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MCHIP Maternal and Child Health Integrated Program

National MNCH Program

MATERNAL NEWBORN CHILD HEALTH CENTER IMPLEMENTATION GUIDE

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in MNCH, immunization, family planning, malaria, nutrition and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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Abbreviations

AMTSL	Active management of third stage of labor
ANC	Antenatal Care
BEmONC	Basic emergency obstetric and newborn care
BHU	Basic health unit
BP	Blood pressure
CEmONC	Comprehensive emergency obstetric and newborn care
CHX	Chlorhexidine
CSG	Community support group
CMW	Community midwife
COC	Combined oral contraceptive
DHIS	District health information system
DOH	Department of Health
EmONC	Emergency obstetric and newborn care
EPI	Expanded program on immunization
FANC	Focused antenatal care
FP	Family planning
HBB	Helping Babies Breathe
HLD	High-level disinfection/disinfected
IMNCI	Integrated Management of Newborn and Child Illnesses
IUCD	intrauterine contraceptive device
LHV	Lady Health Visitor
LHW	Lady Health Worker
MBBS	Bachelor of Medicine/ Bachelor of Surgery
MCH	Maternal and child health
MCHIP	Maternal and Child Health Integrated Program
MCPC	Management of Complications in Pregnancy and Childbirth
$MgSO_4$	Magnesium sulfate
MLBC	Midwife-led birthing centers
MNCH	Maternal, newborn, and child health
MOH	Ministry of health
MVA	Manual vacuum aspiration
NGO	Non-government organization
OJC	On the job coaching
OJT	On the job training
OPD	Outpatient department
OSCE	Objective Structured Clinical Examination
PAINS	Period, abdominal pain, infection, not feeling well, strings
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
PNC	Postnatal care
PPFP	Postpartum family planning

PPH	Postpartum hemorrhage
PPHI	People's Primary Health Initiative
PPIUCD	Postpartum intrauterine device
PROM	Premature rupture of membranes
QIPS	Quality improvement and patient safety
QIT	Quality improvement team
RHC	Rural health centre
SBA	Skilled birth attendant
SG	Support group
TAG	Technical advisory group
TIMS	Training Information Management System
TOT	Training of trainers
TT	Tetanus toxoid
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development

Foreword

The Pakistan Ministry of Health (MOH) has supported a number of maternal, newborn, and child health (MNCH) and family planning (FP) initiatives to improve the health of Pakistani families. Despite these significant efforts, key demographic health indicators in Pakistan are lagging. With a maternal mortality ratio of 276 deaths per 100,000 live births, an infant mortality rate of 74 deaths per 1,000 live births and only 52% of births assisted by a skilled birth attendant, critical gaps remain.

To address these gaps, the national MNCH Program has introduced several significant interventions to improve the uptake of skilled birth attendance. For example, in 2007 an initiative was introduced to train and deploy a new cadre of health care providers: community midwives (CMWs). To date, the new program has deployed 888 CMWs in Sindh Province. However, the program has experienced challenges in the provision of ongoing post-deployment support. The Maternal Newborn Child Health Center initiative is an innovative model that facilitates the provision of comprehensive MNCH/FP care by CMWs and other skilled birth attendants (SBAs). The expected outcome of the MNCH Center initiative is high-quality, accessible, and affordable MNCH/FP services provided to underserved communities by competent, professional SBAs.

The MNCH Center initiative works in collaboration with other key public- and private-sector partners to address the socioeconomic and cultural barriers that delay or prevent women from accessing the lifesaving services they need during the antenatal, intrapartum, and postpartum periods. For example, the initiative will strengthen referral links and emergency transportation plans to ensure that timely referrals take place when they are needed. Community-level efforts, focusing on community education and community mobilization, will further support the initiative by sensitizing women, their partners, and key family decision-makers to the need for birth preparedness and complication readiness plans and the benefits of skilled birth attendance.

Many partners and stakeholders have been involved in the development of this important initiative. In particular, I would like to acknowledge the hard work of the technical advisory group and technical task force members who have contributed significant time and expertise toward the betterment of health care in our communities.

Regards,

Dr. Hasan Murad Shah
Director General Health, Sindh
Chair, MNCH Technical Advisory Group

Acknowledgments

The technical advisory group (TAG) of the MNCH Center initiative hereby acknowledges the efforts, technical support, and guidance of its partners for their review of this *Maternal Newborn Child Health Center Implementation Guide*. Technical review and revisions for the guide were provided by the TAG's technical task force, as represented by the Sindh Province Department of Health, the Sindh Province MNCH Program, the Midwifery Association of Pakistan, the National Committee for Maternal and Newborn Health, the Aga Khan University School of Nursing and Midwifery, People's Primary Health Initiative (PPHI), a member community midwife (CMW), and Component 2 of U.S. Agency for International Development (USAID)/Pakistan's MCH Program. We also wish to acknowledge the SBAs who support this initiative and work tirelessly in their communities to improve the lives of women and their families.

Introduction

The U.S. Agency for International Development (USAID)/Pakistan's Maternal and Child Health (MCH) Program applies a five-pronged strategy to achieve improvements in maternal, newborn, and child health (MNCH). Component 2a of the program focuses on work to improve the quality of MNCH service delivery and close collaboration with the other four components (behavior change communication, health supplies, family planning (FP)/reproductive health, and health systems strengthening). As part of a larger USAID-funded consortium, MCHIP/Jhpiego leads Component 2a working in concert with the Marie Stopes Society, Population Services International, John Snow, Inc., the DELIVER Project, and Johns Hopkins' Center for Communication Programs. Although each partner in the portfolio is responsible for specific activities and deliverables, all partners work in close coordination to achieve the same goal: improved health outcomes for newborns, children, and women.

This *Maternal Newborn Child Health Center Implementation Guide* was produced as part of USAID/Pakistan's MCH Program Component 2a. The purpose of this Implementation Guide is to provide government leaders, program implementers, partners, district teams, supervisors, and SBAs the consolidated programmatic and technical resources and tools needed to effectively introduce, continue, and scale up high-quality MNCH Center services.

The hope is that this guide will serve as a "living" document, to be expanded and refined over the course of the implementation process. As the MNCH Center is a new and exciting model of MNCH/FP health care delivery in Sindh, a period of sensitization and orientation to the MNCH concept at all levels will be needed. This guide is intended to assist in that process.

Maternal Newborn Child Health Center Model

BACKGROUND

In Year 1, the MNCH Services Component proposed to establish the Midwife-Led Birthing Centers (MLBCs) primarily to mobilize the community midwives (CMWs) trained by the government. The aim was to support CMWs to establish private practices offering antenatal care, normal delivery care, postnatal and neonatal care, and family planning. Since the CMWs had limited experience, they were not initially expected to provide basic emergency obstetric and newborn care (EmONC).

Photo credit: Jhpiego
A student at a midwifery school

By December 2013, 112 CMWs were identified and provided support to set up MLBCs in the five target districts of Sindh. However, it soon became clear that the MLBCs run by CMWs would need some time to take root within the communities they served. Meanwhile, a majority of women were utilizing private maternity homes run by Skilled Birth Attendants, or SBAs, (MBBS doctors, Lady Health Visitors, or nurse-midwives) and public-sector health facilities offering basic EmONC. The quality and range of services provided at these facilities varied greatly because there were no set standards for MNCH services in the private sector.

On-the-ground experience during Year 1 and Year 2 and increased understanding of program, highlighting the need to provide standardized skilled birth attendance, basic EmONC, and referral and transportation links with comprehensive EmONC. Thus emerged the idea of the MNCH Center, a standardized facility that serves as the first point of contact between the woman and health services, and that provides all of the basic MNCH services under one roof.

