DAKSHATA

Guidance for

MENTORING AND SUPPORT VISIT

MSV 1

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OBJECTIVE

The key objective of this visit is to build rapport with the facility staff. Additionally, the mentor can facilitate the process of availability of essential supplies, onsite capacity building of health workers on knowledge based practices and record keeping, and action planning through a prioritization activity.

DELIVERABLES OF MSV 1

Time since completion of training	Availability of drugs and supplies	LR organization	Adherence to IP and cleanliness protocols	Data recording and reporting	Essential practices training
15 days	Ensuring availability of 26 essential items as per Dakshata Guidelines	Mapping out LR structure; Pictures; Potential Reorganization	Management of bio-medical waste- availability of color coded bins; Preparation of chlorine solution	Maintaining case sheets including SCC	Initial assessment- Triaging, Assessment of gestational age, Use of ANCS, AMTSL and criteria for rational use of uterotonic drugs

DESCRIPTION OF ACTIVITIES

Prepare

- Inform the facility/medical officer in-charge (MOI/c) at least one day in advance about the visit. Request time to have all relevant staff at one place for on-site training session.
- Ensure complete MSV 1 package and any previous action plan is available on the day of visit.
- Carry mama and neo natalie for onsite capacity building.
- Meet the MOI/c after reaching the facility and then proceed to LR.

Observe

Visit the labor room (LR) and complete the MSV sheet:

1. Physically verify the availability of 26 items as per Dakshata guidelines. Note any missing supplies and the level of bottleneck.
2. Check the availability of different color coded bins at appropriate points of use.
3. Check for preparation of 0.5% chlorine solution and availability at the points of use.
4. Map the LR layout indicating the position of labor tables, newborn care area, privacy provisions, and other important equipment, etc.
5. Review 5 records randomly to assess the status of completeness of the case sheet and the SCC.
6. Observe care on any available client and assess:
   a. Initial assessment of pregnant women and their triaging,
   b. Estimation of gestational age,

c. Use of antenatal corticosteroids (ANCS) wherever needed,
d. Active Management of Third Stage of Labor (AMTSL), and
e. Criteria for use of uterotonic drugs.

Facilitate

Meet with the MOI/c, LR in-charge, and central store keeper to facilitate the following:

1. Availability of 26 supplies (focus on the ones that can be made available immediately at the facility). Ensure that action plans are made with clear timelines and responsibility for supplies that can be ensured through MOI/c. For supplies that need support from district, prepare plan with MOI/c.
2. Based on the layout mapping, propose to the LR in-charge and the MOI/c any immediate reorganization as needed.
3. Share the BMW guidelines with the MOI/c and LR in-charge and point out any areas of improvement.
4. Availability of standardized case sheet and the SCC. Inform them of the need to complete these documents in a timely manner.

Train

Conduct an onsite training session to orient the labor room and other concerned staff on the following (using job-aids attached as annexures):

1. BMW management protocols applicable to the facility (Annexure I).
2. Method of preparation of 0.5% chlorine solution for decontamination (Annexure I) and the need for its availability in proximity to labor tables.
3. Filling of case sheets and SCC for each client. Discuss various components and help clear any doubts about any areas in these documents.
4. Essential practices
   - Initial assessment for triaging of pregnant women- through appropriate client history (obstetric, menstrual, medical, surgical, past etc.) and examination (general, systemic, per abdomen and per vaginal), recording of vitals such as blood pressure, temperature and fetal heart rate (Annexure II).
   - GA estimation- by calculation from LMP, fundal height measurement from PA examination or ultrasonography report, or a combination of these methods (Annexure II).
   - Use of ANCS- identification of cases of 24-34 weeks of gestation with true preterm labor or conditions leading to imminent delivery, and their management using ANCS (Annexure III).
   - AMTSL- ensuring availability of pre-filled oxytocin syringe and performance of 3 critical steps, that is, injection oxytocin 10 IU IM within 1 minute of delivery, controlled cord traction (CCT) and uterine massage (Annexure IV).
   - Rational use of uterotonic drugs- avoiding unnecessary and routine augmentation of labor (Annexure V).

Action Plan Review

1. Review the rapid assessment action plan to see the status of activities. Discuss timelines for pending activities and record timelines for new proposed activities.
2. After training, perform a prioritization activity with the staff (refer to Annexure VI for details of activity).

