November 2019

Helping Mothers Survive

Essential Care for Labor & Birth

Provider's Guide

Helping Mothers Survive

AMERICAN COLLEGE of NURSE-MIDWIVES With women, for a lifetime®

International Confederation of Midwives Strengthening Midwifery Globally

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Acknowledgments

Jhpiego is an international, nonprofit health organization affiliated with Johns Hopkins University. For more than 40 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 Essential Care for Labor & Birth module was conceived and developed by Jhpiego in partnership with the American College of Nurse Midwives and the International Confederation of Midwives and uses the design created for Helping Babies Breathe, a module developed by the American Academy of Pediatrics.

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We express our sincere gratitude to our partners and colleagues around the world who work with us to improve the lives of women and families. We would like to give special thanks to those who provided guidance in the development of these materials: the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, the United Nations Population Fund, the World Health Organization, the International Council of Nurses and the American Academy of Pediatrics.

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Special thanks to Tore Laerdal for his never-ending dedication to the lives of women and their newborns around the globe.

You can make a difference

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. These modules are designed to be delivered at the jobsite to the entire team of providers involved in the care of woman and their families. These teams include skilled birth attendants such as midwives and doctors, and other team members, such as nurses and support staff. Every one of us can work together to make a difference!

Helping Mothers Survive Essential Care for Labor & Birth (ECL&B) reinforces the knowledge, skills, and decision making needed for providers to give the best possible respectful care during childbirth. The focus is on normal, healthy labor and birth. The learning materials for this module include:

Action Plan: A job aid that helps identify and manage normal labor and birth

Flip Chart: Used for instruction during training day

Provider's Guide:
Contains clinical information from the Flip Chart with checklists, more information, and "low-dose, high-frequency" (LDHF) session plans for after training. Learners will work together with an onsite peer who will lead these LDHF activities to solve any problems found during the training day. These activities also include practicing new or refreshed skills. Anyone can help with these LDHF sessions and this Provider's Guide will tell you how.

Birthing simulator: for skills demonstration and practice.

Contents

Provide respectful care to women and their families

Performance Expectation

- *Communicate professionally and respectfully with women and their families.*

Key points

- *Every person deserves respectful care.*
- *Respectful care saves lives.*
- *Women have a right to privacy and confidentiality.*

Key Knowledge

- Everyone is worthy of respect.
- Respectful care saves lives; women may not seek care from facilities where providers do not treat them well.
- All women and babies have the right to be treated equally regardless of ethnic background, culture, social standing, religion, educational level, age, and marital or economic status.
- Everyone has the right to privacy and confidentiality.
- Women have the right to have a companion when receiving care. The presence of a birth companion improves outcomes and can shorten labor.
- Women have the right to refuse care or to leave a facility with their babies, even if they cannot pay.
- Younger women may need additional explanations, very gentle touch and extra reassurance.

(See page 70 of this Provider's Guide)

Key Actions

- Care for women as you would like to be cared for.
- Communicate clearly to women and their families so they know what to expect.
- Do not leave a woman in labor alone. If you must leave, ensure someone stays with her.
- Ask permission before touching women and cover them as much as you can during exams.

How to demonstrate respect:

1. Introduce yourself by name and smile.
2. Look at women when speaking to them.
3. Use simple, clear language.
4. Speak calmly.
5. Pay attention when women speak.
6. Include women and families in discussions about their care.
7. Always explain any procedure and get her permission before you begin.

Special Considerations for Labor and Birth

Performance Expectation

- *Identify women with HIV and syphilis, being treated for tuberculosis, or with a history of female genital mutilation/ cutting (FGM/C) who require special care and attention during labor and childbirth.*
- *Provide treatment for women and their newborns.*

Key points

- *Women with HIV are at increased risk for sepsis.*
- *There is a risk that the baby might be infected with HIV, syphilis, or TB if the woman is not appropriately managed during labor and if their newborns do not receive prophylactic treatment.*
- *Women who have experienced FGM/C may have urinary retention in labor, and they are at risk for prolonged labor, lacerations, or hemorrhage.*

Key Knowledge / Actions

HIV

- Review medical records to evaluate HIV status and management.
- Offer HIV testing to all women in labor whose status is not known. Encourage partner testing.
- For women seropositive for HIV, initiate antiretroviral therapy (ART) promptly per local guidelines. Treat them with dignity and respect.
- Promptly identify prolonged labor and prolonged rupture of membranes. Always observe best IPC practices. Routine cesarean birth is not recommended.
- Provide infant prophylaxis and HIV testing to all HIV-exposed babies according to guidelines.
- Follow local infant feeding guidelines for women with HIV - either exclusively breastfeed and receive ART or avoid all breastfeeding.

Tuberculosis

- If the woman has been diagnosed with TB, review her medical records to assess how long she has been undergoing treatment.
- Follow local protocols for newborn assessment, treatment, and vaccination.

Syphilis

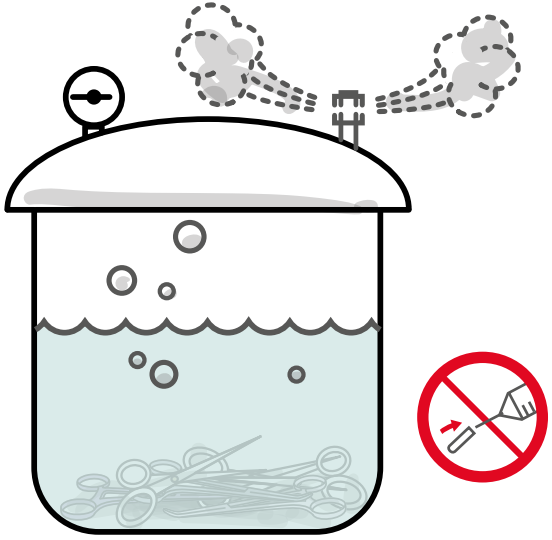
- Review medical records to evaluate syphilis status and management. Offer syphilis testing to all women in labor whose status is not known.
- Newborn death related to syphilis is preventable!
- If a woman tests positive for syphilis at any time, treat per local guidelines.
- Plan to treat her newborn.

FGM/C

- In cases of infibulation FGM/C Type III, tissue needs to be cut and released at birth.

Infection prevention

5 moments for hand hygiene



Clean equipment

Performance Expectation

- *Define steps that are shown to prevent infection.*
- *Demonstrate and promote effective infection prevention interventions while caring for women during labor and birth.*
- *Work with management to ensure essential infrastructure, equipment, and supplies needed to prevent infection are available.*

Key points

- *Infection prevention saves lives.*
- *The three main goals of infection prevention are:*
  - *Protect the patient.*
  - *Protect providers, visitors, and others in the healthcare environment.*
  - *Accomplish the previous two goals in a cost-effective manner, whenever possible.*

Key Knowledge

- Infection prevention begins when a woman comes for care and continues after she and her baby go home.
- Handwashing is the single most effective way to prevent infection. Encourage women and families to wash hands.

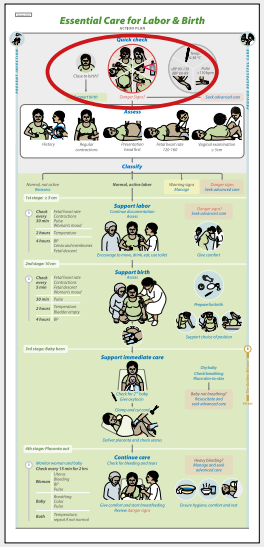
Key Actions

- Wash visibly soiled hands with soap and water for 40 - 60 seconds.
- If not visibly soiled, rub hands with alcohol based hand rub for 20 - 30 seconds.

WHO's 5 moments for hand hygiene:

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

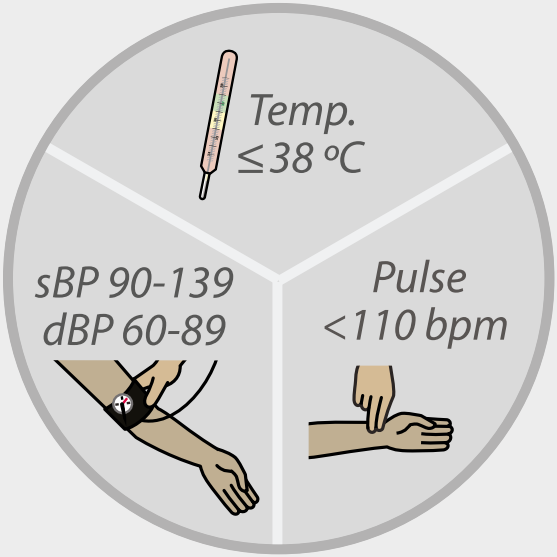
- Wear sterile gloves and protective clothing. Add eye protection during birth.
- Use high- level disinfected (HLD) or sterile instruments and equipment. After use, put all instruments in closed, leak and puncture-proof containers. Wash in soapy water, rinse, dry, and either sterilize or HLD before reuse.
- Clean all surfaces with detergent and water between clients.
- Decontaminate visibly soiled surfaces and spills.
- Handle, process, and store linens safely.
- Separate uncontaminated and contaminated waste and dispose per standards. Place sharps in puncture proof containers.



Quick Check!

Close to birth?

Danger signs?



Vital signs

Performance Expectation

- *Conduct a "Quick Check" on all women as soon as they come to you thinking they are in labor.*
- *Identify danger signs or signs birth is near which require immediate care.*
- *Make a plan to care for each woman based on the quick check.*

Key points

- *The goal of the Quick Check is to identify problems fast and make a plan for additional assessments or urgent care that may be needed.*
- *It is important to remember that a woman may have several problems at the same time that all need to be addressed.*
- *Document findings immediately after completing any assessment.*

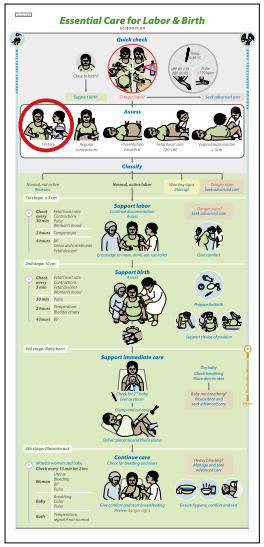
Key knowledge

When a woman first comes for care, she needs a "Quick Check" to be sure she and her baby are ok. This lets us know who needs help right away, and who can wait if the facility is very busy.

If you find a danger sign or if she is close to birth provide care quickly. Get advanced care fast if needed. If findings are normal, give her a clean, comfortable place to wait if you cannot attend to her right away.

Key actions

1. Welcome the woman and introduce yourself.
2. Explain that you will do a Quick Check to make sure she and her baby are ok.
3. Wash your hands and ensure privacy.
4. Is she grunting or wanting to push, suggesting she is close to giving birth?
5. Does she have any danger signs?
   - headache
   - vision problems
   - convulsions/unconscious
   - high fever
   - bleeding
   - severe pain
   - severe vomiting
   - other problems or concerns
6. Are her vital signs normal?
   - Pulse 60-110 beats per minute
   - Temperature ≤ 38 °C
   - Systolic BP 90–139 mmHg and diastolic BP 60–89 mmHg
7. Does she have signs of anemia?
   - Look at her conjunctiva and palms for pallor.
8. Does she have signs of dehydration?
   - Check for sunken eyes and dry mouth.
   - Pinch the skin of her forearm: does it go back quickly?
9. Based on findings, decide what to do.
   - If birth is close, prepare for birth.
   - If any findings are not normal, act quickly to start treatment and refer as needed.
10. Inform the woman about your findings and what you think needs to happen next.



Assess

Take history
Determine gestational age

Performance Expectation

- *Conduct a complete history on women who come to you thinking they are in labor.*
- *Calculate her due date and gestational age.*

Key points

- *The goal of taking a history is to help you get the information you need to decide what care is needed.*
- *Around 37-40 weeks, the fundal height (FH) actually decreases as the baby drops into the pelvis for birth.*

Key knowledge

If the Quick Check shows that birth is not close and that the woman does not have any danger signs, take a complete history.

When measuring FH in labor, a measurement of over 40 cm suggests a very large baby, possible twins or triplets, or another complication, while a measurement of less than 30 cm suggests an early or small baby.