Like the MLBCs, MNCH Centers aim to improve access and availability to quality MNCH services—including antenatal care and risk assessment, normal delivery care, basic EmONC on 24/7 basis, and postnatal and neonatal care—provided by competent skilled birth attendants (SBAs) in rural areas of Sindh. In addition, however, the MNCH Centers expanded the range of services to also include child health care, immunization, nutritional education, and micronutrients to women and children.

While the MLBCs were conceived to operate only in the private sector, the MNCH Center concept is applicable in both the public and the private sectors. In the public sector, the MNCH Center will be a part of a government health facility (Basic Health Unit, BHU, or Rural Health Center, RHC). People's Primary Healthcare Initiative (PPHI) has upgraded some of its health facilities, which are providing normal delivery care and basic EmONC on a 24/7 basis. MCHIP/Jhpiego will support PPHI to ensure the quality of MNCH services at these facilities.

In the private sector, the MNCH Center concept will apply to all private practices run by SBAs, including those supported by the MCH Program partners (e.g., Marie Stopes Society's Suraj-B clinics or Greenstar Plus franchise clinics). The private-sector MNCH Centers will continue to run as for-profit business enterprises; however, MCHIP/Jhpiego will support these facilities to ensure that they provide quality MNCH services. Private MNCH Centers are expected to charge an affordable fee for their services, which will be sufficient to provide a source for livelihood and ensure sustainability. MCHIP/Jhpiego will also build the SBAs' business and entrepreneurial skills through specialized trainings.

ROLE OF THE MNCH SERVICES COMPONENT

Through the MNCH Services Component, MCHIP/Jhpiego will establish the following support systems to enhance efficiency and ensure sustainability of the MNCH Centers:

- Community mobilization through mass media and mid-media to create a demand for quality MNCH services, promote best practices, and reinforce key messages
- Tele-health service to connect the SBAs to more experienced clinicians (obstetricians and pediatricians) to receive guidance in complicated and/or emergency cases
- Pre-hospital transportation systems facilitated by tele-health service and referral links between MNCH Centers and comprehensive EmONC
- Systems for continuous supply of medicines and maintenance of equipment

GOAL

The MNCH Services Component aims to leave behind at least 1,000 fully functional MNCH Centers in strategic locations throughout its target districts. These will include the newly established facilities run by CMWs; already functioning private facilities, including those supported by other MCH Program partners; and the government health facilities. The ultimate aim is to ensure that, in the MNCH Component's target districts, every woman has access to a facility providing high-quality, standardized MNCH services at an affordable cost. The target for Year 2 is 200, including 100 newly constructed/renovated MNCH Centers run by CMWs.

GOVERNING BODY OF MNCH CENTERS

An MNCH Center-specific TAG has been established to provide guidance in the implementation of these centers. The group is a decision-making body and is chaired by the Director General of Health, Sindh. It also includes the MNCH Program Sindh, SBAs, and other prominent private-sector stakeholders, including the National Committee for Maternal and Newborn Health and Agha Khan University.

MNCH Center Program Approach

MNCH CENTER SERVICES

An MNCH Center is any facility that is adequately equipped and staffed to provide seven high-quality MNCH services at an affordable cost. These services include:

- Family planning (routine and postpartum)
- Antenatal care, risk assessment, and birth preparedness
- Normal delivery (24/7)
- Basic EmONC (24/7)
    - Parenteral treatment of infections (antibiotics)
    - Parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants)
    - Parenteral treatment of hemorrhage (uterotonics)
    - Manual removal of the placenta
    - Assisted vaginal delivery
    - Removal of retained products
    - Newborn resuscitation
- Postnatal care for mother and baby
- Child health care and immunization
- Nutrition education and supply of micronutrients

The Program understands that not all supported facilities are currently providing the same complement of the above services. The goal is that MNCH services will be able to provide most services by the end of the life of the project. In the meantime, facilities will be capacitated to add services in a logical, progressive manner according to the individual facility situation and the needs of the community it serves.

TYPES OF MNCH CENTERS

An MNCH Center may fall into one of five categories:

Table: Types of MNCH Centers

Public	DOH
	PPHI
Private	CMWs
	Commercial
	NGO

Department of Health (DOH) facilities. MCHIP/Jhpiego's strategy is to work in close collaboration with the DOH at all primary level public facilities in the target districts. While the RHCs operated by DOH were designed to provide BEmONC services, many are in need of technical and infrastructural upgrading to achieve BEmONC capacity.

PPHI. PPHI is a private organization to which the Government of Sindh has outsourced the majority of its primary healthcare facilities. PPHI has a vast network of primary healthcare facilities in Sindh (mostly BHUs), resources, authority and the commitment to improve the MNCH Services in Sindh.

Commercial. About 17% of the facilities in target districts are commercial/for-profit. These are private facilities with a large, well-established client volume. They usually having multiple providers, some of whom have dual jobs, such as maintaining a posting in a government health facility while running private practices.

CMWs. MCHIP/Jhpiego is expanding the original CMW strategy to include non-active CMWs as well as newly graduated CMWs.

Private facilities run by NGOs. A relatively new category for MCHIP/Jhpiego, these are private facilities operated by NGOs which charge subsidized fees to the clients. For example, some MNCH Centers are affiliated with All Pakistan Women's Association (APWA), or other local NGOs working in the health sector.

MNCH SERVICES COMMUNITY LINKAGES

The initial placement plan would be to have, on average, at least one MNCH Center per union council, with all MNCH Centers linked with comprehensive EmONC services in the district. To ensure smooth and rapid referrals, all MNCH Centers will be linked to higher-level facilities offering comprehensive EmONC. In addition, MNCH Center staff will collaborate with existing service providers, including Lady Health Workers, in a spirit of partnership rather than competition, to ensure strong uptake of MNCH/FP services. As part of the mentoring strategy, community health care providers will assist less-experienced SBAs to forge collegial relationships with traditional birth attendants in their respective areas. A CMW/SBA's endorsement by a Lady Health Worker or Traditional Birth Attendant, usually an older woman who is trusted in her community, will foster acceptance and use of MNCH Center services.

IMPLEMENTATION STEPS

The following steps are needed to establish and support participating SBAs and MNCH Centers in new project supported districts:

- Conduct district-level mapping activities to determine the availability of MNCH/FP services in a given geographic area.
- Identify and select SBAs/existing clinics in program target districts of Sindh; ascertain their interest in MNCH Center participation; and assess their clinical and business skills through multiple approaches.
- Initiate and continue the Quality Improvement and Capacity Building process with each MNCH Center. An essential part of this process (which is discussed in detail in the subsequent section entitled "Quality Improvement and Capacity Building Cycle") is the development and implementation of site strengthening and capacity building action plans that address infrastructure, supply, equipment, knowledge and skills gaps according to defined standards.
- Run community mobilization activities (e.g., utilize technology to engage with the community) and mid- and mass-media activities to enhance the acceptability of SBAs, increasing awareness and use of their services.
- Provide approved upgrading interventions per site assessments (this may include infrastructural renovations and/or supply and equipment procurements.)
- Provide continued knowledge and skills development through group-based and on-site supervision at MNCH Centers.
- Train and provide on-the-job mentorship to private SBAs in entrepreneurship, marketing, small-scale business planning, and management; provide ongoing guidance to sustain and grow their business.

