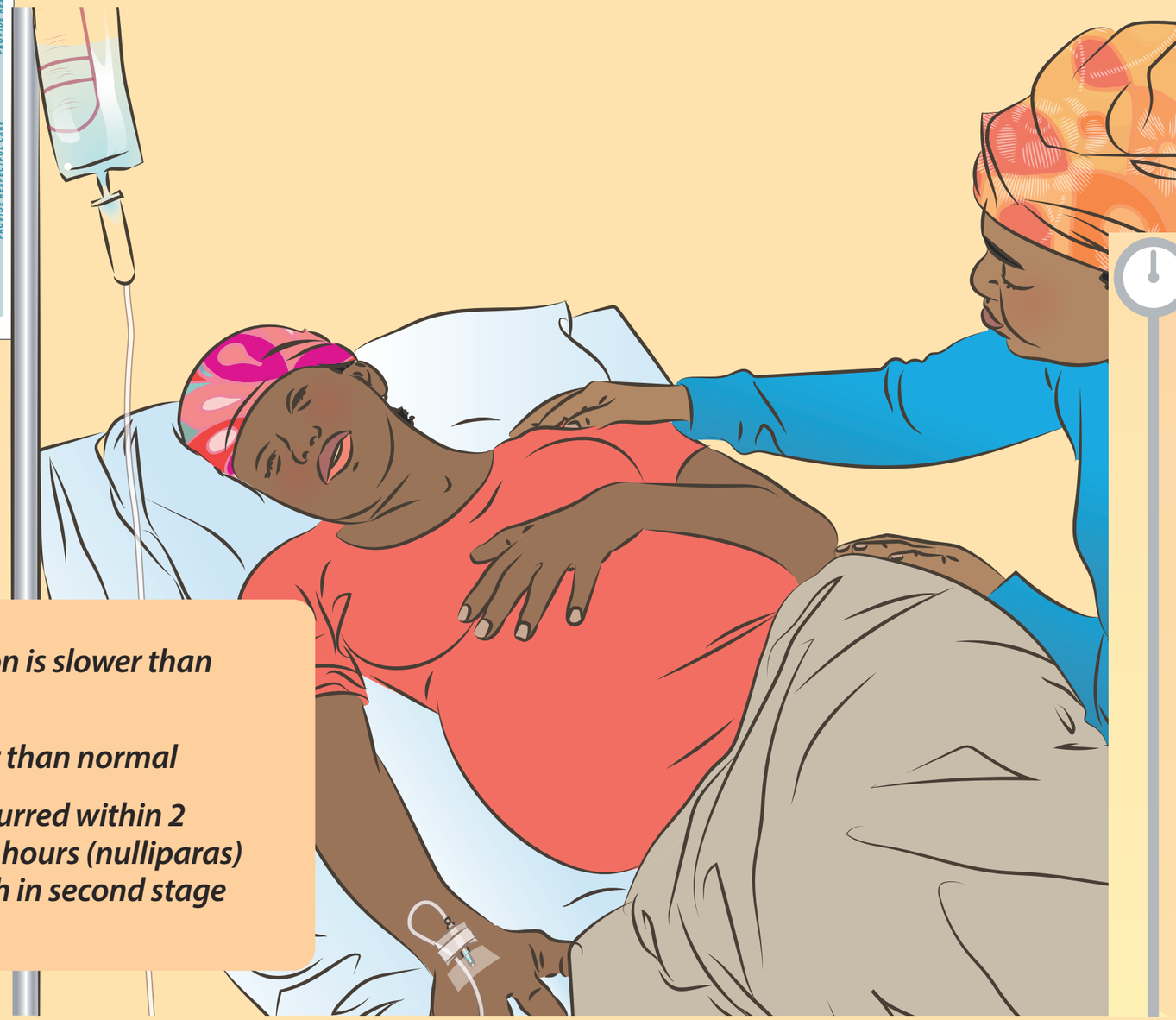
"What other care will you provide?"

- Place the woman in left lateral position to improve blood flow to the uterus and other vital organs.
- Provide pain management as needed.
- Continue to monitor the progress of labor and the condition of the woman and her fetus closely. Never leave her alone.



