



DAKSHATA

Guidance for
**MENTORING AND
SUPPORT VISIT**

MSV 3

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OBJECTIVE

The objective of this visit is to facilitate the process of ensuring availability of essential supplies, organization of labor room (LR), onsite capacity building of health workers on knowledge and skill-based practices and record keeping, and follow-up for completion of activities as planned in the action plan of previous visit.

DELIVERABLES OF MSV 3

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
1.5 month	Ensuring availability of 26 essential items as per Dakshata Guidelines	Ensuring organization of labor tables and functional NBC area and essential drugs and supplies, facility for birth companion	LR cleanliness, IP protocols including PPE, LR entry protocol	Maintaining case sheets including SCC and LR register	Management of severe pre-eclampsia /eclampsia, use of antibiotics and safe birth practices, PV examination, hand hygiene, empowering birth companion

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 3 package and previous action plan is available on the day of visit.
- Carry mama and neo natalie along for onsite capacity building.
- Meet the facility in-charge 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. Observe whether the reorganization of LR done in previous visit is maintained. Also observe whether medicines and drugs are kept as per the guidance provided during previous visit.
3. Observe the availability and use of personal protective equipment (PPE) by concerned staff.
4. Observe whether the facility follows any protocol for entry of various people in LR.
5. Review case records and the safe childbirth checklist (SCC) and labor room register to assess the status of completeness.
6. Observe care on any available client and assess:

- a. Management of severe pre-eclampsia and eclampsia (PE/E),
- b. Appropriate use of antibiotics and safe birth practices,
- c. PV examination technique including procedure for hand hygiene, and
- d. Allowing and empowering birth companion during labor and delivery process.

Facilitate

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

1. Availability of any remaining supplies from the 26 items list as per the Dakshata guidelines.
2. Help them prepare action plan for the remaining supplies in the 61 item list as per Dakshata protocols.
3. Facilitate re-organization of the labor room according to the plan prepared during the last visit, if not already done by the facility staff themselves. In case they have organized as per previous plan, review the appropriateness of placement of equipment to ensure efficient care provision. Help them plan for remaining activities for standardization of labor rooms (Annexure I).
4. Facilitate provision for birth companion's presence during labor, delivery and postpartum period (such as placing stools near each labor table, buffer area before entry to the labor room—can be used for wearing PPE).
5. Share the protocol for entry of personnel into the labor room and help them plan the way for implementing these protocols (Annexure II).
6. Availability of standardized case sheets, SCC and LR register. 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. Protocols for cleaning the LR (Annexure III).
2. Organizing the drugs and supplies in relevant trays for optimizing utility (Annexure IV).
3. Introduce the staff to the LR register. Conduct onsite orientation on the various sections of the register.
4. Resolve any remaining issues related to the use of the case sheet and the SCC.
5. Train staff on essential practices
 - Management of cases with severe PE/E- through monitoring of blood pressure (BP) and urine proteins, timely identification for danger signs and appropriate treatment using injection magnesium sulfate and antihypertensive drugs (Annexure V).
 - Appropriate use of antibiotics and adhering to safe birth practices- rational use of antibiotics for curative and prophylactic purpose, maintaining six-cleans of delivery, limiting the number of internal examinations, etc. (Annexure VI).
 - Technique of performing PV examination including hand hygiene- washing hands before and after any procedure (Annexure VII and VIII). Demonstrate PV technique on mama natalie.
 - Benefits of empowering birth companion during labor and delivery process (Annexure IX).

Action Plan Review

Review the action plan to see the status of activities since the last visit. Discuss timelines for pending activities and record timelines for new proposed activities.

