DAKSHATA

Job-aids and Checklists

Registration No. .....

CHECK-1 On Admission

Record temperature of mother:.....
Record BP of mother:.....
Record Fetal Heart Rate (FHR): .....

Does Mother need referral?
☐ Yes, organized
☐ No

Refer to FRU/Higher centre if any of following danger signs are present, mention reason and given treatment on transfer note:
☐ Vaginal bleeding
☐ High fever
☐ Severe headache or blurred vision
☐ Convulsions
☐ Severe abdominal pain
☐ History of heart disease or other major illnesses
☐ Difficulty in breathing

Partograph started?
☐ Yes
☐ No: will start when ≥ 4 cm

Start when cervix ≥4 cm, then cervix should dilate ≥1 cm/hr
- Every 30 min: Plot maternal pulse, contractions, FHR and colour of amniotic fluid
- Every 4 hours: Plot temperature, blood pressure, and cervical dilation in cm

NO OXYTOCIN/ other uterotonics for unnecessary induction/ augmentation of labor

Does Mother need
- Antibiotics?

☐ Yes, given
☐ No

Give antibiotics to Mother if:
☐ Mother's temperature ≥38°C (≥100.5°F)
☐ Foul-smelling vaginal discharge
☐ Rupture of membranes >12 hrs without labour or >18 hrs with labour
☐ Labour >24 hrs or obstructed labour
☐ Rupture of membranes <37 wks gestation

- Inj. Magnesium Sulfate?

☐ Yes, given
☐ No

Give first dose of inj. magnesium sulfate and refer immediately to FRU/Higher center OR give full dose (loading and then maintenance) if at FRU if:
Mother has systolic BP ≥160 or diastolic ≥110 with ≥+3 proteinuria **OR** BP systolic ≥140 or diastolic ≥90 with proteinuria trace to +2 along with any of:
☐ Presence of any symptom like:
- Severe headache
- Pain in upper abdomen
- Blurring of vision
- Oligouria (passing <400 ml urine in 24 hrs)
- Difficulty in breathing

☐ Convulsions

Corticosteroid
☐ Yes, given
☐ No

Give corticosteriods in antenatal period (between 24 to 34 weeks) to mothers if:
☐ True pre-term labour
☐ Conditions that lead to imminent delivery like APH, Preterm Premature ROM, Severe PE/E
Dose: Inj. Dexamethasone 6 mg IM 12 hourly - total 4 doses

HIV status of the mother:
☐ Positive
☐ Negative

☐ **Follow Universal Precautions**

If HIV+ and in labour:
☐ If mother is on ART, continue same
☐ If not on ART, start ART
☐ If ART is not available, refer immediately after delivery to ICTC/ART Centre/Link ART Centre for further HIV management

If HIV status unknown:
☐ Recommend HIV testing

Encouraged a birth companion to be present during labour, at birth and till discharge ☐ Yes ☐ No

Are soap, water, gloves available?
☐ Yes, I will wash hands and wear gloves for each vaginal exam
☐ No, supplies arranged

☐ **Confirm if mother or companion will call for help during labour if needed**

Explain to call for help if there is:
- Bleeding
- Severe abdominal pain
- Difficulty in breathing
- Severe headache or blurring vision
- Urge to push
- Can't empty bladder every 2 hours

Counsel Mother and Birth Companion on:
- Support to cope up with labour pains
- No bath/oil for baby
- No Pre-Lacteal feed
- Initiate breastfeeding in half-an-hour
- Clothe and wrap the baby

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

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CHECK-2 Just Before and During Birth (or C-Section)

Record temperature of mother:.....
Record BP of mother:.....
Record Fetal Heart Rate (FHR): .....

Does Mother need:

- *Antibiotics?*

☐ Yes, given
☐ No

Give antibiotics to Mother if any of the following are present:
☐ Mother's temperature ≥38°C or ≥100.5°F
☐ Foul-smelling vaginal discharge
☐ Rupture of membranes >18 hrs with labour
☐ Labour >24 hrs or obstructed labor now
☐ Cesarean section

- *Inj. Magnesium sulfate?*

☐ Yes, given
☐ No

Give first dose of inj. magnesium sulfate and refer immediately to FRU/Higher center OR give full dose (loading and then maintenance) if at FRU if:
Mother has systolic BP ≥160 or diastolic ≥110 with ≥+3 proteinuria **OR** BP systolic ≥140 or diastolic ≥90 with proteinuria trace to +2 along with any of:
☐ Presence of any symptom like:
- Severe headache
- Pain in upper abdomen
- Blurring of vision
- Oligouria (passing <400 ml urine in 24 hrs)
- Difficulty in breathing

☐ Convulsions

☐ **Skilled assistant identified and ready to help at birth if needed**

Confirm essential supplies are at bedside/labour room:

For Mother
☐ Gloves
☐ Soap and clean water
☐ Oxytocin 10 units in syringe
☐ Pads for mother

Prepare to care for mother immediately after birth of baby (AMTSL)*
☐ Confirm single baby only (rule out multiple babies)
☐ Give inj. oxytocin 10 units IM within 1 minute
☐ Do controlled cord traction to deliver placenta
☐ Massage uterus after placenta is delivered, check for completeness (all Cotyledons and Membranes)

For Baby
☐ Two clean dry, warm towels
☐ Sterile scissors/blade to cut cord
☐ Mucus extractor
☐ Cord ligature
☐ Bag-and-mask

Prepare to care for baby immediately after birth
☐ Dry baby, wrap, and keep warm, give Vit. K, start breastfeeding
☐ If not breathing: clear airway and stimulate
☐ If still not breathing:
- Cut cord
- Ventilate with bag-and-mask
- Call for help (Pediatrician/SNCU/NBSU/F-IMNCI trained doctor if available)

***AMTSL - Inj. Oxytocin 10 units IM given within one minute of birth of baby?**
☐ Yes
☐ No

Breastfeeding initiated in first half-an-hour of birth of the baby
☐ Yes
☐ No

*AMTSL - Active Management of Third Stage of Labour

Name of Provider: .....Date: ..... Signature: .....

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Adapted from "WHO Safe Childbirth Checklist"

Registration No. .....

CHECK-3 Soon After Birth (within 1 hour)

Record temperature of mother:.....
Record BP of mother:.....
Record temperature of baby:.....
Record respiratory rate of baby:.....

Is Mother bleeding abnormally?

☐ Yes, shout for help, refer if needed or treat if facilities available
☐ No

If bleeding ≥500 ml, or 1 pad soaked in <5 min:

- Call for help, massage uterus, start oxygen, start IV fluids, start oxytocin drip 20 units in 500 ml of RL@40-60 drops/min, treat cause
- If placenta not delivered or completely retained: give IM or IV Oxytocin, stabilize, and refer to FRU/Higher centre
- If placenta is incomplete: remove if any visible pieces, and refer immediately to FRU/ higher centre

Does Mother need:

- *Antibiotics?*

☐ Yes, given
☐ No

Give antibiotics to mother if manual removal of placenta is performed, or if mother's temperature ≥38°C (≥100.5°F) and any of:

☐ Chills
☐ Foul-smelling vaginal discharge
☐ Lower abdominal tenderness
☐ Rupture of membranes >18 hrs during labour
☐ Labour was >24 hours

- *Inj. Magnesium sulfate?*

☐ Yes, given
☐ No

Give first dose of inj. magnesium sulfate and refer immediately to FRU/Higher center OR give full dose (loading and then maintenance) if at FRU if:
Mother has systolic BP ≥160 or diastolic ≥110 with ≥+3 proteinuria **OR** BP systolic ≥140 or diastolic ≥90 with proteinuria trace to +2 along with any of:

☐ Presence of any symptom like:
- Severe headache
- Pain in upper abdomen
- Blurring of vision
- Oligouria (passing <400 ml urine in 24 hrs)
- Difficulty in breathing

☐ Convulsions

Does Baby need:

- *Antibiotics?*

☐ Yes, given
☐ No

Give baby antibiotics if antibiotics were given to mother, or if baby has any of:

☐ Breathing too fast (>60/min) or too slow (<30/min)
☐ Chest in-drawing, grunting
☐ Convulsions
☐ Looks sick (lethargic or irritable)
☐ Too cold (baby's temp <36°C and not rising after warming)
☐ Too hot (baby's temp >38°C)
☐ Excessive crying

- *Referral?*

☐ Yes, organized
☐ No

Refer baby to NBSU/SNCU/FRU/higher centre if:

- Any of the above (antibiotics indications)
- Baby looks yellow, pale or bluish

- *Special care and monitoring?*

☐ Yes, organized
☐ No

Arrange special care/monitoring for baby if any of the following is present:

☐ Preterm baby
☐ Birth weight <2500 gms
☐ Needs antibiotics
☐ Required resuscitation

- *Syrup Nevirapine*

☐ Yes, given and will continue upto 6 weeks
☐ No

Give if mother is HIV+:

- If mother has received >24 weeks of ART, give syrup Nevirapine to baby for 6 weeks
- If mother has received <24 weeks of ART or mother is not on ART, give syrup Nevirapine to baby for 12 weeks

☐ **Started breastfeeding. Explain that colostrum feeding is important for baby.**
☐ **Started skin-to-skin contact (if mother and baby well) and KMC in pre-term and low-birth weight babies.**
☐ **Explain the danger signs and confirm mother/companion will call for help if danger signs present.**

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

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Registration No. .....

CHECK-4 Before Discharge

Record temperature of mother:.....
Record BP of mother:.....
Record temperature of baby:.....
Record respiratory rate of baby:.....

Is Mother's bleeding controlled?

- ☐ Yes
- ☐ No, treat, observe and refer to FRU/ higher centre if needed

Does mother need antibiotics?

- ☐ Yes, give and delay discharge
- ☐ No

Give antibiotics to mother if mother has temperature ≥38°C or ≥100.5°F with any of:

- ☐ Chills
- ☐ Foul-smelling vaginal discharge
- ☐ Lower abdominal tenderness

Does baby need antibiotics?

- ☐ Yes, give, delay discharge and refer to FRU/ higher centre
- ☐ No

Give baby antibiotics if baby has any of:

- ☐ Breathing too fast (>60/min) or too slow (<30/min)
- ☐ Chest in-drawing, grunting
- ☐ Convulsions
- ☐ Looks sick (lethargic or irritable)
- ☐ Too cold (baby's temp <36°C and not rising after warming)
- ☐ Too hot (baby's temp >38°C)
- ☐ Stopped breastfeeding
- ☐ Umbilical redness extending to skin or draining pus

Is baby feeding well?

- ☐ Yes, encourage mother for exclusive breastfeeding for 6 months.
- ☐ No, help mother, delay discharge; refer to NBSU/ SNCU/ Higher centre if needed

- ☐ **Discuss and offer family planning options to mother**
- ☐ **Confirm post delivery stay at facility for 48 hours in normal delivery and 7 days in C-section cases**
- ☐ **Explain the danger signs and confirm mother/companion will seek help/ come back if danger signs are present after discharge**
- ☐ **Arrange transport to home and follow-up for mother and baby**

Thank mother for availing services from you

Danger Signs

Mother has any of:

- Excessive bleeding
- Severe abdominal pain
- Severe headache or visual disturbance
- Breathing difficulty
- Fever or chills
- Difficulty emptying bladder
- Foul smelling vaginal discharge

Baby has any of:

- Fast/difficulty breathing
- Fever
- Unusually cold
- Stops feeding well
- Less activity than normal
- Whole body becomes yellow

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

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Checklist for Abdominal Examination

S.No.		Task	Cases				
			1	2	3	4	5
1.		**Foetal Lie and Presentation (32 Weeks Onwards)**					
		Now ask the woman to flex her knees					
	a.	**Carry out fundal palpation/grip** • Place both hands on the sides of the fundus to determine which part of the foetus is occupying the uterine fundus (the foetal head feels hard and globular, whereas the buttocks (breech) feel soft and irregular.					
	b.	**Carry out lateral palpation/grip** • Place your hands either side of the uterus at the level of the umbilicus and apply gentle pressure. The foetal back feels like a continuous hard, flat surface on one side of the midline, while the limbs feel like irregular small knobs on the other side. • In a transverse lie, the baby's back is felt across the abdomen and the pelvic grip is empty.					
	c.	**Carry out superficial pelvic grip** • Spread your right hand widely over the symphysis pubis, with the ulnar border of the hand touching the symphysis pubis. • Try to approximate the fingers and thumb, by putting gentle but deep pressure over the lower part of the uterus. The presenting part can be felt between the thumb and four fingers. Determine whether it is the head of breech (the head will feel hard and globular, and the breech soft and irregular). • If the presenting part is the head, try to move it from side to side. It it cannot be moved, it is engaged. • If neither the head, nor the buttocks are felt on the superficial pelvic grip, the baby is lying transverse. This is an abnormal lie. Refer the woman to an FRU in the third trimester.					
	d.	**Carry out deep pelvic grip (only in 3rd trimester)** • To perform this grip, face the foot end of the bed. • Place the palms of your hands on the sides of the uterus, with the fingers held close together, pointing downwards and inwards, and palpate to recognize the presenting part. • If the presenting part is the head (feels like a firm, round mass, which is ballotable, unless engaged), this manoeuvre, in experienced hands, will also be able to tell us about its flexion. • If the fingers diverge below the presenting part it indicates					

		engagement of the presenting part. If the fingers converge below the presenting part it indicates that the presenting part has not engaged. • If the woman cannot relax her muscles, tell her to flex her legs slightly and to breathe deeply. Palpate in between the deep breaths. • Feel to assess if there is more than one baby.					
			1	**2**	**3**	**4**	**5**
2		**Foetal Heart Rate (FHR)**					
		Note: Check after 24 weeks.					
	a.	• Place the foetoscope/bell of the stethoscope on the side of the uterus where the foetal back is felt (foetal heart sounds are best heard midway between the umbilicus and anterior superior iliac spine in the vertex and at the level of the umbilicus, or just above it in the breech). • Count the foetal heart sounds for one full minute. This is the FHR.					
	b.	• Record all your findings on the Mother and Child Protection Card and discuss them with the woman.					

Checklist for Gestational Age Estimation

Abdominal Examination, Correct Estimation of Gestational Age								
S. No.		**Task**	**Cases**				
			1	**2**	**3**	**4**	**5**
1.		**Note:**					
		• It is important that abdominal examination during pregnancy be done with an empty bladder. Ask the woman to empty her bladder. • Give the woman a clean bottle and ask her to collect a little urine in the bottle before emptying her bladder completely. The urine will be required later to test for sugar and proteins. • Maintain privacy and obtain the woman's verbal consent.					
2.		Help the woman lie comfortably on her back, supported by cushions or pillows, on the examination table. Ask her to loosen her clothes and uncover her abdomen.					
3.		Check the abdomen for any scars. If there is a scar, find out if it is from a caesarean section or any other uterine surgery.					
4.		**Fundal Height**					
	a.	Ask the woman to keep her legs straight.					
	b	Measuring Fundal Height To estimate the gestational age through the fundal height, the abdomen is divided into parts by imaginary lines. The most important line is the one passing through the umbilicus. Then divide the lower abdomen (below the umbilicus) into three parts, with two equidistant lines between the symphysis pubis and the umbilicus. Similarly, divide the upper abdomen into three parts, again with two imaginary equidistant lines, between the umbilicus and the xiphisternum.					
		At 12^{th} week- Just palpable above the symphysis pubis					
		At 16^{th} week- At lower one-third of the distance between the symphysis pubis and umbilicus					
		At 20^{th} week- At two-thirds of the distance between the symphysis pubis and umbilicus					
		At 24^{th} week- At the level of the umbilicus					
		At 28^{th} week- At lower one-third of the distance between the umbilicus and xiphisternum					
		At 32^{nd} week- At two-third of the distance between the umbilicus and xiphisternum					

		At 36th week- At the level of the xiphisternum					
		At 40th week- Sinks back to the level of the 32nd week, but the flanks are full, unlike that in the 32nd week.					
	c.	Measuring FH (in cms) using Measuring Tape i. Place the ulnar (media/inner) border of the hand on the woman's abdomen starting from the xiphisternum (the lower end of the sternum/breastbone), and gradually proceed downwards towards the symphysis pubis lifting your hand between each step down, till you finally feel a bulge/resistance, which is the uterine fundus. Mark the level of the fundus. ii. - Using a measuring tape, measure the distance (in cm) from the upper border of the symphysis pubis along the uterine curvature to the top of the fundus. - This is the fundal height. Note it down in the Mother and Child Protection Card - After 24 weeks of gestation, the fundal height (in cm) corresponds to the gestational age in weeks (within 1-2 cm deviation).					
		Note: When measuring the fundal height, the woman's legs should be kept straight and not flexed.					