TECHNICAL SUPPORT FOR MNCH CENTERS

Initially, MCHIP/Jhpiego will hire one Senior Clinical Supervisor per district to support and oversee clinical aspects of MNCH Center activities. District-level sub-awardees will also hire Clinical Officers to work intensively at MNCH Center level to deliver high-quality MNCH/FP skills. Clinical Officers will support seven to eight MNCH Centers each, under the technical guidance of Senior Clinical Supervisors. Senior Clinical Supervisors and Clinical Officers will provide supportive supervision and mentorship to SBAs and will reside within the districts. Upon joining the project, new technical staff (including Senior Clinical Supervisors and Clinical Officers) will undergo a rigorous knowledge, skills, and attitudes orientation which includes standardization in effective teaching skills as well as updating in specific technical areas.

The MNCH Center Quality Improvement and Capacity Building Cycle

MNCH Centers will be structured around TAG-endorsed operational standards. These standards will be applied according to a standards-based approach to quality improvement called Quality Improvement and Patient Safety (QIPS). This approach consists of the systematic use of performance standards for assessment, gap analysis, action planning (including capacity building interventions) to address gaps, repeat assessment, and recognition of improvement. The quality assurance/ quality improvement process includes four basic steps:

1. Setting performance standards in an operational way
2. Implementing the standards through a streamlined and systemic methodology
3. Measuring progress to guide the improvement process toward these standards
4. Recognizing the achievement of the standards

This approach will underpin the delivery of uniform high-quality services at MNCH Centers, guiding the initiation of services as well as recognition of high achievement within the centers.

QIPS ASSESSMENT AND TRAINING NEEDS ASSESSMENT

1. **Baseline Assessment** An inter-partner team will support baseline QIPS assessments at all MNCH Centers. Technical staff will work with facility teams to review the findings from the baseline assessment. Then, together, teams will design facility-specific action plans to target gaps. Action plans will address knowledge, skills, and attitude/motivational gaps through tailored capacity building plans. (Detailed QIPS Instructional Guide and QIPS tool included as Annex AN and Annex AO)
2. **Action Planning and Follow up** District-based teams will support MNCH Centers to implement action plans with bi-monthly visits to review progress against the action plans. They will also support the implementation of on-site capacity building interventions. Technical team will compare their own team's assessment with the facility team's assessments, and discuss any areas of divergence. They will engage in one-to-one mentorship with individual team members. Clinical skills assessments will be conducted during regular monthly supportive supervision visits.
3. **Repeat assessment** The inter-partner team will re-assess each MNCH Center every 6 months to track progress and identify any new challenges since the previous QIPS assessment.
4. **Continue to review action plans, follow up, and reward achievement.** The quality improvement cycle is an ongoing process of review, refinement, and continual capacity

building. Progress is consistently documented and tracked, with appropriate reward mechanisms determined in collaboration with district teams. "High quality" is defined as 80% achievement against QIPS standards.

NEEDS-BASED CAPACITY BUILDING FOR SKILLED BIRTH ATTENDANTS

MCHIP/Jhpiego employs mix of capacity building activities to address both provider performance and confidence and help providers achieve quality standards. Trainings may be delivered as:
1) group-based trainings where more than four participants gather at an off-site location for a competency-based learning activity, or as
2) On-the –Job (OJT) trainings, where individual providers (or a facility-based team of providers) participate in a structured learning activity at their facility.
Both group-based trainings and OJTs are followed up by continued supportive supervision through facility-based coaching and mentoring.

Before conducting any specific training in a given technical area, all clinical trainers are expected to:

1. Complete Training Skills (TS) course – this is only completed once. It is not specific to any technical area.
2. Complete a mentored co-training experience
3. Attend the TOT of a specific learning resource package. Or, in the absence of a TOT, participate in a group training experience conducted by certified trainers.
4. Complete six UNFPA e-learning modules (accessible at: http://reprolineplus.org/learning-opportunities).

Photo credit: Jhpiego
A midwife practicing on a MamaNatalie model

Details about e-learning process and tracking of technical staff continuing education can be found in Annex P.

GROUP BASED TRAINING

Training of Trainers

For group-based trainings, the MCHIP/ Jhpiego team will also be responsible for conducting centralized Training of Trainer (TOT) activities and developing district trainers capable of leading subsequent roll-out trainings for SBAs in the districts

Training schedules are finalized quarterly through collaboration between Head Office and the district teams. Following the development and introduction of new Learning Resource Packages for any group-based training, a Training of Trainers (ToT) is conducted by MCHIP/Jhpiego - preparing Master Trainers. TOTs are regularly monitored by the Head Office technical advisors to ensure training consistency and for the provision of additional support as needed.

Learning Resource Packages

MCHIP/Jhpiego has developed standardized Learning Resource Packages in accordance with global and national guidelines to build provider knowledge, skills, and attitudes. Training packages (including trainer and learner materials, as well as supplemental job aids and guidance) are provided for use at district-level. These packages are endorsed by the Sindh DOH.

The following training packages will be rolled out during the course of the project.

Training Name	Training Length	Brief Description
Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)	6 days	Includes management of all normal and routine evidence-based MNCH care, as well as management of postpartum hemorrhage, and pre-eclampsia/ eclampsia, and sepsis.
Management of Complications in Pregnancy and Childbirth (MCPC)	4 days	Includes Post-Abortion Care (uterine evacuation by manual vacuum aspiration or medical management), and assisted vaginal delivery (vacuum assisted delivery), as well as episiotomy and repair.
Post Abortion Care	4days	
Helping Babies Breathe	2 days	Includes neonatal resuscitation.
Competency Base IUCD Doctors	6 days	Includes IUCD and FP overview of all methods for SBAs
Competency Base IUCD CMW/LHVs	10 days	Includes IUCD and FP overview of all methods for SBAs
Advanced family planning: Intrauterine Contraceptive Device	6 days	Includes skills based training on client-centered counseling, and insertion/removal of interval IUCD
Contraceptive Implants (for doctors only) – PWD	2 days	Includes skills based training on client-centered family planning counseling, insertion and removal or implants
Postpartum Intrauterine Contraceptive Device (PPIUCD)	4 days	Includes all aspects of PPIUCD service delivery and technique.
Cough and Difficult Breathing (Pneumonia and Diarrhea)	3 days	Includes diagnosis and management of childhood cough and difficulty breathing, per new WHO guidelines.
Nutrition	2days	Include Mother, infant and young Child nutrition with special focus of breastfeeding skills and counselling.
OJT on Routine Immunization for SBA	1day	Includes overview of routine immunization for mother, newborn, and child per WHO recommendations

Participant Selection for Group-Based Trainings

Selection of participants for training should be based on the following criteria:

- Qualification as a SBA working at an MNCH Center: obstetrician (or general practitioner/ medical officer), Lady Health Visitor, nurse and/or midwife
- Work experience as a provider in a facility delivering MNCH services
- Commitment to utilize the knowledge and skills gained in the course in his/her facility.
- Has not participated in a training in this service delivery area in the last two years. (If a provider has participated in a similar training in the past two years, the Clinical Officer will conduct a Training Needs Assessment (TNA) to determine whether the provider should be retrained. If performance on the (TNA) is acceptable (over 75%), Clinical Officers will make individual plans for continued coaching and mentoring.