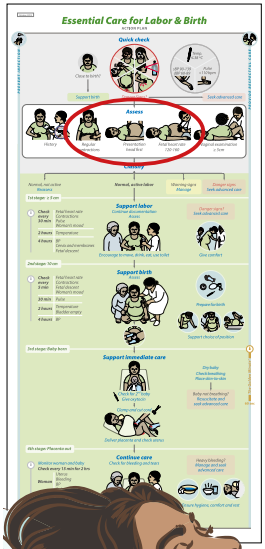
Key actions

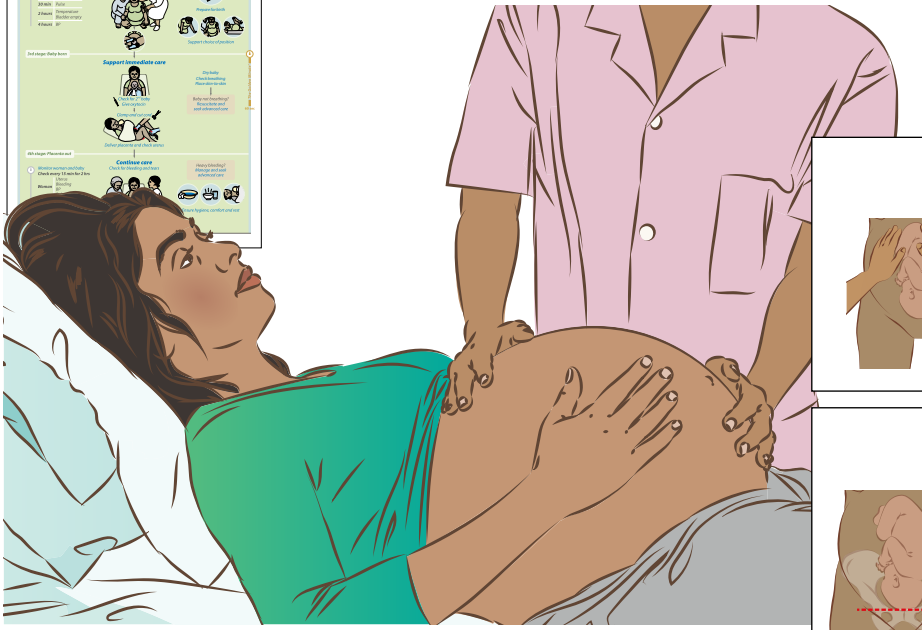
Begin taking her history.

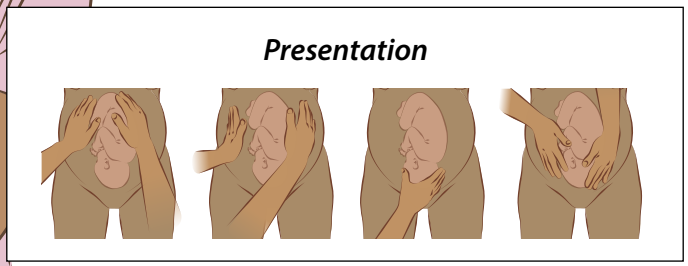
1. **First put her at ease** and ask if she has any concerns or questions.
2. **Review her records and ask about:**
   (See page 56 of this Provider's Guide)
   - This labor
   - Past pregnancies
   - Medical history: Chronic medical problems, allergies, medications.
   - History of this pregnancy
3. **Calculate due date:**
   - Refer to the ANC record for the expected date of childbirth (EDC) and how it was determined - by known last menstrual period, early ultrasound.
   - If no ANC record, ask for the first day of her last menstrual period (LMP) and calculate the EDC using wheels or calendars: First day of LMP + 7 days - 3 months OR First day of LMP + 7 days + 9 months
4. **Determine the gestational age:**
   - Use a pregnancy wheel or mobile app OR count the weeks on a calendar that have passed since LMP or the number of weeks between today and the EDC.
   - You will confirm this with a fundal height during the abdominal examination.
5. **Identify problems** or risk factors and plan for further assessments.
6. **Document findings** immediately after completing assessments.

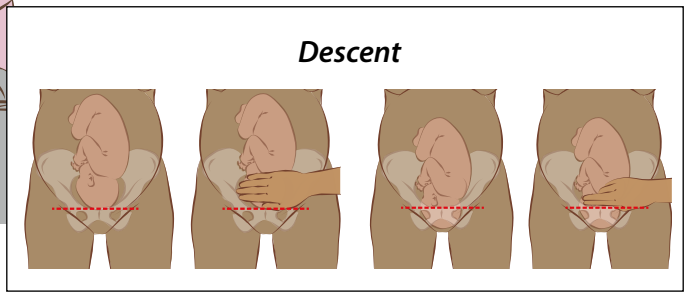
Assess

Contractions, fetal presentation, heart rate









Performance Expectation

- *Assess the woman's abdomen for scars or signs of a Bandl's ring.*
- *Count the number of contractions in 10 minutes, the duration and her response to them.*
- *Assess fetal lie and presentation.*
- *Assess fetal descent in terms of fingers in fifths of fetal head palpable above the symphysis pubis.*
- *Listen to the fetal heart for a full minute. Decide if the baby is tolerating labor.*
- *Decide if the woman needs advanced care based on the abdominal examination.*

Key points

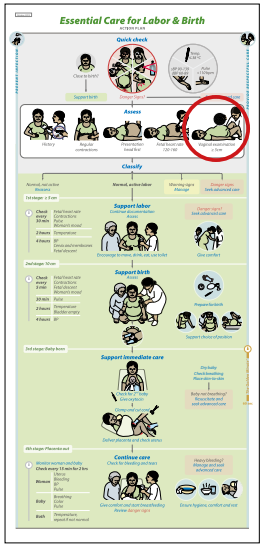
- *Always explain what you will do and why and ask for permission before performing an abdominal examination.*
- *The key to a good abdominal examination is the ability of the provider to know what is normal and what may need advanced care.*
- *Document findings immediately after completing assessments.*

Key knowledge

- Seek advanced care quickly if you see a horizontal ridge across the lower abdomen (Bandl's ring), or a baby in transverse lie. These should be treated as emergencies!
- The uterus should relax between contractions. Contractions may be irregular until active labor begins.
- In general, a woman in active labor will have at least 3 contractions in 10 minutes lasting at least 40 seconds each. However, contractions can be less often and still be ok if the woman's cervix continues to dilate.
- Normal fetal heart rate: 120-160 beats per minute.

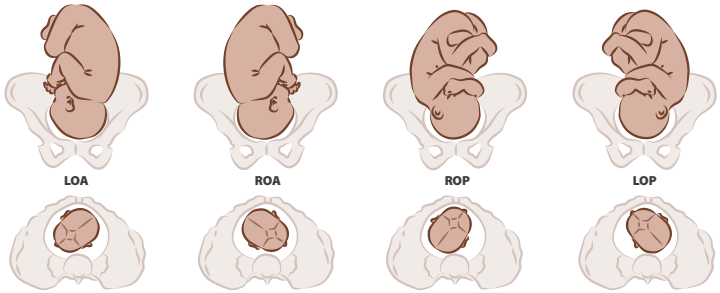
Key actions

1. Wash your hands and ensure privacy.
2. Explain what you will do and why and get permission from the woman before beginning the examination.
3. Measure fundal height. See page 57 of this Provider's Guide.
4. Check abdomen for: cesarean scar and a horizontal ridge across lower abdomen. If you see a ridge, ask her to empty her bladder and look again.
5. Assess contractions:
   - How many in 10 minutes and how long do they last?
   - How strong?
   - How is she coping?
   - Check if the uterus relaxes between contractions.
6. Feel abdomen for:
   - fetal lie—longitudinal or transverse?
   - fetal presentation—head, breech, other?
   - more than one fetus?
   - fetal movement
   - uterine tenderness
7. Listen to the fetal heart:
   - Count beats in 1 minute beween contractions.
   - If less than 120 beats per minute, or more than 160, turn woman on her left side and count again.
8. Assess descent in terms of fifths of fetal head palpable above the symphysis pubis.
9. Identify problems or risk factors.
10. Share findings with the woman and her companion.



Assess

Vaginal examination



Performance Expectation

- *Perform a complete vaginal examination (VE) to assess cervical dilation and effacement, membrane status, fetal presentation, position and descent.*
- *Provide respectful, gentle care when doing the examination to reduce fear and pain during the exam.*

Key points

- *A VE helps determine state of labor and confirms fetal position.*
- *Always explain what you will do and why and ask for permission before performing a vaginal examination.*
- *VEs can increase the risk of infection; do not perform one more than every 4 hours unless there are clear reasons (e.g. the woman has the urge to push, you need to rule out cord prolapse).*
- *The key to a good vaginal examination is the ability of the provider to know what is normal and what may need advanced care.*
- *Document findings immediately after completing assessments.*

Key knowledge

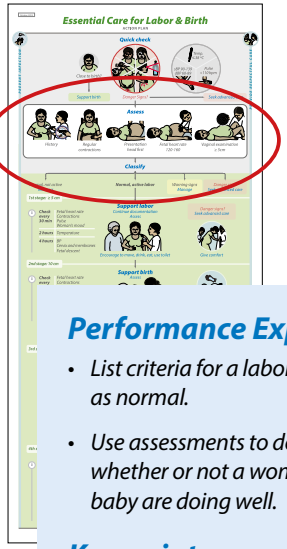
- VEs are uncomfortable and can be frightening. If a woman is young, has never been examined before, or has a history of abuse, take extra time and care.
- **Active labor begins when the cervix is 5 cm dilated.**
- Left occiput anterior is the most common position.
- If the baby is posterior, the labor may take longer and be more painful.

Key actions

1. Ask the woman to pass urine.
2. Ensure privacy.
3. Explain what you will do and why and get permission.
4. If the woman wants a companion with her, facilitate her presence.
5. Keep eye contact with the woman during VE to see how she is coping.
6. Wash your hands and put on exam gloves.
7. Ask the woman to relax and relax her legs open. Never force her legs apart!
8. Look at her vulva for: bulging perineum, any visible fetal parts, vaginal bleeding, leaking amniotic fluid, warts, keloid tissue or scars that may interfere with childbirth.
9. Wash vulva and perineal areas with clean tap water.
10. Put on sterile gloves. DO NOT perform vaginal examination if active bleeding.
11. Perform gentle VE when there is no contraction: Gently insert 2 fingers into vagina to assess: cervix, membranes, presenting part, position, molding, and station. Compare with findings from abdominal examination. Feel for cord – is it felt? Is it pulsating? If so, act immediately.
12. Gently remove fingers and look for blood, meconium and fluid. Remove and dispose of gloves. Wash hands.
13. Explain your assessment to the woman and her companion and decide what care she needs.

Seek advanced care if you find:

- The baby in these positions: Chin-posterior, brow, face, footling, arm, shoulder.
- These signs of obstructed labor: large caput, third degree molding, cervix poorly applied to presenting part, swollen cervix.



Classify: Normal or not?

Performance Expectation

- *List criteria for a labor to be classified as normal.*
- *Use assessments to determine whether or not a woman and her baby are doing well.*

Key points

- *Use your findings to guide active decision-making and management. If findings are not normal, you may need to act fast!*
- *Document findings and your plan for care immediately after completing assessments.*

Key knowledge

Your assessment findings - from Quick Check through physical examination - tell you if the woman and her baby are both healthy.

Key actions

After completing your assessment, review what you have found to classify the labor as NORMAL if all of the following are present:

- GA of 37-42 weeks - if dates are unknown, the estimated weight is at least 2.5 kgs
- One baby
- Uterus with no scar: no history of cesarean birth or other uterine surgery
- Cephalic presentation - head down
- Membranes intact, or membranes ruptured < 18 hours with clear fluid
- No vaginal bleeding
- FHR normal (120-160 bpm)
- Maternal pulse: 60-110 beats/min
- Temperature: ≤ 38ºC
- BP: systolic BP of 90–139 mmHg / diastolic BP of 60–89 mmHg

If any findings are not normal, use the information from the table on page 60 and 61 in this PG to help you decide what care the woman may need.

Advanced Care Note

Act fast when you identify a fetus in transverse position - lying sideways across the woman's abdomen - or if you see a horizontal ridge across the lower abdomen (Bandl's ring). These cases are emergencies and must be referred immediately for advanced care.

Classify: Active labor or not?

Performance Expectation

- *List criteria for a labor to be classified as active.*
- *Use assessments to determine whether or not a woman is in active labor.*

Key points

- *For a labor to be classified as ACTIVE the cervix must be at least 5 cms dilated.*
- *Do not try to speed up labor if the cervix is less than 5 cms dilated.*

Key knowledge

- **For labor to be classified as ACTIVE:**
  - The cervix must be dilated at least 5 cms
  - The woman must have regular, painful contractions.
- If she does not meet these 2 requirements, she is not in active labor. She may be in false or early (latent) labor.
- **If her cervix is < 5cm, do not try to speed up her labor by rupturing her membranes or using oxytocin or other drugs.**

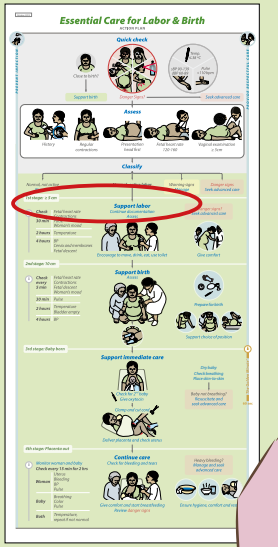
Key actions

Follow local guidelines about sending her home, admitting her or keeping her for observation.

- If she is ***not in active labor, her membranes are intact, all else is normal*** and you think she DOES NOT need observation:
  - Keep her nearby if she has given birth several times or if she has a history of fast labor since labor may progress quickly. Otherwise send her home.
  - Remind her of the signs of active labor and danger signs.
- If she is ***not in active labor, her membranes are intact, all else is normal***, but you think she DOES require observation:
  - Offer a clean, comfortable space to wait where she can be routinely monitored.
- If a woman ***is in active labor***:
  - Begin labor care.
  - Listen to her experience and honor her wishes.
  - Explain what to expect, where she will labor, how to get liquids to drink, and how to find you if she needs you.

Advanced Care Note

If a woman is in active labor but is having a problem, such as high blood pressure or fever, you may continue to manage her labor if you are trained and authorized to do so. You should not follow this action plan for her labor and birth, since she may need closer monitoring or additional care.