Annexures

I.Bio-medical waste management protocol

A.Color coded bins

Biomedical wastes categories and their treatment and disposal options

Category	Type of waste	Type of Bag/ Container to be used	Treatment and Disposal options
(1)	(2)	(3)	(4)
Yellow	**(a) Human Anatomical Waste:** Human tissues, organs, body parts and fetus below the viability period (as per the Medical Termination of Pregnancy Act 1971, amended from time to time).	Yellow colored non-chlorinated plastic bags	Incineration or Plasma Pyrolysis or deep burial*
	(b) Animal Anatomical Waste: Experimental animal carcasses, body parts, organs, tissues, including the waste generated from animals used in experiments or testing in veterinary hospitals or colleges or animal houses.		
	(c) Soiled Waste: Items contaminated with blood, body fluids like dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.		Incineration or Plasma Pyrolysis or deep burial* In absence of above facilities, autoclaving or micro-waving/hydroclaving followed by shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent for energy recovery.

Category	Type of waste	Type of Bag/ Container to be used	Treatment and Disposal options
(1)	(2)	(3)	(4)
	(d) Expired or Discarded Medicines: Pharmaceutical waste like antibiotics, cytotoxic drugs including all items contaminated with cytotoxic drugs along with glass or plastic ampoules, vials etc.	Yellow colored non-chlorinated plastic bags or containers	Expired cytotoxic drugs and items contaminated with cytotoxic drugs to be returned back to the manufacturer or supplier for incineration at temperature > 1200 degree C or to common BMW management facility or hazardous waste treatment, storage and disposal facility for incineration at > 1200 degree C. All other discarded medicines shall be sent back to manufacturer or disposed by incineration.
	(e) Chemical Waste Chemicals used in production of biologicals and used/discarded disinfectants.	Yellow colored containers or non-chlorinated plastic bags	Disposed off by incineration or Plasma Pyrolysis or Encapsulation in hazardous waste treatment, storage and disposal facility.
	(f) Chemical Liquid Waste: Liquid waste generated due to chemicals in production of biologicals and used or discarded disinfectants, Silver X-ray film developing liquid, discarded Formalin, infected secretions, aspirated body fluids, liquid from laboratories and floor washings, cleaning, house-keeping and disinfecting activities etc.	Separate collection system leading to effluent treatment system	After resource recovery, the chemical liquid waste shall be pre-treated before mixing with other wastewater. The combined discharge shall conform to discharge norms.
	(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid.	Non-chlorinated yellow plastic bags or suitable packing material	Non-chlorinated chemical disinfection followed by Incineration or Plasma Pyrolysis or for energy recovery.

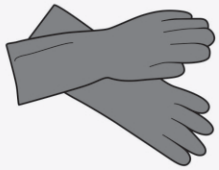
Category	Type of waste	Type of Bag/ Container to be used	Treatment and Disposal options
(1)	(2)	(3)	(4)
			In absence of above facilities, shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent for energy recovery or Incineration or Plasma Pyrolysis.
	(h)Microbiology, Biotechnology and other clinical laboratory waste: Blood bags, laboratory cultures, stocks or specimens of micro- organisms, live or attenuated vaccines, human and animal cell cultures used in research, industrial laboratories, production of biologicals, residual toxins, dishes and devices used for cultures.	Autoclave safe plastic bags or containers	Pre-treat to sterilize with non-chlorinated chemicals on-site as per National AIDS Control Organization or World Health Organization guidelines, thereafter for Incineration.
Red	**Contaminated Waste (Recyclable)** (a) Wastes generated from disposable items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes and vacutainers with their needles cut) and gloves.	Red colored non-chlorinated plastic bags or containers	Autoclaving or micro-waving/ hydro-claving followed by shredding/ mutilation or combination of sterilization and shredding. Treated waste to be sent to registered or authorized recyclers or for energy recovery or plastics to diesel or fuel oil or for road making, whichever is possible. Plastic waste should not be sent to landfill sites.
White (translucent)	**Waste sharps including Metals:** Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object	Puncture proof, leak proof, tamper proof containers	Autoclaving or Dry Heat Sterilization followed by shredding or mutilation or encapsulation in metal container or cement concrete; combination of shredding cum

Category	Type of waste	Type of Bag/ Container to be used	Treatment and Disposal options
(1)	(2)	(3)	(4)
	that may cause puncture and cuts. This includes both used, discarded and contaminated sharps.		autoclaving; and sent for final disposal to iron foundries (having consent to operate from the State Pollution Control Boards or Pollution Control Committee) or sanitary landfill or designated concrete waste sharp pit.
Blue	**(a) Glassware:** Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes.	Cardboard boxes with blue colored marking	Disinfection (by soaking the washed glass waste after cleaning with detergent and Sodium Hypochlorite treatement) or through autoclaving or microwaving or hydro-claving and then sent for recycling.
	(b) Metallic Body Implants.	Cardboard boxes with blue colored marking	