Documentation Requirements for Group-Based Trainings

For each group -based training, trainers should complete the following:

- Fill the TIMS form (See Annex H)
- Administer and grade knowledge pre-assessment for each participant (included in training materials)
- Administer and grade knowledge post-assessment for each participant (included in training materials)
- Complete the analysis of scores of pre/ post-assessment (At the end of all group based trainings, trainees must achieve 80% marks in post-test for certification.)
- Administer and collect the training evaluation form which is completed by all participants (See Annex)
- Administer and score skills checklists for each new skill area (All participants should pass the Structured Clinical Exam or OSCE – as assessed against a standardized skills checklist - with minimum 80% of score)

Certification for Group-Based Trainings

Achieving the minimum pass score on the post-training knowledge assessment and the skills assessment is necessary for training certification. All learners who achieve pass marks of 80% or higher on the post-test and post-training OSCEs will receive training certificates. If a learner does not achieve 80% or higher on the post-test and post-training OSCEs, he or she is not eligible for a training certificate, and a follow-up remediation plan should be developed to help him or her achieve certification.

A providers' experience during skills based trainings also informs his or her individual learning plan – these learning plans guide the selection of topics for continued on-the-job training/coaching/and supportive supervision visits. Clinical support staff (Senior Clinical Supervisors or Clinical Officers, depending upon the district situation, will maintain logbooks for each supported provider at MNCH Centers. These logbooks will contain information about training completed, OJTs completed, OSCE performance, and individual learning needs. The maintenance of these logbooks will be the responsibility of the clinical support staff in partnership with the provider. See Annex O for a sample of the Provider Capacity Building Tracking Sheet which forms the basis of the provider logbooks.

ON THE JOB TRAINING

MCHIP/Jhpiego has prepared 16 OJT modules in key areas of MNCH service delivery. These modules are delivered as a package during PCPNC trainings and singly during OJT sessions. Clinical Officers should select an OJT module for a supportive supervision visit based on the needs of the specific MNCH Center/provider(s). Decisions about OJT support to MNCH Centers are not arbitrary; they are carefully made based on gaps documented in QIPS assessments and program capacity building activities. For example, Clinical Officers may prioritize an OJT session on partograph if a given MNCH Center did not meet partograph-related performance standards in its QIPS assessment.

In some cases, group-based training content may be delivered in an OJT format if providers are not able to attend a full-time group-based training. In this way, it may be possible to combine staff from more than one MNCH Center for a given OJT training session.

OJT modules:

1. Focused Antenatal Care
2. Birth Preparedness and Complication Readiness
3. Vaginal Bleeding in Pregnancy
4. Rapid Initial Assessment and Management of Shock
5. Normal Labor and Childbirth
6. Partograph
7. Active Management of the Third Stage of Labor
8. Normal Childbirth: Beneficial Practices
9. Prevention and Management of Pre-eclampsia/ Eclampsia
10. Postpartum Hemorrhage
11. Management of Postpartum Hemorrhage
12. Postpartum Care
13. Puerperal Sepsis
14. Normal Newborn Care
15. Breastfeeding
16. Infection Prevention and Control

Each OJT module contains a set of materials designed to support on-site learning in that technical area. MCHIP/Jhpiego will provide all Senior Clinical Supervisors, Clinical Officers, and district teams with flash drives containing all OJT content. Technical staff can then reproduce hard copies of OJT materials on an as needed basis. Standardized content in each module includes:

- OJT session objectives and session outline
- Knowledge assessments (pre and post)
- PowerPoint presentations with updated, evidence-based didactic content
- Interactive learning materials – exercises, role plays, case studies, simulations, etc.
- Job aids and handouts
- Clinical Skills Checklists

Documentation Requirements for OJT Visits:

- TIMS forms need to be fill for each SBA who participated in the OJT
- Appropriate skills checklist for that OJT
- Pre and post knowledge assessments
- Training evaluation form
- OJT visit data collection form
- Provider Logbook

How to Conduct an OJT Session

Each OJT module will have its own specific supplies/materials requirements, which are outlined in the course materials. However, Clinical Officers should be prepared with a laptop with OJT content, anatomic models like the MamaNatalie and NeoNatalie simulators, and any other related clinical or demonstration supplies, handouts, etc. Clinical Officers will need to bring these materials with them to the MNCH Center receiving the OJT. On the job training activities should be scheduled and planned well in advance with the facility staff and management.

POST-TRAINING COACHING AND MENTORSHIP

Acquisition of new knowledge, skills, and attitudes is a process that happens over time, as learners progress from competency to proficiency to mastery. In order to support this learning process, is it essential to reinforce training activities through ongoing mentorship and support. On-site capacity building may take several different forms: routine supportive supervision, or a targeted on the job coaching (OJC) and mentorship visit.

Supportive Supervision Visits

Supportive supervision is a term used to describe facility visits to observe, coach, assist in problem-solving, and track progress in providers' clinical capacity. During these follow up visits, staff should discuss the QIPS assessment tool (the QIPS tool itself can be used to coach and support the SBAs in their daily work) and progress against the facility/ learner action plans. Action plans are further refined with facility teams during supportive supervision visits.

The objectives of supportive supervision visits are:

- To fill the gaps related to knowledge, skills, confidence and current practices of SBA's after training.
- To provide additional coaching in clinical skills.
- To work with supervisors to help ensure that SBAs have the support needed to apply new knowledge and skills at their job sites.
- To collect information about SBAs performance in order to assess the progress of action plan of QIPS.

The number of supportive supervision visits provided to any single MNCH Center will vary according to the needs of that Center. For instance, a lower performing MNCH Center (as determined by QIPS findings and SBA performance in training activities) should receive more support than a higher performing MNCH Center. The frequency of supportive supervision visits will also depend upon the range of services available in the MNCH Centers and the Centers hours of operations (24/7, 24/6, 12/7, 12/6, 8/6). However, Clinical Officers should visit each MNCH Center for at least two twice per month.

Technical staff members are advised to make the most of these supportive supervision visits. In other words staff should try to complete multiple objectives within one visit to an MNCH Center – for example, a Clinical Officer may review the QIPS action plan, conduct an OJT, and provide OJC with that day's clientele. Technical staff should also be sensitive to the many competing demands on busy SBA's time. Supportive supervision and on-site training should not interfere with the delivery of high-quality, respectful client care. A flexible approach that allows Clinical Officers to adapt to MNCH Center scheduling is advised. For instance, SBAs may not be able to dedicate the time to an OJT if clients are waiting to be seen. However, high client volume presents an excellent opportunity for learning transfer via coaching and mentorship.

If after several visits, an individual SBA is having difficulty grasping particular knowledge or skills in a given area, additional attention is required. Technical staff should document these findings and notify the district team (including District Coordinator, Senior Clinical Supervisor, District Health Officer, PPHI District Manager, Neonatal and Child Health Coordinator, field manager and Technical Advisors). Some learners may require more intensive mentorship through peer learning, or more frequent contact with technical support.

Preparing for a Facility Visit:

1. Plan to spend at least 1 hour with each SBA in each scheduled visit for OJC and monitoring.
2. Contact the SBA/facility and agree to a date for the visit. Review the purpose of this follow up visit.
3. Contact the learner's supervisor/ facility In-charge to confirm your visit. Review the purpose of the follow up visit and make appointment to meet with the supervisor before and after your visit.
4. Prepare the required teaching, learning and documentation materials – including blank copies of the clinical skills checklists and any anatomic model(s) that will be required for the skills to be practiced and evaluated.
5. Review the SBAs performance during the course (test and skills scores achieved), as well as the provider/facility action plan.
6. Meet with the Supervisor/ In-charge at the beginning and end of the visit and share your findings and recommendations with her/them.
7. Encourage SBAs to work with their teams and supervisors to practice skills through role plays and with models and checklists and to reinforce their knowledge with the assistance of knowledge questionnaires and case studies.