Annexures

I.Protocol for labor room standardization

The placement of labor tables should be as per specification below:

- Distance from side wall- at least 3 feet
 - Distance from head end wall- at least 2 feet
 - Distance between two labor tables- at least 6 feet
-

Overall specifications for the general environment of labor room:

- No broken window or door panes
 - No dampness, cracks, cobwebs, etc. in the walls
 - Walls and floors made of white vitrified anti-skid tiles
-

There should be provision for privacy of clients such as:

- Frosted window and door glass panes
 - Curtains/ screens on window and doors
 - Screen on three sides for each labor table
-

Newborn care area should be placed in a way so that it is:

- Accessible within labor room for shifting of newborn within 5 seconds if resuscitation is needed
 - Open from 3 sides for ease of movement
-

LR complex should have provision for adequate lighting:

- LED lights on the ceiling
 - One focus light/shadow-less lamp for each labor table
-

Provision for adequate ventilation in the LR should be as per specification below:

- AC in the labor room/ Air handling unit as per standardization guidelines
 - Fan for each labor table
-

The handwashing station should have:

- Elbow operating tap
 - Surgical sink
 - 24 hour running water
 - Soap
-

Specification for creating a buffer area:

- Buffer area before entry into the labor room
 - Can have provision for changing shoes and wearing PPE by birth companions
-

LR complex should have provision for birth companions as below:

- Stool next to each labor table
- Storage lockers near labor room

Recommendation for number of labor tables per health facility based on the delivery load is as follows:

Criteria	No. of labor tables
< 20 deliveries/month	1
20-99 deliveries/month	2
100-199 deliveries/month	4*
200-499 deliveries/month	6*
> 500 deliveries/month	To be calculated as per the given formula for LDR and Conventional Labor Room concept
FRU CHCs/ AH/SDH/DH	To be calculated as per the given formula for LDR and Conventional Labor Room concept

***The number given is for conventional labor rooms. Even for these facilities, if LDR concept is being used, number of beds should be calculated using the formula given below**

Formula to calculate the number of beds for LDR units:

No. of LDR beds = $\{(\text{Projected LDR events in a year}) * (\text{Average length of stay})\} / \{(365) * (\text{Occupancy rate})\}$

Calculation:

- **Step 1:** Determine the number of LDR events in a year, i.e. the number of vaginal births per annum (projected number of births per annum plus the projected number of unplanned C-section births).
- **Step 2:** Take 0.67 days or 16 hours (12 hours for labor and delivery, 4 hours recovery, including the roomclean-up) as the average length of stay.
- **Step 3:** 75% or 0.75 is the recommended occupancy rate for health facilities.
- **Step 4:** Insert the numbers attained in the above steps, in the formula, and calculate the number of LDR beds required.

Formula to calculate the number of labor beds/tables for conventional labor rooms

No. of labor beds = $\{(\text{Projected labor events in a year}) * (\text{Average length of stay})\} / \{(365) * (\text{Occupancy rate})\}$

Calculation:

- **Step 1:** Determine the number of labor and delivery events in a year, i.e. the number of vaginal births per annum (projected number of births per annum plus the projected number of unplanned C-section births).
- **Step 2:** Take 0.33 days or 8 hours (4 hours for pre-delivery preparations and delivery, and 4 hours for recovery and labor room cleaning) as the average length of stay.
- **Step 3:** 75% or 0.75 is the recommended occupancy rate for health facilities.
- **Step 4:** Insert the numbers attained in the above steps, in the formula, and calculate the number of

II. Protocol for labor room entry

- Entry to the labor room should not be direct. Ideally a buffer zone needs to be created if possible for changing of shoes, wearing of mask and cap before entering the labor room.
- Entry to the labor room should be restricted to the pregnant woman, her birth companion, doctor, nurse/ANM on duty, cleaning staff periodic entry as per the SOP and protocols of cleaning.
- Before entering the labor room, slippers, cap and mask should be worn by all visitors including birth companion.
- Any visits of people other than on-duty staff, pregnant women, and birth companion to the labor room should be short and timed to the task (such as cleaning etc.)
- Entry of male staff should be strictly restricted to those who are on duty or have been called for any accessories and fittings. They should be polite and respectful to the dignity and privacy of the women.