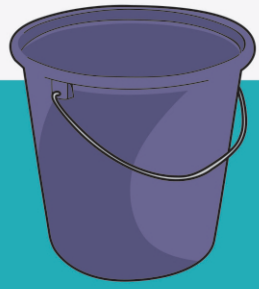
*Disposal by deep burial is permitted only in rural or remote areas where there is no access to common BMW treatment facility. This will be carried out with prior approval from the prescribed authority and as per the standards specified. The deep burial facility shall be lacated as per the provisions and guidelines issued by Central Pollution Control Board from time to time.

B.Preparation of 0.5% chlorine solution

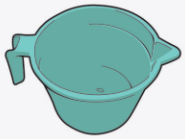
PREPARATION OF 1 LITRE BLEACHING SOUTION



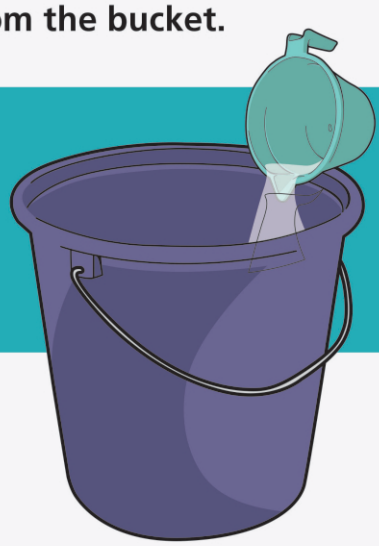
Wear utility gloves and plastic apron.



Take 1 litre of water in plastic bucket.



Make thick paste in a plastic mug with 3 level tea-spoons of bleaching powder and some water from the bucket.



Mix paste in the bucket of water to make 0.5% chlorine solution.

Maintain same ratio for larger volumes.

Guidance for applicability to facility

- Assess the daily requirement of 0.5% chlorine solution at the facility
- Based on this requirement, demonstrate the method of making 0.5% chlorine solution, as follows:
  - For example, if the daily requirement at a particular facility is 10L, measure the need for bleaching powder- 150gms in this case (15g per liter) by measuring on a weighing scale,
  - Fill a container with 150gms of bleaching powder,
  - Mark the container at this level, remove the powder and cut container now at this level,
  - This levelled container is now to be used by the concerned staff for making daily requirement of 0.5% chlorine solution at this facility
- Keep the prepared solution covered and discard when either visibly dirty or within 24 hours of preparation
- 0.5% chlorine solution to be kept in close proximity with each labor table for ease of use

II.Triaging

A.History taking

- Medical History
- Surgical History
- Obstetric History
- Menstrual History
- Past History

B.Importance of vitals for mother and fetus

	Vitals	Screening of conditions
1	Temperature	**Hypothermia**: Shock **Hyperthermia**: Fever, maternal exhaustion, infection/sepsis
2	Pulse	**Tachycardia:** Shock, fever, maternal exhaustion, infection/sepsis, anemia, heart or respiratory disease
3	Respiratory Rate	**Tachypnea:** Shock, fever, maternal exhaustion, infection/sepsis, anemia, heart or respiratory disease
4	Blood Pressure	**Hypertension (=>140/90):** Hypertensive disorders of pregnancy **Hypotension (Systolic <90):** Shock
5	Fetal Heart Rate	**>160 or <120:** Fetal distress

C.Gestational age estimation

LMP method	
EDD= Date of LMP+ 9 months+7 days For LMP method to be correct, the following pre requisites should be fulfilled: • Menstrual cycle is regular of 28 days, in which case ovulation occurs 14 days prior to the next menses. However, in a shorter cycle, the EDD will be moved earlier and it will be moved forward with a longer cycle • The patient is not on any form of hormonal contraception • The patient is not lactating	
Fundal height	
a	Ask the woman to empty her bladder and 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 12th week- Just palpable above the symphysis pubis
	At 16th week- At lower one-third of the distance between the symphysis pubis and umbilicus
	At 20th week- At two-thirds of the distance between the symphysis pubis and umbilicus
	At 24th week- At the level of the umbilicus
	At 28th week- At lower one-third of the distance between the umbilicus and xiphisternum
	At 32nd 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 (medial/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)

D.Per abdominal examination

Steps for PA examination	
Fetal Lie and Presentation (32 Weeks Onwards) Ask the woman to empty bladder and lie down with knees flexed	
a	**Carry out fundal palpation/grip** • Place both hands on the sides of the fundus to determine which part of the fetus is occupying the uterine fundus (the fetal 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 fetal 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 or 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. If 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 maneuver, 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 slightly flex her legs and take deep breaths.Palpate in between the deep breaths. • Feel to assess if there is more than one baby.