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

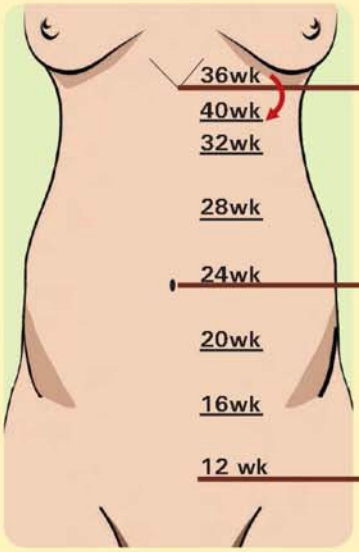
Antenatal Examination

NATIONAL RURAL HEALTH MISSION

Preliminaries

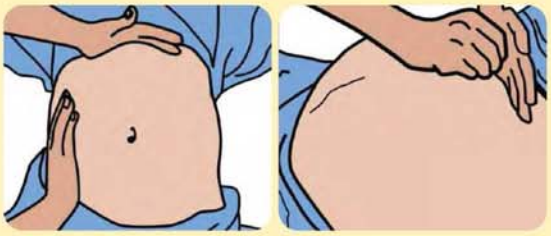
- Respect woman's rights
- Explain procedure and ensure privacy
- Ensure bladder is empty
- Examiner stands on right side
- Abdomen is fully exposed from xiphisternum to pubis symphysis
- Keep woman's legs straight
- Centralise uterus

FUNDAL HEIGHT

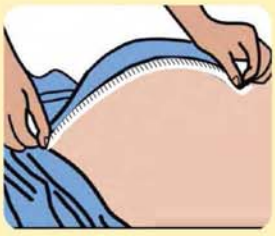


Symphsio-fundal height in cms corresponds to weeks of gestation after 28 weeks

Correct dextrorotation



Ulnar border of left hand is placed on upper most level of fundus and marked with pen



Measure distance between upper border of pubic symphysis and marked point

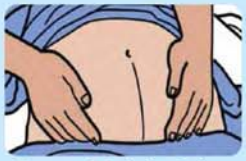
GRIPS

Legs are slightly flexed and separated for obstetrical grips

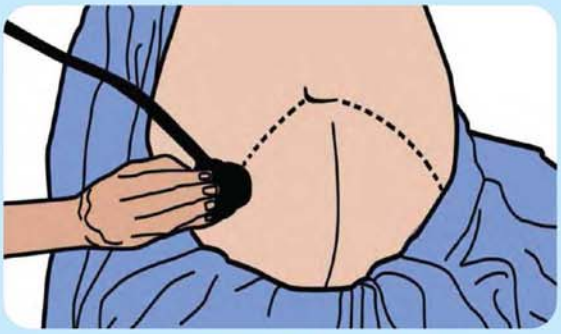
Fundal Grip

Lateral Grip

First Pelvic Grip



Second Pelvic Grip



Foetal heart sound is usually located along the lines as shown

Checklist for Blood Pressure (BP) Recording

S. No	Task	Cases			
		1	2	3	4
1.	Checks that bulb is properly attached to the tubing				
2.	Checks for any crack and leakage in the bulb and cuff				
3.	Checks mercury column knob is in open mode				
4.	Asks the person to sit on a chair or lie down on flat surface				
5.	Place the apparatus on a horizontal surface at the person's heart level				
6.	The mercury column is at the observer's eye level.				
7.	Ties the cuff 1 inch above the elbow placing both the tubes in front.				
8.	Raises the pressure of the cuff to 30 mmHg above the level at which pulse is no longer felt				
9.	Releases pressure slowly and listens with stethoscope keeping it on brachial artery at the elbow				
10.	Notes the reading where the sound is heard (systolic pressure)				
11.	Follows the sound and notes reading where the sound disappears (diastolic)				
12.	Deflates and remove the cuff; closes the mercury column knob				
13.	Records the reading on MCP card				

Key points BP recording

- In a pregnant woman, BP must be recorded during each visit.
- Hypertension is diagnosed when two consecutive readings taken four hours or more apart show the systolic blood pressure to be 140 mmHg or more and/or the diastolic blood pressure to be 90 mmHg or more.
- High blood pressure during pregnancy may signify Pregnancy-Induced Hypertension (PIH) and/or chronic hypertension.
- If the woman has high blood pressure, check her urine for the presence of albumin. The presence of albumin (+2) together with high blood pressure is sufficient to categorise her as having pre-eclampsia. Refer her to the MO immediately.
- If the diastolic blood pressure of the woman is above 110 mmHg, it is a danger sign that points towards imminent eclampsia. The urine albumin should be estimated at the earliest. If it is strongly positive, the woman should be referred to the FRU IMMEDIATELY.
- If the woman has high blood pressure but no urine albumin, she should be referred to the MO at 24 hours PHC.
- A woman with PIH, pre-eclampsia or imminent eclampsia requires hospitalisation and supervised treatment at a 24-hour PHC/FRU.
- Reading must be entered in the MCP card

MEASUREMENT OF BLOOD PRESSURE USING MERCURY SPHYGMOMANOMETER

1

Tell the woman about the procedure

2

Ask the person to sit on a chair or lie down on flat surface

3

Check that bulb is properly attached to the tubing

4

- Place the apparatus on a horizontal surface at the person's heart level
- The mercury column is at the observer's eye level

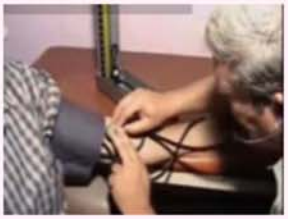
5

Checks for any crack and leakage in the bulb and cuff

6

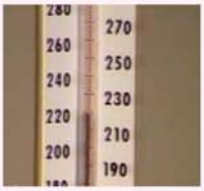
Opens the mercury column knob

7



- Tie the cuff 1 inch above the elbow placing both tubes in front
- Place the diaphragm of a stethoscope over the brachial artery

8



Raise the pressure of the cuff to 30 mmHg above the level at which pulse is no longer felt

9

Release pressure slowly and listens with stethoscope keeping it on brachial artery at the elbow

10

- Note the reading where the sound is heard (systolic pressure)
- Follow the sound and notes reading where the sound disappears (diastolic)

11

Deflate and remove the cuff; closes the mercury column knob

12

- Inform the woman the findings
- Record the reading

Checklist for Hemoglobin Estimation

S. No	Task	Cases			
		1	2	3	4
1.	Keep all the necessary items ready (Sahli's Hbmeter , N/10 HCl, gloves, spirit swabs, lancet, distill water and dropper, puncture proof container, 0.5% Chlorine solution)				
2.	Washes hands and wears gloves				
3.	Cleans the Hb tube and pipette				
4.	Fills the HB tube with N/10 HCl upto 2 grm with the dropper				
5.	Cleans tip of the person's ring finger with spirit swab				
6.	Pricks the finger with lancet and discards first drop of blood				
7.	Allows a large blood drop to form on the finger tip and sucks it with pipette upto 20 cmm mark. Takes care that air entry is prevented while sucking the blood.				
8.	Wipes tip of the pipette and transfers the blood to the Hb tube containing N/10 HCl				
9.	Rinses the pipette 2-3 times with N/10 HCl				
10.	Leaves the solution in test tube for 10 min				
11.	After 10 minutes, dilutes the acid by adding distil water drop-by-drop and mix it with stirrer				
12.	Matches with the colour of the comparator				
13.	Notes down the reading (lower meniscus)				
14.	Disposes off the used lancet in puncture proof container				
15.	Drops the used gloves in 0.5% Chlorine solution				

Key Points -Hb estimation

- In a pregnant woman, Hb estimation must be done during each visit.
- The initial haemoglobin level will serve as a baseline with which the later results, obtained at the three subsequent antenatal visits, can be compared.
- Interpretation of findings:
  - Hb > 11 gm% (absence of anaemia) –
    - Prophylactic IFA tablet (100 mg elemental iron and 0.5 mg folic acid) once a day for six months,
    - Starting after the first trimester, at 14–16 weeks of gestation.
    - Regimen is to be repeated for six months post-partum.
  - Hb 7-11 gm% (moderate anaemia)-
    - Therapeutic IFA tablet twice a day.
    - Regimen is to be repeated for six months post-partum.
  - Hb < 7 gm % (severe anaemia) or those who have breathlessness and tachycardia (pulse rate of more than 100 beats per minute) due to anaemia-
    - Start the therapeutic dose of IFA and
    - Refer the woman to FRU.

ESTIMATION OF HEMOGLOBIN USING SAHLI'S HEMOGLOBINOMETER

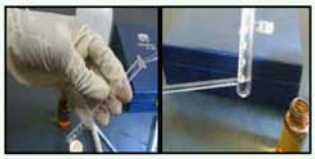
1

Keep all necessary items ready (Sahli's Hbmeter, N/10 HCl, gloves, spirit swabs, lancet, distill water and dropper, puncture proof container, 0.5% Chlorine solution) Cleans the Hb tube and pipette

2

Wash hands and wears gloves

3



Fill the Hb tube with N/10 HCl up to 2 gm with the dropper and places it in the Hb Meter

4

Clean tip of the person's ring finger with spirit swab

5

Prick the finger with lancet and discards first drop of blood

6

Allow a large blood drop to form on the finger tip and sucks it with pipette upto 20 cm mark. Takes care that air entry is prevented while sucking the blood

7

Wipe tip of the pipette and transfers the blood to the Hb tube containing N/10 HCl

8

Rinse the pipette 2-3 times with N/10 HCl

9

Leave the solution in Hb tube for 10 minutes

10

After 10 minutes, dilute the acid by adding distil water drop-by-drop and mix it with stirrer

11

Note down the reading (lower meniscus) when the color of the solution exactly matches that of the comparators on both side of the Hb Meter

12

Rinse the Hb tube 2-3 times with N/10 HCl and disposes off the used lancet in puncture proof container

13

Drop the used gloves in 0.5% Chlorine solution

Checklist for Urine testing

S.NO.	Task	Observations
1.	Keep all the necessary items ready (Urine specimen collection bottles/container and dipsticks)	
2.	Checks the expiry date on the kit	
3.	Remove one strip from the bottle and replace the cap	
4.	Completely immerse reagent area of the strip in the urine and remove it immediately	
5.	While removing the strip from urine run the edge against the rim of the container to wipe off the excess urine	
6.	For Glucose: -After 30 seconds compare the blue colored reagent area against the color chart area on the bottle and records the finding *Read instructions on bottle	
7.	For Protein :- Immediately or within 30 seconds (as per instruction on bottle), compare the yellow colored reagent area against the color chart area on the bottle and records the finding *Read instructions on bottle	
8.	Discard the stick in yellow bin.	

Key Points -Urine test

- In a pregnant woman, urine testing for protein and sugar must be done during each visit.
- **Testing the urine for the presence of protein (albumin)** is a very important test used for the detection of pre-eclampsia, which (along with eclampsia) is one of the five major causes of maternal mortality.
- **Testing urine for the presence of sugar** is a test used to diagnose women with gestational diabetes (which may cause delivery-related complications due to the infant's large size, development of diabetes later in life, increased risk of newborn death and stillbirth or Low blood sugar (glucose) or illness in the newborn, and jaundice)
- The presence of albumin together with high blood pressure is sufficient to categories her as having pre-eclampsia. Refer her to the MO immediately
- If urine is positive for sugar, refer her to the MO to get her blood sugar examined and a glucose tolerance test carried out, if required.
- Reading must be entered in the MCP card.
- Store the tightly sealed bottle in cool dark place
- Each strip should be used only once.

(Day 1) 10

Checklist for PV Examination during Labour

Step	Task	Cases				
		1	2	3	4	5
1	**GETTING READY**					
a.	Keeps the following equipment ready: • Sterile surgical gloves • Plastic apron • Sterile swabs in a bowl • Povidone Iodine, Chlorhexidine • 0.5% chlorine solution for decontamination					
b.	Tells the woman and her support person what is going to be done and encourages them to ask questions					
c.	Listens to what the woman and her support person have to say					
d.	Asks the woman to pass urine and lie down on the examination table with her knees flexed and legs apart					
e.	Puts on a clean plastic apron					
f.	Uncovers her genital area and covers or drapes her to maintain privacy					
g.	Washes her hands thoroughly with soap and water, air dries them					
h.	Wears sterile gloves on both hands					
i.	Checks the vulva for the presence of: • Mucus discharge • Excessive watery discharge • Foul-smelling discharge					
j.	Cleans the vulva from above downwards with one gloved hand (not the examining hand), using a swab dipped in an antiseptic solution (povidone iodine/chlorhexidine)					
2	**EXAMINING THE VAGINA**					
a.	Uses the thumb and forefinger of the left hand to part the labia majora, so that the vaginal opening is clearly visible					
b.	Gently inserts the index and middle fingers of the examining hand					

Step	Task	Cases				
		1	2	3	4	5
	into the vagina. (Once your fingers are inserted, do not take them out till the examination is complete)					
c.	Examining the cervix and deciding the stage of labour i. Keeps the other hand on the women's lower abdomen, just above the pubic symphysis. When the examining fingers reach the end of the vagina, turns fingers upwards so that they come in contact with the cervix ii. Locates the cervical os by gently sweeping the fingers from side to side. The os will be felt as an opening in the cervix. The os is normally situated centrally, but sometimes in early labour, it will be far posterior (backwards) iii. Feels the cervix. It should be soft and elastic, and closely applied to the presenting part iv. Measures the dilatation of the cervical os by inserting the middle and index fingers into the open cervix and gently opening the fingers to reach the cervical rim (distance in centimetres between the outer aspect of both examining fingers) • 0 cm indicates a closed external cervical os • 10 cm indicates full dilatation Deciding the stage of labour: • 1st stage of labour: This is the period from the onset of labour pain to the full dilatation of the cervix, i.e. 10 cm • 2nd stage of labour: This is the period from full dilatation of the cervix to the delivery of the baby v. Feels the application of the cervix to the presenting part: • If the cervix is well applied to the presenting part, it is a favourable sign • If the cervix is not well applied to the presenting part, you have to be alert vi. Feel the membranes: • Intact membranes can be felt as a bulging balloon during a contraction through the dilating os • Feels for the umbilical cord. If it is felt, it is a case of cord presentation and requires urgent referral to an FRU • If the membranes have ruptured, checks whether the amniotic fluid is clear or meconium-stained vii. Identifies the presenting part:					

Step	Task	Cases				
		1	2	3	4	5
	• Tries and judges if it is hard round and smooth. If so, it is the head • In a breech presentation, the buttocks or legs are felt at the cervix. Refers the woman to the FRU • In a transverse lie, an arm or shoulder is felt at the cervix. Refers the woman to the FRU viii. Assessing the pelvis • Tries to reach the sacral promontory if the head is not engaged. If the sacral promontory is felt, the pelvis is contracted. Refers the woman to the FRU for expert care • If the sacral promontory is not felt, traces downwards and feels for the sacral hollow. A well-curved sacrum is favourable • Spreads two fingers to feel for the ischial spines. If both ischial spines can be felt at the same time, the pelvic cavity is contracted • Takes out fingers & keeps them in pubic angle. If 2 fingers easily accommodate means anteriorly outlet is adequate. Now try to accommodate 4 knuckles in between 2 ischial tuberosity. If they fit easily means posteriorly outlet is adequate ix. Removes the gloves by turning them inside out • If disposing of the gloves, places them in a leak-proof container or plastic bag • If the surgical gloves are to be re-used, submerges them in 0.5% chlorine solution for 10 minutes to decontaminate them x. Washes hands thoroughly with soap and water and air dries them					
d.	Informs the woman about the findings and reassures her					
e.	Records all findings of the vaginal examination on the partograph. If the woman is in active labour (cervix dilated 4 cm or more and at least 2 uterine contractions per10 minutes, each of 20 seconds duration), starts noting the findings on the partograph. If she is not in active labour, notes down the findings in the client's case record					

Flow Chart for Antenatal Corticosteroid (ANCs) Administration {24-34 Weeks gestational Age}

Assess the gestational age of pregnant woman reporting with the complaints of labour pain.
If between 24-34 weeks then

Check whether the pregnant woman is in true preterm labour using the table* given below:

- If the pregnant woman is in true labour
  - Delivery imminent
    - Give one dose of Injection Dexamethasone as described in the box** and prepare for delivery and neonatal resuscitation.
  - Delivery NOT imminent
    - Give one pre-referral dose of Injection Dexamethasone if the patient is to be referred, otherwise complete the course. Tocolysis (delay of uterine contractions) is to be done under medical supervision.
      - Before referral
        1. Check vitals, BP
        2. Do Hb, Blood Sugar, Urine Examination (Ex)
        3. Give ANCS first dose - Refer to higher facility
        4. Arrange transport
        5. Referral slip
      - Referral refused or not possible
        1. Check vitals, BP
        2. Do Hb, Blood Sugar, Urine Ex.
        3. Give ANCS first dose - then 3 additional doses 12 hourly
        4. Arrange for delivery, resuscitation and care of preterm baby
- If the pregnant woman is not in true labour
  - Observe for the symptoms, discharge if the symptoms resolve with advice to report immediately if danger signs appear.

    If symptoms do not resolve, treat her as in true preterm labour and follow the chart.

**Dexamethasone protocol	
Dose/injection	6 mg
Route	Intramuscular
Interval	12 hours
No. of Injections	4

Contraindication for use of ANCS is Frank Chorioamnionitis

*Symptoms of True and False Labour Pain	
TRUE Labour Pain	FALSE Labour Pain
1. Begins irregularly but becomes regular and predictable 2. Felt first in the lower back and sweeps around to the abdomen in a wave pattern 3. Continues no matter what the woman's level of activity 4. Increases in duration, frequency and intensity with the passage of time 5. Accompanied by 'show' (blood-stained mucus discharge) 6. Associated with cervical effacement and cervical dilatation	1. Begins irregularly but becomes remains irregular 2. Felt first abdominally and remains confined to the abdomen and groin 3. Often disappears with ambulation or sleep 4. Does not increase in duration, frequency or intensity with the passage of time 5. Show absent 6. Does not associate cervical effacement and cervical dilatation

Checklist for Administering Inj. $MgSO_4$ for Initial Management of Eclampsia

S. No	Task	Cases			
		1	2	3	4
1.	Wash hands thoroughly with soap and water and dry before and after the procedure				
2.	Keep ready 10 ampoules (20 ml=10 gms) of 50% Mg SO4				
3.	Prepares 2 syringes(10ml syringe and 22 gauze needle) with 5 g of 50% magnesium sulfate solution				
4.	Carefully cleans the injection site with an alcohol wipe.				
5.	Gives 5 g by DEEP IM injection in one buttock.				
6.	Disposes of used needle and syringe in a puncture proof box				
7.	Carefully cleans the injection site in the alternate buttock with an alcohol wipe.				
8.	Gives 5 g by DEEP IM injection into the other buttock.				
9.	Disposes of used needle and syringe in puncture proof box				
10.	Records drug administered				

Key Points

If the woman is conscious, tell her that she may experience a feeling of warmth, headache and vomiting when magnesium sulphate is given

Refer the woman to FRU, for further necessary action. Ensure to send a referral slip with mention of 1st dose given.