On the Job Coaching (OJC)

OJC and clinical mentorship can be conducted on actual clients, or on anatomical models such as MamaNatalie. OJCs are used to assess competency of specific clinical skills. So, if a provider is seeing a client for a focused antenatal care visit, the Clinical Officer should use the FANC skills checklist to guide mentorship. The completion of skills checklists is essential for determination of competency. The skills checklists have been adapted to include steps that are considered most "critical" in determining whether an SBA is competent in providing that skill.

Documentation Requirements for OJC Visits:

- OJC data collection form (for each coaching session with an SBA).
- Provider Logbook including all completed skills checklists.

Frequently Asked Questions and Answers Related to Capacity Building Activities

Question 1: How do I know if a provider is eligible for a group-based training or an OJT training?
Answer 1: *If a provider scores below 75% on a Training Needs Assessment on that particular topic, he or she should receive additional training. An OJT is the right training choice for providers who are not willing to travel due to busy clinical schedules.*

Question 2: After a group-based training activity, what kind of ongoing support does the provider receive?

Answer 2: *After a group-based training, Clinical Officers should follow up trained providers with on-the-job coaching and mentorship (NOT on the job training).*

Question 3: How many OJCs should be done in one visit?
Answer 3: *Clinical Officers should not complete more than one OJC session in one day at one MNCH Center.*

MNCH CENTER BUSINESS MODEL

In addition to established public-sector institutions, Pakistan has a thriving private health care system. Studies have shown that Pakistanis of all income levels are willing to pay for high-quality services. The MNCH Center model builds on the private health care foundation to supplement and support existing services offered within the public sector. Following the initial 6 to 12 month start-up period in which CMWs will receive considerable business, material, educational, and clinical support, it is expected that MNCH Center CMWs will have the knowledge, skills, and confidence necessary to continue the MNCH Centers as independent private practices.

In addition, private-sector MNCH Center CMWs will charge for services according to a locally acceptable fee structure. The fee structure will include a sliding scale to make life-saving MNCH/FP services available to all women and families who need them. In close collaboration with a small business advisory firm, private CMW-led MNCH Centers will function according to detailed strategic business and management plans, which will ultimately establish the MNCH Center approach as a long-term, self-sustaining option for all families seeking accessible, high-quality MNCH/FP services.

Photo credit: Jhpiego

A practicing CMW at her clinic in Sindh

Appendix A: Signal Functions of Basic and Comprehensive Emergency Obstetric and Newborn Care

LEVEL OF CARE	SIGNAL FUNCTIONS
Basic Emergency Obstetric and Newborn Care	1. Parenteral treatment of infections (antibiotics) 2. Parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants) 3. Parenteral treatment of hemorrhage (uterotonics) 4. Manual removal of the placenta 5. Assisted vaginal delivery 6. Removal of retained products 7. Newborn resuscitation
Comprehensive Emergency Obstetric and Newborn Care	8. Cesarean sections/surgical capability 9. Blood transfusion

Appendix B: MNCH Supply, Equipment, and Medicine List

NO COLOR = supplies provided according to needs identified on assessment
PINK = items provided after training completed
YELLOW = all centers are provided with these items regardless of need

SN	Items Description
General Items and Furniture	
1.	Office table
2.	Office chair
3.	Exam table
4.	Cabinet, for drugs / instruments
5.	patient stool (Revolving)
6.	waiting bench for high volume facilities
7.	Wall Clock
Medical Equipment	
8.	Screen/curtain for privacy
9.	Instrument Trolley with two trays
10.	Delivery table
11.	IV Infusion Stand,
12.	Autoclave/Boiler for HLD
13.	Emergency standby light
14.	Refrigerator/for facility providing Immunization
15.	Mobile examination light (SMIC China)
16.	BP Apparatus - functional (at least one per service site)
17.	Stethoscope - functional(at least one per service site)
18.	Nelaton catheter/ Foley catheter
19.	Safety Box for used syringes / needles
20.	Adult Weighing scale
21.	Thermometer, clinical, 35-42°C
Medical Supplies	
22.	Patients drape
23.	**Vacuum extractor (for assisted delivery)**
Documentation	
24.	DHIS Child OPD register
25.	IMNCI case investigation forms for pneumonia and diarrhea
26.	IMNCI Chart for pneumonia and diarrhea
27.	Box file (Partograph, QIPS, OJT etc.)
28.	Antenatal register

SN	Items Description
29.	Labor Register
30.	Referral record
31.	Immunization
32.	Partographs book or clip file
Examination Kit	
33.	Double-ended, Sims Vaginal medium size/Cusco's Vaginal Speculum medium size
34.	Stainless steel Kidney Basin, 825 ml
35.	Straight Artery Forceps 140 mm
36.	Sponge holder/straight Artery Forceps, 140 mm
37.	Stainless steel Bowl, 600 ml
Implants kit	
38.	Implants Insertion/removal kit
39.	Small straight artery
40.	Small curved artery
41.	Scalpel/Blade holder
42.	Sponge holding forceps
43.	Plain forceps
44.	Kidney tray
45.	Plain Scissor
46.	Tenaculum
47.	Uterine sound
48.	Cuscos speculum medium size
49.	Sponge holding forceps
50.	Plain forceps
51.	Long straight artery forcep
52.	Thread retriever
53.	IUCD Hook
PPIUCD Insertion Kit	
54.	Tenaculum
55.	Sims speculum medium
56.	Sponge holding forceps
57.	Plain forceps
58.	Long kelley forcep
59.	kidney tray
Pneumonia and Diarrhea	
60.	Weighing scale
61.	One Jug (1L), 6 Cups(50), 6 cups (100 ml), 12 Spoon(5ml)
62.	Chair for ORT Corner
63.	ARI Timer
64.	Thermometer

SN	Items Description
Case Management of newborn Sepsis (CEmONC Hospitals)	
65.	Pulse Oximeter
66.	ARI Timer
67.	Baby weighing scale
68.	Thermometer
69.	Baby stethoscope
Infection Prevention (IP) Set	
70.	Waste bucket with lids (Blue and Black color)
71.	Apron
72.	Plastic /Macintosh Draw Sheet, 90 x 180 cm
73.	Boiler-Sterilizer larger
74.	Brush to clean Instrument
75.	Tub or Bucket with Lid for Chlorine & Detergent Water
76.	Bucket stand for chlorine buckets or tubs
77.	Utility gloves (pair)
78.	Close toed Cut Shoes
79.	Plastic sheets to cover waste bins
80.	Goggles/face shield
81.	Mops
82.	Hand sanitizer
83.	Hamam where tap water is not available
84.	Chlorine solution (3-5L)
85.	Measuring Jug (1L)
Delivery Set	
86.	Instrument Tray 300 x 200 x 30 mm
87.	Fetoscope Aluminum
88.	Stainless steel bowl 600ml
89.	Angular Episiotomy Scissors, 145 mm
90.	Cord clamps stainless steel
91.	Scissors for cutting the cord
92.	Cylindrical Drum, diameter, 150 mm,250 mm
93.	Mayo-Hegar Straight Needle Holder, 180 mm
94.	Standard Straight Tissue Forceps, 145 mm
95.	Sponge holding forceps
96.	Deaver Scissors, 140 mm
97.	Tooth tissue forcep
98.	Plain tissue forcep
99.	Blunt Scissor
100.	Measuring Tape
101.	Stainless steel kidney Basin

SN	Items Description
Newborn Resuscitation Set	
102.	**HBB Resuscitation KIT (Neonatalie, Ambubag, Masks 0 and 1 size, penguin suction device,**
103.	Cord cutting Scissor
104.	Cord ties or clamps
105.	Baby Stethoscope
106.	Ventilation area (table)
107.	ARI Timer
108.	Cotton cloth (2 Pieces) for baby dry
109.	Action Plan Wall Poster
110.	HBB Stickersb