Antenatal Examination

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

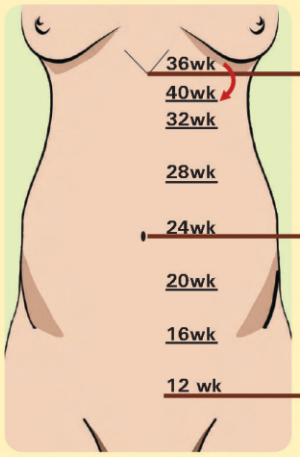
Antenatal Examination

NATIONAL RURAL HEALTH MISSION

Preliminaries

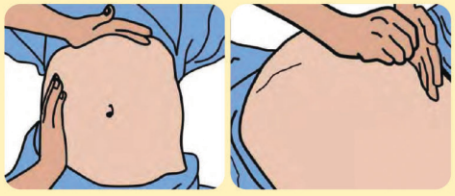
- Respect woman's rights
- Explain procedure and ensure privacy
- Ensure bladder is empty
- Examiner stands on right side
- Abdomen is fully exposed from xiphisternum to pubis symphysis
- Keep woman's legs straight
- Centralise uterus

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

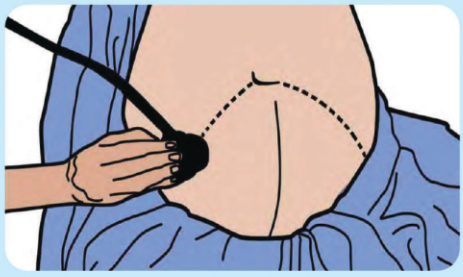
Legs are slightly flexed and separated for obstetrical grips

Fundal Grip

Lateral Grip

First Pelvic Grip

Second Pelvic Grip



Foetal heart sound is usually located along the lines as shown

For use in medical colleges, district hospitals and FRUs

E.PV examination

1	**GETTING READY**
a.	Keeps the following equipment ready: • Sterile/HLD 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 HLD/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.	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)
b.	Gently inserts the index and middle fingers of the examining hand 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 labor i. Keeps the other hand on the woman'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

labor, 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 centimeters 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 labor:

- 1st stage of labor: This is the period from the onset of labor pain to the full dilatation of the cervix, i.e. 10 cm
- 2nd stage of labor: 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 favorable sign
- If the cervix is not well applied to the presenting part, you have to be alert

vi. Feels 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:

- 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. Assesses 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 favorable
- 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, tries 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 off 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 labor (cervix dilated 4 cm or more and at least 2 uterine contractions per 10 minutes, each of 20 seconds duration), starts noting the findings on the partograph. If she is not in active labor, notes down the findings in the client's case record

Guidance for applicability to facility

- If no client is available, interview the staff to assess their knowledge on the practice for initial assessment- triaging. In such cases, abdominal and vaginal examinations can be demonstrated on mama natalie
- Ensure availability of functional equipment like BP apparatus, thermometer, measuring tape etc. at the point of use

III. Antenatal corticosteroid administration

A. Indications and contraindications

Indications	Contraindications
• True preterm labor (between 24-34 weeks of gestation) • Conditions that lead to imminent delivery (between 24-34 weeks of gestation) ◦ Antepartum hemorrhage ◦ Preterm premature rupture of membrane ◦ Severe pre-eclampsia/Eclampsia	• Frank chorioamnionitis (absolute contraindication) signs and symptoms: ◦ H/O fever, lower abdominal pain ◦ Foul smelling vaginal discharge ◦ Tender uterus ◦ Maternal and fetal tachycardia

B. Flow-chart for administration

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 Labor Pain	
TRUE Labor Pain	FALSE Labor 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

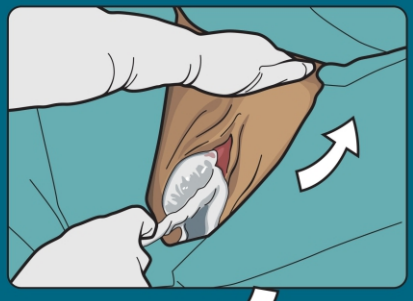
IV.Active management of third stage of labor

Pre-filled syringe with Inj. Oxytocin 10 IU (2ml = 2 amp)/Tab. Misoprostol 600mcg (200mcg, 3 tab) must be kept ready in the delivery tray before conducting birth, to ensure the injection is given within one minute of birth, after exclusion of second baby.