Management with Intravenous and Intramuscular Dose

S. No.	Task	Cases			
		1	2	3	4
	Administering Loading Dose (IV+ IM) of Magnesium Sulfate				
1.	Washes hands thoroughly with soap and water and air dry. Puts clean examination gloves on both hands.				
2.	Prepares magnesium sulfate 20% solution, 4 g . (Take one 20ml sterile syringe, draw 4 ampoules of Mg So4 (8ml=4g) into the syringe, add 12 ml of distilled water /normal saline for injection to make it 20%)				
3.	Carefully cleans the injection site with an alcohol wipe.				
4.	Gives magnesium sulfate 20% solution, 4 g by IV injection SLOWLY over 5 minutes				
5.	Disposes of used needle and syringe in a sharps disposal box				
	Administering IM loading Dose of Magnesium Sulfate				
6.	Prepares 2 syringes(10ml syringe with 22 gauze needle) with 5 g of 50% magnesium sulfate solution with 1 mL of 2% Lignocaine in the same syringe				
7.	Carefully cleans the injection site with an alcohol wipe.				
8.	Gives 5 g by DEEP IM injection in one buttock.				
9.	Disposes of used needle and syringe in a sharps disposal box				
10.	Carefully cleans the injection site in the other buttock with an alcohol wipe.				
11.	Gives 5 g by DEEP IM injection into the other buttock.				
12.	Disposes of used needle and syringe in a sharps disposal box				
13.	Disposes of gloves in a 0.5% decontamination solution				
14.	Washes hands thoroughly with soap and water then air dry.				
15.	Records drug administration and findings on the woman's record.				
	Administering IV Dose of Magnesium Sulfate for recurrent fits / convulsions				
16.	Washes hands thoroughly with soap and water and air dry. Puts clean exam gloves on both hands.				
17.	Prepares syringe with 2 g magnesium sulfate (50% solution) Take one 10ml sterile syringe, draw 2 ampoules of Mg So4 50%(4ml=2g) into the syringe add 6 ml of distilled water /normal saline				
18.	Carefully cleans the injection site with an alcohol wipe.				
19.	Gives magnesium sulfate 20% solution, 2 g by IV injection SLOWLY over 5				

	minutes				
20.	Disposes of used needle and syringe in a sharps disposal box				
21.	Disposes of gloves in a 0.5% decontamination solution				
22.	Washes hands thoroughly with soap and water and dries with a clean, dry cloth or air dry.				
	Maintenance dose of MgSo4				
23	Washes hands thoroughly with soap and water and air dry. Puts clean exam gloves on both hands.				
24	Prepares 1 syringe(10ml syringe with 22 gauze needle) with 5 g of 50% magnesium sulfate solution with 1 mL of 2% Lignocaine in the same syringe				
25	Carefully cleans the injection site with an alcohol wipe.				
26	Gives 5 g by DEEP IM injection every 4 hourly in alternate buttock.				
27	Maintenance dose of MgSO4 to be continued till 24 hours after delivery or the last convulsion whichever is later				
28	Disposes of used needle and syringe in a sharps disposal box				
29	Disposes of gloves in a 0.5% decontamination solution				
30	Washes hands thoroughly with soap and water and dries with a clean, dry cloth or air dry.				
31	Records drug administration and findings on the woman's record				

Key Points

- If the woman is conscious, Tell her that she may experience a feeling of warmth when magnesium sulphate is given
- PIH includes:
  - Hypertension—systolic blood pressure of 140 mmHg or more and/or diastolic blood pressure of 90 mmHg or more, on two consecutive readings taken four hours or more apart
  - Pre-eclampsia—hypertension with proteinuria
  - Eclampsia—hypertension with proteinuria and convulsions
- Always check expiry dates before using any medications
- Replenish the drug immediately after using and store at the place which is easily accessible to all staffs
- DO NOT give next dose of Mg So4 if absent knee jerk or urinary output less than 100ml/4hours or respiratory rate less than 16/min
- Signs of reaction: After receiving the injection, the woman may have flushing, may feel thirsty, get a headache, feel nauseous or even vomit.
- Normal strength and availability: Magnesium Sulphate50% w/v, 1 g in each 2 ml ampoule
- Keep Inj.Calcium Gluconate, 10% ,10ml as an antidote

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

Eclampsia

Pregnancy with Convulsion; BP≥140/90 mmHg; Proteinuria

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Immediate Management

1. Keep her in quiet room in bed with padded rails on sides
2. Position her on left side, Oropharyngeal airway to be kept patent.
3. Ensure preparedness to manage maternal and foetal complications

Oxygen by mask at 6-8 l/min, Start IV fluids-RL/ NS at 60 ml/hr, Catheterize with indwelling catheter

Anti Hypertensive

- If Diastolic BP≥ 100 mmHg
- Strict BP monitoring
- Oral Nifedepine 10 mg stat, repeat after 30 minutes if needed (if pt unconscious through ryles tube) OR
- Inj Labetalol 20 mg IV bolus, repeat 40 mg after 10 minutes again repeat 80 mg every 10 minutes if needed (maximum 220 mg) with cardiac monitoring

Anti Convulsants

- Magnesium Sulfate is drug of choice
- Loading dose:
  - 50% of 4 gm diluted to 20% (8 ml drug with 12 ml NS) to be given slowly IV in 5 minutes
  - 5 gm IM (50%) each buttock with 1 ml of 2% Xylocaine (Total 10 gm)
  - If recurrent fits after 30 minutes of loading dose – repeat 2 gm 20% (4 ml drug with 6 ml NS) slow IV in 5 minutes
- Maintenance dose:
  - 5 gm IM (50%) alternate buttocks after monitoring every 4 hourly
- Monitor:
  - Presence of patellar jerks
  - Resp. rate (RR) ≥16/min
  - Urine output ≥ 30 ml/hr in last 4 hours
- Continue till 24 hours after last fit/delivery which ever is later
- If Patellar jerk absent or urine output < 30 ml/hr withhold Magsulf and monitor hourly– restart maintenance dose if criteria fulfilled
- If RR < 16/min, withhold Magsulf, give antidote – Calcium Gluconate 1 gm IV 10 ml of 10% solution in 10 minutes

- Deliver the baby irrespective of gestational age
- Admission-delivery interval should not be more than 12 hours

Favourable Cervix

- Induction with ARM and Oxytocin
- 2nd stage to be cut short by Forceps/ Ventouse

Unfavourable Cervix

- Ripening with Dinoprostone gel/ intracervical indwelling catheter and after 6 hours

LSCS:

- If fits not controlled/ status eclampticus
- Failed Induction
- Foetal distress
- Any other obstetric indication
- Deteriorating maternal condition

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

Pre Eclampsia

- BP≥140/90 mm Hg on 2 occasions, 4 hours apart
- Urine proteinuria ≥ traces or ≥ 300 mg/24 hrs sample
- Period of gestation > 20 weeks

Mild Pre eclampsia

- BP ≥ 140/90 mm Hg
- Protienuria ≥ traces to 2 + or ≥ 300 mg/24 hrs

- Hospitalize to evaluate and investigate
- Reassure, no restriction on routine salt intake
- Rest with limited activity
- Start anti hypertensive when DBP ≥ 100 mm Hg
- Tab Alpha Methyl Dopa 250–500 mg 6-8 hourly (max 2 gm/day) OR
- Tab Labetalol 100 mg BD (max 2.4 gm/day)
- Investigate — Hgm, LFT, KFT, S Uric acid, S LDH and fundus exam
- BP and urine output monitoring

- Continue OPD management in mild disease
- Continue hospitalization in worsening hypertension/proteinureia
- Regular foetal + maternal surveillance (foetal movement count, NST, AFI, wt gain, BP and urine output monitoring, weekly Hgm, LFT, KFT, S Uric acid and S LDH)

- Maintain DBP 90-100 mm Hg
- No foetal compromise

If disease severe, manage as severe pre eclampsia

- Deliver at 38-39 weeks

Severe Pre eclampsia

- BP ≥ 160/110 mm Hg
- Proteinuria ≥ 3 + by dipstick or ≥ 5 gm/24 hrs
- Headache, epigastric pain, blurring of vision, oliguria, pulmonary odema, thrombocytopenia, IUGR. Creatinine > 1.2 mg/dl, ↑ serum transaminase levels, S LDH > 600 IU/L

- Urgent hospitalization
- Start anti hypertensive
- Oral Nifedepine 10 mg stat, repeat after 30 minutes if needed OR
- Inj Labetalol 20 mg IV bolus, repeat 40 mg after 10 minutes if BP not controlled again repeat 80 mg every 10 minutes (max 220 mg) with cardiac monitoring

- Continue Tab Nifedepine 10 mg TDS (max 80 mg/day) OR Tab Labetalol 100 mg BD (max 2.4 gm/day)
- Investigate — Hgm, LFT, KFT, S Uric acid, S LDH and fundus exam
- Urine output charting
- BP Monitoring

< 24 weeks → Foetal salvage difficult

≥24 -< 34 weeks → Inj. Betamethasone
- 12 mg IM
- Repeat 12 mg after 24 hours

≥34 weeks

Treatment should be individualised

BP controlled
- Explain maternal and foetal adverse effect to relatives
- Regular maternal + foetal surveillance

→ Terminate at 37 weeks

BP uncontrolled
- Worsening of clinical / biochemical parameters
- Signs of foetal compromise

≥37 weeks

- Terminate pregnancy
- Induction of labor as per Bishop score and give Magsulf as in Eclampsia

No role of diuretics

For use in medical colleges, district hospitals and FRUs

THE SIMPLIFIED PARTOGRAPH

Identification Data

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

Date & Time of Admission: Date & Time of ROM:

A) Foetal Condition

Foetal heart rate

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

Amniotic fluid

B) Labour

Cervic (cm) (Plot X)

10 9 8 7 6 5 4

Alert

Action

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

Time

Contraction per 10 min.

5 4 3 2 1

C) Interventions

Drugs and I.V. fluid given

D) Maternal Condition

Pulse and BP

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

Temp (°C)

Initiate plotting on alert line

Refer to FRU when ALERT LINE is crossed

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Government of India

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Trays to be kept in Labour Room (As per GoI's MNH Toolkit)

Delivery tray

- Gloves
- Scissors
- Artery forceps
- Cord clamp
- Sponge holding forceps
- Urinary catheter
- Bowl for antiseptic lotion
- Gauze pieces and cotton swabs
- Speculum
- Perineal pads
- Kidney tray

Episiotomy tray

- Inj. Xylocaine 2%
- 10 ml disposable syringe with needle
- Episiotomy scissors
- Kidney tray
- Artery forceps
- Allis forceps
- Sponge holding forceps
- Toothed forceps
- Needle holder
- Needle (round body and cutting)
- Chromic catgut no.0
- Gauze pieces
- Cotton swabs
- Antiseptic lotion
- Thumb forceps
- Gloves

Baby tray

- Two pre-warmed towels/sheets for wrapping the baby
- Cotton swabs
- Mucus extractor
- Bag and mask
- Sterilized thread for cord/cord clamp
- Nasogastric tube
- Gloves
- Inj. Vitamin K
- Needle and syringe. (Baby should be received in a pre-warmed towel. Do not use metallic tray)

Medicine tray*

- Inj. Oxytocin (to be kept in fridge)
- Cap Ampicillin 500 mg
- Tab Metronidazole 400 mg
- Tab Paracetamol
- Tab Ibuprofen
- Tab B complex
- IV fluids
- Inj. Oxytocin 10 IU
- Tab. Misoprostol 200 micrograms
- Inj. Gentamycin
- Vit K
- Inj. Betamethasone
- Ringer lactate
- Normal Saline
- Inj. Hydralazine
- Nifedipine
- Methyldopa
- Magnifying glass

(*-Nevirapin and other HIV drugs only for ICTC and ART Centres)

Emergency drug tray**

- Inj. Oxytocin (to be kept in fridge)
- Inj. Magsulf 50%
- Inj. Calcium gluconate-10%
- Inj. Dexamethasone
- Inj. Ampicillin, Inj.Gentamicin
- Inj. Metronidazole
- Ceftriaxone (3rd generation cephalosporins) - For L3 facility
- Inj. Lignocaine-2%
- Inj. Adrenaline
- Inj. Hydrocortisone Succinate
- Inj. Diazepam
- Inj. Pheneramine maleate
- Inj. Carboprost
- Inj. Fortwin
- Inj. Phenergan
- Ringer lactate
- Normal saline
- Inj. Hydralazine
- Nifidipine
- Methyldopa
- Inj. Betamethasone
- IV sets with 16-gauge needle (at least 2)
- Controlled suction catheter
- Mouth gag
- IV Cannula
- Vials for blood collection

(–only for L2, L3 facilities)**

MVA/ EVA tray: Gloves, speculum, anterior vaginal wall retractor, posterior vaginal wall retractor, sponge holding forceps, MVA syringe and cannulas, MTP cannulas, small bowl of antiseptic lotion, sanitary pads, pads /cotton swabs, disposable syringe and needle, misoprostol tablet, sterilized gauze/pads, urinary catheter.

PPIUCD tray*–** PPIUCD Insertion Forceps, Cu IUCD 380A/ Cu IUCD 375 in a sterile package.

(* – only for L3 facilities with PPIUCD trained provider)**

Additional Trays/Kits to be kept in Labour Room

Examination tray

- SS tray
- Bowl with cotton swabs
- Sterile floves
- Antiseptic solution bottle
- Measuring tape
- Stethoscope/Foetoscope
- Uristix bottle
- BP apparatus
- Thermometer
- Knee hammer
- MCP cards
- Blood and urine collection vials
- Alcohol swabs
- RDKs (to be kept in fridge)

PPH Management Kit

- Wide bore cannula (number 16/18) - at least 2
- IV set, IV fluids (NS, RL)
- Syringes (10 ml, 5 ml, 2 ml)
- Blood and urine collection vials
- Inj. Oxytocin (to be kept in refrigerator), Tab. Misoprostol, Inj. Methylergometrine, Inj. Carboprost (to be kept in refrigerator)
- Bowl with cotton swabs
- Alcohol/spirit swabs, Dry cotton swabs
- Antiseptic solution bottle
- Adhesive tape
- Suture material
- Self-retaining catheter, Urobag
- Syringe & distilled water for inflation
- Long elbow-length sterile gloves
- Sterile gloves
- For Condom Tamponade: SS tray with lid, Sims speculum, SS bowl with swabs, Sponge holders, Suture material, Scissors, Foley's catheter (16 no.), Condoms, IV set, 500 ml NS, PPE

*Ensure availability of functional oxygen source with attachments, functional suction machine and functional BP apparatus and stethoscope

Severe PE/E Management Kit

- Mouth gag
- Suction catheter
- IV cannula, IV set, IV fluids (RL)
- Syringes (20 ml, 10 ml, 5 ml)
- Antihypertensive drugs (Labetalol - Tab & Inj., Tab. Nifedipine)
- Inj. Magnesium sulfate - at least 20 ampoules (1 amp = 1 gm)
- 2% xylocaine
- Alcohol swabs
- Adhesive tape
- Antiseptic solution bottle
- Blood and urine collection vials
- Self-retaining catheter, Urobag
- Syringe & distilled water for inflation
- Dry cotton swabs
- Sterile gloves
- Knee hammer
- Inj. Calcium Gluconate

*Ensure availability of functional oxygen source with attachments, functional suction machine and functional BP apparatus and stethoscope

Checklist for Conducting Normal Delivery (II stage of labor), ENBC and AMTSL

S. No.	Task	Cases				
		1	2	3	4	5
1	**Getting ready** • Keep the equipment, supplies and drugs necessary for conducting a delivery ready: **For the provider** • Plastic apron, mask, shoe covers, goggles-1 each • Sterile gloves (no. 6½/7/7½)-2 pairs according to size of provider's hand • Functional light source **For the mother and the baby** • Delivery table with mattress, pillow and disposable/linen sheet, Kellys pad and foot stool • BP instrument and stethoscope- 1 each and functional • Foetoscope-1 • Thermometer-1 • Plastic sheet-1 • Pre-warmed towels for the baby-2 • Clock with second's hand on the wall-1 • Woman's record and partograph • Measuring tape-1 • Adhesive tape-1 • Delivery tray with lid containing: ➢ Sponge holding forceps-1 ➢ Artery forceps-2 and scissors-1 ➢ Urinary catheter (plain)-1 ➢ Cord ligatures-3 or cord clamp-1 ➢ De Lees mucus extractor-1					

	➢ Stainless steel kidney tray 10 inches or SS bowl 10 inches diameter-1 ➢ Pads for mother-4 ➢ Sterile disposable needle and syringe 2 ml-1 ➢ Oxytocin injection-10 IU loaded in the sterile syringe/misoprostol tablets 600 mcg (out of the tray) ➢ Injection Vit. K loaded in a sterile syringe for the baby • IV stand, IV set, normal saline/ringers lactate-1 each **Infection prevention equipment and supplies** • Swabs/pieces of gauze-at least 6-10 • Small bowl for cotton swabs and antiseptic lotion • Antiseptic solution (Povidone Iodine) freshly poured on the swabs • Leak proof container to dispose soiled linen-1 • Puncture proof container to discard needle and syringe-1/needle and hub cutter-1 • Colour coded plastic containers with biodegradable plastic liners to dispose of the placenta, contaminated and biomedical waste-1 each as per government guidelines • Plastic container with 0.5% chlorine solution for decontamination-1 **Baby resuscitation equipment and tray ready for use if required** Radiant warmer switched on half an hour prior to delivery **Sterile episiotomy tray** with its contents should be available in the labour room for use if indicated **Medicine and emergency drug trays** to be available in the labour room and **PPIUCD tray** in the labour room of facilities with PPIUCD trained providers					
	• Allows the woman to adopt the position of her choice					
	• Maintains privacy					
	• Tells the woman and her support person what is going to be done and encourages them to ask questions					
	• Listens to what the woman and her support person have to say					
	• Provides emotional support and reassurance					

2	**Conduction of delivery:** • Removes all the jewelry, watch and puts on a clean plastic apron, mask, goggles and shoes/shoe covers					
	• Places one clean plastic sheet from the delivery kit under the woman's buttocks					
	• Washes hands thoroughly with soap and water, air dries them					
	• Wears sterile gloves on both the hands and cleans the perineal area from above downward with cotton swabs dipped in antiseptic lotion					
	Delivery of the head once crowning occurs: • Keeps one hand gently on the head under the sub-pubic angle as it advances with the contractions to maintain flexion • Supports the perineum with the other hand and covers the anus with a pad held in position by the hand • Tells the mother to take deep breaths and to bear down only during a contraction • Feels gently around the baby's neck for the presence of the umbilical cord, checks: ➢ If the cord is present and is loose around the neck, delivers the baby through the loop of the cord, or slips the cord over the baby's head ➢ If the cord is tight around the neck, places two artery clamps on the cord and cuts between the clamps, and then unwinds it from around the neck					
	Delivery of the shoulders and the rest of the body: • Waits for spontaneous rotation of the head and shoulders and delivery of the shoulders. This usually happens within 1–2 minutes • Applies gentle pressure downwards on the shoulder under the sub-pubic arch to deliver the top (anterior) shoulder • Then lifts the baby up, towards the mother's abdomen, to deliver the lower (posterior) shoulder					