Appendix C: Program Data Collection Tools

SESSION EVALUATION FORM

Please provide feedback by ticking appropriate score		Strongly Disagree	Disagree	Agree	Strongly Agree
1	Workshop objectives were clear and achieved				
2	Use of different teaching methodologies in presenting sessions were effective				
3	Training materials (for example: flip cards, reporting forms, procedure checklists, etc.) are useful for my day-to-day work				
4	Training experience will improve my clinical practice				
5.	Timing/length of course was appropriate				
6	Venue was appropriate for training experience				
7	Facilitators provided satisfactory answers to my question				

1. What was the most useful part of the training for you?

2. What, if any, parts of the training will not be useful for you?

3. What suggestions do you have for improving the training course?

4. Other comments:

Appendix D: Reporting Formats Summary

REPORTING FORMATS SUMMARY

S. No	Name of Checklists	Purpose	Responsible Person	Frequency	Data Collection Point
1	Capacity Building quality assessment checklist	To capture the information about the quality of group based, OJT or OJC and mentoring training	Observer	Random	Training venue
2	Support Group monitoring checklist	To monitor CSG	SMC	Random	Community
3	Support Group Exit Interview	To assess knowledge of mother after CSG	SMC	Random	Community
4	TIMS – Facilitators/Trainer Registration Form	To capture the information about trainer by type of training	Trainer /facilitator	Every training	Training venue
5	TIMS – Participants Registration Form	To capture the information about trainees	Trainer /facilitator	Every training	Training venue
6	TIMS -Training Registration Form	To capture the information about type of training conducted in a district by type of training, location, date	Trainer /facilitator	Every training	Training venue
7	Facility monitoring Checklist	To capture the information on structural, technical (input and process) areas on monthly basis (including MNCH center, CEMONC and referral and linkages)	Clinical Officer /NCH Coordinator	Monthly per facility	MNCH center and CEMONC facility
8	Coaching Visit report	On-site technical quality assessment of facility/providers and staff on specific technical areas	District technical team (CO, nutrition officer and NCH coordinators)	At least two per facility per month	MNCH center and CEMONC facility
9	Routine Service delivery reporting form	Facility based output and outcome information about selected indicators	M&E assistant, MIS data entry operator and NCH coordinator	Monthly	MNCH center and CEMONC facility
10	QIPS	Technical quality of providers against set standards	Facility staff	Six monthly	MNCH center Facility

Appendix E: Capacity Building Quality Assessment Checklist

District Name/Location: □ Thatta □ Tharparkar □ Dadu □ Khairpur □ Tando Allahyar □ Naushahro Feroz □ Sukkur □ Umerkot □ Sanghar □ Jacobabad □ Ghotki □ Shikarpur □ Larkana □ Mirpur Khas □ Matiari

Training / Facility Name Venue):_____

Training Start Date (dd/mm/yyyy): ☐☐☐☐☐☐☐☐☐☐

Training End Date(dd/mm/yyyy): ☐☐☐☐☐☐☐☐☐☐

Type of training:

□ General Disease Module (Complete sections B and C)

□ Community based training on Miso and CHX (Complete section B)

□ Family Planning - General (Complete section B and C)

□ Implants (Complete section B and C)

□ BEmONC

a. Part I (Complete section B and C)

b. Part II (complete section B and C)

□ Nutrition (Complete section B and C)

□ CEmONC

a. For Providers Complete section B and C)

b. OT staff/Technicians Complete section B and C)

c. For Anesthetists Complete section B and C)

d. For Lab Technicians Complete section B and C)

□ Community Support Group (Complete sections)

□ Helping babies breathe (Complete section, B, C, and E)

□ PPIUCD (Complete section B and C)

□ Implants (Complete section B and C)

□ Immunization

a. In Practice (Complete section B and C)

b. For mid-level providers (Complete section B and C)

□ Pneumonia and Diarrhea (Complete section B and C)

□ OJC visit (Complete section D)

□ OJT visit (Complete section D)

SECTION B: Fill For All Group-based Trainings (including Clinical and community based)

I. Was the training conducted according to the agenda ?
   a. Unsatisfactory
   b. Satisfactory
   c. Average
   d. Good
   e. Excellent

II. Trainer has a grip on topic ?
   a. Unsatisfactory
   b. Satisfactory
   c. Average
   d. Good
   e. Excellent

III. Participants are actively participating in the training ?
   a. Unsatisfactory
   b. Satisfactory
   c. Average
   d. Good
   e. Excellent

IV. Facilitator ensured the participants involvement?
   a. Unsatisfactory
   b. Satisfactory
   c. Average
   d. Good
   e. Excellent

SECTION C: Fill for all clinical skills training

I. Training team completes all the training preparation as per training cehcklist and all necessary material and supplies are in place
   a. Unsatisfactory
   b. Satisfactory
   c. Average
   d. Good
   e. Excellent

II. Facilitator has and employs all the materials and supplies necessary for effective demonstrations, role plays, and simulations?
   a. Unsatisfactory
   b. Satisfactory
   c. Average
   d. Good
   e. Excellent

III. Facilitator used clinical skills checklists to assess learner competency?

a. Unsatisfactory
b. Satisfactory
c. Average
d. Good
e. Excellent

IV. Classroom environment/training hall is adequate for the clinical skills training (space, comfort, resources available)?

a. Unsatisfactory
b. Satisfactory
c. Average
d. Good
e. Excellent

V. Clinical environment is conducive to skills transfer (facility is standardized to quality standards with adequate patient volume and supportive clinical staff)?

a. Unsatisfactory
b. Satisfactory
c. Average
d. Good
e. Excellent
f. Not Applicable

SECTION D: Fill for all on-site visits (OJT or OJC)

I. Purpose of visit: _____

II. Topic/area covered during visit: -

_____

III. Was clinical skills checklist filled, based on provider performace?

a. Yes
b. No

IV. Was follow up plan drafted and reviewed with provider?

a. Yes
b. No

SECTION E: For Helping Babies Breathe (HBB) only

I. What was the ratio of learners to facilitators?_____ learners to_____ facilitators

II. What was the ratio of learners to neonatal simulators/ mannequins? _____ learners to _____ simulators

III. What was the total lengh of workshop (in hours)? _____ hours

IV. What was the total time spent in practice? _____ hours _____ minutes

V. Was the evaluation conducted on the same day as the training? Yes / No

Assessment	Number Attempting	Number Successful	Proportion Successful
Written/verbal knowledge check			
Bag and mask ventilation skills check			
OSCE A			
OSCE B			

Comments / Observations: _____

Take Picture: Record Location:

Name of Supervisor / Monitor: _____

Reporting Date & Time: Auto

Appendix F: Support Group Monitoring Checklist

District Name/Location: □ Thatta □ Tharparkar □ Dadu □ Khairpur □ Tando Allahyar □ Naushahro Feroz □ Sukkur □ Umerkot □ Sanghar □ Jacobabad □ Ghotki □ Shikarpur □ Larkana □ Mirpur Khas □ Matiari

Attached Facility Name: _____

Facilitator Name: _____

Facilitator Designation: □ LHW □ FHW □ Male Volunteer

Support Group Type: □ Women Support Group □ Men Support Group

Number of Participants: _____

TOPICS COVERED DURING SUPPORT GROUP MEETING?