III. Protocol for labor room cleaning

Cleaning and disinfection of labor room	<ul style="list-style-type: none"> • The labor room along with all equipment and all surfaces should be cleaned every morning and all equipment and surfaces used should be cleaned after every delivery • Labor table should be cleaned in each shift and after each delivery with (a) cloth soaked in clean water (and soap water if required) (b) cloth soaked in chlorine solution • Cheatles forceps should not be kept in antiseptic, and should be autoclaved daily and kept in autoclaved bottle with the date and time labelled each day • Toilet should be cleaned with phenyl or lysol at start of each shift and after each delivery • The overhead tank supplying water to the labor room should be cleaned at least once a week
Daily at the beginning of the day	<ul style="list-style-type: none"> • The floor and sinks should be cleaned with detergent (soap water) or chlorine solution daily in the morning and thereafter every three hours. The floor should be kept dry • All the table tops and other surfaces such as lamp shades, almirah, lockers, trollies, etc. should be cleaned with low level disinfectant (2% carbolic acid) • Monitor machines should be cleaned with 70% alcohol
After each delivery	<ul style="list-style-type: none"> • Table tops should be cleaned thoroughly with chlorine solution or disinfectant (2% carbolic acid) • Disposable absorbent sheet placed on the labor table should be changed • Any spillage of blood or body fluids on the floor should be soaked with chlorine solution for 10 minutes. Should be absorbed in a newspaper and then mopped. The newspaper should be discarded in appropriate plastic bin

Procedure for mopping

- Prepare 3 buckets with clear water. Put phenyl or lysol or bleaching solution in one of the buckets. (So that you have two buckets of clean water and one bucket containing disinfectant)
- The clean water buckets should be labelled as 1st, 2nd and 3rd bucket. The 3rd bucket will be containing disinfectant
- The cleaning begins on the floor starting from inside to outside. Towards the end, all corners and groves have to be cleaned
- After each sweep of the floor, the mop should be dipped first in the 1st bucket then in the 2nd bucket and lastly in the 3rd bucket containing disinfectant
- Mops should be cleaned in the dirty utility area and put in the stand under the sun with the mop head upward and tilted, not straight
- Mopping of floors should be done at least thrice a day and in-between whenever required
- Mopping of floors should be done with water with detergent and disinfectant (phenolic based) in Negative Pressure Isolation rooms
- In case of visible blood/body-fluids spills, the protocol of managing spills should be followed
- All soiled mops should be treated as soiled linen and transported likewise in a covered (lid) container
- At the end of each shift & a cleaning schedule for an area, all soiled mops should be sent through lift, in a hamper, to the laundry for washing
- Mops should be visibly clean before starting cleaning of an area
- Mops should be replaced after interim cleaning is done, as and when called for and mops kept in the wringer trolley should be well squeezed and out of the solution
- Mops should be changed routinely and immediately following the cleaning of blood, body-fluids secretions and excretions, after cleaning contaminated areas, operation theatres or isolation rooms
- Mops should not be left wet
- Store mops dry in a designated well demarcated area away from the clean area
- Mops should be washed in a laundry in a cycle dedicated for mops washing only with 1% Hypochlorite. This should be followed by a non-load disinfectant cycle with 1% Hypochlorite giving an exposure of 20 minutes at least
- Personnel carrying out the cleaning and transporting the soiled mops should wear adequate PPE (gloves, mask, gown)
- Trolleys transporting mops would be cleaned as per schedule with detergent followed by 1% hypochlorite / 70% isopropyl alcohol –as per compatibility according to manufacturer's instructions
- Hand-mops mounted on wipers should be used for the bathroom mopping after putting on gloves

IV. Trays to be kept in labor room

Trays to be kept in Labor Room

Delivery tray

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

Episiotomy tray

- Inj. Xylocaine 2%
- 10 ml disposable syringe with needle
- Episiotomy scissor
- 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 and 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. Betamethason
- Ringer lactate
- Normal Saline
- Inj. Hydrazaline
- Nefedipin
- 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
- Inj. Lignocaine-2%
- Inj. Adrenaline
- Inj. Hydrocortisone Succinate
- Inj. Diazepam
- Inj. Pheneramine maleate
- Inj. Carboprost
- Inj. Fortwin
- Inj. Phenergan
- Ringer lactate
- Normal saline
- Betamethazone Inj. Hydrazaline
- Nefedipin
- Methyldopa
- IV sets with 16-gauge needle at least two
- Controlled suction catheter
- Mouth gag
- IV Canula
- Vials for drug collection Ceftriaxone (3rd generation cephalosporins) - For L3 facility