	• The rest of the baby's body follows smoothly by lateral flexion					
	Essential newborn care (ENBC) and initiation of Active management of third stage of labour (AMTSL): • Notes the sex and time of birth					
	• Places the baby on the mother's abdomen in a prone position with face to one side					
	• Looks for breathing or crying of the baby. If the baby is breathing or crying*****, proceeds immediately to dry the baby with a pre-warmed towel or piece of clean cloth. (Does not wipe off the white greasy substance–vernix, covering the baby's body)					
	• After drying, discards the wet towel or cloth after wiping the mother's abdomen also • Wraps the baby loosely in another clean, dry and warm towel. If the baby remains wet, it leads to heat loss					
	• **Initiates AMTSL:** Palpates the mother's abdomen to feel for foetal parts to exclude the presence of another baby to initiate the active management of third stage of labour • **A. Uterotonic drug:** Gives 10 units Oxytocin IM in the anterolateral aspect of the woman's thigh if she is at the health facility (preferred) or gives misoprostol tablets (600 mcg that is 3 tablets of 200 mcg each or a single tablet of 600 mcg) if it is a home delivery and oxytocin is not available • **Completes drying and wrapping of the crying baby and giving injection Oxytocin within the first minute after birth of the baby**					
	• **Continues ENBC:** Checks for cord pulsations • Clamps the cord with artery clamps at two places when cord pulsations stop. Puts one clamp on the cord at least 3 cms away from the baby's umbilicus and the other clamp 5 cms from the baby's umbilicus. • Cuts the cord between the artery clamps with a sterile scissors by placing a sterile gauze over the cord and scissors to prevent splashing of blood • Applies the disposable sterile plastic cord clamp tightly on					

	the cord 2 cms away from the umbilicus just before the artery clamp (instrument) and removes the artery clamp on the side of the baby's abdomen; gently places and directs the other clamped cord end towards the contaminated waste bin under the labour table to avoid spillage • (In the absence of sterile disposable cord clamp, ties, clean thread ties tightly around the cord at approximately 2-3 cm and 5 cms from the baby's abdomen and cuts between the ties with a sterile, clean blade. If there is oozing, places a second tie between the baby's skin and the first tie) • Places the baby between the mother's breasts for warmth and skin to skin care. Tells the mother or the attendant to hold the baby in place to prevent falling • Puts the identification tag on the baby. Covers the baby's head with a cloth. Covers the mother and the baby with a warm cloth.					
3	**Continues active management of third stage of labour (AMTSL):** • **B. Controlled cord traction (CCT):** (attempts only when the uterus is contracted) ➢ Assures the woman that delivering the placenta will not hurt, because it is much smaller and softer than the baby ➢ Clamps the maternal end of the umbilical cord close to the perineum with an artery clamp					
	➢ Holds the clamped end with one hand and places the other hand just above the symphysis pubis, for counter traction on the uterus to prevent inversion ➢ Holds the cord with the help of the clamp and waits for a contraction ➢ Only during contractions, gently pulls the cord downwards and then downwards and forwards to deliver the placenta ➢ With the other hand, pushes the uterus upwards by applying counter traction. (If the placenta does not descend within 30-40 seconds of CCT, does not continue to pull on the cord. Waits for about 5 more minutes for					

	the uterus to contract strongly, then repeats CCT with counter traction) ➢ As the placenta appears at the vaginal introitus, holds it with both hands and twists it clock wise to deliver it complete and prevents tearing of the membranes ➢ Gently keeps twisting the placenta with membranes so that they get twisted in to a rope and are expelled and slip out of the introitus intact and complete ➢ Places the placenta in a tray					
	• **C. Uterine massage:** ➢ Places the cupped palm on the uterine fundus and feels for the state of contraction ➢ If the uterus is soft and not-contracted, massages the uterine fundus in a circular motion with the cupped palm until the uterus is well contracted. A well contracted uterus feels like a cricket ball or the forehead ➢ When the uterus is well contracted, places her fingers behind the fundus and pushes down in one swift action to expel clots ➢ Estimates and records the amount of blood loss approximately ➢ Encourages the attendant to help the woman to breast feed					
	• **Examination of the lower vagina and perineum.** ➢ Ensures that adequate light is falling on the perineum ➢ With gloved hands, gently separates the labia and inspects the perineum and vagina for bleeding, laceration/tears ➢ If lacerations/tears are present, manages them as per the protocols (will be dealt with in detail during PPH) ➢ Cleans the vulva and perineum gently with warm water or an antiseptic solution and dries with a clean soft cloth ➢ Places a pad or clean, sun-dried cloth on the woman's perineum ➢ Removes soiled linen to make the woman comfortable and shifts her up to lie comfortably on the delivery table					

	• **Examination of the placenta, membranes and the umbilical cord:** • Maternal surface of the placenta: ➢ Holds the placenta in the palms of the hands, keeping the palms flat. Makes sure the maternal surface is facing up ➢ Checks if all the lobules are present and fit together ➢ After the maternal side has been rinsed carefully with water, it should shine because of the decidual covering ➢ If any of the lobes is missing or the lobules do not fit together, suspects that some placental fragments may have been left behind in the uterus • Foetal surface: ➢ Holds the umbilical cord in one hand and lets the placenta and membranes hang down like an inverted umbrella ➢ Looks for holes which may indicate that a part of the lobe has been left behind in the uterus ➢ Looks for the point of insertion of the cord, the point where it is inserted into the membranes and from where it travels to the placenta • Membranes : ➢ Puts one hand inside the membranes to open them and see for any holes or irregular edges other than the one from where the membranes ruptured and the baby came out ➢ Places the membranes together and makes sure that they are complete • Umbilical cord: ➢ Inspects the umbilical cord for two arteries and one vein. If only one artery is found, looks for congenital malformations in the baby					
	• **Decontamination and disposal of waste:** ➢ Disposes the placenta in the yellow coloured contaminated waste bin after removing the artery clamp ➢ Places the instruments used in 0.5% chlorine solution for 10 minutes for decontamination ➢ Decontaminates or disposes of the syringes and needles					

	➢ Immerses both the gloved hands in 0.5% chlorine solution o Removes the gloves by turning them inside out o For disposing of the gloves, places them in a leak proof container or red plastic bin o If the surgical gloves are to be re-used, submerges them in 0.5% chlorine solution for 10 minutes to decontaminate them					
	• Washes hands thoroughly with soap and water and air dries • Completes the records of the woman					
*	**Prepare for newborn resuscitation (NBR) if required:** Immediately after birth- • Prepare for newborn resuscitation (NBR) if required: Immediately after birth- • If the baby is not crying or not breathing, irrespective if the meconium is present or not, quickly applies suction to the mouth and then the nose to clear the airways while the baby is on the mother's abdomen and quickly dries the baby with the warm towel • **Assesses the baby's breathing:** • If the baby starts breathing well and the chest is rising regularly, between 30–60 times a minute, provides routine care • If the baby is still not breathing or is gasping, calls for help. Clamps the cord immediately, even before 1 minute and asks the co-provider to take the baby to the radiant warmer at the NBCC in the LR for further suction and resuscitation with bag and mask while she manages the third stage of labour • The steps of resuscitation (as described in the checklist for NBR) need to be carried out immediately					
	Immediate care of mother after delivery (within 2 hours of delivery- in or near the labour room): • Checks the uterus and vaginal bleeding at least every 15 minutes for the first 2 hours, massaging as and when necessary to keep it hard. Makes sure the uterus does not become soft (relaxed) after massage is discontinued. Ensures, the mother is comfortable and her vitals are normal.					
	• Ensures the baby is breathing normally. Checks weight of the baby and gives injection Vitamin K intramuscular, 1 mg to > 1000 gms baby and 0.5 gm to the baby weighing < 1000 gms in the anterolateral thigh to prevent haemorrhagic disease of the newborn. • If both mother and baby are normal shift them together to the postpartum ward.					

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Active Management of Third Stage of Labour (AMTSL)

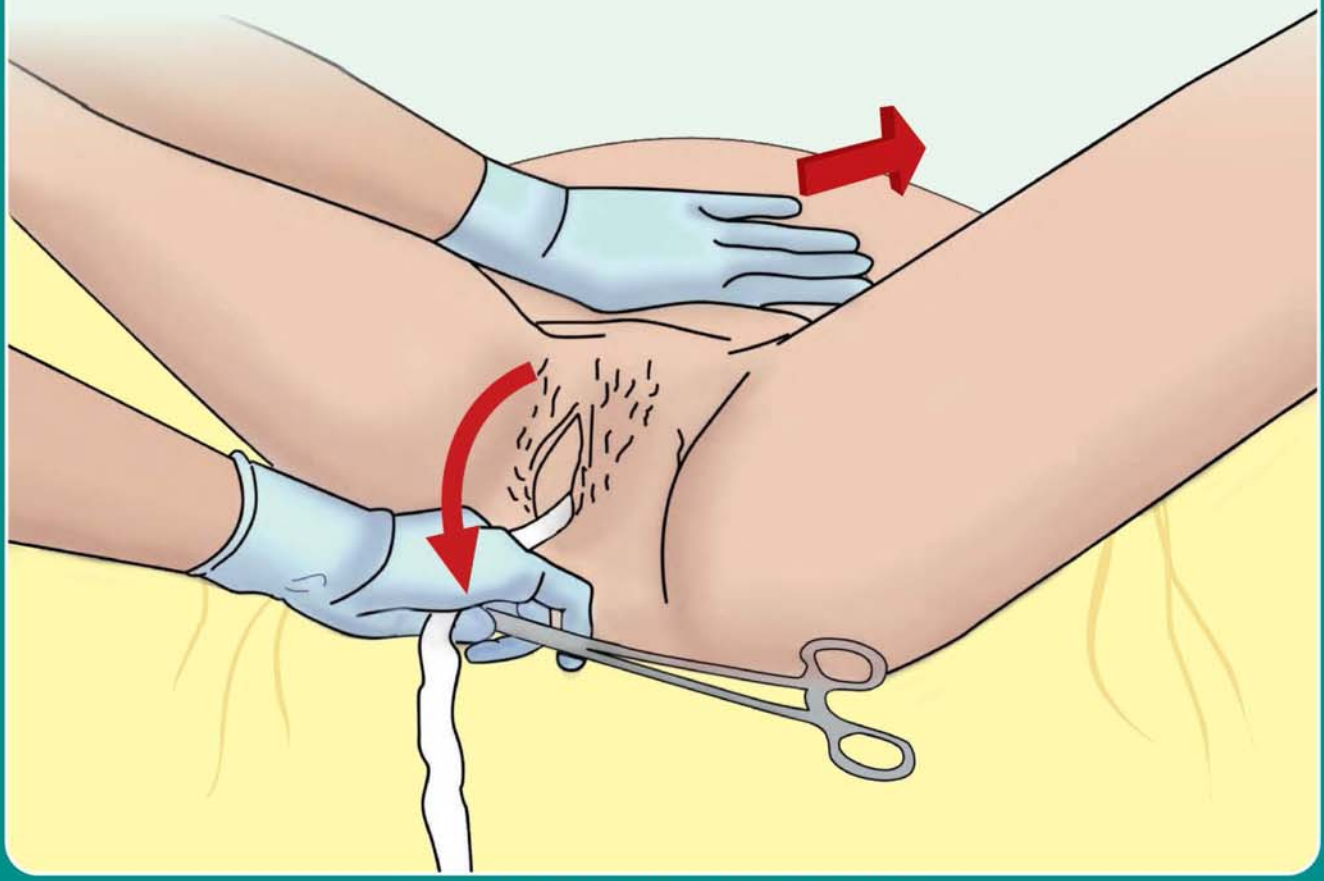
NATIONAL HEALTH MISSION

- Mandatory for all deliveries (vaginal and abdominal)
- Exclude presence of another baby after delivery of first baby

Step 1 Inj. Oxytocin 10 units IM immediately after birth

Step 2
- Controlled cord traction once uterus is contracted and cord is cut
- Apply cord traction (pull) downwards and give counter-traction with other hand by pushing uterus up towards umbilicus

Step 3 Uterine massage to keep uterus contracted



For use in medical colleges, district hospitals and FRUs

Use of Injection Vitamin K Prophylaxis in Newborns

Who
will receive?

All newborns delivered in the facilities at all levels (both public and private)

Preparation
to be used

Injection Vitamin K1 (Phytonadione):

a) 1 mg/1 ml
b) 1 mg/0.5 ml

Dose
to be given

- Birth weight 1000 gm or more: 1 mg
- Birth weight less than 1000 gm: 0.5 mg

Site and route
of injection

- Antero-lateral aspect of the thigh, intramuscular injection

Who
will give?

- Medical Officer, staff nurse or ANM

Where
it will be given

- In labour room
- It can be given in post-natal ward if missed in labour room
- In case of referral the injection should be given at the SNCU/NBSU

When
it will be given

- Soon after delivery, ensuring skin-to-skin contact with mother and initiation of breast feeding
- Not later than 24 hours of birth

Logistics
required

- 26 gauze needle and 1 ml syringe

Storage

- Room temperature in a dry place

Recording

- Labour room register
- Case sheet
- Referral slips
- Discharge ticket of the newborn

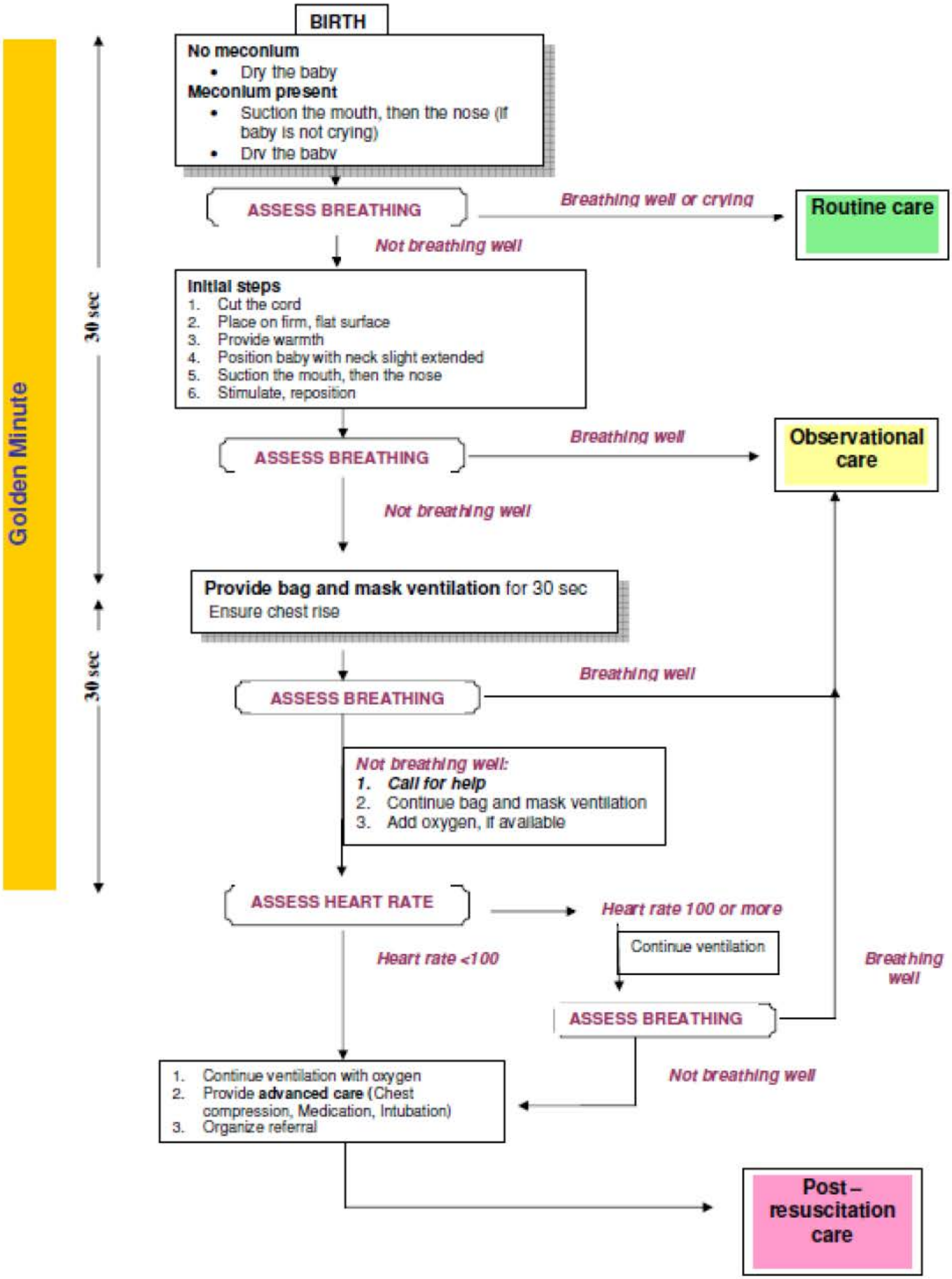
(Day 2) 20

Checklist for Newborn Resuscitation

S.NO	Task	Yes/No	Remarks
1	Getting ready with : ▪ Bag and masks (Sizes '0' and '1') ▪ Suction equipment ▪ Radiant warmer or other heat source ▪ Warm towels-2 ▪ Clock with seconds hand ▪ Oxygen source ▪ Gloves ▪ Shoulder roll ▪ Cord tie ▪ Scissor		
2	Look for breathing, if not and l**iquor meconium stained**, suck mouth and nose at the mother's abdomen		
3	Dry the baby, remove wet towel by cleaning the mothers' abdomen also and wrap baby in warm dry towel		
4	Assess breathing, if not breathing or difficulty in breathing then-		
5	Cut the cord immediately		
6	Place the baby on a warm, firm flat surface (Radiant Warmer)		
7	**P**osition the baby in slight neck extension using a shoulder roll **S**uction of mouth and nose **S**timulate the baby **R**eposition and reassess breathing		
8	If not breathing provide bag and mask ventilation for 30 seconds, make sure that the		

	chest rises.		
9	Reassess the baby after 30 seconds of ventilation.		
10	If still not breathing continue bag and mask ventilation, start oxygen and assess the heart rate.		
11	If the baby is still not breathing, continue bag and mask ventilation and refer to higher center		
12	At any point if baby starts breathing, provide observational care		

Flow Diagram for Basic Neonatal Resuscitation



(Day 2) 22

Checklist for Breast Feeding

S.No.	Steps	Observations
1	Advice mother to sit or lie in comfortable position and help the mother to initiate breastfeeding	
2	Advice for cleaning of nipples and breasts	
3	Describe and demonstrate rooting reflex	
4	Describe and ensure correct position • Baby's body is well supported • The head, neck and body of baby are kept in the same plane • Entire body of baby faces mother • Baby's abdomen touches mother's abdomen	
5	Describe and ensure good attachment • Baby's mouth is wide abdomen • Lower lip is turned out • Chin is touching mother's breast • Larger area of areola is visible above than below	
6	Describe and ensure effective suckling-Slow deep sucks with pauses	
7	Advice burping after breastfeeding	
8	Inform the mother regarding frequency of feeding (at least 8 times in 24 hours including night feeds) and importance of emptying the breasts and hind milk	
9	Inspect breasts for sore nipples, cuts and engorgement	
10	Counsel on advantages of colostrum feeding and reinforce exclusive breastfeeding	
11	Counsel regarding correct diet, adequate rest and stress free environment	