1st stage: ≥ 5 cm

Support labor

Continue documentation

Performance Expectation

- *Appropriately document all necessary assessments, clinical management decisions, and progress notes in client records.*

Key points

- *Good documentation helps providers make decisions and communicate clearly to each other.*

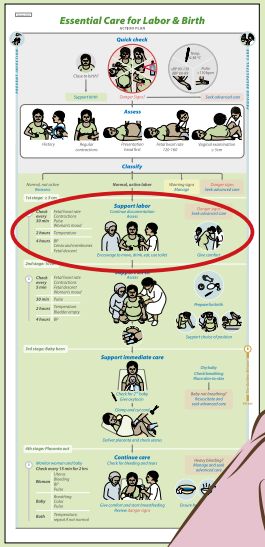
Key knowledge

- Good medical documentation is in the best interest of both clients and providers.
- Recording all relevant information of a woman's care helps providers monitor what has been done, improves care and minimizes the risk of errors.
- Different providers may see the same patient, but not always at the same time. All providers need to know what others have done. Without good documentation, the woman's care could suffer.
- Accurate recording of all problems, symptoms, findings from examinations (physical exam and laboratory or other diagnostic tests) also helps providers identify trends, while helping them develop treatment and care plans.
- Good documentation improves clinical outcomes.
- If an assessment, procedure, or treatment is not written in the record, it is considered to not have been done.

Key actions

Using the medical record from your facility:

1. Locate where to record findings from the Quick Check, history, and physical examination.
2. Immediately record all findings and the time any examination was done.
3. Document all treatments prescribed and counseling provided.
4. Document the time any request for advance care was made.



Support labor

Assess

Check every 30 min	*Fetal heart rate* *Contractions* *Pulse* *Woman's mood*
2 hours	*Temperature*
4 hours	*BP* *Cervix and membranes* *Fetal descent*

Performance Expectation

- *Consistently and properly monitor all women in the first stage of labor according to guidelines.*
- *Classify findings as "normal" or requiring action.*
- *Make decisions about care based on findings from monitoring.*

Key points

- *The goal of monitoring labor is to quickly identify problems.*
- *Providers need to act fast if they suspect a problem during labor.*
- *Do not attempt to speed labor if the woman and baby are doing well and labor is progressing.*

Key knowledge

- Careful monitoring is the only way to know if labor is progressing and if the woman and her baby are doing well. We cannot know who will develop problems, so carefully monitor all women, even when caring for more than one at a time.
- The active first stage of labor lasts from 5 cms until 10 cms. It usually does not last > 12 hours in first labors and > 10 hours in subsequent labors.
- **Never try to shorten labor with oxytocin or rupturing membranes if the woman and baby are doing well, the cervix continues dilating, and her labor is within these limits.**
- As long as all findings remain normal, the woman needs ongoing emotional support and comfort.
- **Act fast** if you suspect a problem!

Key actions

During the 1st stage of labor, check and record:

Every 30 minutes

- FHR: 120 - 160 beats per minute
- Contractions: three or more in 10 minutes, each lasting more than 40 seconds
- Woman's pulse: 60 -100 beats per minute
- Woman's mood and behavior

Every 2 hours

- Temperature: ≤38 ºC

Every 4 hours

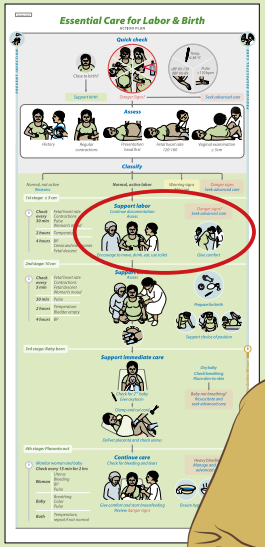
- Woman's BP: systolic BP 90–139 mmHg/ diastolic BP 60–89 mmHg
- Cervix: not swollen, soft, keeps dilating. Remember, do not do VEs more often than every 4 hours unless there is a reason.
- Membrane status. Check whenever examining the cervix or if leaking, fluid should be clear.
- Fetal descent: moving downward

Classify findings as "normal" or a problem.

- If findings are normal, the woman requires only ongoing supportive, respectful care.
- If findings are not normal, provide care as needed.

Document all findings, care decisions, and counseling provided.

Share your findings with the woman and her companion.



Support Labor

Encourage to move, drink, eat, use toilet

Performance Expectation

- *Offer comfort and support to women in labor.*
- *Encourage the presence of a companion of the woman's choice during labor.*
- *Help companions to provide labor support.*

Key points

- *Offering good support during labor is one way of giving respectful care and may make labor progress faster.*

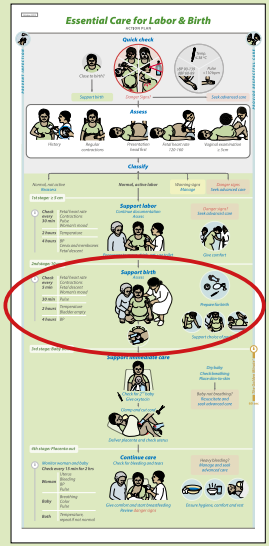
Key knowledge

Support labor by ensuring:

- She has a companion of her choice
- Good communication and support by staff
- She and her environment are clean
- She can move around, keep her bladder empty and get food and drink if she wants
- She knows breathing techniques to help her cope

Key actions

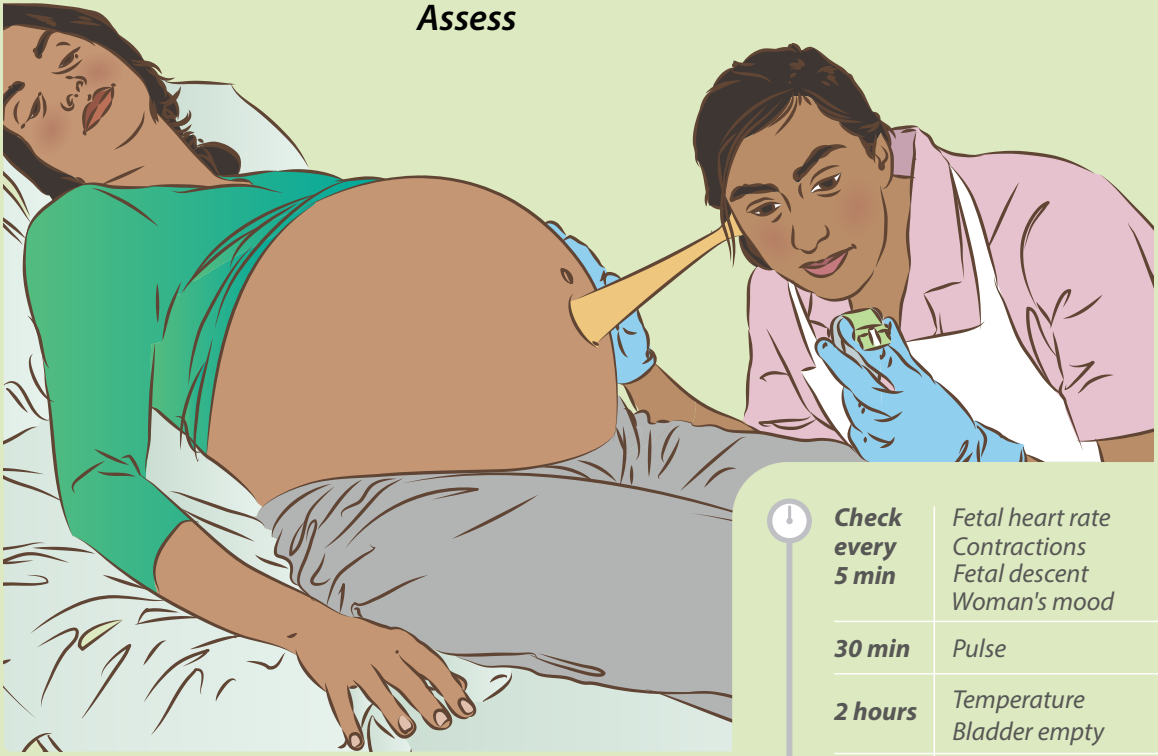
- Encourage the woman and help her companion to give labor support.
- Offer reassurance and explain what to expect.
- Help women to:
  - Find laboring positions that are comfortable and keep her from lying on her back
  - Move and change position as desired
  - Drink water, tea, or juices - at least 1 cup per hour.
  - Eat light food when hungry
  - Keep her bladder empty but avoid catheterizing her.
  - Make noises such as groaning and singing if it helps her cope.
- Give comfort. You and her companion can:
  - Sponge her with cool or warm water.
  - Help her bathe or shower.
  - Support her in different positions.
  - Offer light food and drinks.
  - Offer massage.
  - Fan her to keep her cool.
  - Ensure she is not left alone.
- Help women in labor who are anxious, fearful or distressed by pain.
  - Offer healthy women requesting pain relief during labor options such as epidural or opioid analgesia - based on their preferences and availability.
  - The baby's position may cause women to feel pain in certain areas. If a baby is turned so her back presses on the mothers spine (LOP, ROP, OP), this may cause women to have more back pain. Positions such hands and knees or leaning over can be helpful. Applying pressure to her lower back can also help.
- Avoid interventions that are not clinically indicated or potentially harmful - such as routine augmentation of labor, vaginal cleansing with chlorhexidine, perineal shaving, and enemas.



2nd stage: 10 cm

Support birth

Assess



Check every 5 min	*Fetal heart rate* *Contractions* *Fetal descent* *Woman's mood*
30 min	*Pulse*
2 hours	*Temperature* *Bladder empty*
4 hours	*BP*

Performance Expectation

- *Consistently and properly monitor all women in the second stage of labor according to guidelines.*
- *Classify findings as normal or needing action.*
- *Make decisions about care based on findings.*
- *Support women to begin pushing if the cervix is fully dilated and they feel the urge to push.*

Key points

- *The goal of monitoring is to quickly identify problems.*
- *Providers need to act fast if they suspect a problem.*
- *Do not intervene if the woman and baby are doing well.*

Key knowledge

- The second stage is the period of time between full cervical dilatation and birth of the baby.
- Women in second stage need more support and closer monitoring.
- In first labors, second stage lasts 2-3 hours. If a woman has given birth before, second stage is usually less.
- During the latent phase of second stage, the woman will be fully dilated but will not have the urge to push. It is important to allow her to rest until she does have this urge.
- General supportive care during second stage will help the woman tolerate labor pains.
- Once she feels the urge to push, you can do a VE to confirm that she is in the second stage of labor.

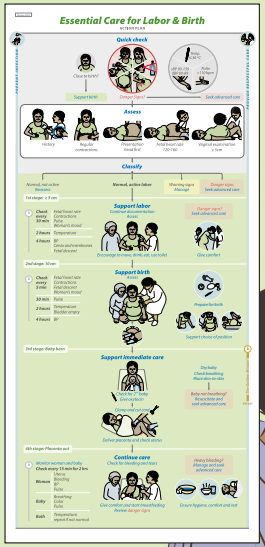
Key actions

1. Encourage her to continue to drink water, tea, juice and to keep her bladder empty.
2. Provide general support and comfort.
3. During the 2nd stage of labor, monitor and record the following:
   Every 5 minutes
   - Fetal heart rate
   - Contractions vary in 2nd stage, should be palpable, regular, and result in descent of fetal head.
   - Descent - visually check for descent during contractions.
   - Woman's mood and behavior

   Every 30 minutes
   - Woman's pulse

   Every 2 hours
   - Encourage her to empty her bladder
   - Woman's temperature

   Every 4 hours
   - Woman's BP
4. Classify findings as normal or not.
   - If findings are normal, the woman requires only ongoing supportive, respectful care.
   - If findings are not normal, provide care as needed.
5. Document all findings, care decisions, and counseling provided.
6. Share your findings with the woman and her companion and reassure them if findings are normal.



Support birth

Prepare for birth

Performance Expectation

- *Tell women and companions what to expect during and immediately after the birth.*
- *Begin to prepare for birth when women enter the second stage of labor or earlier.*
- *Prepare uterotonic before birth and place within reach.*
- *Check bag and mask for newborn resuscitation before birth.*

Key points

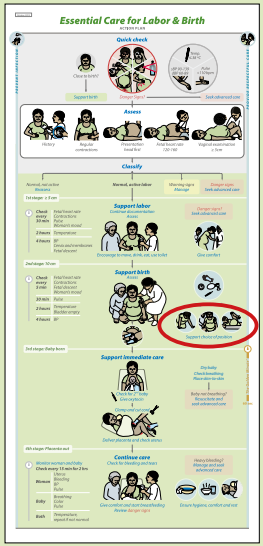
- *How a woman feels emotionally is as important as how she is doing physically. When a woman feels informed and understood, she will feel more secure and can participate actively in her care.*
- *Lack of preparation may result in delays in providing care.*

Key knowledge

- Preparing the woman and her companion about what to expect will help her be more comfortable.
- Ensuring necessary equipment, supplies, and medications are prepared beforehand will ensure that you can provide timely care.