(** - 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)

Guidance for applicability to facility

Facilitate availability of adequate number of delivery trays, PPIUCD trays as per delivery load (as mentioned in Annexure), and other trays as per need

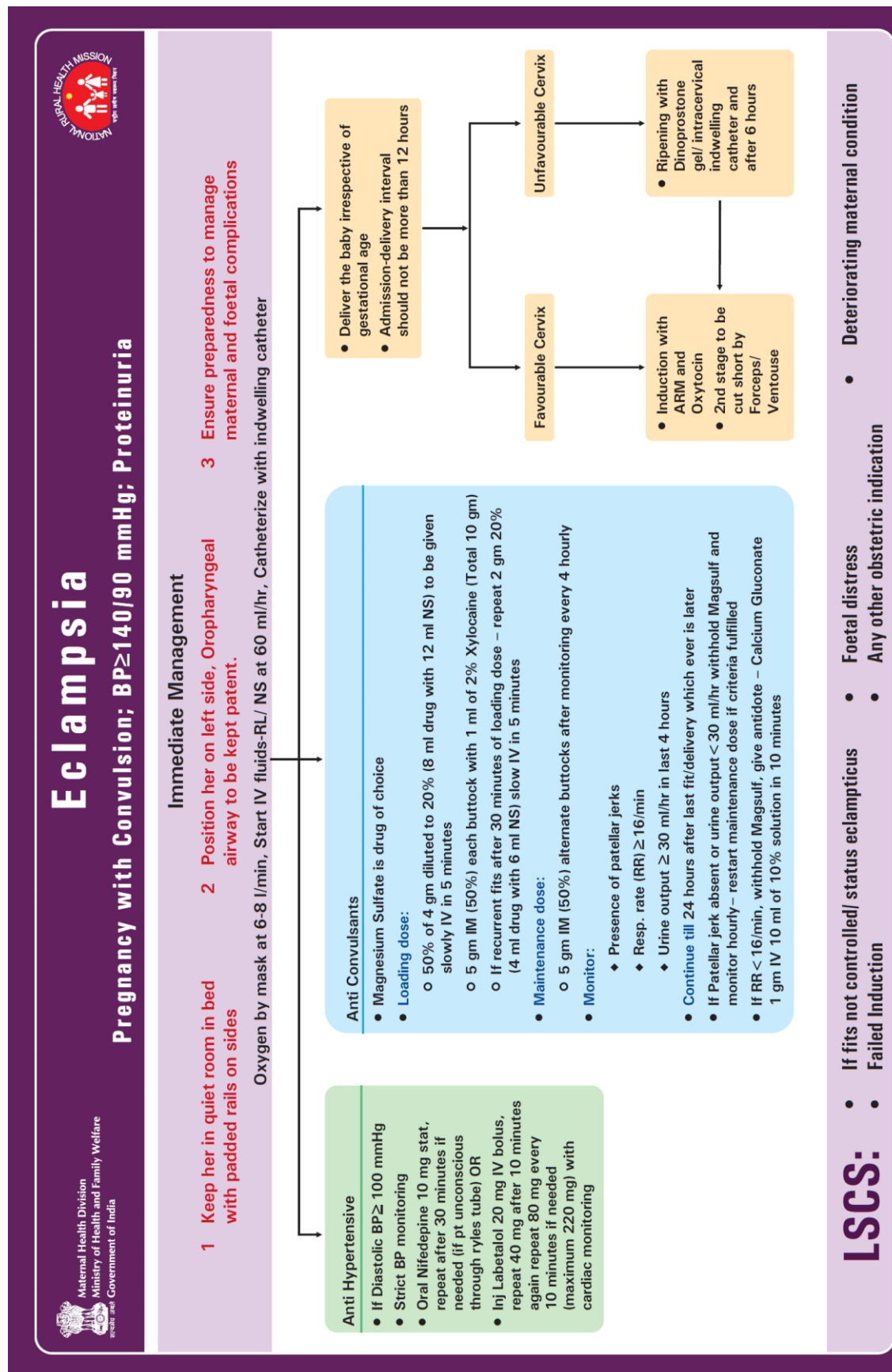
Organize the equipment and supplies into different functional areas, such as

- Important equipment for mother
- Important equipment for baby
- Important medicines for mother
- Important medicines for baby
- Storage area for sterilized items
- Storage area for other supplies, such as IV fluids, cannulas etc.