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Breastfeeding

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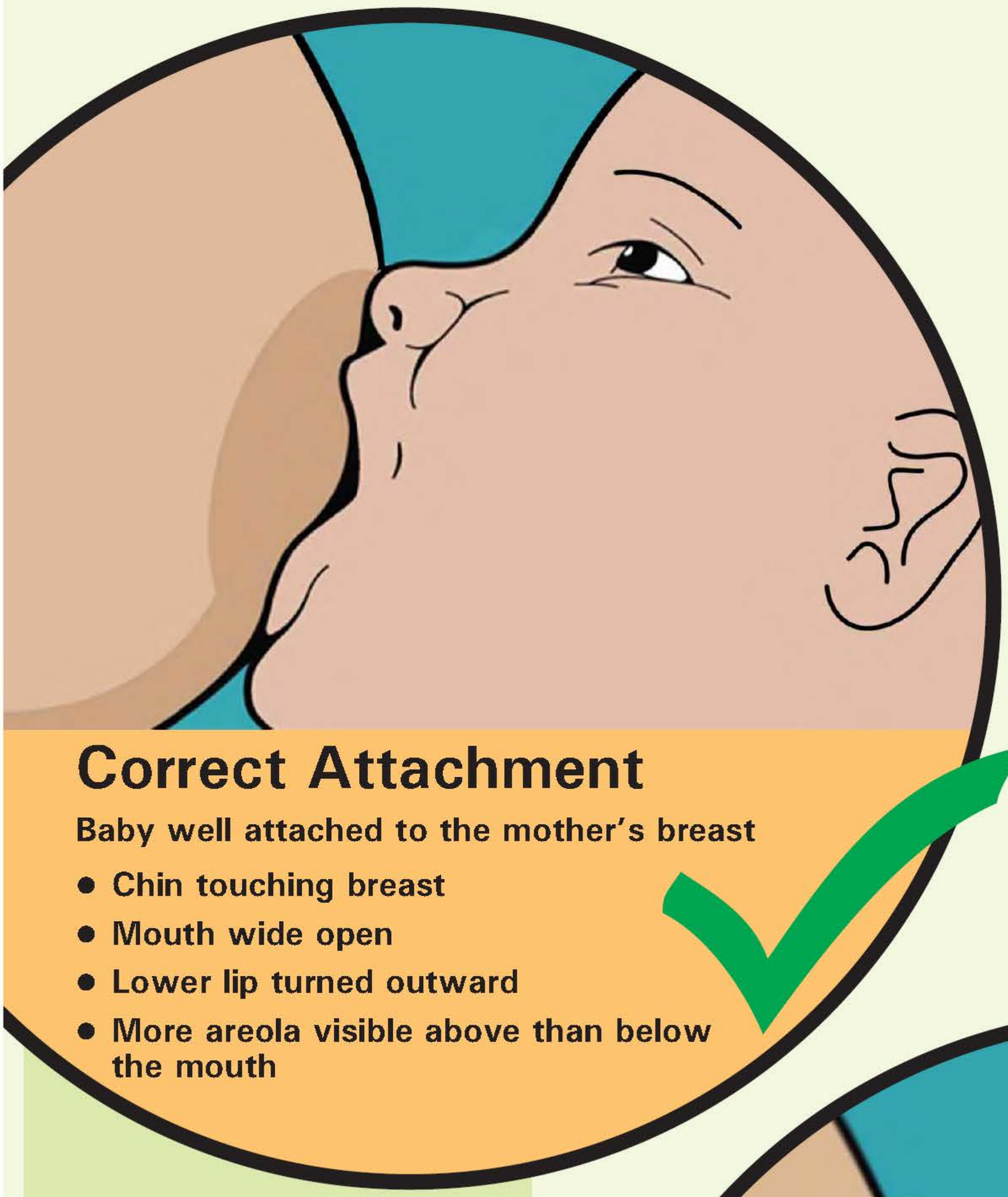


Correct Attachment

Baby well attached to the mother's breast

- Chin touching breast
- Mouth wide open
- Lower lip turned outward
- More areola visible above than below the mouth

- **Start breastfeeding within 1 hour of delivery**
- **Feed on demand**
- **Feed completely on one breast, then shift to other breast**

Exclusive breastfeeding for 6 months; continue breastfeeding for 2 years

Wrong Attachment

Baby poorly attached to the mother's breast

For use in medical colleges, district hospitals and FRUs

Checklist for Management of PPH Due to Retained Placenta

Situation: You are alone in a rural health facility, you gave a uterotonic medication within 1 minute of delivery, and have provided controlled cord traction during contractions and monitored your patient's bleeding for the past 30 minutes. She remains stable, but continues to bleed slowly, and her placenta has not delivered.

S.No.	Task	Cases				
		1	2	3	4	5
1	Provide controlled cord traction with each contraction					
2	Guard uterus while providing controlled cord traction					
3	Identify that the placenta may be retained					
4	Give a second dose of medication telling what dose, route and why (IV drip with Injection oxytocin 20 units in 1000 ml of Ringer Lactate at 40-60 drops per minute)					
5	Identify that the patient must be transported					
6	The baby will be kept with the mother					
7	Communicate respectfully and provide needed information to the mother throughout					
8	Plan to transport mother and baby to higher centre					

Checklist for Management of PPH due to Atonic Uterus

Situation: You are alone in a rural facility. You have given 10 units of oxytocin IM and performed controlled cord traction with 3 contractions resulting in delivery of the placenta. The uterus never contracts and bleeding starts out moderate, then increases

S.No.	Task	Cases				
		1	2	3	4	5
1	Massage the uterus					
2	Check the woman's bleeding					
3	Inspect the placenta for completeness and any missing pieces					
4	Re-check the tone of uterus and bleeding					
5	Give a second dose of medication telling what dose, route and why (IV drip with Injection oxytocin 20 units in 1000 ml of Ringer Lactate at 40-60 drops per minute)					
6	Re-check bleeding and uterine tone					
7	Ensure that the urinary bladder is empty/catheterize if bladder is full					
8	Put on long gloves					
8	Explain to patient that you will be providing bi-manual compression					
9	Provide bi-manual compression					
10	Make the decision to transfer					
11	Explain to the patient about the need to be transported for advanced care as she is at risk for complications that cannot be treated at this local facility, or is "too high risk", or "might bleed again", or may need blood transfusion					

CHECKLIST FOR INTERNAL BIMANUAL COMPRESSION OF THE UTERUS

(To be used by the **Facilitator/Teacher** at the end of the module)

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

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

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

guidelines **Not Observed**: Step or task not performed by learner during evaluation by facilitator

PARTICIPANT_____**DATE OBSERVED** _____

CHECKLIST FOR INTERNAL BIMANUAL COMPRESSION OF THE UTERUS (Many of the following steps/tasks should be performed simultaneously.)					
STEP/TASK	**CASES**				
GETTING READY					
1. Tell the woman (and her support person) what is going to be done, listen to her and respond attentively to her questions and concerns.					
2. Provide continual emotional support and reassurance, as feasible.					
3. Put on personal protective barriers.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
BIMANUAL COMPRESSION					
1. Wash hands thoroughly and put on high-level disinfected or sterile surgical gloves.					
2. Clean vulva and perineum with antiseptic solution.					
3. Insert fist into anterior vaginal fornix and apply pressure against the anterior wall of the uterus.					
4. Place other hand on abdomen behind uterus, press the hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.					
5. Maintain compression until bleeding is controlled and the uterus contracts.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POSTPROCEDURE TASKS					
1. Remove gloves and discard them in leak-proof container or plastic bag if disposing of or decontaminate them in 0.5% chlorine solution if reusing.					
2. Wash hands thoroughly.					
3. Monitor vaginal bleeding, take the woman's vital signs and make sure that the uterus is firmly contracted.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

(Day 2) 25.B

Checklist for Condom Tamponade

STEPS	CASES				
PREPARATION					
1. Prepares all necessary equipment. All instruments and materials should be sterile. Connects infusion bag that will be used to inflate the condom, to IV catheter.					
2. Tells the woman (and her support person) what is going to be done, listens to her and responds attentively to her questions and concerns.					
3. Provides emotional support and reassurance, as feasible.					
4. Ensures the bladder is empty. Catheterizes it if necessary.					
5. Gives prophylactic antibiotics.					
6. Puts on all personal protective barriers.					
INSERTION AND INFLATION					
1. Washes hands and forearms thoroughly and puts on sterile (use elbow-length gloves, if available).					
2. Places condom over the Foley's catheter leaving a small portion of the condom beyond the tip of the catheter.					
3. Using sterile suture or string, ties the lower end of condom snugly on the Foley's catheter. Tie should be tight enough to prevent leakage of saline solution but should not strangulate catheter and prevent inflow of water.					
4. Places a Sims speculum in the posterior vaginal wall. Holds the cervix with the sponge or ring forceps. Using an aseptic technique, places the condom's end high into uterine cavity, past the cervical canal and internal os with aid of a forceps.					
5. Connects outlet of Foley's catheter to IV set which has been connected to infusion bag. Inflates condom with saline to about 300-500 ml (or to amount at which no further bleeding is observed).					
6. Folds over the end of the catheter and ties when desired volume is achieved and bleeding is controlled.					

7. Maintains it in-situ for 12-24 hours if bleeding is controlled and client is stable.					
8. Continues uterotonic infusion: 20 IU Oxytocin in 1000 ml saline solution, 60 drops/minute.					
9. Continues to monitor the client closely for first 2 hours (vital signs, urinary output, uterine tone, vaginal bleeding), every 30 minutes for 3-4 hours, and then every hour for next 5-6 hours. - Resuscitates and/or treats shock, if necessary.					
10. Places a pen mark on the abdomen at the level of uterine fundus. - Any increase in uterine size above this mark, along with changes in vital signs, suggests that blood is accumulating within the uterine cavity above the tamponade.					
11. If bleeding is not controlled within 15 minutes of initial insertion of condom tamponade, abandons the procedure and seeks surgical intervention immediately. - The inflated uterine tamponade should remain in place until surgical interventions are available. - Mobilizes to higher center if surgical facilities not available					
DEFLATION					
1. When no further bleeding has occurred and the client has been stable for at least 12 hours, slowly deflates the condom by letting out 200 ml of saline every hour.					
2. Re-inflates it to the previous level if bleeding reoccurs whilst deflating, and considers surgical intervention.					
POST-PROCEDURE TASKS					
1. Removes gloves and discards them in appropriate bag.					
2. Washes hands and forearms thoroughly.					
3. Regularly monitors vaginal bleeding. Takes the woman's vital signs and makes sure that the uterus is firmly contracted.					
4. Documents the procedure and all the parameters in woman's case record.					

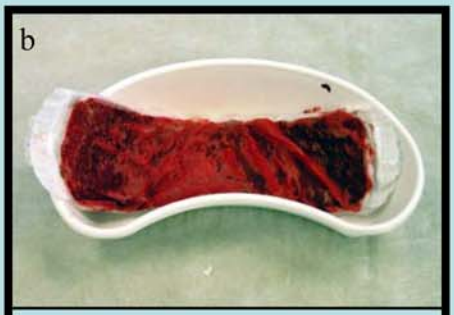
A Pictorial Reference Guide to Aid Visual Estimation of Blood Loss at Obstetric Haemorrhage: Accurate Visual Assessment is Associated with Fewer Blood Transfusions

Dr Patrick Bose, Dr Fiona Regan, Miss Sara-Paterson Brown

a

Soiled Sanitary Towel
30ml

b



Soaked Sanitary Towel
100ml

c

Small Soaked Swab 10x10cm
60ml

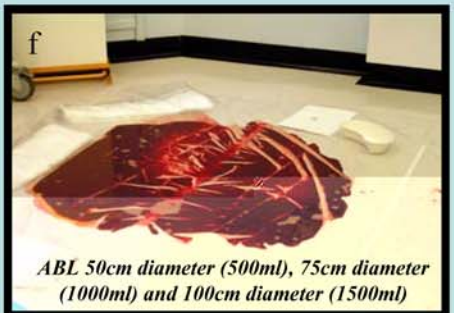
d

Incontinence Pad
250ml

e

Large Soaked Swab 45x45cm
350ml*

f



100cm Diameter Floor Spill
1500ml*

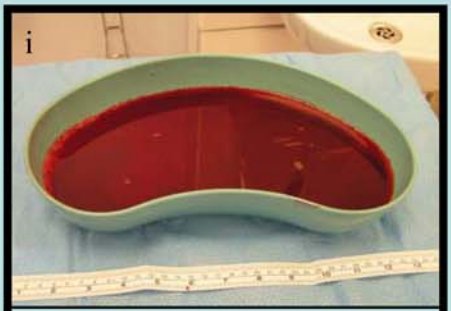
g

PPH on Bed only
1000ml

h

PPH Spilling to Floor
2000ml

i



Full Kidney Dish
500ml

***Multidisciplinary observations of estimated blood loss revealed that scenarios (e-f) are grossly underestimated (> 30%)**

For Further Information please contact Miss Sara Paterson-Brown
Delivery suite, Queen Charlottes Hospital, London

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Management of PPH

- Shout for help, Rapid Initial Assessment - evaluate vital signs: PR, BP, RR and Temperature
- Establish two I.V. lines with wide bore cannulae (16-18 gauge)
- Draw blood for grouping and cross matching
- If heavy bleeding P/V, infuse RL/NS 1 L in 15-20 minutes
- Give O_2 @ 6-8 L /min by mask, Catheterize
- Check vitals and blood loss every 15 minutes, monitor input and output

↓

- Give Inj. Oxytocin 10 IU IM (if not given after delivery)
- Start Inj. Oxytocin 20 IU in 500 ml RL @ 40-60 drops per minute
- Check to see if placenta has been expelled

Placenta not delivered

- Continue Oxytocin
- Do P/V examination to rule out inversion of uterus
- Attempt controlled cord traction

Placenta not delivered
- Do manual removal of placenta under anesthesia
- Give IV antibiotics

Placenta delivered
- Continue uterine massage and Oxytocin drip

Placenta delivered

- Massage uterus
- Examine placenta and membranes for completeness (if available)
- Explore uterus for retained placental bits – if present, evacuate uterus

P/A for uterine consistency

Uterus well contracted (Traumatic PPH)
- Look for cervical/ vaginal/ perineal tear - repair tear, continue Oxytocin
- Scar dehiscence / rupture uterus – Laparotomy

Uterus soft flabby (Atonic PPH)

Manage as Atonic PPH Chart

If bleeding continues check for Coagulopathy

Blood transfusion if indicated

For use in medical colleges, district hospitals and FRUs

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Management of Atonic PPH

- Placenta expelled, uterus soft and flabby
- Traumatic causes excluded

↓

- Shout for help, Rapid Initial Assessment to evaluate vital signs: PR, BP, RR and Temperature
- Establish two I.V. lines with wide bore cannulae (16-18 gauge)
- Draw blood for grouping and cross matching
- If heavy bleeding, infuse NS/RL 1L in 15-20 minutes
- Give O_2 @ 6-8 L /min by mask, Catheterize
- Check vitals & blood loss every 15 minutes, Monitor input & output

↓

- Perform continuous uterine massage
- Give Inj. Oxytocin 20 IU in 500 ml RL/ NS @ 40 drops/minute
- Do not give Inj. Oxytocin as IV bolus

↓

Uterus still not contracted

↓ If bleeding P/V not controlled

Inj Ergometrine* 0.2 mg IM or IV slowly (contraindicated in high BP, severe anemia, heart disease)

↓

Inj Carboprost* (PGF2) 250 µg IM (contraindicated in Asthma)

↓ If bleeding P/V not controlled

Tab Misoprostol (PGE1) 800 µg Per rectal

↓

Bleeding not controlled by drugs

↓

Explore uterine cavity for retained placental bits

↓

- Perform bimanual compression
- If fails perform compression of abdominal aorta

↓

- Check for coagulation defects
- If present give blood products

Uterine Tamponade (Indwelling Catheters/ Condom/ Sangstaken tube/ Ribbon gauze packing) as life saving measure

Surgical intervention
- Uterine compression suture (B-Lynch)
- Uterine/Ovarian A ligation
- Hysterectomy

Bleeding controlled by drugs

↓

- Repeat uterine massage every 15 minutes for first 2 hours
- Monitor vitals closely every 10 minutes for 30 minutes, every 15 minutes for next 30 minutes and every 30 minutes for next 3-6 hours or until stable
- Continue Oxytocin infusion (Total Oxytocin not to exceed 100 IU in 24 hours)

• Continue vital monitoring • Transfuse blood if indicated • Monitor Input/ Output

* Wherever needed

Inj. Ergometrine can be repeated every 15 minutes (max 5 doses = 1 mg)

Inj Carboprost can be repeated every 15 minutes (max 8 doses = 2 mg)

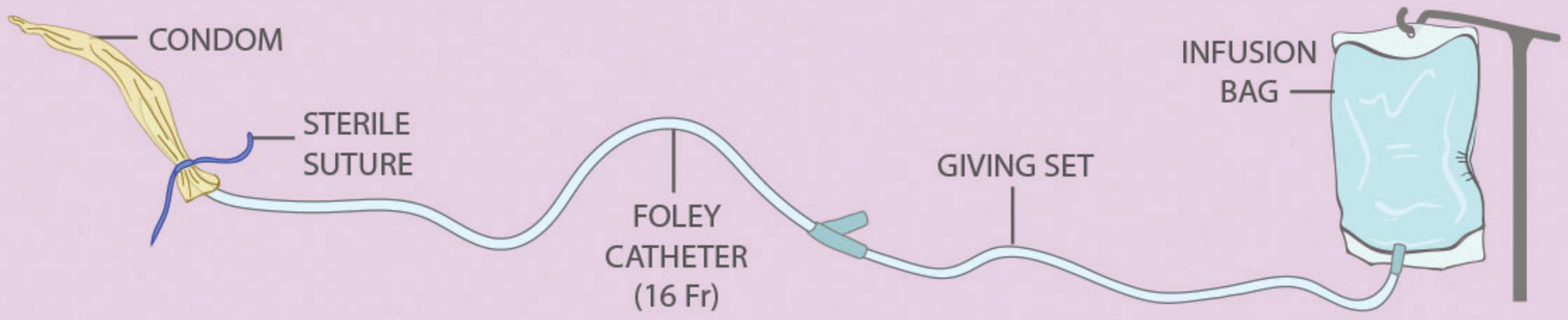
For use in medical colleges, district hospitals and FRUs

Uterine Balloon Tamponade to Treat Postpartum Hemorrhage

innovating to save lives
Jhpiego
an affiliate of Johns Hopkins University

Preparation Kit

Use sterile suture to tie lower end of condom snugly on Foley catheter.



Insertion

Use aseptic technique.