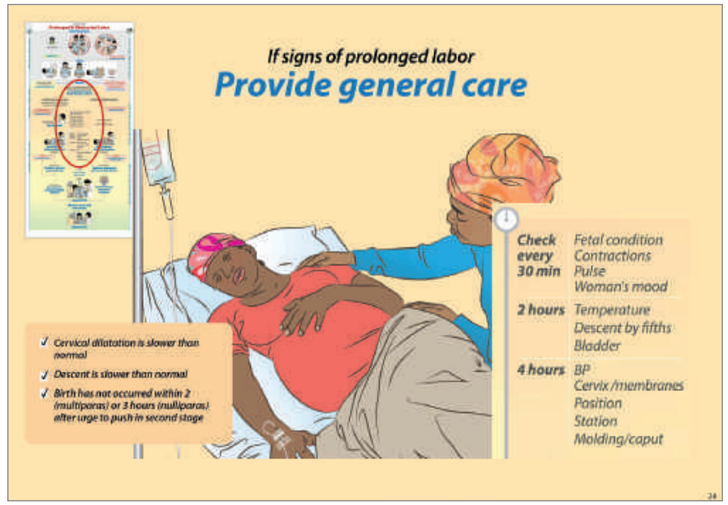
If signs of prolonged labor

Provide general care



- ✓ *Cervical dilatation is slower than normal*
- ✓ *Descent is slower than normal*
- ✓ *Birth has not occurred within 2 (multiparas) or 3 hours (nulliparas) after urge to push in second stage*

Check every 30 min	*Fetal condition* *Contractions* *Pulse* *Woman's mood*
2 hours	*Temperature* *Descent by fifths* *Bladder*
4 hours	*BP* *Cervix /membranes* *Position* *Station* *Molding/caput*



Explain

Before managing prolonged labor, ensure you have ruled out obstructed labor, CPD and malpositions requiring cesarean birth.

- Remember, the cervix may not dilate at a rate of 1 cm/hour even during active phase. **If both the woman and her baby are doing well, there are no signs of obstructed labor or CPD, and labor is at least slowly progressing, do not try to speed up labor and birth by augmentation or cesarean.**
- Give supportive care that may improve contractions and progress.
- Always explain what is happening, what options she has, and gain consent before proceeding.
- Continue close monitoring of the woman, her baby, and labor progress so you can quickly identify any problems and act fast.

Demonstrate

▶ *Giving good care in labor*

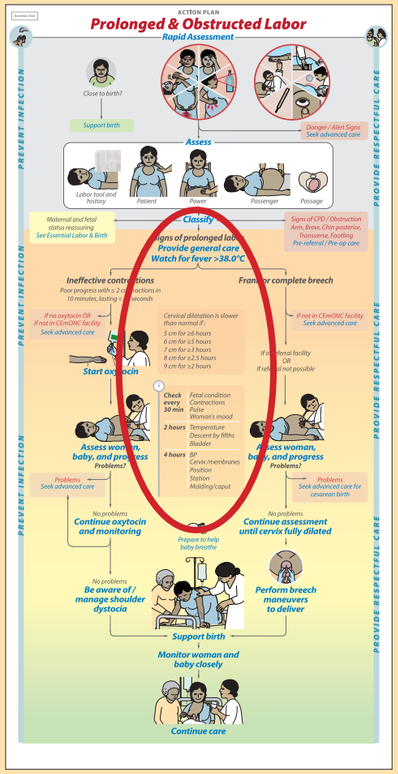
When video is not available

Demonstrate

- **Give supportive care:**
  - Ensure privacy.
  - Allow her to have a companion of her choice.
  - Encourage her companion to give comfort. Have them offer the woman to rub her back, wipe her face and brow with a cool cloth, help her move and change position.
  - Be supportive and encouraging. Respect her wishes.
  - Demonstrate and encourage breathing techniques.
- If you have identified why her labor is prolonged, manage the problem.
- Continue to monitor and record the well-being of the woman and her baby and **respond immediately if you identify any problems:**
  - progress of cervical dilatation
  - FHR
  - molding
  - amniotic fluid
  - fetal descent
  - uterine contractions
  - maternal temperature, pulse, blood pressure and urinary output
  - maternal coping
- Watch for fever.
- Encourage the woman to empty her bladder regularly.
- Encourage her to drink at least one cup of fluid each hour.
- Encourage her to eat if she is hungry.
- Encourage her to move and to remain upright instead of lying down if possible.
- Explain your findings from all assessments to the woman and her companion.
- **Offer pain management** during labor based on her preferences and availability: relaxation techniques, emotional support, massage, warm or cold compresses, breathing, bathing, epidural or opioid analgesia.
- If any findings are not reassuring, act fast and seek advanced care.