Key actions

- Tell the woman and her companion that you will:
  - Place her baby directly onto her abdomen to keep the baby warm and help with breastfeeding.
  - Recommend giving an injection in her thigh to prevent too much bleeding after birth. Obtain her consent while preparing for birth, if possible.
  - You will feel her uterus often to make sure it is contracted after the placenta delivers and that you will watch her bleeding closely.
- Once she enters second stage, or earlier if this is not her first birth, prepare for birth:
  - Draw up 10 IU oxytocin into a syringe OR prepare 400 - 600 mcg of misoprostol if oxytocin is not available BEFORE birth and have it within reach.
  - Ensure the area is private, clean, warm, and well lit.
  - Have everything in easy reach for birth.
  - Check the bag and mask for newborn resuscitation.
  - Alert another provider or helper that the birth will happen soon so that he or she is ready to help.



Support birth

Support choice of position

Performance Expectation

- *Support women to give birth in the positions they choose.*

Key points

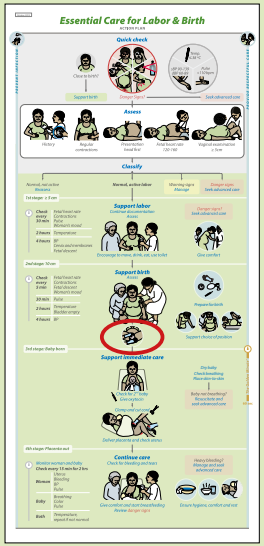
- *Having a choice of birth positions during the second stage of labor may improve the woman's experience of care.*
- *It is important that a woman is not forced into any position and that she is encouraged and supported to find the position that is most comfortable for her.*

Key knowledge

- The mechanism of birth does not change regardless of position.
- Hand maneuvers during birth of the baby need to be adjusted based on the birthing position (See page 58 of this Provider's Guide).
- Oxygen and blood flow to the baby are decreased when the woman is lying flat on her back. Upright positions improve blood flow to the uterus and fetus.
- Upright positions (standing, squatting, or kneeling) may shorten labor, reduce the need for vacuum or forceps, and may result in fewer problems with the FHR. However, there may be a risk of increased blood loss of more than 500 ml.
- Ensure that the well-being of the baby can be monitored in the woman's chosen position. Communicate with the woman if a change in position is necessary while checking the FHR.

Key actions

- When the cervix is fully dilated and the woman feels the urge to push, encourage and support her to push:
  - according to her own urge
  - in the position of her choice
  - with legs relaxed and open while half-sitting, on hands and knees, squatting, or lying on her side
  - without holding her breath
- This is the time to:
  - Encourage her to empty her bladder but avoid pit latrines so the baby is not born there!
  - Help her to get into the position she chooses. Note that pushing on hands and knees may help with babies who are posterior.
  - Show her companion how to support her.
  - Counsel the woman and companion what to expect during birth.
  - Double check that the equipment is ready.
- Share your findings and progress with the woman and her companion and reassure them if findings are all normal.
- As second stage progresses, the perineum will thin and bulge with contractions.
  - If after 30 minutes of pushing you do not see this bulging, do a VE to confirm that the cervix is fully dilated and have the women change positions.
  - If there is no progress after 1 hour of pushing with strong contractions, the woman and baby are at risk and may need advanced care.



Support birth

Performance Expectation

- *Use evidence-based practices to support birth.*
- *Use best infection prevention practices.*

Key points

- *Communicate often during the birth to reassure the woman so she knows what is happening.*
- *Avoid practices that may be harmful to women and babies such as applying fundal pressure, manipulating the perineum, cutting routine episiotomies, manipulating the babies head at the time of birth, and pulling on the baby's arms before the body is born.*

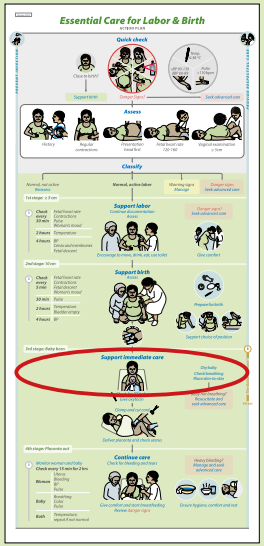
Key knowledge

Avoid these harmful practices:

Do not...	Because...
Apply fundal pressure	*May increase risk of uterine rupture or cause baby´s shoulder to become stuck*
Manipulate and stretch the perineum	*May cause tears in the vaginal wall*
Routinely cut episiotomies	*Increases risk of bleeding and 3rd and 4th degree tears. Episiotomy is only needed if there is a problem.*
Manipulate baby's head instead of allowing external rotation to happen naturally	*Can result in serious injury or nerve damage to the newborn*
Reach in to deliver arms after shoulder is born	*May cause tears in the vaginal wall*

Key actions

- When birth is close, communicate with the woman and her companion.
- Alert and gather your team.
- Be sure to wash hands, double glove, put on a mask and eye protection.
- Clean the perineum with soap and water if soiled with stool.
- Prepare a clean surface under the woman and place a blanket on her abdomen for the baby.
- Use your hand to support her perineum.
- Encourage her to follow her urge to push.
- Keep the baby's head flexed towards the woman's back.
- Once the head delivers, allow it to turn naturally. You may wipe the nose and mouth, but do not suction routinely.
- Check for cord. If found, slip it over the baby's head or deliver the baby through the cord.
- Wait for a contraction before assisting birth.
- Gently pull on the head towards the woman's back to deliver the anterior shoulder. Then lift the baby towards her abdomen to deliver the posterior shoulder.
- Place the baby on the towel on the mother's abdomen and note time of birth. Congratulate her!



Support immediate care

Dry baby
Check breathing
Place skin-to-skin

Performance Expectation

- *Immediately after birth, dry baby, check breathing, and place him in skin-to-skin contact with his mother.*

Key points

- *All babies should start breathing in the first "golden" minute after birth.*
- *A healthy baby will breathe on her own or cry and have good muscle tone.*
- *Babies quickly become very cold, even in a warm room.*
- *Do not routinely suction or slap babies after birth.*

Key knowledge

Practicing skin-to-skin for the first hour helps:

- Keep the baby warm
- Support early breastfeeding
- Promote warmth and protection which may reduce the risk of death from hypothermia.

Key actions

Immediately after birth:

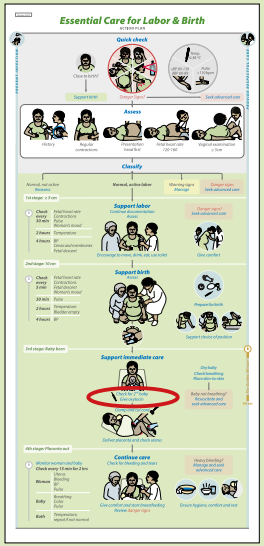
1. Dry the baby thoroughly with a clean, dry cloth. Remove the wet cloth.
2. Assess breathing as you dry the baby. **Act fast if the baby is not breathing**!
3. Place the baby skin-to-skin on the woman's abdomen and cover the baby with a clean, dry cloth and a hat.
4. Keep the baby dry, warm, in skin-to-skin contact with the mother, and covered with a dry cloth and a hat.
5. Continually assess the baby's breathing, color, and temperature.
6. Help the woman initiate breastfeeding within the first hour.

Care if the baby is not breathing

1. If secretions are blocking the airway, clear the mouth first and then the nose with a suction device. Routine suctioning is not recommended for babies who breathe on their own.
2. Stimulate the baby by rubbing the baby's back gently 2-3 times.
3. If the baby is not breathing after you have cleared the mouth and nose and rubbed his back, call for help and immediately begin bag and mask ventilation using Helping Babies Breathe.

Avoid these harmful practices:

Do not...	*Because...*
Routine suctioning of baby	*No benefit. It may interfere with first breath and can slow breathing.*
Slapping the baby	*Harsh handling may cause distress.*



Support immediate care

Check for second baby
Give oxytocin

Performance Expectation

- *Offer and provide active management of the third stage of labor (AMTSL) after all births.*

Key points

- *To prevent heavy bleeding, begin active management of the third stage of labor within 1 minute of birth to help the uterus contract and deliver the placenta.*
- *Ensure oxytocin is properly stored to preserve quality.*

Key knowledge and Skills

- Giving a uterotonic drug within a minute of birth is the most important step of AMTSL.
- Oxytocin 10 IU IM is the recommended uterotonic for AMTSL.
- Keep oxytocin refigerated at 2 - 8°C before use. Follow manufacturer's instructions for storage. Oxytocin loses its strength if it gets too warm for too long.
- Oxytocin takes 2-3 minutes to stimulate a uterine contraction.
- AMTSL will prevent most but not all cases of postpartum hemorrhage. (PPH).

Key actions

1. Check for a second baby! If there is a twin, giving any uterotonic before the second baby is born can cause a strong contraction which could kill the baby and rupture the uterus.
2. If you have not asked the woman already, get her permission to give oxytocin.
3. In the absence of an additional baby(s), give 10 IU units of oxytocin by IM injection within one minute after birth.

If you don´t have oxytocin, give:

- Misoprostol 400 or 600 µg orally (2 or 3 tablets of 200 µg each). Misoprostol has side effects that do not last long and are not harmful, but can be uncomfortable. The woman should be told she may experience shivering, nausea, diarrhea and fever.

OR

- Ergometrine/methylergometrine 200 µg IM/IV

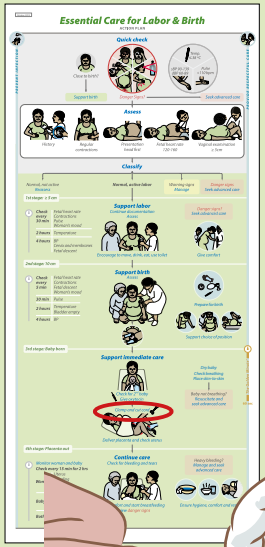
OR

- The fixed-dose combination of 5 IU oxytocin/500 µg ergometrine IM

OR

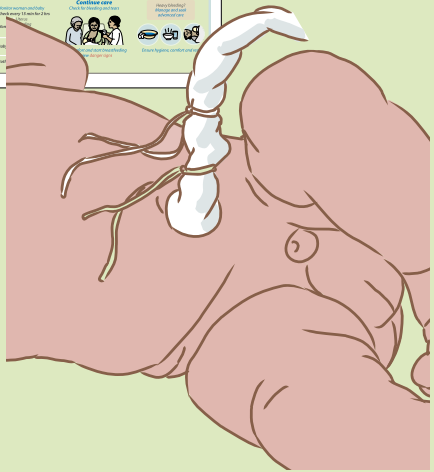
- Carbetocin 100 µg, IM/IV

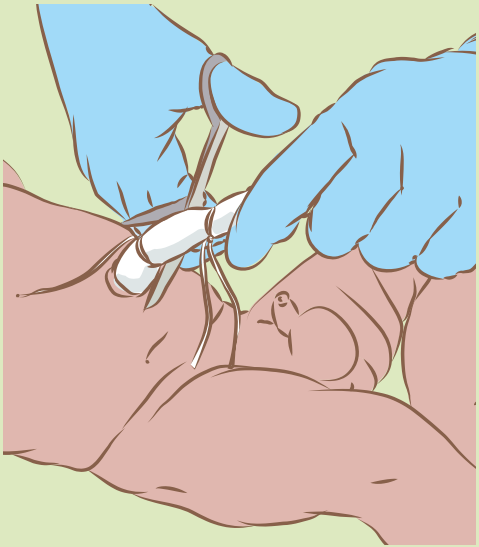
NOTE: Do not give ergometrine to women with pre-eclampsia, eclampsia or high blood pressure.

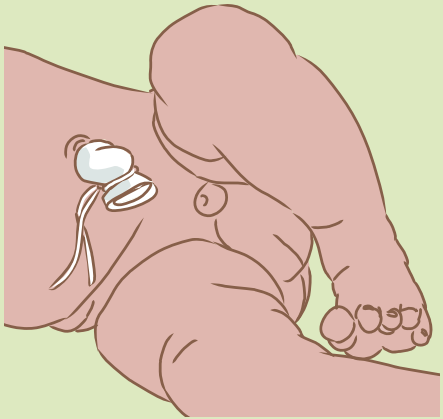


Support immediate care

Clamp & cut cord







Performance Expectation

- *Practice delayed cord clamping unless the baby is not breathing or the woman is bleeding heavily.*

Key points

- *Wait 1 - 3 minutes after birth to clamp and cut the cord.*
- *Do not apply anything to the umbilical stump, unless local guidelines call for use of CHX gel.*

Key knowledge

- The baby receives the maximum amount of blood from the placenta when cord clamping is delayed by 1-3 minutes.
- Delayed cord clamping reduces the incidence of neonatal anemia. It is also recommended for women who are living with HIV or whose HIV status is unknown.
- All supplies used for clamping and cutting the cord should be sterile.