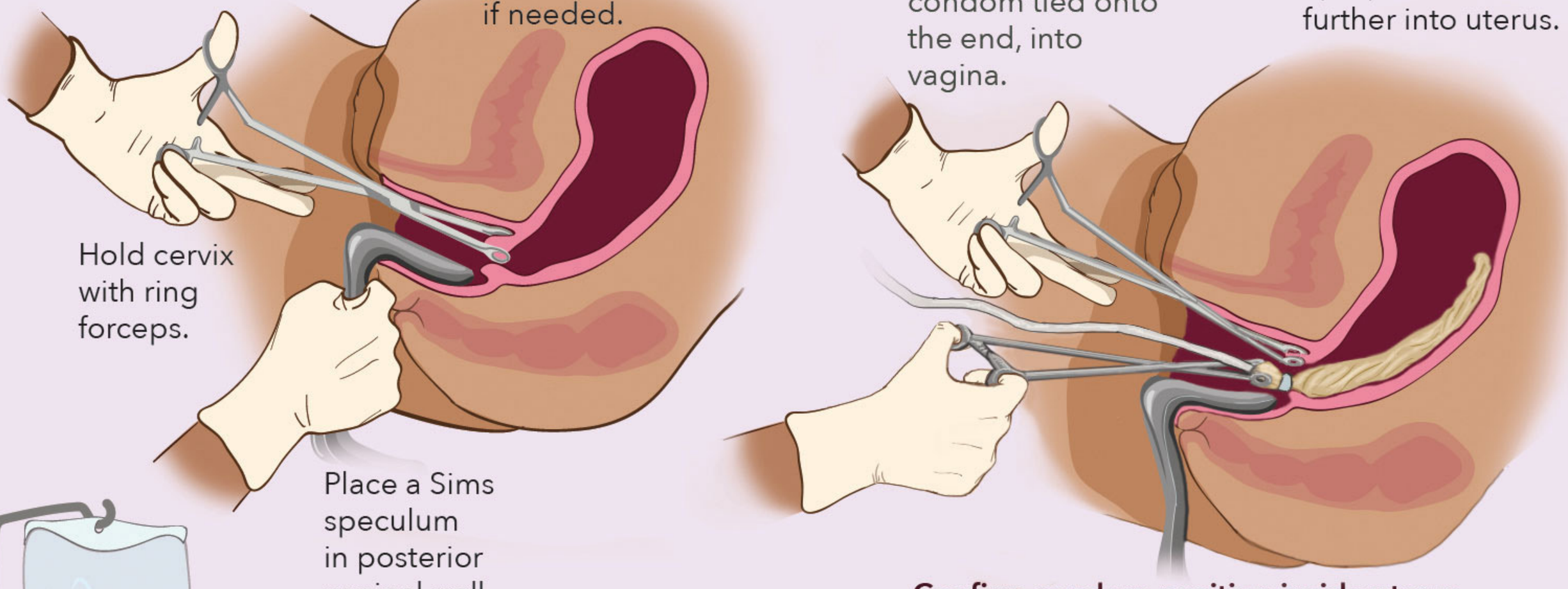
Ensure bladder is empty, use catheter if needed.

Hold cervix with ring forceps.

Place a Sims speculum in posterior vaginal wall.

Insert catheter with condom tied onto the end, into vagina.

Holding cervix with forceps, push condom further into uterus.

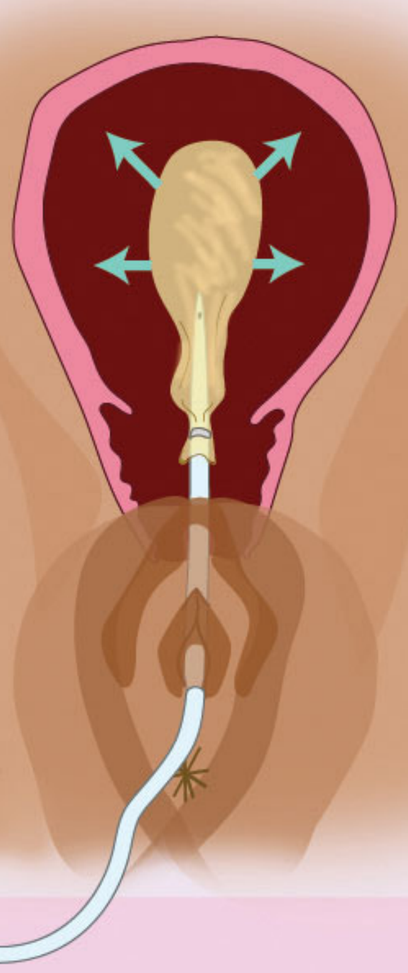


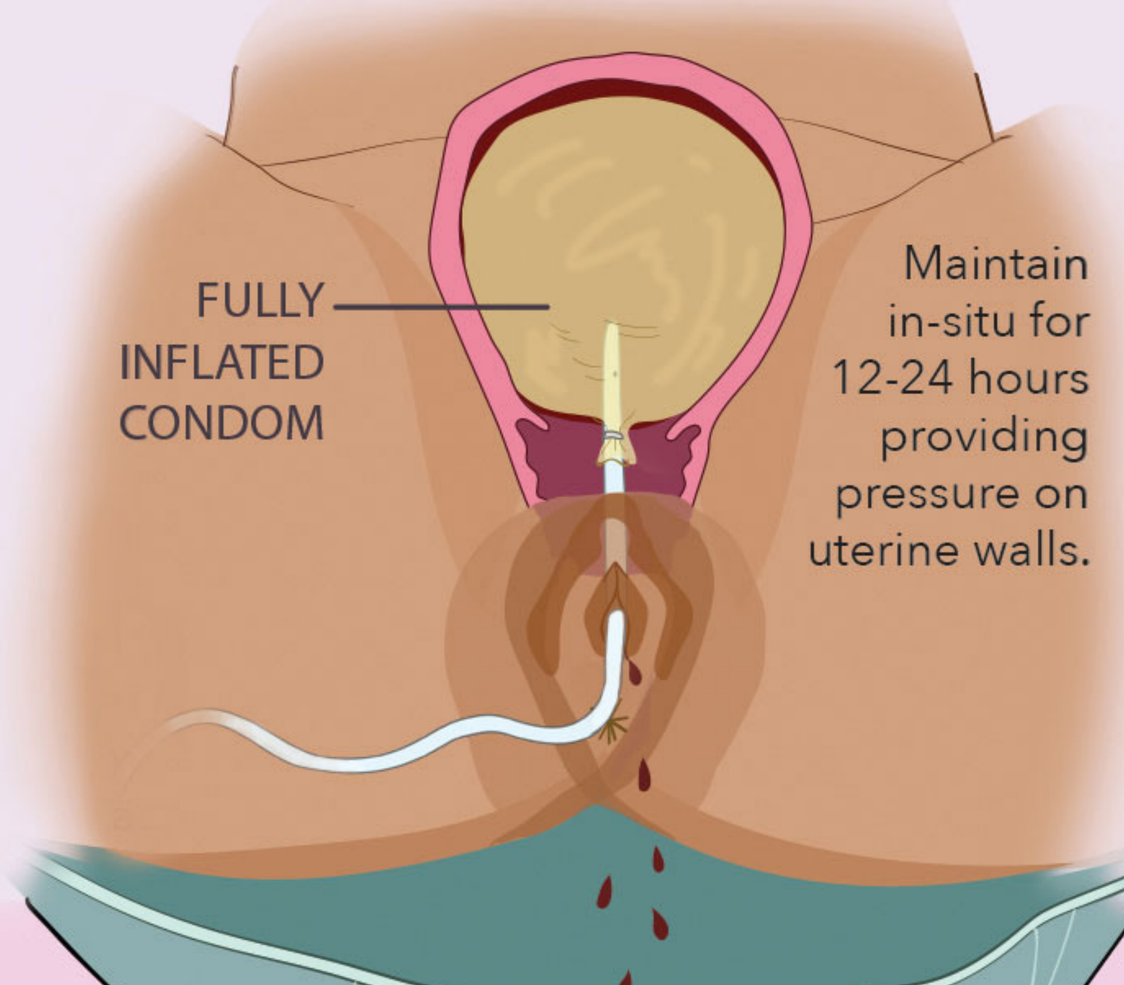
Confirm condom position inside uterus.

Inflation

Connect open end of catheter to giving set, attached to infusion bag.

Inflate condom with 300-500 mL of saline.





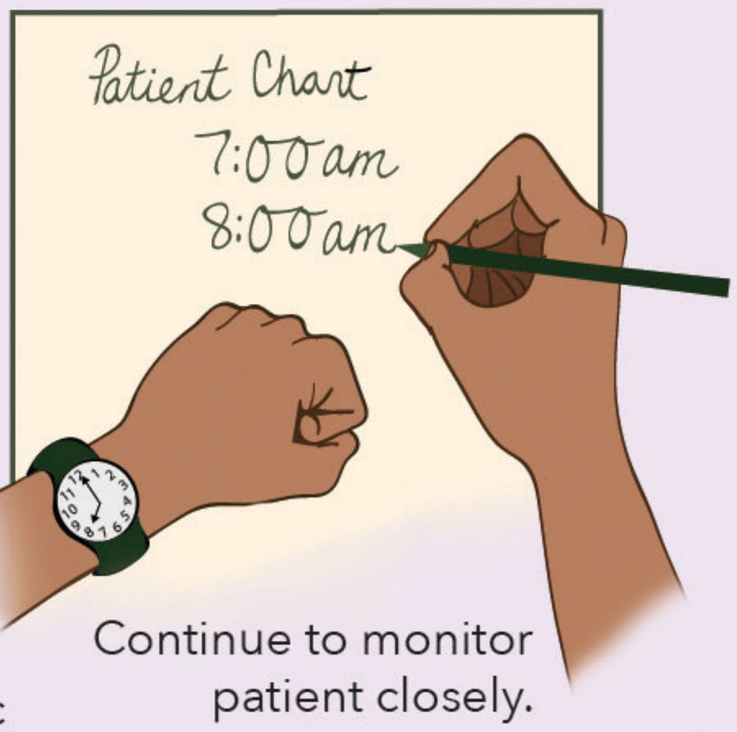
Maintain in-situ for 12-24 hours providing pressure on uterine walls.

Deflation

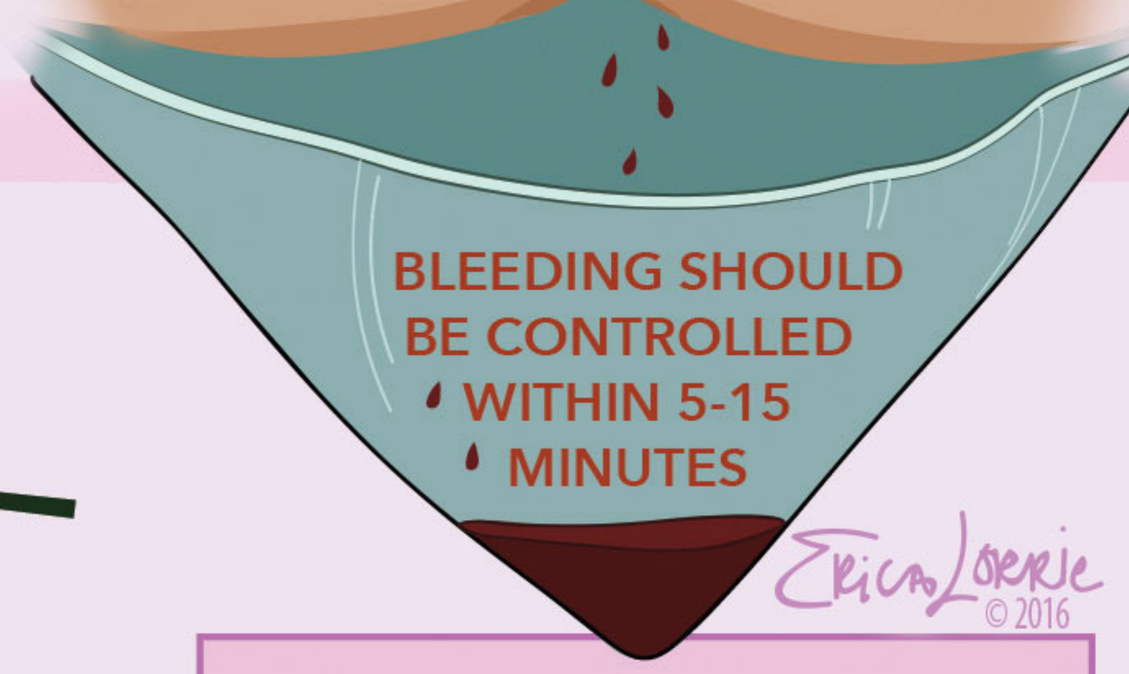
When patient is stable, slowly deflate condom by letting out 200 mL of saline every hour, recording each time.

Re-inflate condom if bleeding reoccurs while deflating.

Give broad spectrum antibiotic to prevent intrauterine infection.



Continue to monitor patient closely.



IF BLEEDING PERSISTS

and is not controlled within 15 minutes of initial insertion, abandon procedure and seek surgical intervention immediately.

Preventing Complications in Newborns

Tips for preventing hypothermia in newborns

- Regularly monitor the temperature of the baby. Temperature below 36.5 ^{0}C is a cause of concern
- Maintain temperature of labor room at around 25 ^{0}C
- Dry the baby immediately after birth and wrap the baby in a pre-warmed towel
- In case new-born resuscitation is required, always perform it under a heat source i.e., radiant warmer
- Keep the baby in skin to skin contact with mother as long as possible
- Initiate breast feeding as early as possible
- Keep the baby adequately covered (cap, socks, etc.)
- Postpone the bathing of baby for at least 24 hours and at least for seven days for preterm and LBW babies
- In case there is need for transportation, maintain warmth of the baby

Tips for preventing infection in newborns

- Appropriately manage maternal infections and use prophylaxis wherever needed
- Use of Partograph
- Do not do un-necessary PV examination
- Maintain “Six Cleans” during delivery
- Perform hand hygiene every time before handling the baby
- Early initiation of breast feeding and exclusive breast feeding, avoid pre-lacteal feeds
- Dry cord care
- Avoid unnecessary interventions for the baby like routine suctioning of every newborn

Tips for preventing asphyxia in newborns

- Monitoring the labor progress through plotting of partograph
- Emotional support with birth companions
- Use of ANCS in pre-term births
- Appropriate management of pre-eclampsia/eclampsia
- Avoid un necessary augmentation of labor
- Maintain hydration of mothers at all times
- Allow mother to assume left lateral position during labor
- Ask mother to push only during contractions
- Ask mothers take deep breaths in between contractions
- Do not apply fundal pressure during labor

Checklist for KMC

SI NO	Task	Cases				
		1	2	3	4	5
1.	Counsels the mother, Provides privacy to the mother. Requests the mother to sit or recline comfortably					
2.	Undresses the baby gently, except for cap, nappy and socks.					
3.	Places the baby prone on mother's chest in an upright position with the head slightly extended, between her breasts in skin to skin contact in a frog like position; turns baby's head to one side to keep airway clear. Supports the baby's bottom with a sling/binder.					
4.	Covers the baby with mother's 'pallu' or gown; wraps the baby-mother duo with an added blanket or shawl depending upon the room temperature					
5.	Advises mother to breastfeed the baby frequently					
6.	Ensures warm room with room temperature maintained between 26 – 28^0 C.					
7.	Advises the mother to provide KMC for at least 1 hour per session. The length of skin-to-skin contact should be for as long as possible					

Key Points

1. Eligibilty criteria for KMC
   - All LBW babies.
   - Baby stable and doesn't require special care (e.g. oxygen or IV fluid): begin continuous KMC
2. The two components of KMC are:
   - Skin-to-skin contact
   - Exclusive breastfeeding
3. The two prerequisites of KMC are:
   - Support to the mother in hospital and at home
   - Post-discharge follow up
4. Benefits of KMC
   - Reduces risk of hypothermia
   - Promotes lactation and weight gain
   - Reducing infections and hospital stay
   - Better bonding between mother and newborn

Time of Initiation of KMC

Birth Weight**

Less than 1200 gram	More than 1200 upto less than 1800 grams	More than 1800 upto less than 2500 grams
Most infants suffer from serious morbidities, therefore birth should take place in specialized centres	• Many infants suffer from serious morbidities • Transfer to a specialized centre, if possible • Best transported in STS with mother/family member (if transport incubator not available)	Generally stable at birth
May take days to weeks before KMC can be initiated	May take days before KMC can be initiated	KMC can be initiated immediately after birth

(Day 2) 32.A

Checklist for EBM technique and katori-spoon/paladai feeding

S No.	Task	Cases				
		1	2	3	4	5
1.	**Technique of expressing breast milk by hand:** • Obtains a clean (washed, boiled or rinsed with boiling water and air dried) katori, cup or container to collect and store the milk • Washes her hands with soap and water thoroughly before expression • Sits or stands comfortably, and holds the clean container under her breast • **Expresses the milk-** • Supports the breast with four fingers and places the thumb above the areola • Squeeze the areola between the thumb and fingers while pressing backwards against the chest • Squeezes and releases, and repeats • Presses the areola in the same way from the sides, to make sure that milk is expressed from all segments of the breast Expresses each breast for at least 3-5 minutes, alternating breasts until the flow of milk stops (both breasts are completely expressed)					
2.	**Feeding by katori-spoon or paladai:** • Uses a medium sized cup and a small (1-2ml size) spoon. Both utensils must be washed and cleaned • Takes baby onto lap and in semi-upright position with head well supported and with a napkin around the neck to mop up the spillage • Stimulates the angle of the mouth and rests the spoon with 1-2ml of milk at the angle of the mouth • Pours the milk slowly into the open mouth and lets the milk flow into the baby's mouth slowly, avoiding the spill					

	• Watches for swallowing • Continues feeding in this manner till the desired amount has been fed • Burps the baby • Repeats the process till the required amount has been fed • Baby may also feed directly by the cup • If the baby does not actively accept and swallow the feed, tries gentle stimulation by stroking behind the ear or on the sole (**If baby still sluggish, do not insist on this method**- It is better to switch back to gavage feeds till the baby is ready)					

Key Points

- To express breast milk adequately it may take 20-30 minutes
- Having the baby close or handling the baby before milk expression may help the mother to have a good let-down reflex
- To stimulate and maintain milk production one should express milk frequently – at least 8 times in 24 hours. It is important not to try to express in a shorter time
- Process of expressing breast milk should not hurt– if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times, milk starts to drip out
- Storage of EBM: Stored in a clean and covered container- at room temperature for 8 hours or in refrigerator for 24 hours or in deep freeze at -20°C for 3 months
- Feeding with a spoon/paladai and cup has been found to be safe in LBW babies
- This mode of feeding is a bridge between gavage (OG/NG tube) feeding and direct breast feeding
- While estimating the intake, account for the spilled milk weighing the napkin will provide exact amount of milk spilled

(Day 2) 32.B

Checklist for Assisted Feeding
(Insertion, Feeding and Removal of Orogastric Tube)