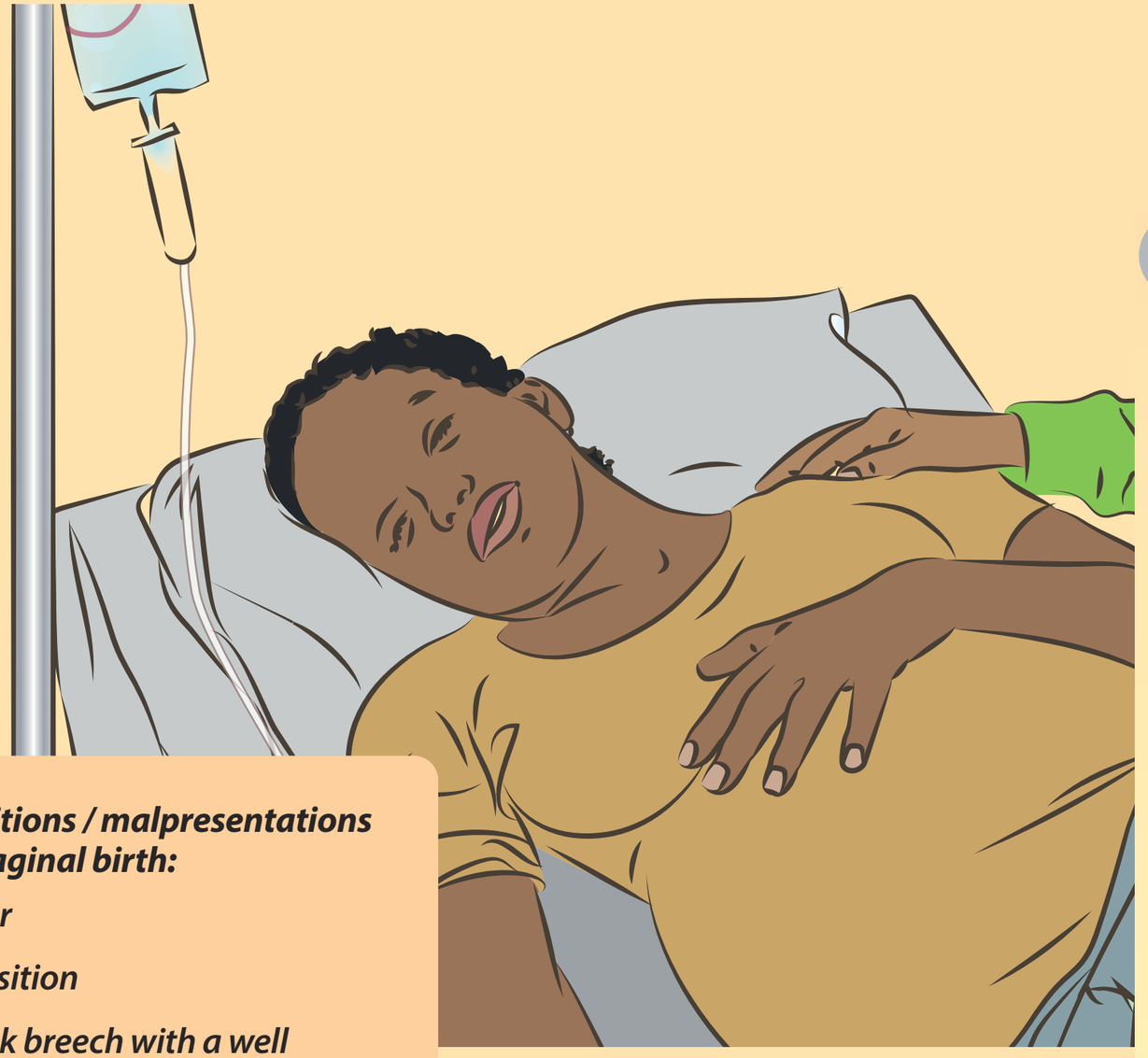
Advanced Care Note

Based on local protocols and standards, seek advanced care immediately if labor progress continues to be slow in spite of care or maternal and/or fetal status is not reassuring.
If learners have additional training and authorization to provide advanced care, they should act within their scope of practice.