Key actions

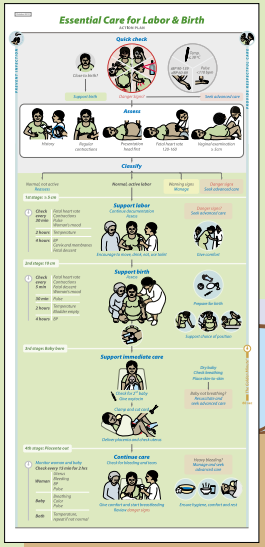
When cutting the cord:

1. Change your gloves or remove the first pair.
2. **1-3 minutes after birth**, place one clamp or tie around the cord about 2 finger breadths from the baby's abdomen.
3. Push the blood from the first clamp or tie away from the baby to prevent blood splash when you cut the cord.
4. Place another clamp or tie about 5 finger-breadths from the abdomen.
5. Cut between clamps or ties with sterile scissors or blade.
6. Do not put anything on the cord unless national guidelines call for use of chlorhexidine (CHX) gel.
7. Keep the baby skin-to-skin and covered with a dry cloth and a hat.
8. Ensure that the cord is not bleeding. Re-tie or re-clamp if needed.

VARIATION

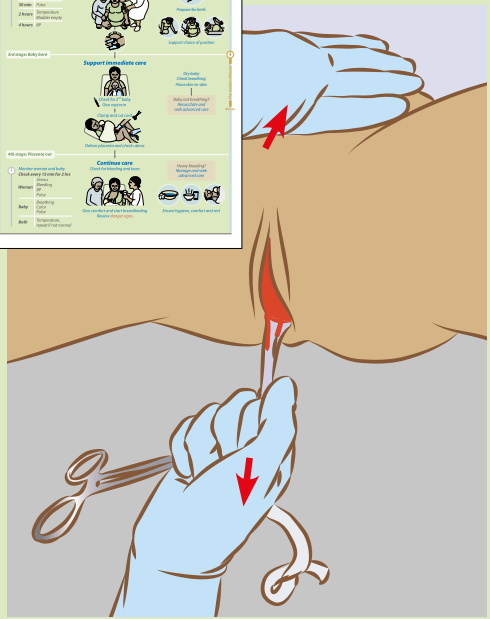
Timing of cutting the cord may vary if there is a problem:

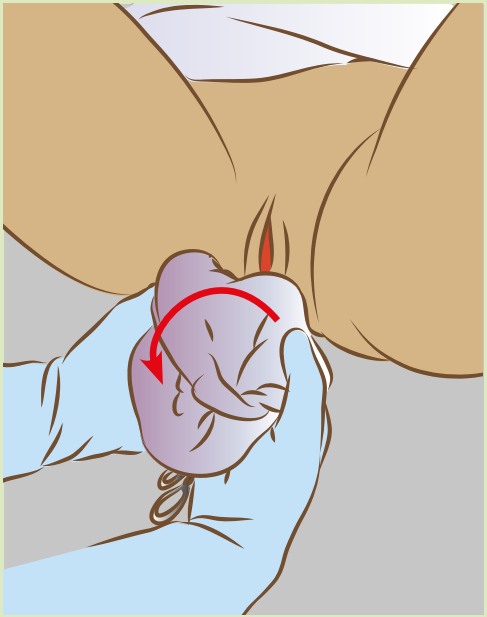
- If the baby is not breathing after drying and stimulation and you need to move the baby for resuscitation, cut the cord immediately, call for help, and immediately help the baby breathe using a bag and mask.
  See Helping Babies Breathe.
- If the woman is bleeding heavily, clamp and cut the cord, and call for help.
  See Bleeding after Birth Complete.

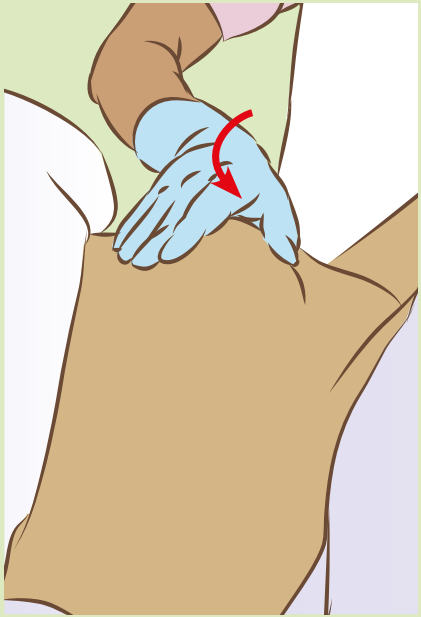


Support immediate care

Deliver placenta
Check uterus







Performance Expectation

- *Deliver the placenta by applying controlled cord traction (CCT).*
- *Check tone of the uterus after delivery of the placenta and massage if soft.*
- *Check the placenta for completeness*

Key points

- *Most placentas deliver within 10 minutes, but it can take up to one hour and still be normal if the woman is not bleeding heavily and other findings are normal.*

Key knowledge

- To prevent inversion of the uterus:
  - always apply counter-traction during CCT and
  - only apply CCT during contractions.
- Pulling too hard on the cord or when there is no contraction may cause the cord to tear off.

Key actions

1. Clamp the cord close to the perineum.
2. Hold the cord and the clamp with one hand.
3. Place the other hand just above the woman's pubic bone and stabilize the uterus by applying counter-traction during controlled cord traction.
4. Keep slight tension on the cord and await a strong contraction.
5. When the uterus contracts, apply traction on the cord while applying counter-traction to the uterus with the other hand.
6. If the placenta does not descend during 30 to 40 seconds of CCT, do not continue to pull on the cord. Instead, gently hold the cord and wait until the uterus contracts again to do CCT.

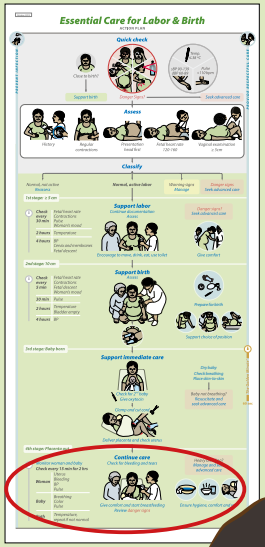
Note: If the placenta does not deliver in 30 minutes, repeat oxytocin 10 IU IM. Do not repeat misoprostol! Continue with CCT as above.

7. When the placenta is at the opening, grasp it with both hands and twist it to help the membranes deliver.
8. Immediately after the placenta delivers, place a hand on the uterus to check for tone and massage if soft.
9. Teach the woman how to check her own uterus and massage it and call you if it is soft.
10. Check the placenta and membranes for completeness. Act fast if it is not complete!
11. Dispose of the placenta in a correct, safe and culturally appropriate manner.

Advanced Care Notes
Providers may have the training and authorization to provide more advanced care. Act within your scope of practice.

If the placenta does not deliver in 1 hour OR the placenta is out but not complete OR the woman is bleeding heavily at any time, seek advanced care.

See HMS Bleeding after Birth Complete.



Continue care

Check for bleeding
Look for tears
Comfort

Performance Expectation

- *Identify bleeding too much or postpartum hemorrhage (PPH).*
- *Diagnose if there are tears than need repair.*

Key points

- *Postpartum hemorrhage causes the majority of maternal deaths.*
- *PPH is blood loss > 500 ml however women who are anemic may be at risk even if they lose less than 500ml.*

Key knowledge

- Estimating blood loss after birth will ensure timely care for PPH.
- Check if she is bleeding too much and act quickly to prevent PPH.
- Tears are the third leading cause of PPH. It is important to check thoroughly to see if women have tears that need repair.

Key actions

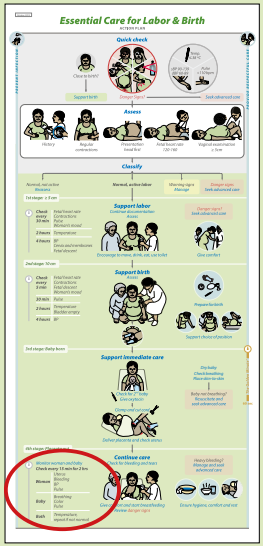
Continue to talk to and reassure the woman and her companion.

1. Estimate and record blood loss. **Act quickly if you observe heavy bleeding, a fast pulse, low BP or if the woman feels unwell!**
2. Examine the woman carefully and repair any tears to the cervix or vagina or perineum, or repair an episiotomy if one was needed.
3. If a woman is eligible, has been appropriately counselled and has chosen postpartum insertion of an intrauterine device (IUD), verify the placenta is complete and then insert the IUD.
4. Clean the woman and the area beneath her. Put a sanitary pad or folded clean cloth under her buttocks to collect blood. Help her change clothes if necessary.
5. Offer food and drink.
6. Encourage her to keep her bladder empty.
7. Document birth in the medical record and delivery register.
8. Congratulate the woman again on her achievement and thank the birth companion for his or her help!

Keep the woman and her baby together for at least one hour after delivery of the placenta. Avoid separating her from her baby whenever possible and keep them skin-to-skin for at least one hour. Do not leave them unattended at any time.

Clean up the delivery area

- Clean and sterilize delivery instruments. Be sure to reprocess newborn bag and mask.
- Dispose of medical waste and sharps safely.
- Decontaminate any blood on the floor.
- Make sure linens are properly processed.



Continue care

Monitor woman and baby

Check every 15 min for 2 hrs	
Woman	Uterus Bleeding BP Pulse
Baby	Breathing Color Pulse
Both	Temperature, repeat if not normal

Performance Expectation

- *Monitor the woman and her newborn for the first 6 hours after birth.*
- *Identify abnormal findings and respond immediately.*

Key points

- *The woman and her baby should be kept together and at the facility for at least 24 hours.*
- *Women and their newborns need to be watched closely for the first 6 hours after birth.*

Key knowledge

After birth, a healthy woman will have:

- A contracted uterus
- Minimal bleeding
- Pulse < 110 bpm and BP 90-139/60-89 mmHg
- Temperature <38°C
- No bleeding tears

And a healthy baby will be:

- Breathing well and pink
- Alert with good tone
- Warm but not hot
- Able to breastfeed
- Cord not bleeding

Key actions

Monitor women and their babies every

- 15 minutes for 2 hours.
- Then every 30 minutes for the next 1 hour.
- Then every hour for 3 hours

For the woman, check:

- **Uterine Tone:** the uterus should be firm, in the center, and near the umbilicus. If it is soft or enlarged, start massage and assess bleeding.
- **Bleeding:** If bleeding is heavy or does not stop, check tone and massage the uterus if soft. Ensure empty bladder, give another 10 IU of oxytocin, start IV, and seek advanced care. For more information on managing PPH, see *HMS Bleeding after Birth Complete.*
- **Vital signs:** Temperature, BP, and pulse should be within normal range. Investigate any abnormal findings. If BP is high → *see HMS Pre-eclampsia & Eclampsia.*

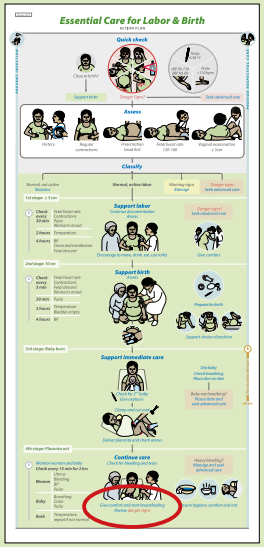
For the baby, check:

- **Temperature:** Feel the baby's foot or forehead. Use a thermometer within 90 minutes after birth or if the skin feels cool or hot. The temperature should be 36.5 - 37.5 C.
- **Breathing:** a baby should breathe easily between 40-60 times a minute. Count his breathing rate for one minute.
- **Color:** normal color is pink, may have bluish hands and feet but should not have bluish tongue and lips
- **Pulse:** normal is 100 - 160 beats per minute

If any abnormal findings → *see Helping Babies Breathe* and *Essential Care for Every Baby.*

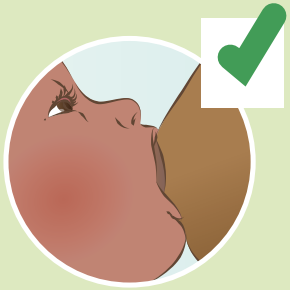
Document all findings, care decisions, and counseling provided on the client record.

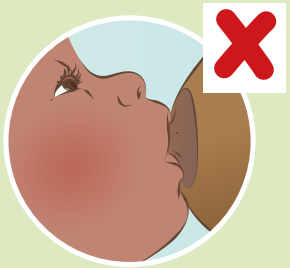
Share your findings with the woman and her companion.



Continue care

Start breastfeeding





Performance Expectation

- *Assist women to successfully start breastfeeding in the first hour*
- *Counsel women to give their babies colostrum.*

Key points

- *Early breastfeeding and colostrum saves newborn lives.*

Key knowledge

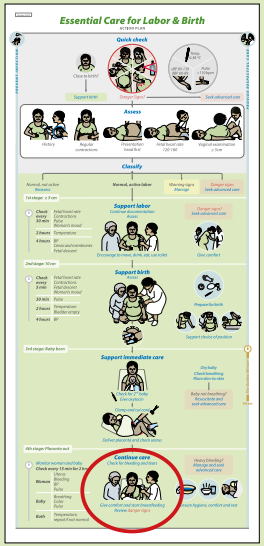
- Early breastfeeding causes the uterus to contract.
- Babies who are fed within 30 minutes of birth are likely to remain breast-feeding for longer and neonatal deaths are decreased.
- Antibodies that protect the baby are at the highest levels in the first milk or colostrum in the first twelve post-partum hours.