S.N.	Task	Cases				
		1	2	3	4	5
A.	**Getting ready/supplies:** • Sterile/clean examination gloves • Clean orogastric (OG)/nasogastric tube (6F or 8F) • Writing pen or flexible tape measure • 2-5 mL syringe (for aspiration) • Sterile 10mL syringe (for feeding) • Cap of gastric tube • Kidney dish or bowl • Pediatric stethoscope • Scissors • Normal saline • Adhesive tape					
B.	**Procedure for insertion:**					
1.	Arranges necessary supplies					
2.	Washes both hands, air dries and wears sterile/clean examination gloves on both hands					
3.	Measures required length of tube without removing it from its sterile packet. Notes the point of graduated marking from the angle of mouth or the tip of nostril to the lower tip of the ear lobe and then to the mid-point between the xiphisternum and umbilicus (this corresponds to the point just below the rib margin). Notes this length and marks the tube at this point with a pen					
4.	Elevates the baby's head to flex the baby's neck slightly, holds the tube at least 5-6 cms from the tip with the remaining tube in the package for no-touch technique of insertion					
5.	Moistens the tip of the tube with normal saline and gently inserts it through the mouth or through one nostril pointing towards the back of throat to the required distance					
6.	Confirms correct positioning of the tube ➢ Aspirates some fluid or ➢ If no aspirate, then places a stethoscope just below xiphisternum					

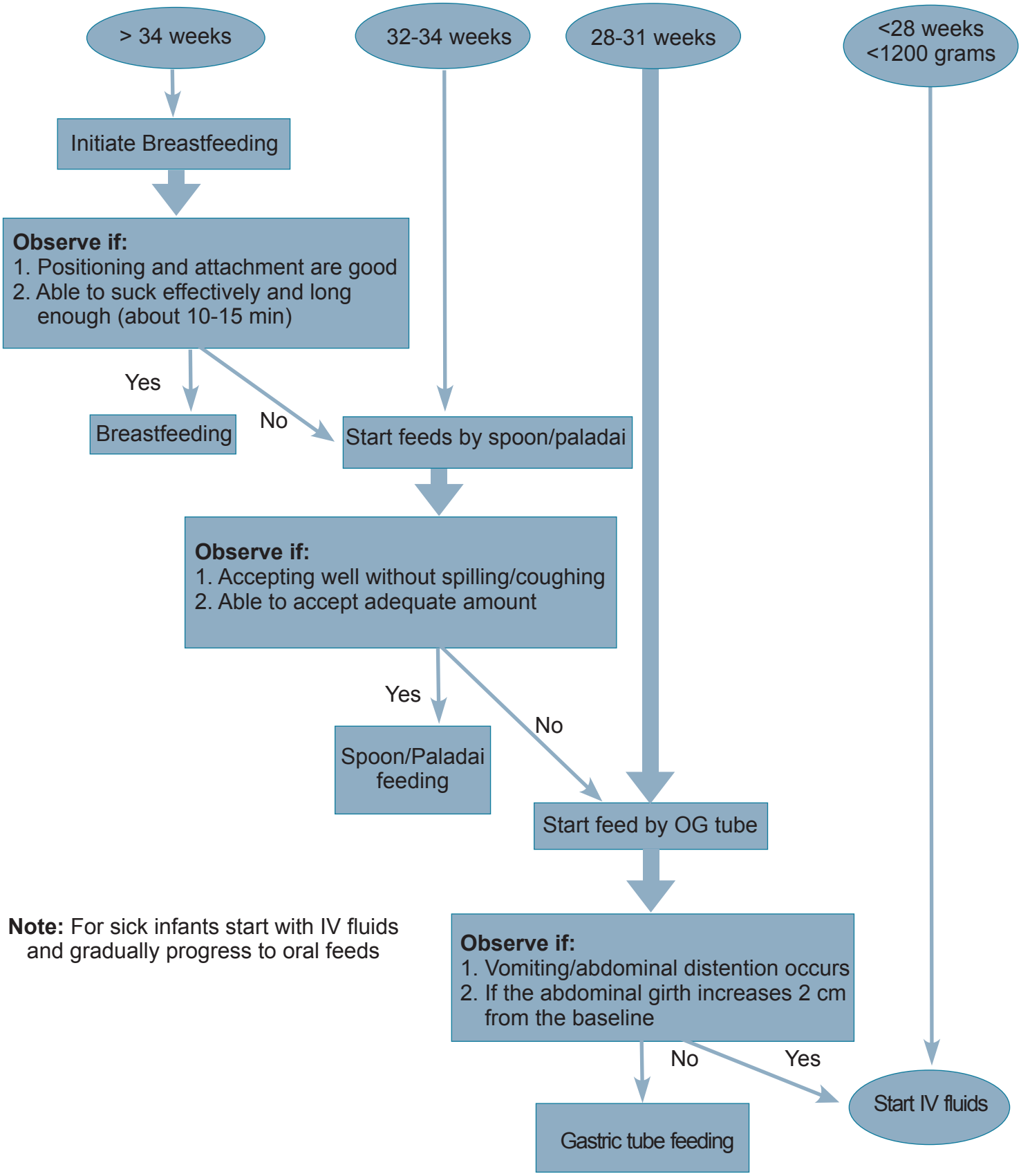
S.N.	Task	Cases				
		1	2	3	4	5
	slightly to the left side of the upper abdomen. Attaches a syringe having 2-3 cc air, auscultates with a stethoscope for sound of gush of air in the stomach when all the air is pushed. ➢ If no sound heard, withdraws the tube immediately by kinking it and reinserts it once again ➢ Removes the syringe and closes the OG tube hub with the stopper (for next feed) or leaves it open (if it is for gastric distension)					
7.	Secures tube in place gently with tape on the cheek and records point of its insertion in cms at the angle of mouth/nostril before each feed					
C.	**Feeding with OG tube:**					
1.	Washes hands properly					
2.	Takes the required amount of feed (breast milk) in a clean bowl					
3.	Ensures the tube is in the stomach by noting its point of measurement at the angle of mouth and cross-checks it with the records					
4.	Attaches the appropriate size syringe for feeding (10 mL or more) without its plunger to the OG tube					
5.	Keeps the syringe vertical, pours the required amount of milk in the syringe and allows the feed to go down slowly with gravity					
6.	Pinches the tube when the syringe is empty to prevent the passage of air, removes the syringe and closes the hub of the tube					
7.	Disposes the syringe in the red bin or processes it for next use by decontamination for 10 minutes, washing and sterilization					
D.	**Removal of the OG tube:** (Remove the tube by kinking it if it is not required, or replace it after 3 days with a new tube or earlier if it is pulled out or becomes blocked)					
1.	Gently removes adhesive tape after wetting it					
2.	Pinches and gently pulls out the tube to prevent spilling or aspiration of contents in the trachea					
3.	Disposes the tube in the red bin after cutting it. To re-use, decontaminates in 0.5% chlorine solution for 10 minutes, washes and does sterilization					

Key points

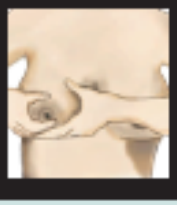
- **Indications:** Feeding sick, preterm baby or low birth weight babies who cannot suck; gastric drainage in babies with abdominal distension or neonates with congenital or surgical conditions like duodenal atresia
- **Feeding tube size** 8F (2.70 mm) for babies >1500gms and 6F for babies <1500gms
- While inserting the tube, observe closely for breathing difficulty and colour changes. If the baby develops difficulty breathing or turns blue or vomits, remove the tube immediately as it may be in the trachea. Always pinch the tube before removing
- If resistance is felt during insertion, do not push further. Remove the tube and retry or call for assistance

- While feeding do not push the milk in the syringe with its plunger, let it go slowly with gravity
- Insertion of orogastric tube is preferred over nasogastric tube in a newborn baby
- If gastric tube is inserted for drainage, leave the tube uncapped and wrap clean gauze around the end, fix with tape to keep the tube clean and absorb the drainage from the stomach

Method of providing fluids and feeds for low birth weight infants



Note: For sick infants start with IV fluids and gradually progress to oral feeds



EXPRESSION OF BREAST MILK

1

Wash your hands well with soap and water

2

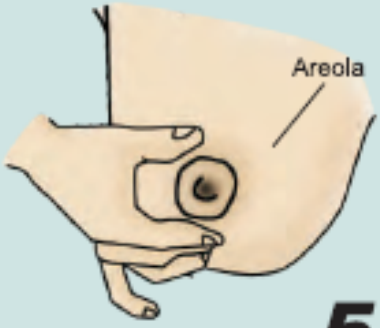
Place a clean container below your breast to collect milk

3

Massage the breast gently towards the nipple

4

Place your thumb and index finger opposite each othe just outside the areola (Areola is the dark soft circle around the nipple)

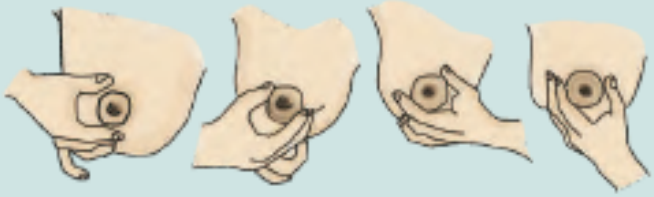


5

Now press back towards your chest, then gently squeeze to express milk

6

Repeat step 5 at different positions around the areola



Source: Facility Based Newborn Care Operational Guide, MoHFW, Government of India

(Day 3) 34

CHECKLIST: Family Planning Counselling For PPFP/Interval Periods Following Balanced Counselling Strategy

SN	STEP/TASK	CASES				
I	**PREPARATION FOR COUNSELLING**					
1.	Ensures room/counselling corner is well lit, ventilated and there is availability of chairs and table					
2.	Prepares equipment and supplies					
3.	Ensures availability of writing materials (eg., client file, daily activity register, follow-up cards, FP job-aids such as counselling kit, checklists, posters, samples of contraceptives, client education material, flip book)					
4.	Ensures privacy					
	SKILL/ACTIVITY PERFORMED SATISFACTORILY					
II	**GENERAL COUNSELLING SKILLS – (Pre-Choice Stage)**					
A.	**GREET-Establishes a good rapport and initiates counselling for FP**					
5.	Greets the woman with respect and kindness. Introduces self: offers the woman a place to sit and ensures her comfort.					
6.	Uses body language to show interest in and concern for the woman. Confirms woman's name, address and only other required information.					
7.	Asks the woman the purpose of her visit. Reassures the woman that the information in the counselling session will be confidential					
8.	Tells the woman that this session is going to help her to take decision on her own as per her needs and or ensuring good health for herself and her children (if any). Encourages the woman to ask questions and responds to the woman's questions/concerns					
9.	Includes client's husband/family member with her consent					
10.	Uses language that the woman can understand. Asks questions that elicit more than 'Yes' or 'No' answers					
B.	**ASK-Determines reproductive goals and use of other contraception**					
11.	Asks to explore client's knowledge about return of fertility and benefits of spacing pregnancies					

SN	STEP/TASK	CASES				
12.	Rules out pregnancy by asking the 6 questions to be reasonably sure that the woman is not pregnant ▪ Have you had a baby in last 4 weeks ▪ Did you have a baby less than 6 months ago? If so, are you fully or nearly fully breastfeeding? Have you had no monthly menstrual bleeding since giving birth? ▪ Have you abstained from sexual intercourse since your last menstrual period or delivery? ▪ Did your last menstrual period start within past 7 days (or 12 days if you plan to use IUCD)? ▪ Have you had a miscarriage or abortion in the last 7 days? ▪ Have you been using a reliable contraceptive method consistently and correctly? (If client's response to any of the above question is "Yes" and she is free of signs and symptoms of pregnancy, pregnancy is unlikely.)					
13.	Displays the counselling kit/flip book page/ tray with contraceptives showing all the FP methods, and asks if client is interested to use any particular method ▪ If client has a method in mind, provides method specific counselling on that method (from step 18). ▪ If client does not have any specific method in mind, asks the following 4 questions and eliminates methods according to client's response: i. Do you want more children in the future? (If yes, does not discuss male and female sterilization) ii. Are you breastfeeding an infant of less than 6 months old or will you breastfeed your baby upto 6 months? (If yes, does not discuss oral contraceptive pills) iii. Will your partner use condoms? (If yes, discusses about condoms. Also, irrespective of client's response, assesses woman's risk for STIs and HIV and explains that condom is the only method that can protect from STI and HIV) iv. Is there an FP method you could not tolerate in the past? (If yes, asks which method. Does not discuss the method if the problem experienced was really related to the method)					
C.	**TELL-Provides the client with information about the postpartum/ interval family planning methods**					

SN	STEP/TASK	CASES				
14.	Provides general information about benefits of spacing births (if client wants more children in future or has not yet decided whether she wants more children or not) ▪ Informs that to ensure her health and the health of her baby (and family) she should wait at least two years after this birth before trying to get pregnant again ▪ Informs about the return of fertility postpartum and the risk of pregnancy ▪ Informs how LAM and breastfeeding are different Provides information about the health, social and economic benefits of spacing births					
15.	Briefly provides general information about those contraceptive methods that are appropriate for woman based on her facts to questions asked in step 13. ▪ How to use the method ▪ Effectiveness ▪ Possible common side effects ▪ Need for protection against STIs including HIV/AIDS ▪ Informs COCs will not be appropriate in the postpartum period and may be taken later					
16.	Clarifies any misinformation or misconception the woman may have about family planning methods					
D.	**HELP-Assists the client to arrive at a choice or gives her additional information that she needs to make a decision**					
17.	Shows the methods (using samples of contraceptives or flip book) and allows the client to feel the items. Asks which method interests the woman. Helps her choose a method					
18.	Supports the client's choice and tells her the next steps for providing her choice					
III	**METHOD-SPECIFIC COUNSELLING – once the woman has chosen a method (Method Choice Stage)**					
E.	**EVALUATE AND EXPLAIN-Determines if she can safely use the method and provides key information about how to use the method**					
19.	Screen's the woman's medical condition using MEC wheel for appropriateness of the chosen method. Performs or sends the client to the provider for physical assessment that is appropriate for the method chosen, if indicated, refers the woman for evaluation. (BP for hormonal methods, pelvic examination for IUCD and female sterilization)					
20.	Ensures there are no medical conditions that are category 3 or 4 which limit the use of the chosen method. ▪ If the chosen method is not appropriate for her, helps the woman to find a more suitable method					

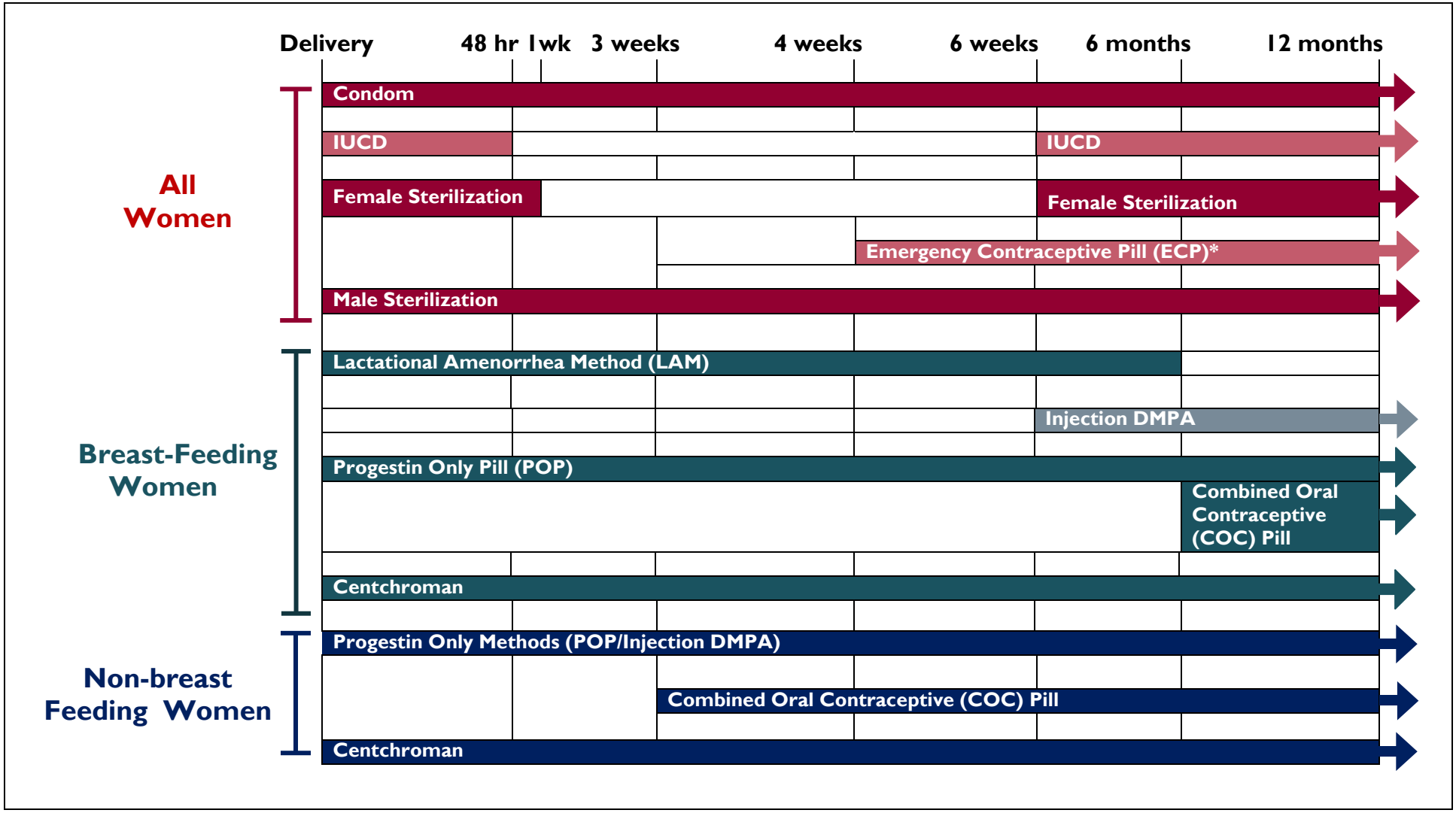
SN	STEP/TASK	CASES				
21.	Explains the woman about key information of the chosen family planning method: ▪ Type ▪ How to take/use it, and what to do if she is late/forgets taking her method ▪ How does it work ▪ Effectiveness ▪ Immediate return of fertility on discontinuation ▪ Effect on breastfeeding ▪ Advantages and non-contraceptive benefits ▪ Limitations ▪ Common side effects ▪ Warning signs and where to go if she experiences any					
22.	Asks the woman to repeat the instructions about her chosen method of contraception: ▪ How to use the method of contraception ▪ Possible side effects and what to do if they occur ▪ When to return to the health facility					
23.	Provides the method of choice if available or refers the woman to nearest health facility where it is available					
24.	Asks if the woman has any questions or concerns. Listens attentively, addresses her questions and concerns					
F.	**RETURN-Plans for next steps**					
25.	Plans for next steps: ▪ If client arrive at a conclusion on this visit, asks her to plan for a discussion with her family and a follow-up discussion on her next visit ▪ Schedules when the client should come for the follow-up visit. Encourages the woman to return to the health facility at any time if necessary and where to go for more supplies					
26.	Records the relevant information in the woman's chart					
Information for Other Services						
27.	Educates the woman about prevention of STIs and HIV/AIDS. Provides her with condoms if she is at risk and counsels her to take treatment with her partner					
28.	Using information collected in earlier steps, determines client's needs for postpartum, newborn, and infant care services. ▪ If client reported giving birth recently, discusses or refers for postpartum care, newborn care, postpartum family planning (PPFP) counselling ▪ For clients with children less than 5 years of age, discuss and arrange or refer for immunizations and growth monitoring services					