If signs of prolonged labor with malposition

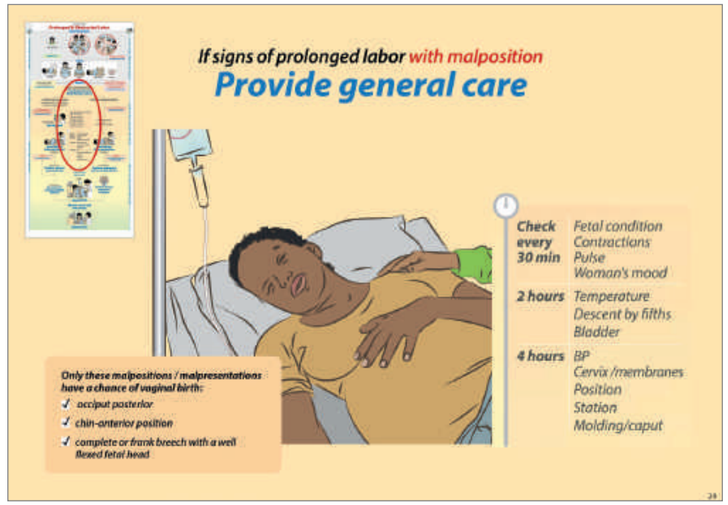
Provide general care



Only these malpositions / malpresentations have a chance of vaginal birth:

- ✓ *occiput posterior*
- ✓ *chin-anterior position*
- ✓ *complete or frank breech with a well flexed fetal head*

Check every 30 min	*Fetal condition* *Contractions* *Pulse* *Woman's mood*
2 hours	*Temperature* *Descent by fifths* *Bladder*
4 hours	*BP* *Cervix /membranes* *Position* *Station* *Molding/caput*



Explain

Only these malpositions / malpresentations have a chance of vaginal birth:

- occiput posterior
- chin-anterior position
- complete or frank breech with a well flexed fetal head

If ultrasound is available, confirm presentation and position using ultrasound. **Act fast if you identify** chin posterior position; transverse lie; shoulder, brow, footling breech, or arm presentation; complete or frank breech with a poorly flexed fetal head! **She needs advanced care and may need cesarean birth.**

Provide general care and monitor the woman, baby, and labor progress closely. **Act fast if you identify any abnormal findings!**

Knowledge check

How would you manage a woman with the fetus in OP position?

- *Tell the woman and her companion that OP position may slow her progress and cause back pain.*
- *Ask her to get on her hands and knees to help the fetus to change position to OA.*
- *Re-assess position at each vaginal examination.*

How would you manage a woman with the fetus with asynclitism?

- *Explain what this means and that many babies enter the pelvis in this position. Tell her most babies straighten out during labor.*
- *Tell her it may slow down her labor progress and she may feel pain in one hip or the other.*
- *Have her try 1) Kneeling forward with her arms folded on the floor in front of her and her head resting on top. 2) Walking up and down stairs, or if there are none, taking small steps forward while in a half squat or full squat position.*
- *Re-assess position at each vaginal examination.*

What is the risk for the labor if the fetus is in OP or an asynclitic position?

- *Prolonged or obstructed labor.*

How will you monitor women with a malposition or malpresentation that has a chance of a vaginal birth?

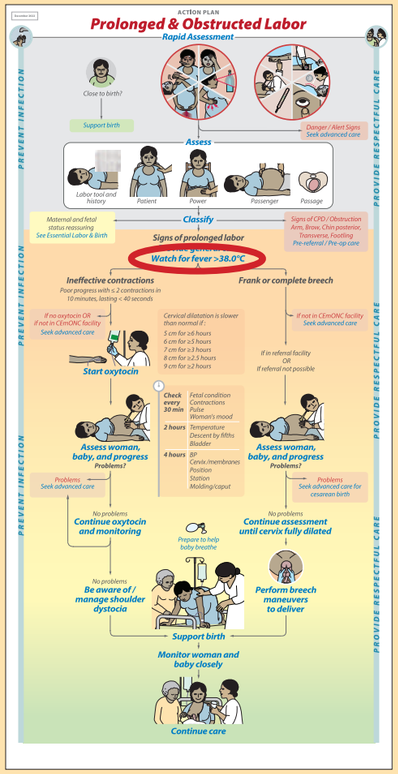
- *Provide general labor support.*
- *Monitor the woman, her baby, and the progress of labor very closely because she is at risk for prolonged or obstructed labor.*
- *Make sure she has adequate pain relief!*
- *Be sure to record all findings on the labor record or partograph, including the position/presentation.*
- *If obstructed labor or CPD is suspected, the woman should be referred for advanced care.*