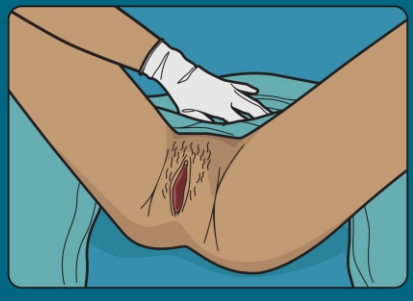
Active Management of Third Stage of Labour

(AMTSL)

After the birth of the baby, exclude the presence of another baby and give Injection Oxytocin 10 units I.M.



Once the uterus is contracted, apply [illegible]traction (pull) downwards and give counter-traction with the other hand by pushing uterus up towards the umbilicus.



Uterine massage to prevent atonic PPH

V.Do's and Don'ts for use of uterotonic drugs

DO'S

FRU/DH

- Use oxytocin as a part of AMTSL for all cases just after delivery
- Use oxytocin as a first line of management of PPH
- Use misoprostol for AMTSL (600 mcg orally) and PPH management (800 mcg sublingually) if oxytocin is not available
- Always store oxytocin with appropriate temperature management and save misoprostol from moisture
- Induce labour only in cases of confirmed post term pregnancy (reached 41 weeks), pre-labour rupture of membranes at term, dead/anomalous foetus, eclampsia/severe preeclampsia, placental abruption
- Use oxytocin only (IV infusion gradual dose increase) for induction of labour in case prostaglandins are not available
- Use oral or low dose misoprostol for induction of labour only in indicated cases
- Augment labour only in cases where there is a clear medical indication and the expected benefits outweigh the potential harms

SC/PHC

- Use oxytocin (10 IU IM injection)as a part of AMTSL for all cases just after delivery in facilities where it can be used under cold chain
- Use Misoprostol (600 mcg orally) for AMTSL in all cases in case Oxytocin is not available or cold chain can't be maintained
- Use oxytocin as a first line of management of PPH if available and IV line facility is available
- Use misoprostol for PPH management (800 mcg sublingually) if oxytocin is not available
- Always store oxytocin with appropriate temperature management and save misoprostol from moisture

DON'Ts

FRU/DH

- Do not use methyl ergometrin in cases of pre-eclampsia/ eclampsia or hypertension
- Do not use Oxytocin as IV bolus
- Do not use uterotonics for induction of labour in normal pregnancies at term
- Do not use misoprostol for induction of labour in cases of previous caesarean sections
- Do not augment labour in absence of prolonged labour and cases where uterine contractions are good
- Do not augment labour using uterotonics in cephalopelvic disproportion, or any other reasons with a potential for obstruction of labour such as malpresentations or malpositions, or presence of a scarred uterus
- Do not use uterotonics for augmentation of labour in health centres where caesarean section facilities are not available
- Do not use misoprostol for augmentation of labour

SC/PHC

- Do not use methyl ergometrin in cases of pre-eclampsia/ eclampsia or hypertension
- Do not use Oxytocin as IV bolus
- Do not use uterotonics for induction of labour in normal pregnancies at term
- Do not attempt induction or augmentation of labour, refer such cases to FRU/District Hospitals

VI.Prioritization activity for action planning

- Draw a tree on a flip-chart paper and divide it into three sections/parts- as shown in the picture
- Label the sections as low, middle and high hanging fruits from below upwards
- Explain the division and relevance of these sections for the activity
- Make the staff come and place/stick the post-it/paper slips with essential practices mentioned on them, in either of these three parts as per their perception
- This will help set the priority actions for them, on practices which are easily achievable- placed in the lower most section (LOW HANGING FRUITS), practices which will require some level of effort and time for improvement- placed in the middle section (MID HANGING FRUITS) and practices which will require extra effort and are not so easy to achieve- placed in the upper most section (HIGH HANGING FRUITS)
- Also make the staff mark suitable time frame for completion of each of these 3 sections. This will help in time bound follow-up of actions
- Ask the staff members to place this 'tree' at their work-station for close follow-up