Key actions

- Ensure that the mother and baby have quiet time for skin-to-skin. The baby will show several signs she is ready to feed.
- Help a mother to recognize these signs or cues. The baby will:
  - rest briefly in an alert state to settle to new surroundings;
  - bring his hands to his mouth, and make sucking motions;
  - touch the nipple with his hand;
  - focus on the dark area of the breast;
  - move towards the breast with mouth open;
  - find the nipple and attach with a wide open mouth.
- Do not pressure the mother or baby about how soon the first feed takes place, how long a first feed lasts, how well attached the baby is or how much colostrum the baby takes.
- Provide more assistance at the next feeding to help the mother learn about positioning, attachment, feeding signs and other skills she will need.
- Help the mother to find a comfortable position.
- Look for signs of good latching: The latch is comfortable and pain free; the baby's chest and stomach rest against the mother's body; the baby's chin touches the breast; the baby's mouth opens wide around the breast, not just the nipple; the baby's lips turn out.
- Point out positive behaviors of the baby such as alertness and rooting;
- Build the mother's confidence.
- Avoid rushing the baby to the breast or pushing the breast into the baby's mouth.

Counseling Note

In some settings people believe that babies should not have the colostrum, or first milk. Remind women and their families of the health benefits of colostrum. It is nutritious and helps protect the newborn from infection.



Continue care

Performance Expectation

- *Before discharge, counsel women about breastfeeding, baby care, self-care, and family planning.*

Key points

- *Women and their companions need information to care for themselves and their babies and to recognize when urgent care is needed.*

Key actions

Breastfeeding

Advise about the following:

- Feed whenever the baby seems hungry. Signs that a baby is full:
  - Breasts soften with feeding
  - Swallowing sounds heard while feeding
  - Baby feeds every 2-4 hours
  - Baby sleeps well between feedings
  - Baby has 6 or more wet diapers per day
- Seek additional help and support to successfully breastfeed if they feel they have decreased milk volume, pain, or poor weight gain.
- If the woman is positive for HIV, continue ARVs while breastfeeding. Exclusive breastfeeding minimizes the risk of transmission to the baby.
- Exclusively breastfeed for the first 6 months.

BABY CARE

- Remind women and family to wash hands before caring for or feeding babies.
- Keep the cord clean and dry. Do not apply anything unless chlorhexidine gel is recommended.
- If there is a risk for malaria, advise her to sleep with her baby under a bed net.
- Remind women and families when to come for infant immunizations.

SELF-CARE

Advise about the following:

- **Uterus:** Should feel hard like a forehead. Show women where it is and how it feels. If uterus feels soft or rises up, encourage an empty bladder. If it stays soft, have her massage and call for help.
- **Bleeding:** Large gushes of blood or small, continuous trickles are not normal. She should get help.
- **Food & rest:** Women need enough healthy food and lots of fluids. She needs an extra meal each day or several extra snacks. Encourage rest.
- **Hygiene:** She should bathe daily and clean her perineum after using the toilet.

FAMILY PLANNING

- Ensure women leave your care with the family planning method of their choice. Offer condoms for protection from sexually transmitted infections.
- Delaying pregnancy for at least 2 years is best for women and their children.
- It is safe to resume sex once bleeding stops and women feel ready. If women are sexually active while bleeding, encourage condoms.
- Women who exclusively breastfeed may not get pregnant for several months. Those who do not, can get pregnant less than a month after birth.

BOTH WOMAN AND BABY

Return for 3 postnatal checks: after 48 – 72 hours, after 7 to 14 days, and at 6 weeks or according to national protocols.

Continue care

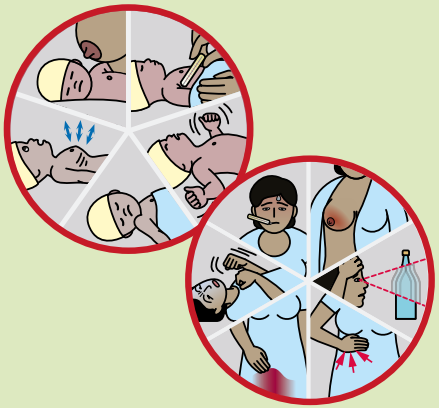
Review danger signs

Performance Expectation

- *Provide counseling on danger signs and care seeking to women and their companions.*

Key points

- *If danger signs are found early and families get help, lives can be saved.*



Key actions

Before discharge, help women and their family members to develop a plan on where and how they will seek emergency care if needed.

Review maternal danger signs

- Bleeding: more than 2 or 3 pads soaked in 20-30 minutes OR bleeding increases rather than decreases.
- Convulsions
- Severe abdominal pain
- Severe headache or blurred vision
- Fast or difficult breathing or chest pain
- Fever
- Too weak to get out of bed
- Calf pain, redness or swelling
- Painful, red, breasts or bleeding nipples
- Problems emptying bladder
- Foul smelling vaginal discharge

Review baby's danger signs

- Fast breathing: > 60 breaths per minute
- Slow breathing: less than 30 breaths per minute
- Gasping or chest in-drawing: pulling in between ribs or below ribcage
- Grunting
- Convulsions: shaking of arms or legs
- Swollen abdomen
- Feels hot or cold to the touch
- Not feeding normally
- Skin color: very yellow OR blue on whole body
- Decreased movement, floppy or still
- Increased heart rate: > 180/min
- Fever: If the baby feels very hot to touch or >37.5°C
- Bleeding or pus from umbilical cord
- Skin swelling, redness,or hardness

Warning signs, manage and reassess

Performance Expectation

- *Identify problems when monitoring and caring for a woman during and after labor and birth.*
- *Begin care to women with a problem.*
- *Seek help if you do not know how to manage a problem.*

Key points

- *A woman's condition can quickly get worse if she does not receive the right care quickly.*
- *Correct management of mild problems will prevent them from becoming serious and life-threatening problems.*

Key knowledge

- Always take action if findings are not normal and let the woman and her companion know what is happening.
- Abnormal findings may be mild, such as a slightly increased pulse or severe such as a very high blood pressure or heavy bleeding.

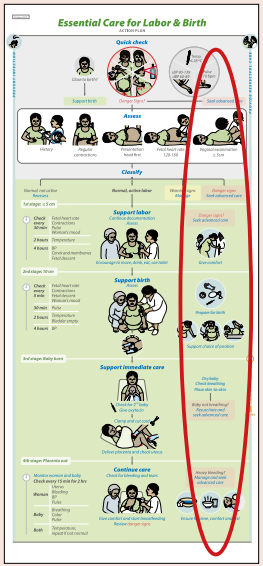
Key actions

When a woman has an abnormal finding, use the following clinical decision-making skills to make a diagnosis and decide on what care she needs:

1. Does she have danger signs? Does she need emergency care?
2. What questions and physical examinations will help you understand her problem? Should testing be done (e.g. laboratory tests, ultrasound, x-ray)?
3. What is the most likely diagnosis?
4. Do you need help from a co-worker to make a diagnosis, decide on a plan of care, or care for the woman?
5. What care does she need?
6. Can the problem be managed where you are or is referral to another facility needed?

Use the information from the color-coded table on page 60 and 61 of this PG to help you decide how and where to care for the woman having an abormal finding.

If something needs immediate attention, or if a problem continues, call for help and seek advanced care.



Danger signs, manage or advanced care

Performance Expectation

- *Identify danger signs when caring for a woman in labor.*
- *Provide emergency care.*
- *Get the right help from your team when caring for women with a danger sign.*

Key points

- *Women who have a danger sign may be having a life-threatening complication.*
- *As soon as a danger sign is found, emergency care should be given and a decision made on the best place for her to receive care.*

Key knowledge

If you identify a danger sign OR you have treated an abnormal finding and it is still abnormal, seek advanced care.

Depending on the problem, you may:

- Begin treatment
- Consult with a co-worker
- Transfer to another facility

Key actions

If referral to another facility is needed, you should:

- Decide where the woman will be transported and how she will get there.
- Contact the hospital before transporting and explain the problem and care provided.
- Choose a provider that can go with her and care for her during transport.
- Complete the referral slip and make sure the woman has a copy of her client record, including partograph.

If consultation by another provider in your facility is needed, you should decide:

- Who should be called?
- How soon can this person come to assist you?

While seeking advanced care/ waiting for the co-worker to arrive:

- Continue care and monitoring.
- Never leave a woman with a complication alone.
- Communicate with the woman and her family. Explain what is happening, what you are doing and why.
- Provide supportive care (IV, monitoring, emotional/psychological support)
- Provide care for the problem until she arrives at the referral facility / help arrives.
- Provide the following information about the patient / her care:
  - Time and date of arrival
  - Name, age, and address of the woman
  - Main reason for advanced care
  - Major findings (clinical and laboratory findings)
  - Treatments given and time
  - Information given to the woman and companion about the reasons for referral

Remember:

- Communicate confidently and clearly with team members. Do not assume others know what you are thinking.
- Identify team members and clearly establish roles for each member.

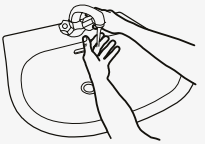
Use the information from the color-coded table on page 60 and 61 of this PG to help you decide how and where to care for the woman having an abormal finding.

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0

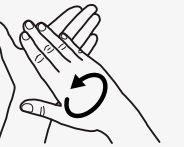


Wet hands with water;

1

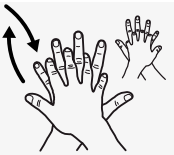
Apply enough soap to cover all hand surfaces;

2



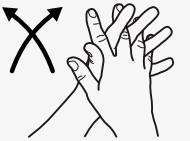
Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

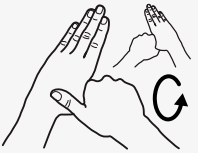


Palm to palm with fingers interlaced;

5

Backs of fingers to opposing palms with fingers interlocked;

6

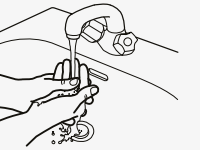


Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

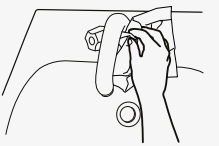


Rinse hands with water;

9

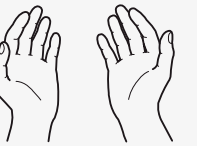
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a

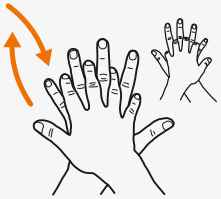
1b

Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

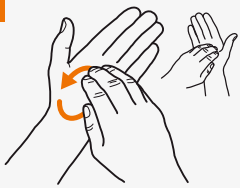
5

Backs of fingers to opposing palms with fingers interlocked;

6

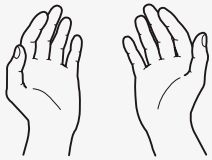
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

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May 2009

Taking a history for a woman who may be in labor

Review records and ask the woman about:

1. **History of this labor**
   - When did contractions begin? How often? How strong?
   - Is fluid leaking from the vagina? If yes, since when did it start, and what color?
   - Is the baby moving?
   - Do you have any other concerns?

2. **History of past pregnancies**
   - How many total pregnancies?
   - How many births or losses?
   - For past births, were they spontaneous vaginal, assisted by forceps or vacuum, or cesarean? Any premature births?
   - What were previous birth weights and outcomes?
   - Any problems in previous pregnancies or births (such as bleeding, high blood pressure, infection, or severe tears)?

3. **Medical history**
   - Do you have any allergies?
   - Any chronic medical problems?
   - Any medications for chronic medical problems?

4. **History of this pregnancy**
   - What is the expected due date (EDD) and how was it determined (last known menstrual period, ultrasound at what GA)?
   - Any problems with this pregnancy (such as bleeding, high blood pressure, or infections), treatments received?
   - Are you taking any medications now?
   - Have you had any sexually transmitted infections (i.e. syphilis, chlamydia, gonorrhea) or treatment for these? If she has not been tested for syphilis, test now if possible.
   - What is her HIV status? If she is living with HIV, is she on antiretroviral therapy and virally suppressed? Has her partner been tested? If not tested, test now if possible.
   - Any history of tuberculosis? If so treatment received?
   - What is her most recent hemoglobin, hematocrit?
   - What is her tetanus immunization status?
   - How will she feed her newborn?
   - What is her postpartum family planning choice?
   - Any other concerns?

Confirming gestational age by measuring fundal height

1. Ask the woman to lay down so you can measure her fundal height. Explain what you are doing and why. Ask her to expose her abdomen so that you can measure.
2. Stretch tape measure from the top of the pubic bone to the top of the fundus. Hold the 0 (zero) on the tape at the top of the pubic bone.
3. Follow the curve of the abdomen with the measuring tape to the top of the fundus.
4. Record the number of centimeters from the top of the public bone to the top of the fundus.
5. Share findings with the woman.

Notes on Fundal Height:

- The fundal height should be within 2 – 3 centimeters of the calculated gestational age in weeks when the woman is not in labor. A baby that is well engaged or for a woman in labor, the fundus may measure smaller than the gestational age.
- For measurements to be considered normal and term, the gestational age must be at least 37 completed weeks.
- If the last menstrual period (LMP) is not known, use fundal height to estimate the gestational age. Also estimate the fetal weight – an estimation of at least 2.5 kilograms is needed to be considered normal.
- When measuring fundal height in labor, a measurement of over 40 centimeters suggests a very large baby, possible twins/multiples, or another clinical complication, while a measurement of less than 30 centimeters suggests an early or small baby.
- Follow local guidelines on what to do if the fundus measures smaller than 37cm.