Help better organize the medicines by ensuring the following:

- Different medicines are stored in clearly labelled containers/partitioned areas in the medicine tray with date of expiry
- There should be some space/good partition between different medicine containers/storage areas to avoid mixing of drugs

V.Management of eclampsia and pre-eclampsia



Pre Eclampsia

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

Mild Pre eclampsia

- BP \geq 140/90 mm Hg
- Proteinuria \geq traces to 2 + or \geq 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 \geq 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/proteinurea
- 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

- Deliver at 38-39 weeks

If disease severe, manage as severe pre eclampsia

No role of diuretics

Severe Pre eclampsia

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

- Urgent hospitalization
- Start anti hypertensive
- Oral Nifedipine 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 Nifedipine 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

\geq 24 - $<$ 34 weeks

- Inj. Betamethasone
- 12 mg IM
- Repeat 12 mg after 24 hours

Treatment should be individualised

\geq 34 weeks

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

Terminate at 37 weeks

\geq 37 weeks

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

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

For use in medical colleges, district hospitals and FRUs



Availability of Inj Magnesium Sulphate

1 ampoule has 2 ml and 1 gram of 50% strength $MgSO_4$

Pre-referral dose

For facilities where full loading dose cannot be given

At least 10 ml (5 gram) of 50% magnesium sulphate to be given in each buttock deep IM (a total 10 gm deep IM)

Patient should ideally reach FRU within 2 hours

Full loading dose

For FRUs

- 8 ml (4 gram) of 50% magnesium sulphate + 12 ml NS or distilled water in 20 ml syringe i.e. 20% magnesium sulphate given slow IV in 10 to 20 minutes.
- Followed by 10 ml (5 gram) of 50% magnesium sulphate to be given in each buttock deep IM (a total 10 gm deep IM)

Maintenance dose

- 10 ml (5 gm) of 50% magnesium sulphate in alternate buttocks 4 hourly for 24 hours from last convulsion or delivery whichever is later.
- Continue RL at 60 ml/hour

Nursing care

- Put mouth gag and perform suction to clear airway
- Start oxygen at 6 to 8 l/min
- Start RL at 60 ml/hour
- Catheterize with Foley's indwelling catheter
- Mention time and dose of inj. Magnesium sulfate on referral slip (if referring out). Patient should ideally reach FRU within 2 hours

In recurrent fits

- 4 ml (2 gm) of 50 % magnesium sulphate with 6 ml of distilled water /normal saline, give slow IV over 5-10 minutes
- We can administer the 2 gm IV dose only once

Uncontrolled convulsions

- Give diazepam, 5-10 mg IV stat, may be repeated every 10-15 minutes up to maximum of 30 mg dose
- Cesarean section for status eclampticus

Signs of magnesium sulfate toxicity

- Urine output drops to less than 25 to 30 ml/hour
- Absent knee jerk (DTR)
- Respiratory rate drops to <16/minute

In case of any toxicity

- Skip next maintenance dose
- Give Inj. 10% calcium gluconate 10 ml over 10 minutes in case respiratory depression is seen

Signs of reaction to injection

- Blister formation if not given deep IM
- Warmth, thirst, headache, nausea or vomiting

Guidance for applicability to facility

- Emphasize on the safety of MgSO₄ to all care providers (including doctors and nurses)
- Facilitate approval of the use of MgSO₄ by staff nurses (the initial IM dose of 5 gm in each buttock) in cases of severe Pre-eclampsia and Eclampsia
- Consider the facility specific protocol for management with injection MgSO₄; for example, at non-FRU level recommend at least the initial dose before referral
- Use antihypertensive drugs only when diastolic blood pressure is > 100 mmHg. Review the choice of antihypertensive used in the facility in line with the guidelines