Advanced Care Note

Based on local protocols and standards, seek advanced care immediately if:

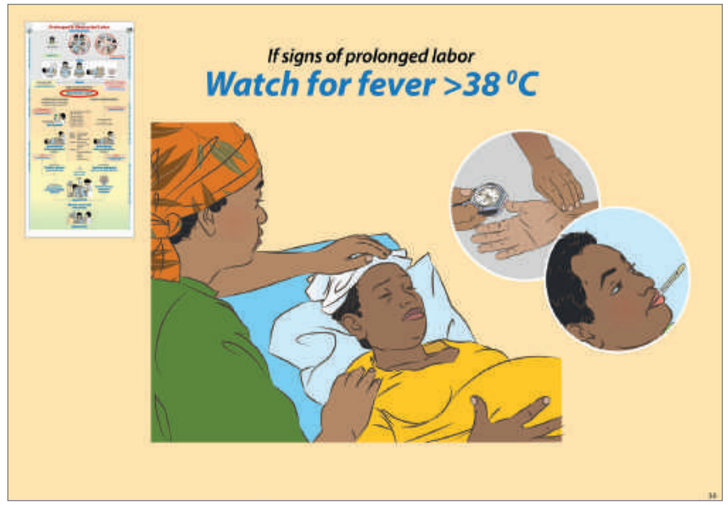
- Labor is not progressing normally with frank or complete breech presentation, OP or asynclitic position.
- There are no providers competent and comfortable to assist with a vaginal breech birth.

If learners have additional training and authorization to provide advanced care, they should act within their scope of practice. Ideally, breech births should only take place in facilities with capacity to perform a cesarean birth.



If signs of prolonged labor

Watch for fever >38 ⁰C



Explain

A woman with prolonged labor may be at greater risk for infection. Carefully monitor her temperature and respond immediately if it is higher than 38°C.

There are 4 major causes of fever in labor:

- Uterine infection or chorioamnionitis
- Non-obstetric infection
- Overheating or dehydration
- Epidural for more than 4 hours

Chorioamnionitis puts both the woman and her fetus at risk and should always be ruled out when a woman's temperature is elevated and/or the FHR is faster than normal.

Be aware of common causes of fever in your community. Focus your history and exam to find the cause.

Demonstrate

Demonstrate how to identify the most likely cause of fever in labor, asking a volunteer to wear the simulator. Ask learners to refer to pages 42 and 43 in Provider Guide 1 while you demonstrate.

Perform a **rapid check** of the woman's general condition including vital signs, behavior, blood loss, and skin color.

- **If shock is suspected,** act fast to treat her!
- Check fetal heart rate.
- Conduct a focused physical examination based on signs and symptoms.
- Check if she has abdominal tenderness, foul odor to vaginal discharge, pain on urination, severe back pain around the kidneys, productive cough, shortness of breath, chest pain, pain when breathing, sore throat, headache, chills, abdominal pain, diarrhea, vomiting, etc.
- Ask about exposure to malaria or other diseases.
- Review the labor record and history including medical, obstetric, current pregnancy, and labor.
- Do laboratory tests as directed by examination.
- Make a diagnosis and manage the fever based on the cause.
- Continue to monitor the woman, fetus, and labor progress closely.

Knowledge check

What are signs of a uterine infection during labor?

- *Temperature >38°C, abdominal or uterine tenderness, foul smelling vaginal discharge or amniotic fluid, rapid FHR >160 bpm, rapid maternal HR >100 bpm. Other signs may include chills or light vaginal bleeding.*

What are other possible causes of fever during labor?