Tips for supporting birth in alternate positions

Tips for hand maneuvers when assisting birth in alternate positions

- Maintain head flexion **towards the woman's bottom/back.**
- Allow the baby's head to turn spontaneously.
- Deliver the first shoulder by gently pulling the baby **towards the woman's bottom/back**
  - If squatting, you will deliver the first shoulder by pulling downward
  - If side-lying, you will deliver the first shoulder either by pulling to the right or left, depending on which side the woman is lying on
  - If on hands and knees, you will deliver the first shoulder by pulling upward
- Deliver the second shoulder by gently pulling the baby towards **the woman's abdomen.**
  - If squatting, you will deliver the second shoulder by pulling upward
  - If side-lying, you will deliver the second shoulder either by pulling to the right or left, depending on which side the woman is lying on
  - If on hands and knees, you will deliver the second shoulder by pulling downward

Tips for supporting birth in hands-knees position

- Place a clean, dry cloth on the woman's back OR underneath her abdomen if she is going to receive the baby as she turns.
- Keep talking to the woman because she cannot see your face. Explain what you are doing.
- Ask the woman to focus on deep breathing and to give only small pushes if she has an uncontrollable urge to push.
- Control birth of the head with fingers of one hand (palm up) to maintain flexion of the head upward toward the ceiling.
- Maintain flexion toward the woman's bottom/back.
- Allow the baby's head to turn spontaneously and deliver the first shoulder upward away from the floor and toward the ceiling.
- To deliver the second shoulder, move the head towards the woman's belly. When the axillary crease is seen, guide the head downward as the second shoulder is born.
- Support the rest of the baby's body with one hand and continue as you would after any birth.

Team Action Plan - to improve care for labor and birth

To do/Action	**S.M.A.R.T** Goals	Person responsible	Timeframe
	S ..... **M** ..... **A** ..... **R** ..... **T**	....	....
	S ..... **M** ..... **A** ..... **R** ..... **T**	....	....
	S ..... **M** ..... **A** ..... **R** ..... **T**	....	....

Clinical Decision Making

	Normal findings	Action needed	Emergency - seek advanced care!
FHR	**120-160 beats per minute (BPM)**	**100-119 BPM** • Change position, recheck in 5 minutes • Check cervical dilation; check for cord prolapse • Give fluids and oxygen	**<100 BPM or 100-119 BPM for > 10 minutes or no response to position change** • Shout for help! • Start IV and give oxygen
		> 160 BPM • Recheck in 5 minutes. • Check for infection, bleeding, and dehydration, and treat any identified conditions • Give fluids	**> 160 BPM for > 10 minutes or no response to interventions** • Continue / Begin interventions in yellow • Start IV • Give oxygen
Amniotic fluid	• Clear • No foul odor • Membranes ruptured for < 18 hours	**If meconium-stained re-assess FHR** **If foul odor or yellow/greenish** • Check for infection • Give antibiotics if membranes ruptured >18 hours and/or if signs/symptoms of infection • Re-assess FHR	**Bleeding (not "bloody show")** • Start IV • Give oxygen
Contractions	• 3-5 every 10 minutes, each lasting > 40 seconds • > dilatation • Uterus relaxed in between	2 or less in 10 minutes, each lasting < 40 seconds and no > dilatation See cervical dilation section	**> 5 in 10 minutes, or last > 60 seconds/ continuous/ constant or sudden pain in between contractions** • Conduct rapid evaluation • If hyperstimulation, stop any oxytocin infusion • Start IV • Give oxygen
Maternal pulse	**< 100 BPM**	**100-120 BPM** • Recheck between contractions. • Check for infection, bleeding, dehydration, fear and anxiety, and treat any identified conditions. • If findings are normal and pulse still 100-120 BPM, give fluids.	**> 120 BPM** • Check for fear, anxiety, infection, dehydration, bleeding, shock • Treat identified conditions • Start IV • Give oxygen

	Normal findings	Action needed	Emergency - seek advanced care!
Temperature	**≤ 38°C**	**> 38°C** • Check for infection and give antibiotics if appropriate • Check for shock • If no signs of infection, give fluids and paracetamol	**> 38°C with signs/symptoms of shock** • Treat any identified conditions, including shock • Start IV
Blood pressure (BP)	• Systolic BP (sBP) 90–139 mmHg • Diastolic BP (dBP) 60–89 mmHg	**BP 140-160/90-110 mmHg** • Recheck between contractions with woman on her side. • If BP still elevated, assess for pre-eclampsia	**BP > 160/110 mmHg** • Recheck between contractions with woman on her side • Assess for severe pre-eclampsia • See HMS Pre-eclampsia & Eclampsia
		sBP < 90 mmHg • Recheck between contractions with woman on her side • Check vital signs and for shock • Treat any identified conditions • If findings normal, give fluids	**sBP < 90 mmHg and signs and symptoms of shock and/or bleeding** • Treat any identified conditions, including shock • Start IV
Cervical dilation (during active phase of 1st stage only)	• 0.5-1 cm/hour once cervix is 5 cm • Dilatation on or to left of alert line if using	**No dilatation > 4 cm after 8 hours of regular contractions OR dilation to right of alert line but to left of action line** • Assess FHR, general condition, contractions, fetal presentation and position • Treat according to cause • Provide supportive care, encourage ambulation, food and fluids • If referral anticipated start referral process now	**Dilation is to right of action line. Rule out obstruction!** • Conduct rapid evaluation to rule out obstruction • Start IV • Seek advanced care and refer if needed
Descent (during 2nd stage only)	• Spontaneous urge to push • Descent with contractions	**Presenting part does not descend despite adequate contractions and effort** Perform rapid evaluation, treat by cause, and provide supportive care as above for poor dilatation, PLUS: • Encourage woman to assume position of choice, but NOT lying flat on her back • Support spontaneous pushing and assess with every contraction • Seek advanced care if progress not made	**Lack of descent that does not respond to interventions** • Seek advanced care

LDHF ACTIVITIES

What is "continued practice" and why is it important?

Training alone is not enough to improve care. Regular practice and other activities are needed to reinforce new knowledge and skills. Practice also improves teamwork and clinical decision-making.

Who helps you practice?

One or two people from your facility will be asked to coordinate practice sessions. The coordinator will remind you to practice and will guide the sessions. She/he is a colleague who has learned how to support these activities. **Remember though, you and your peers can practice without a coordinator if they are not available!**

Session objectives

Each session has objectives. Practice will help you refine your skills, and meet these objectives. For all sessions, be sure to demonstrate respectful care, teamwork, and communication.

Session preparation

Each session plan includes a list of items you need and how you should prepare. Practice coordinators are responsible for making sure everything is ready. Session plans also include instruction for coordinators and providers about how to run the session. You will need this Provider's Guide (PG) for reference. Coordinators will give friendly coaching as needed.

Videos

Some sessions include watching videos from Global Health Media Project (GHMP) as part of preparation. Ensure that providers can access the GHMP videos - either offline via a flash drive or pre-downloaded to a device, or online via the video links provided. Videos can be watched independently, or together with your coordinator. In addition we invite you to visit the FIGO website which has tutorials for labor and birth. https://www.glowm.com/resource_type/resource/tutorials

Simulating with role plays

To help us practice skills and clinical decision-making, we will use role plays as we did during training. When conducting a role play, coordinators will:

- Establish a safe learning environment
- Run the role play
- Conduct an organized debrief
- Support discussion to improve learning
- Identify and explore gaps
- Help providers transfer what they learned into clinical practice

Debrief

During debrief, coordinators guide providers to review their own performance and that of the team. This gives everyone the chance to learn by talking about what happened. Coordinators and providers should be kind and constructive and avoid embarrassing each other. The goal is self-reflection and team improvement.

Session 1: Revisiting Taking Action!

45 minutes

Read objectives aloud:

- Review personal commitments and team SMART goals made at the end of the training day.
- Update commitments and goals.
- Do a facility walk through from the client's perspective.

Preparation:

- Review the team's Taking Action! goals.
- Invite all labor ward staff who are on duty the day of the session to participate, even if they did not join the original training.

Materials:

- Marker/pens/paper
- Taking Action! Plan

Activity:

20 minutes

Part I: Review and Update Taking action! Plan

Begin by asking staff who were at the ECL&B training to recall the closing activity. During that activity, each person chose one thing they would do differently after training. Ask them to take a moment to remember the personal commitment they made. These do not need to be shared with the group, however, if anyone wants to share their commitment and any progress they made, this is a great opportunity for recognition and motivation! Then ask providers, ***"Do you remember which SMART goals we agreed to work together to improve?"***

Share the completed Taking Action! Plan and ask a volunteer to review it with the group. Say, ***"Please turn to page 59 in your Provider's Guides and write each SMART goal as we review it."*** Pause after each objective and ask:

- ***"Do we need any additional resources or support to achieve this objective? If so, how can we get these resources?***
- ***What activities or tasks do we need to do to reach this objective? Who will be responsible for moving it forward?***
- ***Do we need to adjust this objective?"***

Update the action plan as needed and be sure everyone has a role. Tell providers that you will come together again in 6 weeks to review progress.

Part II: Facility Walk Through/ Patient Pathway

25 minutes

After updating the action plan say, ***"Now we are going to walk through our facility together. Each of us will imagine we are coming here as a woman in labor. We want to learn if there are barriers for women who come for care."*** Ask a volunteer to serve as the group's note-taker during the walk-through. Start at the entrance and walk through triage, admission, maternity, postpartum, etc. **At each location,** discuss:

- Can we maintain privacy and confidentiality for women here?
- Can we accommodate companions here?
- Can women walk and move as they labor here?
- Are there toilets and drinking water?
- Are these spaces clean and welcoming?
- Are there ways to make the space more comfortable?
- Are providers able to use best infection prevention practices in these locations (proper sharps and waste disposal, access to handwashing, etc.) ?

After the walk-through, debrief as a group:

- How did you see your workplace when seen from the woman's perspective?
- What improvements can we make ourselves such as moving furniture or adding curtains to improve mobility and privacy?
- Which improvements need help from management such as painting or purchasing handwashing stations?

Update the Taking Action! plan with additional interventions to improve clients' experience of care.

Session 2 Encourage handwashing

20 minutes

Read objectives aloud:

- Review the critical importance of the "5 moments of handwashing" from page 9 of this PG.
- Review findings from facility walk through related to infection prevention and handwashing.
- Describe how to make alcohol based hand rub.

Materials:

- Glycerin
- Ethyl or isopropyl alcohol solution
- Clean containers 100 - 200 ml with caps/lids
- Measuring cup
- 10 or 20ml syringe
- Providers Guide open page 8 and 9

Preparation:

- Go to www.globalhealthmedia.org and watch the "Preventing Infection at Birth" video prior to the activity.
- If handwashing is a challenge at your facility, meet with management to see if supplies can be purchased to make handrub. Buy glycerin (a skin softener sold in medical and cosmetics stores) and ethyl or isopropyl alcohol solution (available at most medical stores). The amount you will need depends on the size of your facility.
- Set up materials on a clean table.

Activity:

1. Ask a volunteer to recall the 5 moments of handwashing from the ECL&B training. See PG page 8.
2. Watch GHMP video together if possible.
3. Review, any handwashing challenges that came up during the training day or during the facilty walk-through in Session 1.
4. Say, ***"We can easily make handrub to use when our hands are not visibly soiled. Today we will learn how to make it."***
5. Demonstrate how to make handrub. Measure 2mls of glycerin with a syringe and put it into a clean container. Then add 100mls of alcohol. Close then shake the container.
6. Apply 5 ml of handrub to your palm and rub for 20 - 30 seconds. See PG page 55.
7. Ask participants to make their own handrub and try using it.

Session 3
Abdominal Assessment

30 minutes

Read objectives aloud:

- Do a complete and accurate abdominal asessment.

Materials:

- Fetoscope
- Tape measure
- Watch or clock with a second hand
- Simulator if client not available

Preparation:

- You need at least 2 people: 1 coordinator, and 1 provider.
- Set up the learning corner with the materials above if there is no client.
- Ask all providers to go to www.globalhealthmedia.org and watch the "The Position of the Baby" video prior to the activity.

Activity:

1. Watch GHMP video together if needed and review page 14 and 15 of the PG.
2. Identify a woman who is at least 34 weeks GA and is at the facility for an antenatal visit or a labor check. Choose a healthy client with no apparent complications.
3. After welcoming the woman, conducting a Quick Check, taking history if she is there for labor, and calculating GA, ask her if it would be okay if another provider helped with her assessment.
4. If she agrees, invite your colleague into the room to introduce himself/herself and review the woman's record.
5. Have the provider perform a complete abdominal examination.

The coordinator should observe if the provider:
- Asked the woman to empty her bladder.
- Washed her hands.
- Measured fundal height and looked for scars and a retraction ring.
- Felt for contractions if in labor. Noted how often and how long they last and how she is coping.
- Felt for fetal presentation, lie, descent and how many babies.
- Checked FHR for one full minute.
- Told the woman the results.

6. Complete the client visit.

7. After the visit is finished, the coordinator and provider should sit together to debrief in private Turn to page 15 in the PG. Ask the provider:
   - How do you think it went? How do you think the woman felt?
   - What assessment did you make? Did you remember everything?
   - Is there anything you want to improve for next time?