□ ANC □ PNC □ MATERNAL NUTRITION
□ Child Nutrition □ Immunization (TT)
□ Danger Signs of Pregnancy/Delivery and after delivery □ Birth Preparedness (three delays)
□ Family Planning (important + methods) □ Cord care and use of chlorhexidine
□ Breast Feeding □ Newborn Danger Signs □ Neonatal Care
□ Use of misoprostol □ Child immunization
□ Any other topic (mention): _____

ASSESSMENT (PROTOCOL)

I. Greetings to the participants?
   a. Yes
   b. No
   c. Not Applicable

II. Introduction of participants?
   a. Yes
   b. No
   c. Not Applicable

III. Setting of ground rules?
   a. Yes
   b. No
   c. Not Applicable

IV. Sensitization on the topic through open ended question?
   a. Yes
   b. No
   c. Not Applicable

V. Provision of complete information on selected topic?
   a. Yes
   b. No
   c. Not Applicable

VI. Provision of information through the use of counseling card (IEC material)?
   a. Yes
   b. No
   c. Not Applicable

VII. Summarization of the discussion?
   a. Yes
   b. No
   c. Not Applicable

VIII. Exploring the support within the group to solve the problem?
   a. Yes
   b. No
   c. Not Applicable

IX. Planning for the next SG meeting (Schedule, date, time, topic and venue)?
   a. Yes
   b. No
   c. Not Applicable

Comments / Observations:

_____

_____

Action taken by supervisor on the basis of observations:

_____

_____

_____

Take Picture: Record Location:

Name of Supervisor / Monitor: _____

Program: ☐ MCHIP Staff ☐ MCHIP Sub-awardee Staff ☐ MNCH Program
☐ LHW Program ☐ District Health Office ☐ PPHI Staff

Reporting Date & Time:

Activity G: Participant Exit Interview—Post Support Group Session

LHW ID: _____ Client Name (optional): _____

Client Education: _____ Age (years): _____

Interviewer's Name: _____

Interviewer's Organization: _____

1. **Since last 12 months how many times you have attended the Support Group meeting including today's session?**
   a. 1 Time
   b. 2 Times
   c. 3 Times
   d. 4 Times
   e. 5 Times
   f. If more than 5 (specify the number): _____

2. **Topics covered during support group session?**
   - ANC
     a. At least 4 ANC visit
     b. ANC by SBA
     c. Iron tablet intake
     d. TT immunization
   - PNC
     a. 5 Postnatal Checkups of Mother & Newborn
     b. Initiation of Breastfeeding just after birth
     c. Monitor the bleeding after delivery
     d. Decision for Birth spacing
   - Maternal Nutrition
     a. 3 meals and 2 Snacks daily
     b. Green leafy vegetables
     c. Increase quantity of food which is available
     d. Pregnant women can take all type of food
   - Vaccination
     a. Child immunization keeps the child safe
     b. For vaccination contact with local Vaccinator or public health facility
     c. Complete child immunization according to national guidelines
     d. Regular growth monitoring till age of 3 years

- Danger Signs of Pregnancy/Delivery and after delivery
    a. Vaginal bleeding
    b. Severe headache/blurring of vision
    c. Severe abdominal pain
    d. Respiratory difficulty
    e. Fever
    f. Convulsion/loss of consciousness
    g. Foul-smelling vaginal discharge
    h. Loss of fetal movement
    i. Leaking of greenish/brown meconium
    j. Extreme fatigue
    k. Immediately go to hospital in case of any danger sign

- Birth Preparedness (three delays)
    a. Ensure the availability of SBA
    b. Ensure the availability of Transport
    c. Ensure the availability of money
    d. Ensure the availability of Misoprostol Tablet

- Family Planning (important + methods)
    a. Definition of Family planning
    b. Advantages of Family planning (any 3)
    c. Temporary methods
    d. Permanent methods

- Exclusive Breast Feeding
    a. Initiation of BF just after birth
    b. Importance of colostrum
    c. Baby should feed at least 8-12 time in 24 hours
    d. No need of extra milk or water for EBF baby till 6 month

- Newborn Danger Signs
    a. Low birth weight baby
    b. Infected cord
    c. Breathing difficulty
    d. Fever
    e. Fits/Convulsions
    f. Diarrhea/ vomiting

- Neonatal Care
    a. Baby wrapping and warming
    b. Delay bathing till 6 hour after birth
    c. Cord care (Use of Chlorhexidine)
    d. Initiation of BF just after birth

3. What need to improve in this meeting?
    a. Facilitator's communication
    b. Use of pictorial booklet
    c. Sitting arrangement
    d. Information dissemination
    e. Timely invitation for meeting
    f. Other

4. In light of today's discussion what do you think …? Now what is your role?
    a. Spread this message among community
    b. Practices this message
    c. Discuss this message with family
    d. Discuss this message with husband
    e. Other

Appendix H: TIMS Trainer Registration Form

PLEASE PRINT CLEARLY AND LEGIBLY IN BLOCK LETTERS

Name of Training: _____

Training Location: _____ Start Date (dd/mm/yyyy):

☐☐–☐☐–☐☐☐☐

PERSONAL DATA

First Name: _____ Surname: _____

CNIC Number: __ __ __ __ __ - __ __ __ __ __ __ __ - __
(National ID Card Number

Birth Date (dd/mm/yyyy): :

☐☐–☐☐–☐☐☐☐

Gender: ☐ Male ☐ Female

QUALIFICATION OR JOB TITLE

Professional qualification

- ☐ Community Midwife
- ☐ Obstetricians/Gynecologist
- ☐ Lady Health Visitor (LHV)
- ☐ Medical Doctor
- ☐ Registered Nurse
- ☐ Other Licensed Health Professional

Specify:_____

Job Title

- ☐ Professor/Associate Professor
- ☐ Assistant Professor
- ☐ Consultant
- ☐ Obstetricians/Gynecologist
- ☐ Consultant Pediatrician
- ☐ Medical Officer
- ☐ Lady Health Worker
- ☐ Lady Health Supervisor
- ☐ Lab Assistant
- ☐ Lab Technician
- ☐ Anesthetists
- ☐ Medical Assistant
- ☐ Senior Clinical Supervisor
- ☐ Clinical Officer
- ☐ Blood Bank Technician
- ☐ Counselor

Other

☐ Specify: _____

_____
_____

Comments / Notes / Other Information:

_____
_____
_____

CONTACT INFORMATION

Work Place Name and Address: _____

Mobile phone: _____ Work phone: _____

E-mail: _____

TRAINER INFORMATION

Trainer Type:

☐ In-service trainer ☐ Pre-service trainer

Trainer Level (in Trainer Development Pathway):

☐ *Training Expert ☐ Master Trainer ☐ Qualified Trainer

Primary Language (Select Only One):

☐ English ☐ Sindhi

☐ Urdu ☐ Other: _____

Secondary Languages in which you can teach (select as many as apply):

☐ English ☐ Sindhi

☐ Urdu ☐ Other: _____

Primary Training Topic (select one):
Course Name:

- ☐ Support Group
- ☐ PPIUCD
- ☐ BEmONC Part II
- ☐ CEmONC for OT staff/Technician
- ☐ OJT
- ☐ Immunization For mid –Level Providers
- ☐ General Disease Module
- ☐ HBB
- ☐ Implant
- ☐ Pneumonia and Diarrhea
- ☐ CEmONC for Anesthetist
- ☐ OJC
- ☐ Immunization in Practice
- ☐ Other (mention): _____ _____
- ☐ Family Planning (General)
- ☐ BEmONC Part I
- ☐ CEmONC for Providers
- ☐ CEmONC for Lab Technician
- ☐ Nutrition support group
- ☐ Miso and CHX for LHWs