SN	STEP/TASK	CASES				
29.	Thanks the woman politely, says goodbye and encourages her to return to the clinic if she has any questions or concerns					
	SKILL/ACTIVITY PERFORMED SATISFACTORILY					
IV	**FOLLOW-UP COUNSELLING**					
1.	Greets the woman with respect and kindness. Introduces self					
2.	Confirms the woman's name, addresses and obtains other required information					
3.	Asks the woman the purpose of her visit					
4.	Reviews her record/chart					
5.	Checks whether the woman is satisfied with her family planning method and is still using it. Asks if she has any questions, concerns, or problems with the method					
6.	Explores changes in the woman's health status or lifestyle that may mean she needs a different family planning method					
7.	Performs any necessary physical assessment (eg. Blood pressure check for the pill use; pelvic examination for IUCD)					
8.	Reassures the woman about side effects she is having and refers them for treatment if necessary					
9.	Asks the woman if she has any questions. Listens to her attentively and responds to her questions or concerns					
10.	Refers to the doctor for any physical examination if necessary					
11.	Provides the woman with more supply of her contraceptive method (e.g. the pill, condoms, etc.)					
12.	Schedules return visit as necessary and tells her. Thanks her politely and says goodbye. Records information in her chart					

COUNSELING GUIDE: IMMEDIATE POSTPARTUM FAMILY PLANNING

METHODS	BENEFITS	LIMITATIONS	CLIENT ASSESSMENT/CONSIDERATIONS
Postpartum IUCD	• right after delivery; long term protection • 99% effective. • Immediate return of fertility upon removal.	• Heavier, painful menses (first few cycles). • Does not protect against STIs/ HIV.	Not appropriate for women who have: • Chorioamnionitis; ROM >18 hrs; PPH
Progestin Only Pills	• Woman can start 6 weeks postpartum, even if breastfeeding. • About 99% effective. • Immediate return of fertility after stopping pills.	• Must be taken daily. • Bleeding changes may be experienced. • Does not protect against STIs/ HIV.	• Not appropriate for women who have: cirrhosis or active liver disease, blood clot in legs or lungs, history of breast cancer or take medications for TB or seizures.
Condom	• Can prevent pregnancy, some STIs and HIV. • Can be used once couple resumes intercourse.	• Must have reliable access to resupply. • About 85% effective.	• Must be used correctly with EVERY act of sex. • Can provide supply before discharge.
Postpartum Ligation	• Permanent method of FP. Simple procedure • >99% (not 100%) effective. • Serious complications are rare.	• Does not protect against STIs/HIV. • Requires surgical procedure.	• For women who certainly want no more children. • Hospital must be set up to offer the surgery. • Can be done in first 7 days postpartum.
LAM	• Good for mother and newborn. • Start immediately after birth. • 98% effective if all 3 criteria met.	• Does not protect against STIs/ HIV. • Short-term method-reliable for 6 months. • Use another method if any criteria not met.	• Effective if ALL 3 criteria present: exclusive breastfeeding day & night; menses not returned; baby less than six months old.
Male Sterilization	• Permanent method for men. Simple procedure • 99% effective. • Serious complications are rare. • No weakness or difficulty during intercourse.	• Does not protect against STIs/HIV • Requires use of condoms or another contraceptive for three months post-procedure to be effective.	• Appropriate for those couples who have decided to limit family; are aware of the permanent nature of the method. • Men who do not have infection of the genitalia.
Emergency Contraception 1. Emergency Contraceptive Pills (ECPs) 2. IUCD	• Safe, easy to use and available at chemist shop or at health center. • Can be used by all women. • 85% effective if used within 120 hours (5 days) after an unprotected intercourse. • IUCD for Emergency Contraception can be continued as a regular method if appropriate.	• Not a regular FP method, intended for emergency use only. • A regular FP method use required • Not effective once implantation of fertilized ovum has begun. • Effectiveness dependent on the time of use after the unprotected intercourse.	• Not effective in pregnant women. • Should not be used as an abortifacient. • IUCD not appropriate for women who have: Cervical cancer or trophoblastic disease; Abnormality in the structure of the uterus (fibroids, septum); risk of STIs.

TIME OF INITIATION OF POSTPARTUM FAMILY PLANNING METHODS



* This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.

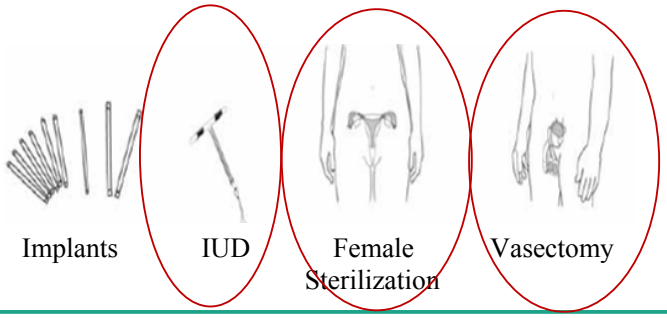
सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

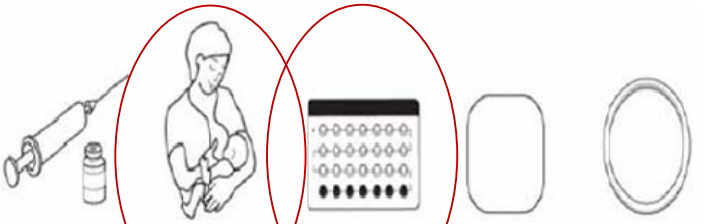
Comparing Effectiveness of Family Planning Methods

More effective

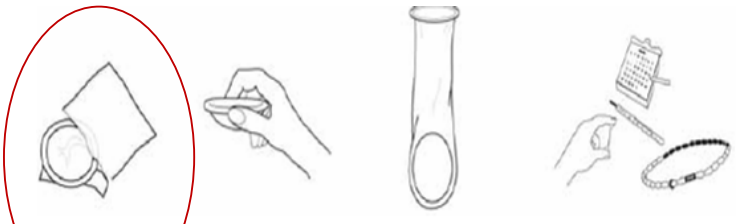
Less than 1 pregnancy per 100 women in 1 year



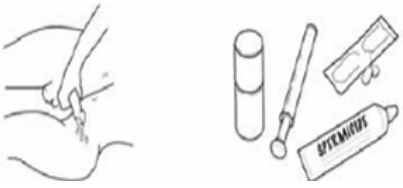
Implants | IUD | Female Sterilization | Vasectomy



Injectables | LAM | Pills | Patch | Vaginal ring



Male condoms | Diaphragm | Female Condoms | Fertility awareness methods



Withdrawal | Spermicides

Less effective

About 30 pregnancies per 100 women in 1 year

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables: Get repeat injections on time

Lactational amenorrhea method, LAM (for 6 months): Breastfed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Condoms, diaphragm: Use correctly every time you have sex.

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and Two Day Method) may be easier to use.

Withdrawal, spermicides: Use correctly every time you have sex.

USAID FROM THE AMERICAN PEOPLE

World Health Organization

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सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

International Planned Parenthood Federation

YOUR RIGHTS

EVERY CLIENT HAS THE RIGHT TO:

WWW.IPPF.ORG

INFORMATION
to know about the benefits and availability of sexual and reproductive health services and to know their rights in this regard

ACCESS
to obtain services regardless of ra ce, sex or sexual orientation, marital status, age, religious or political beliefs, ethnicity or disability

CHOICE
to decide freely on whether and how to control their fertility and which method to use

SAFETY
to be able to protect themselves from unwanted pregnancy, disease and from violence

PRIVACY
to have a private environment during counselling and services

CONFIDENTIALITY
to be assured that any personal information will remain confidential

DIGNITY
to be treated with respect, empathy, courtesy, consideration and attentiveness

COMFORT
to feel comfortable when obtaining services

CONTINUITY
to re ceive sexual and reproductive health services and supplies for as long as needed

OPINION
to fr eely express views on the services provided

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World Health Organization

hrp

The prevention and elimination of disrespect and abuse during facility-based childbirth

WHO statement

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care.

photo: UNICEF

Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue.

Background

Ensuring universal access to safe, acceptable, good quality sexual and reproductive health care, particularly contraceptive access and maternal health care, can dramatically reduce global rates of maternal morbidity and mortality. Over recent decades, facility delivery rates have improved as women are increasingly incentivized to utilize facilities for childbirth, through demand generation, community mobilization, education, financial incentives or policy measures.

However, a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture. Many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities. (*1-3*) This constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services. (*4*) While disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth. Such practices may have direct adverse consequences for both the mother and infant.

Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.(*5*) Among others, adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment.(*5*)

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination. Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.(*6-9*) In particular, pregnant women have a

right to be equal in dignity, to be free to seek, receive and impart information, to be free from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.(*10*)

Despite the existing evidence that suggests women's experiences of disrespect and abuse during facility-based childbirth are widespread,(*1-3,5*) there is currently no international consensus on how disrespect and abuse should be scientifically defined and measured. Consequently, its prevalence and impact on women's health, well-being and choices is not known. A considerable research agenda exists to better define, measure and understand disrespectful and abusive treatment of women during childbirth, and how it can be prevented and eliminated.

To achieve a high standard of respectful care during childbirth, health systems must be organized and managed in a manner that ensures respect for women's sexual and reproductive health and human rights. While many governments, professional societies, researchers, international organizations, civil society groups and communities worldwide have already highlighted the need to address this problem (*11-14*) in many instances policies to promote respectful maternal care have not been adopted, are not specific, or have not yet been translated into meaningful action.

photo: World bank

In order to prevent and eliminate disrespect and abuse during facility-based childbirth globally, the following actions should be taken:

1. Greater support from governments and development partners for research and action on disrespect and abuse

Greater support from governments and development partners is needed for further research on defining and measuring disrespect and abuse in public and private facilities worldwide, and to better understand its impact on women's health experiences and choices. Evidence on the effectiveness and implementation of interventions in different contexts is required to provide the necessary technical guidance to governments and health-care service providers.

2. Initiate, support and sustain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care

Greater action is needed to support changes in provider behaviour, clinical environments and health systems to ensure that all women have access to respectful, competent and caring maternity health care services. This can include (but is not limited to) social support through a companion of choice, mobility, access to food and fluids, confidentiality, privacy, informed choice, information for women on their rights, mechanisms for redress following violations, and ensuring high professional standards of clinical care. The focus on safe, high-quality, people-centered care as part of universal health coverage can also help inform action.

3. Emphasizing the rights of women to dignified, respectful health care throughout pregnancy and childbirth

International human rights frameworks highlight disrespect and abuse during childbirth as an important human rights issue, (*6-8,15*) and can aid women's health advocates in raising awareness and developing policy initiatives on the importance of respectful maternal care. Rights-based approaches to organizing and managing health systems can facilitate the provision of respectful, quality care at birth.

4. Generating data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support are required

Health systems must be accountable for the treatment of women during childbirth, ensuring clear policies on rights and ethical standards are developed and implemented. Health-care providers at all levels require support and training to ensure that childbearing women are treated with compassion and dignity. Those health services that already provide respectful maternity care, promote participation of women and communities and have implemented processes to track and continuously improve respectful care need to be identified, studied and documented.

5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices

Ending disrespect and abuse during childbirth can only be achieved through an inclusive process, involving the participation of women, communities, health-care providers, managers, health professional training, education and certification bodies, professional associations, governments, health systems stakeholders, researchers, civil society groups and international organizations. We call upon these entities to join in efforts to ensure that disrespect and abuse is consistently identified and reported, and that locally appropriate preventative and therapeutic measures are implemented.

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If your organization would like to endorse this statement, please contact: vogeljo@who.int

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This statement is endorsed by:

American Refugee Committee

Averting Maternal Death and Disability, Mailman School of Public Health, Columbia University

Center for Health and Gender Equity (CHANGE)

Center for Reproductive Rights

Center for the Right to Health (CRH)

Commonwealth Medical Trust (Commat)

Family Care International

Human Rights in Childbirth

Human Rights Watch

International Federation of Gynecology and Obstetrics (FIGO)

International Islamic Center for Population Studies and Research, Al Azhar University

International Motherbaby Childbirth Organization

IntraHealth International

Jhpiego-an affiliate of Johns Hopkins University

Makererere University College of Health Sciences School of Medicine Department of Obstetrics and Gynaecology

Maternal Adolescent Reproductive & Child Health (MARCH), London School of Hygiene & Tropical Medicine

Maternal and Child Survival Program

Maternal Health Task Force

Population Council

Reproductive Health Matters

Safe Motherhood Program, Bixby Center for Global Reproductive Health and Policy, Dept. of Obstetrics, Gynecology & Reproductive Sciences at UCSF

Swedish International Development Cooperation Agency

Swiss Tropical and Public Health Institute

University Research Co., LLC (URC)

United States Agency for International Development (USAID)

The White Ribbon Alliance

WHO/RHR/14.23

HAND WASHING – A SIMPLE AND EFFECTIVE METHOD FOR PREVENTION OF NOSOCOMIAL SEPSIS

Palm and fingers

Back of hands

Finger & knuckles

Thumbs

Finger tips

Wrists and forearms

Wash hands for 2 complete minutes before entering NICU & before any procedure

Wash hands for at least 20 seconds before and after touching baby

Golden rules

- Remove all jewelry and watch before hand washing. Roll the shirt to above elbow level.
- Wet and apply soap on hands and forearm up to elbow level.
- A normal, non-medicated soap is good enough.
- Dry hands either in air or by single-use sterile towel or sterile paper. Multiple-use cloth towels are not recommended
- Alcohol-based hand rub solutions may be used as an alternative. The 5 ml solution should be spread on all parts of the hands; follow Above steps; rub hands to dry.

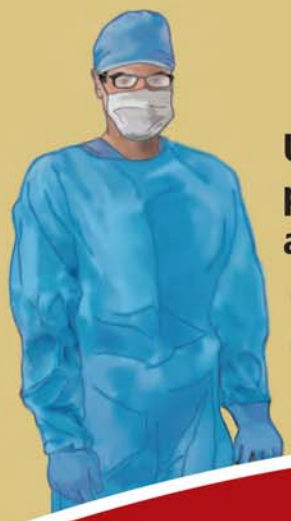
www.newbornwhocc.org

Division of Neonatology, Department of Pediatrics, All India Institute of Medical Sciences

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

Universal Infection Prevention Practices

National Rural Health Mission



Use of protective attire

Hand Washing

Ensuring general cleanliness

(walls, floors, toilets and surroundings)

Waste Disposal

Bio-Medical Waste Disposal

1. Segregation
2. Disinfection
3. Proper storage before transportation
4. Safe disposal

Yellow Bag

Human tissue, placenta, products of conception, used swabs/gauze/ bandage, other items (surgical waste) contaminated with blood

Red Bag

Used mutilated catheters, I.V bottles and tubes, syringes, disinfected plastic gloves, other plastic material

Black Bag

Kitchen waste, paper bags, waste paper/ thermocol, disposable glasses and plates, left over food

Proper handling & disposal of sharps

All needles/sharps/I.V. cannulae/broken ampules/ blades in puncture proof container

All plastic bags should be properly sealed, labeled and audited before disposal

Liquid Medical Waste (LMW) Disposal

- Avoid splashing
- Treat the used cleaning/disinfectant solution as LMW
- Pour LMW down a sink/drain/flushable toilet or bury in a pit
- Rinse sink/drain/toilet with water after pouring LMW
- Pour disinfectant solution in used sink/drain/toilet at the end of each day (12 hrly)
- Decontaminate LMW container with 0.5% bleaching solution for 10 minutes before final washing

PEP

(Post Exposure Prophylaxis)

To be given in case of accidental exposure to blood and body fluid of HIV +ve woman

The Children's Investment Fund Foundation

राजस्थान

Jhpiego
an affiliate of Johns Hopkins University

For use in medical colleges, district hospitals and FRUs

Checklist on Preparation of Labour Room (LR)

SN	Task	Observation
1.	• Environment in the LR to be maintained with adequate lighting, cleanliness, appropriate temperature depending on the surroundings(approximately 25-28^{0}C, curtains/screens, windows closed with intact panes, attached functional toilet with running water • Each labour table must have a light source • All the important protocols displayed at appropriate places for their reference in the labour room.	
2.	Equipment needed in the LR is available and functional.	
3.	Ensure that all the 7 trays are sterilized and arranged properly with labels.	
4.	All the surfaces are cleaned with bleaching powder solution including the labour tables after each delivery.	
5.	Arranging newborn care corner: • Radiant warmer (RW) plugged in, is functional and switched on at least half an hour before the time of delivery. • A pretested and functional newborn resuscitation bag and masks are kept ready on the shelf just below the RW. • A clock with seconds hand placed at prominent place.	
6.	Suction apparatus: • For newborn: DeeLees' suction apparatus in the tray • For mother: functional foot operated/electric suction along with disposable suction catheter is available.	
7.	Oxygen Cylinder: Check • Oxygen is available and flow is checked under water (in a bowl) before use to keep it ready for use • The knobs are pre-checked • New disposable tube is used every time oxygen is administered. • An extra full oxygen cylinder is available for back-up.	
8.	IP practices: • Hand washing area has soap and running water, long handle tap which can be operated with elbow • Drums to store sterilized items like gloves, instruments, linen, swabs and gauze pieces. • Exclusive functional autoclave for LR is available, delivery instruments are wrapped in a sheet and autoclaved in enough numbers (1 set for each delivery) and available as per client load autoclaving is done at least twice a day (at the end of morning	

	and evening shift). • Soiled instruments are first soaked in 0.5% chlorine solution before processing • PPE are used while working in the LR	
9.	Waste disposal: colour coded bins are availablewith plastic bag lining.	
10.	Records-partograph, case sheets, labour register, refer-in/refer-out registers are available and filled for each case as relevant.	

Key Points:

- Temperature between 25-28 ^{o} C must be maintained in LR. Hilly, cold areas will need warmers during winters
- Equipment must be checked for its functionality during change in shifts of nursing staff
- Privacy (use plastic curtains between tables) and dignity of the woman to be ensured
- Use sterilized instruments for every delivery
- LR should be draught free
- 20% buffer stock of labour room drugs must be available all the time
- NBC should not get any direct air from any corner
- Initiation of breast feeding within one hour of child brth
- Injection Oxytocin should be kept in fridge (not freezer)
- All the staff, doctors, nurses, cleaning staff, practice and adhere to infection prevention protocols
- The color coded bins are emptied at least once a day or as and when they get 3/4th filled.