- *Urinary tract infection, pyelonephritis, pneumonia, malaria, dehydration, epidural anesthesia.*

What pulse rate and BP indicate the woman may be in shock?

- *Fast, weak pulse: 110 beats per minute or more*
- *Low blood pressure: systolic less than 90 mmHg*
- *Respirations > 30 breaths per minute or more.*

EXERCISE

Cause of maternal fever

ACTION PLAN

Prolonged & Obstructed Labor

PREVENT INFECTION

PROVIDE RESPECTFUL CARE

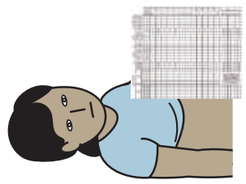
Rapid Assessment

Close to birth?

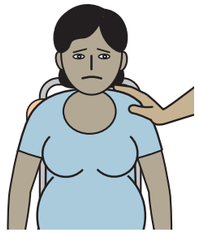
Support birth

Danger / Alert Signs
Seek advanced care

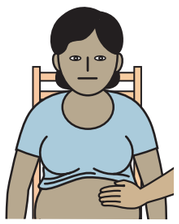
Assess



Labor tool and history



Patient



Power

Passenger

Passage

Classify

Maternal and fetal status reassuring
See Essential Labor & Birth

Signs of CPD / Obstruction
Arm, Brow, Chin posterior, Transverse, Footling
Pre-referral / Pre-op care

Signs of prolonged labor

Watch for fever >38.0°C

Ineffective contractions

Poor progress with ≤ 2 contractions in 10 minutes, lasting < 40 seconds

If no oxytocin OR if not in CEmONC facility
Seek advanced care

Cervical dilatation is slower than normal if :

5 cm for ≥6 hours
6 cm for ≥5 hours

Frank or complete breech

If not in CEmONC facility
Seek advanced care

EXERCISE

Cause of maternal fever

Divide learners into groups of 3-4.
As facilitator, play the role of the "woman" and give results of assessments only if the learner playing the role of "provider" does each assessment.

SCENARIO:
Ms. I. was in labor at home for about 4 hours before coming to the health center. She says her membranes ruptured about 1 hour after labor started. She lives in a malarial endemic area and had her last dose of Fansidar 2 weeks prior to going into labor.

Contractions:
Ms. I. is talking through her contractions and does not have a desire to push. She is having 3 contractions/10 minutes each lasting 60 seconds.

Danger signs:
Complaining of high fever and chills

Vital signs:
- Pulse 100 b/min
- Temp. 39.8°C
- BP 112/72

Conjunctivae:
- Pale

Signs of dehydration:
- Mouth is dry
- Skin returns slowly to normal when pinched

Psyche:
- Anxious and scared about upcoming birth

Signs/Symptoms:
- She denies frequent, painful urination or urgency; productive cough, chest pain, pain when breathing; sore throat; headache; diarrhea, vomiting.

Focused physical exam:
- Neck is not stiff
- Lung sounds clear
- Uterus is tender
- Presentation: Cephalic
- FHR: 164 bpm
- Bladder is not tender, there is no costovertebral angle tenderness
- Vaginal exam: Vulva is not edematous, there is foul-smelling, greenish amniotic fluid (liquor)

Cervical exam: 6 cm, soft, OA position

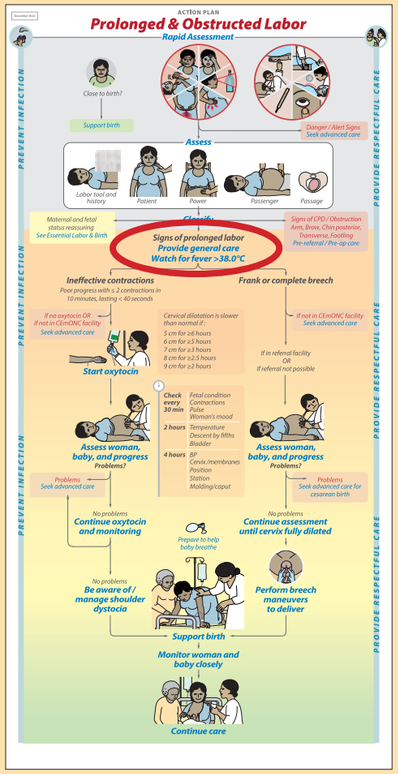
Labs:
Ketones ++, leukocytes 0, nitrite 0, protein +