VI.Appropriate use of antibiotics

A.Indications for antibiotic use in mother and newborn

Indications for mother	Indications for newborn
<ul style="list-style-type: none">• Fever (Temperature above 38°C/100.5°F)• Foul smelling vaginal discharge• Prolonged labor lasting more than 24 hours• Obstructed labor• Planned Cesarean section• Lower abdominal tenderness after delivery• Manual removal of placenta• Preterm Pre-labor rupture of membranes (before 37 weeks)• Prolonged rupture of membranes:<ul style="list-style-type: none">o More than 12 hours without labor paino More than 18 hours with labor pain	<p>Therapeutic- clinical signs of neonatal sepsis:</p> <ul style="list-style-type: none">• Baby has very fast breathing (>60 per minute) or very slow breathing of newborn (<30 per minute) chest in drawing, grunting• Convulsions• Sick looking baby• Baby has stopped breastfeeding• Excessive crying or lethargic baby• Fever (Temperature above 38°C)• Hypothermic baby, not responding to warmth (Temperature below 36°C)• Umbilical redness extending to skin or draining pus <p>Prophylactic- mother had uterine infection during intrapartum period and upto 3 days after delivery</p>

B.Recommended antibiotics for mother

Not very sick mother	Very sick mother
Ampicillin 1 gm - 6 hourly Oral Metronidazole 400mg - 8 hourly Oral Gentamycin 80mg - BD Intramuscularly	Ampicillin 1 gm - 6hrly Intravenous Metronidazole 500mg - 8 hourly Intravenous Gentamycin 80 mg - BD Intramuscularly

D.Recommended antibiotics for newborn (if FBNC is not available)

Weight	Dose of injection gentamicin	Dose of syrup amoxicillin
Less than 1.5 kg	To be referred to higher facility	
Above 1.5 kg – upto 2.0 kg	0.2 mL	2 mL
Above 2.0 kg – upto 3.0 kg	0.3 mL	2.5 mL
Above 3.0 kg – upto 4.0 kg	0.4 mL	3 mL
Route of administration	Intramuscular	Oral
Dosage	5 mg/kg/dose Once a day	25mg/kg/dose Twice a day

Guidance for applicability at facility

- Conditions mentioned for use of antibiotics is not the exhaustive list, but most critical for care during labor and delivery
- Discourage routine use of antibiotics

VII. Technique for PV examination

Steps for PV examination

1	GETTING READY
a.	Keeps the following equipment ready: <ul style="list-style-type: none">• 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: <ul style="list-style-type: none">• 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 <ul style="list-style-type: none">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 cervixii. 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

VII. Technique for handwashing

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB



Duration of the entire procedure: 40-60 seconds

0



Wet hands with water;

1



Apply enough soap to cover all hand surfaces;

2



Rub hands palm to palm;

3



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

4



Palm to palm with fingers interlaced;

5



Backs of fingers to opposing palms with fingers interlocked;

6



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

7



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

8



Rinse hands with water;

9



Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.



World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES

Clean Your Hands

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Guidance for applicability at facility

- Discuss with the MOI/c, labor room in-charge and staff the importance of allowing birth companion with each laboring woman
- Birth companion is someone who will be with laboring woman during and immediately after delivery, such as- any family member, ASHA, AWW etc
- Consider the cultural sensitivity while allowing birth companion, especially if the birth companion is a male

What Birth Companions should Know

Danger Signs for Mother	Danger signs for baby	Counselling advice
Excessive Bleeding	Fast/difficulty in breathing	Support to cope up with labour pains
Severe abdominal pain	Fever	No bath/oil for baby
Difficulty in feeding	Unusually cold	No Pre-Lacteal feed
Sever headache or blurring of vision	Stops feeding well	Initiate breastfeeding in half-an-hour
Urge to push	Less activity than normal	Clothe and wrap the baby
Can't empty bladder every 2 hours	Whole body becomes yellow	
Fever or chills		
Foul smelling vaginal discharge		