8. Repeat steps 2 – 7 for additional providers.

NOTE: If it is not possible or practical to practice abdominal assessment on a client, providers can practice doing a complete abdominal assessment on simulators. The coordinator or another provider wears the simulator. Providers should complete all steps above using page 15 in the PG as a guide.

Session 4
Vaginal Examination

30 minutes

Read objectives aloud:

- Do a complete and accurate vaginal examination (VE).

Materials:

- VE job aid or common items with diameters of 10cms or less: cups, laboratory tubes, toilet paper rolls, etc. Use a tape measure to confirm diameters.
- Childbirth simulator with cervix inserts
- Exam gloves, gauze, supplies for handwashing

Preparation:

- You need at least 2 people: 1 coordinator, and 1 provider.
- Set up the learning corner with the materials above if there is no client.
- Ask all providers to go to www.globalhealthmedia.org and watch the "Vaginal Exam in Labor" video prior to the activity.

Activity:

1. Watch GHMP video if needed and review page 16 and 17 of the PG.
2. Providers should begin by practicing cervical dilation on a VE job aid, common items, or cervix inserts as available. The coordinator selects a simulated cervix. Providers can "test" themselves as many times as needed to build confidence. If providers are using the VE job aid or the cervix inserts, they should close their eyes when checking for dilation.
3. Practice on the childbirth simulator using PG page 17 as a guide.
4. Identify a healthy client with no apparent complications or problems who has come for a labor check.
5. After welcoming the woman, conducting a Quick Check if not done, taking history, calculating GA, and conducting an abdominal assessment, explain the VE and seek her consent.

6. Have the provider request the coordinator come in to support the woman and observe. Obtain her consent. The provider should do the VE and the coordinator should observe if the provider:
   - Asks the woman to pass urine.
   - Washes hands, put on gloves, and asked her to relax her legs.
   - Cleans vulva with clean water.
   - Checks for sores, blood and scars.
   - Gently checks and verbalizes: visual inspection for sores, blood, scars, cervix, membranes/liquor, presenting part, position/molding/caput, and station.
   - Explains findings to woman.
7. Only if the provider is unsure of findings, ask permission from the client for the coordinator or another colleague to repeat the VE for confirmation.
8. After the VE, the provider and coordinator should sit together to debrief in private. The coordinator should ask the provider:
   - How do you think it went? How do you think the woman felt?
   - What assessments did you make? Did you remember everything?
   - Is there anything you might want to improve for next time?

NOTE: Repeated VEs for learning are not recommended. A repeat VE should be done only if a provider is unsure. All providers can practice VE on simulators. The coordinator or another provider can wear the simulator. Providers should complete all steps above. Using page 17 in the PG as a guide.

Session 5
Strengthening documentation

30 minutes preparation, 10 minutes discussion

Read objectives aloud:

- Improve documentation of client care.
- Review documentation practices and note strengths and gaps.
- Share findings with team and brain-storm potential ways to improve documentation.

Materials:

- Marker/pens/paper
- PG page 71 "ECL&B Record Check Tool"
- Maternity ward register
- Client records

Preparation:

The coordinator selects 5 client records as follows: Look at the maternity register and identify the most recent birth. This is the first client record you will review. Check the register again and go back 5 births, this will be your second client record to review. Continue this pattern until you have 5 birth records.

- Complete the "ECL&B Record Check Tool" on page 71 of the PG, completing one column for each of the selected client records. **Do not write provider or client names on the tool.**
- Note any areas where documentation of an item is less than 80% out of 5 records.

Activity:

Share results of the documentation review with staff. Stress that this activity is not intended to criticize anyone – we are all learning together! Rather, it is intended to identify gaps in documentation so that we can all improve. Review any items where the item was documented in less than 80% of charts. Ask why this may be. No BP cuff? No time to document? Explore

how we can improve documentation on these items. Ask the team to share how they feel and discuss why documentation is important.

Repeat this activity each month to track progress and improve documentation.

Session 6
Supporting Birth and Immediate Care after Birth

30 minutes

Read objectives aloud:

- Support birth to standard.
- Support immediate care after birth to standard.

Materials:

- BP machine, stethoscope
- Thermometer
- Birth simulator with newborn model
- Gloves
- Fetoscope/doppler and ultrasound gel
- Towels, baby hat, and blanket
- Scissors and/or blade
- Hemostats, clamps, ties for cord
- Basin/receiver for placenta
- Personal protection for provider
- Mock oxytocin, misoprostol, vitamin K, syringes and needles
- Suction device
- Ventilation bag and mask for baby
- Clock/watch

Preparation:

Ask all providers to go to www.globalhealthmedia.org and watch

- "Managing the Second Stage of Labor"
- "Birthing the Baby" and
- "Immediate Care After Birth"

prior to the activity.

Activity:

In lower volume facilities, simulate birth in pairs with the coordinator wearing the birth simulator. In higher volume facilities, the coordinator can respectfully observe provider giving care during birth. In either case, the observer should watch as the provider supports birth and immediate postnatal care. Go to PG pages 28-43 for a guide.

After completing the birth or simulation, the coordinator and provider should sit together to debrief in private. Ask the provider:

- How do you think it went? How did you feel?
- How do you think the woman felt?
- Is there anything you might do differently next time?

Repeat for other providers.

Session 7
Continuing to Take Action!

20 minutes

Read objectives aloud:

- Review personal commitments and team SMART goals made at the end of the training day.
- Update commitments and goals.

Preparation:

- Review the team's Taking Action! Goals.
- Invite all labor ward staff who are on duty the day of the session to participate.

Activity:

Ask providers, ***"Today we will revisit the Taking Action! Goals we made following the ECL&B training and in Session 1."*** Review the goals, pausing after each one and ask the group to reflect:

- What progress have we made since Session 1?
- Have planned activities or tasks taken place? Why or why not?
- Have we completed any goals? If so, congratulate the team!
- What goals remaining and what work needs to be done?
- Can we commit to completing these and meeting again?
- Do we need any resources or help to achieve our goals? How will we do this?
- Share progress, outstanding goals, and support needs with facility management.

Session 8
Care when something is not normal

30 minutes

Read objectives aloud:

- Understand what to do when assessments during labor are not normal

Preparation:

- Ask all providers to open their PGs to page 60 and 61.

Activity:

Read the following cases:

Case 1

"Ms. M is 38 weeks pregnant. She was admitted 4 hours ago in labor with a cervix dilated 5 cms. Her vital signs and FHR have been normal and her water just broke. You recheck her cervix and she is 9cm, +1 station, clear fluid.

- BP 134/80
- Pulse 118
- Temperature 37
- FHR 140
- Contraction strong and regular

Ask providers:

- Is Mrs. M's labor progressing? Yes
- Is everything normal? No, her pulse is high
- What could be the problem? Dehydration or infection
- What will you do? Give her something to drink and check in 1 hour

Tell participants: ***"After she drinks a cup of tea and 2 glasses of water, her pulse is 82. What else do we need to do?"***
Continue monitoring and care.

Case 2:

"Mrs. B is 6cm and is complaining of a severe headache. She is lying on her left side and has a BP of 165/112.

- What will you do? Act fast! Presume severe pre-eclampsia while checking for protein in her urine and doing laboratory tests. Give loading dose of $MgSO_4$ and antihypertensive medicine.
- What can we do here to care for Mrs. B?
- Must she be referred or can we care for her here?
- What would you say to Mrs. B and her family?

See Helping Mothers Survive Pre-eclampsia & Eclampsia

Session 9
Encourage women's choice of position for birth

30 minutes

Read objectives aloud:

- Increase confidence to support various positions for pushing and birth.
- Practice hand manuevers for supporting birth in alternate positions.

Materials:

- Birth simulator with newborn model
- Supplies for birth.

Preparation:

- Ask all providers to watch the *GHMP Positions for Birth video* prior to this activity.

Activity:

- Remind providers that women should be encouraged to push and give birth in the position they find most comfortable.
- Ask them, "Why do you think most women lie on their backs to give birth?"
- Allow group to respond and discuss. Answers may include:
  - Comfort and convenience for providers
  - Provider training
  - Physical set up of the delivery room
- Explain that choices for alternative birth position include:
  - Standing
  - Hands and knees or leaning forward
  - Squatting
  - Sitting
  - Side lying
- Ask providers, ***"Do we have space here where women can give birth in different positions? If not, what can we do to make this happen?"***
- Ask participants to work in pairs. One participant will be the woman either holding a newborn simulator or wearing the birthing simulator with a newborn simulator inside, and the other her provider.
- Practice supporting birth in at least two other positions including hands and knees. Turn to page 58 in the PG for tips on how to support birth in hands and knees. Circulate and offer guidance as needed.
- Debrief with participants at the end of the activity. Ask the providers:
  - What went well?
  - What did you find difficult, confusing, or uncomfortable?
  - Do you think you could help women give birth in these positions?

The Universal Rights of Women & Newborns

1. Everyone has the right to **freedom** from harm & ill-treatment
2. Everyone has the right to **information**, informed **consent**, & respect for their choices & preferences, including companion of choice during maternity care & refusal of medical procedures
3. Everyone has the right to **privacy** & **confidentiality**
4. Everyone is their own person from the moment of birth & has the right to be treated with **dignity** & **respect**
5. Everyone has the right to equality, freedom from discrimination & **equitable care**
6. Everyone has the right to **healthcare** & the highest attainable level of health
7. Everyone has the right to **liberty**, **autonomy**, self-determination & freedom from arbitrary detention
8. Every child has the right to be **with their parents** or guardians
9. Every child has the right to an **identity** & **nationality** from birth
10. Everyone has the right to adequate **nutrition** & **clean water**

Find out more at: www.whiteribbonalliance.org/rmcresources

Essential Care for Labor & Birth Record Check Tool

Facility Name: _____

Practice Coordinator: _____ **Date:** _____

Documentation Requirement	Chart 1 If yes, put a check	Chart 2 If yes, put a check	Chart 3 If yes, put a check	Chart 4 If yes, put a check	Chart 5 If yes, put a check	% of charts with item documented	Comments
Check the medical record if the provider/team did the following:							
1. Checked and documented client's blood pressure on admission							
2. Checked and documented the fetal heart rate on admission							
3. Checked and documented the client's temperature at least once							
4. Calculated and documented the gestational age							
5. Checked and documented the fetal position							
6. Checked and documented the fetal heart rate during second stage							
7. Documented the time of birth							
8. Checked and documented the client's blood pressure at least one additional time							
9. Administered oxytocin (or misoprostol or other uterotonic) within one minute of birth and documented it							
10. Checked and documented newborn weight							

Scoring: Each item is scored according to the number of charts with each of the requirements met (use a checkmark for "yes"). For example, if 4 out of 5 charts met the documentation requirement, that item receives a score of 80%. Meaning 80% of charts chosen documented that item.

80 – 100% = Documentation of item meets standard
60 – 79% = Some improvement needed to meet standard
<60% = Significant improvement needed to meet standard
Practice coordinator should decide with the team which of the items need improvement and how they will work to ensure items are done and documented.

October 2019

Essential Care for Labor & Birth

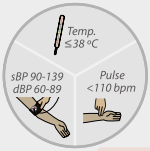
ACTION PLAN

PREVENT INFECTION

PROVIDE RESPECTFUL CARE

Quick check

Close to birth?



Support birth

Danger Signs?

Seek advanced care

Assess

History

Regular contractions

Presentation head first

Fetal heart rate 120-160

Vaginal examination ≥ 5cm

Classify

Normal, not active
Reassess

Normal, active labor

Warning signs
Manage

Danger signs
Seek advanced care

1st stage: ≥ 5 cm

Check every 30 min	Fetal heart rate Contractions Pulse Woman's mood
2 hours	Temperature
4 hours	BP Cervix and membranes Fetal descent

Support labor

Continue documentation
Assess

Encourage to move, drink, eat, use toilet

Danger signs?
Seek advanced care

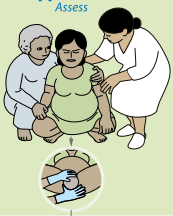
Give comfort

2nd stage: 10 cm

Check every 5 min	Fetal heart rate Contractions Fetal descent Woman's mood
30 min	Pulse
2 hours	Temperature Bladder empty
4 hours	BP

Support birth

Assess



Prepare for birth

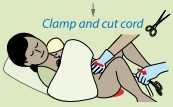
Support choice of position

3rd stage: Baby born

Support immediate care

Check for 2nd baby
Give oxytocin

Clamp and cut cord



Deliver placenta and check uterus

Dry baby
Check breathing
Place skin-to-skin

Baby not breathing?
Resuscitate and seek advanced care

The Golden Minute™

60 sec

4th stage: Placenta out

Continue care

Check for bleeding and tears

Give comfort and start breastfeeding
Review danger signs

Heavy bleeding?
Manage and seek advanced care

Ensure hygiene, comfort and rest

Monitor woman and baby
Check every 15 min for 2 hrs

Woman	Uterus Bleeding BP Pulse
Baby	Breathing Color Pulse
Both	Temperature, repeat if not normal

Scan QR Code

Use the camera if you have an Iphone, or download the QR Code App to go directly to the digital version of the Essential Care for Labor & Birth course materials.