Negative rapid malaria test

Ask the provider;
"What is the most likely cause of the fever?"
Uterine infection (or chorioamnionitis)
Dehydration

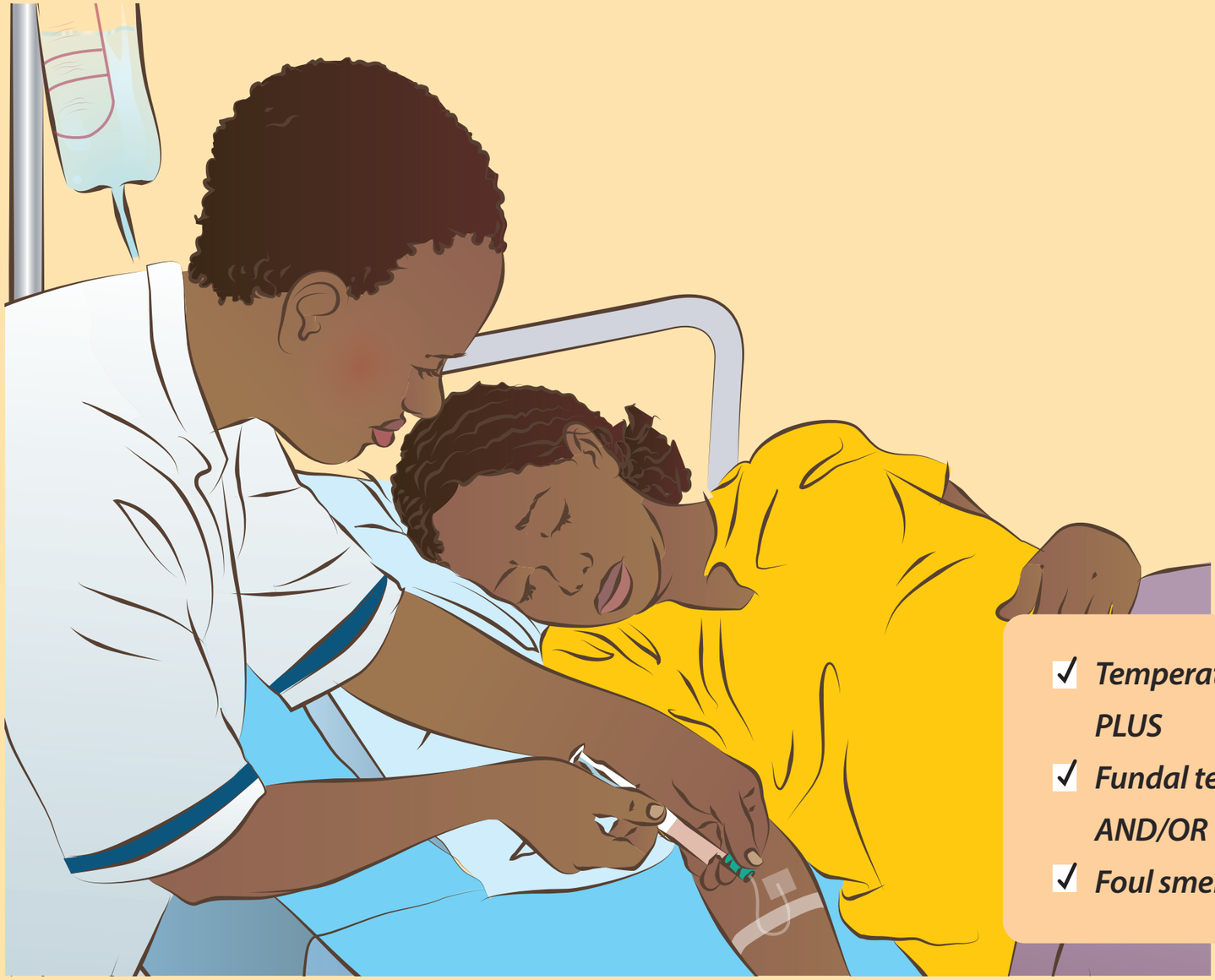
Debrief
After scenario is complete, ask the provider to evaluate his/her performance and then invite comments from others:

1. What did the provider do well?
2. Did the provider miss anything?
3. What additional examinations or labs need to be done?
4. Is there additional information that the provider needs to get from the woman?



If uterine infection

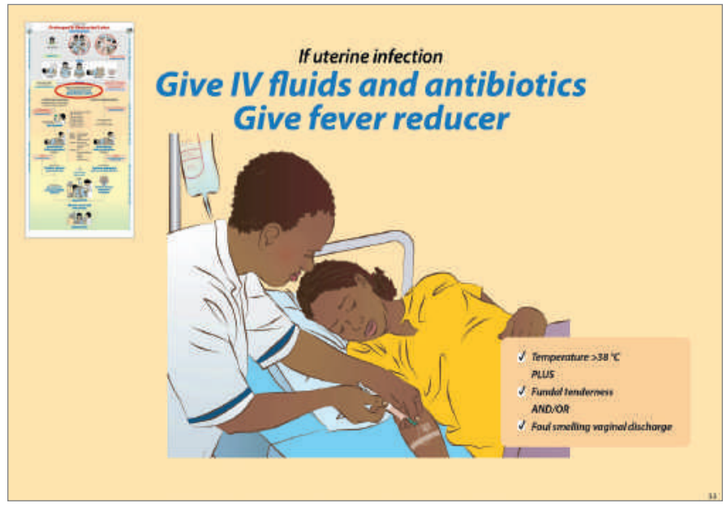
Give IV fluids and antibiotics
Give fever reducer



- ✓ *Temperature >38 °C*

  PLUS
- ✓ *Fundal tenderness*

  AND/OR
- ✓ *Foul smelling vaginal discharge*



Explain

Early diagnosis and treatment of uterine infection improves the chance of a healthy woman and baby.

- A woman with a uterine infection may develop shock from sepsis. It is a leading cause of maternal and neonatal death.
- Closely monitor the woman, her baby, and her labor.
- After birth, give the baby prophylactic antibiotics for at least 2 days and watch closely for signs of sepsis!

Treat uterine infection during labor:
Antibiotics. Follow local protocols or give:

- Ampicillin 2 g IV every 6 hours PLUS
- Gentamicin 5 mg/kg body weight IV every 24 hours
- If the woman will have a cesarean birth, cleanse the vagina with povidone-iodine before surgery.

Supportive care
If **shock is suspected**, immediately begin treatment. If no signs of shock, keep shock in mind and act quickly if it develops!

- Encourage fluids (by mouth or IV). If you suspect dehydration, adjust the IV rate to replace fluid and treat dehydration.
  - **If in shock**, rapidly infuse IV fluids (normal saline or Ringer's lactate) at 1 L in 15–20 minutes. Give at least 2 L in the first hour. If the woman's condition improves, adjust the rate of infusion to 1 L in six hours.
  - For fever or dehydration, infuse IV fluids initially at 1 L in 4 hours. If the woman's condition improves, adjust the rate of infusion to 1 L in six-eight hours.
  - For maintenance IV, infuse IV fluids at 1 L in 6 hours.
- Use a fan or cool sponge to give comfort and help reduce temperature.
- Give paracetamol 500–1000 mg every six to eight hours (maximum of 3000 mg in 24 hours) to reduce temperature.
- **Make sure she has adequate pain relief – contractions with an infected uterus may be very painful!**

Monitoring
Monitor the woman, labor progress, and the baby closely.

- Begin additional treatment or refer if her condition worsens.
- As long as all other findings remain normal, continue treatment for infection and provide ongoing emotional support and comfort.

Demonstrate

▶ *Uterine infection*

If you can, show the video to review care of women with uterine infection in labor. If the video is not available, demonstrate giving IV antibiotics.

Knowledge check

What are the recommended dose sof antibiotics for treating uterine infection during labor?
Ampicillin 2gm IV every 6 hours and Gentamycin 5mg/kg IV daily - adjust per local protocol.

Acknowledgments

Helping Mothers Survive Prolonged & Obstructed Labor

Facilitator Flip Chart
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Jhpiego is an international, nonprofit health organization affiliated with Johns Hopkins University. For nearly 50 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidenced-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

The Helping Mothers Survive Prolonged & Obstructed Labor module was conceived and co-developed by a team in the Technical Leadership Office of Jhpiego and the American College of Obstetricians and Gynecologists.

.....

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