OJT Modules:

- ☐ Focus Antenatal Care (ANC)
- ☐ Birth Preparedness and Complication Readiness
- ☐ Active Management of Third Stage of Labor
- ☐ Normal Child birth: Beneficial Practices
- ☐ Postpartum Hemorrhage
- ☐ Postpartum Care
- ☐ Newborn Care
- ☐ Normal Labor Child Birth
- ☐ Vaginal Bleeding in Pregnancy
- ☐ Rapid Initial Assessment and Management of Shock
- ☐ Management of Pre-eclampsia/Eclampsia
- ☐ Management of Postpartum Hemorrhage
- ☐ Newborn Sepsis
- ☐ Breast Feeding
- ☐ Use of Partograph
- ☐ Infection Prevention
- ☐ Other:_____

Additional Information :

_____

_____

_____

Appendix I: TIMS Participant Registration Form

PLEASE PRINT CLEARLY AND LEGIBLY IN BLOCK LETTERS

Name of Training: _____

Training Location: _____ Start Date (dd/mm/yyyy): ☐☐–☐☐–☐☐☐☐

PERSONAL DATA

First Name: _____ Surname: _____

CNIC Number: __ __ __ __ __ - __ __ __ __ __ __ __ - __
National ID Card Number

Birth Date (dd/mm/yyyy): ☐☐–☐☐–☐☐☐☐

Gender: ☐ Male ☐ Female

Registration #: __ __ __ __ __ __ __ __ _
Professional Registration Number

PLACE OF WORK

Official Facility Name/Posted Office: _____

Province: _____ District: _____

Taluka/Tehsil: _____ UC: _____

Facility Type:

- ☐ Basic Health Unit managed by DoH
- ☐ Education/Training Institution
- ☐ Private clinic NGO
- ☐ Maternal & Child Health Center / Govt. dispensary
- ☐ Rural Health Center
- ☐ District Headquarter Hospital
- ☐ Basic Health Unit managed by PPHI
- ☐ Private Clinic –for profit
- ☐ CMW Led MNCH Center
- ☐ Taluka/Tehsil Headquarter Hospital
- ☐ Other (please specify):_____

QUALIFICATION OR JOB TITLE

Professional qualification

- ☐ Community Midwife
- ☐ Obstetricians/Gynecologist
- ☐ Lady Health Visitor (LHV)
- ☐ Medical Doctor
- ☐ Registered Nurse
- ☐ Other Licensed Health Professional

Specify:_____

Job Title

- ☐ Professor/Associate Professor
- ☐ Assistant Professor
- ☐ Consultant
- ☐ Obstetricians/Gynecologist
- ☐ Consultant Pediatrician
- ☐ Medical Officer
- ☐ Lady Health Worker
- ☐ Lady Health Supervisor
- ☐ Lab Assistant
- ☐ Lab Technician
- ☐ Anesthetists
- ☐ Medical Assistant
- ☐ Senior Clinical Supervisor
- ☐ Clinical Officer
- ☐ Blood Bank Technician
- ☐ Counselor

Other

- ☐ Specify:

_____
_____
_____
_____

Comments / Notes / Other Information:

_____
_____
_____
_____

Work Place Name and Address: _____

Mobile phone: _____ Work phone: _____

E-mail: _____

ALUMNI NETWORK

Do you wish to be a member of the Jhpiego Alumni Network? As a member, you will be able to utilize the network to actively participate in the forums, post images to the photo galleries, share new resources, search the library, and participate in Jhpiego events. There is no cost to you to be a member of the Alumni Network.

If yes, check here: ❑

TRAINING TEST SCORES (This Section to Be Completed by Trainer)

Pre-Test Score: _____ Post-Test Score: _____

Comments: Please include any additional comments

_____

_____

_____

Trainer name *(please print)*: _____

Signature: _____

Appendix J: TIMS Training Registration Form

PLEASE PRINT CLEARLY AND LEGIBLY IN BLOCK LETTERS

Technical Area (Select the Primary Technical Area):

□ General Diseases □ Health Systems Strengthening

□ Maternal and Newborn Health □ Reproductive Health

Course Name:

□ Support Group	□ HBB	□ Family Planning (General)
□ PPIUCD	□ Implant	□ BEmONC Part I
□ BEmONC Part II	□ Pneumonia and Diarrhea	□ CEmONC for Providers
□ CEmONC for OT staff/Technician	□ CEmONC for Anesthetist	□ CEmONC for Lab Technician
□ OJT	□ OJC	□ Nutrition support group
□ Immunization For mid–level Providers	□ Immunization in Practice	□ Miso and CHX for LHWs
□ General Disease Module	□ Other (mention): _____	_____

Start Date (dd/mm/yyyy): End Date (dd/mm/yyyy):

□□□□□□□□□□ □□□□□□□□□□

Training Length: _____ hours / days / weeks (circle one) No. of Participants Attended: _____

Training Organizer (select one):

This should be the group that will be reporting on the training. If it was organized by a sub-grantee, please select the lead grantee as the training organizer. Please only check one.

□ Jhpiego □ Other: _____

Training Location: _____ _____ _____

Location Name Province District

Training Method (select one): Please indicate the primary training methodology used in this training.

□ Group Based	□ E-Learning	□ M-Learning
□ Blended Learning	□ OJT	□ OJC

OJT Modules covered in the visit:

- ☐ Focus Antenatal Care (ANC)
- ☐ Normal Labor Child Birth
- ☐ Use of Partograph
- ☐ Birth Preparedness and Complication Readiness
- ☐ Vaginal Bleeding in Pregnancy
- ☐ Active Management of Third Stage of Labor
- ☐ Rapid Initial Assessment and Management of Shock
- ☐ Normal Child birth: Beneficial Practices
- ☐ Management of Pre-eclampsia/Eclampsia
- ☐ Postpartum Hemorrhage
- ☐ Management of Postpartum Hemorrhage
- ☐ Postpartum Care
- ☐ Newborn Sepsis
- ☐ Infection Prevention
- ☐ Newborn Care
- ☐ Breast Feeding
- ☐ Other:_____

Training Type (select one):

- ☐ Training of Trainers
- ☐ Competency based skill training (Certification)
- ☐ Community based
- ☐ Refresher/Further Skills

Name all the facilitators of the training: (Make sure each facilitator completes a Facilitator/Trainer Registration Form.)

1.		3.	
2.		4.	

Comments : Please include any additional comments about this training

_____

_____

_____

Appendix K: Facility-based Monitoring Checklist

District Name/Location: _____

Date of visit: ☐☐☐☐☐☐☐☐☐☐ Time of Visit (hh/mm): ☐☐–☐☐

Name of Health Facility: _____

Visited by: a) Name: _____ Designation: _____
b) Name: _____ Designation: _____

Staff Availability:

Please write down how many of the following staff are present in the health facility. Here staff availability means those staff present on the day of visit or that staffs not on leave within 7 days or that are not on deputation outside.

Medical Officer	Medical Technician	Dispenser	LHV	Vaccinator	Helper	LHS	Sweeper/ Cleaner

MNCH SERVICES

Record Keeping

Sr. #	Service Type	Y (Yes)	N (No)
1.	Updated health facility action plan present		
2.	Daily client register/OPD register maintained		
4.	Record of all cases referred maintained in referral register/DHIS register		
5.	Results of last QIPS assessments and action plans are available at facility		
6.	Duty Roster		
7.	All DHIS register maintained		
8.	Results of internal assessment are maintained at facility		
9.	Partographs are available in labor room for every client		

Availability of Basic Supplies and IEC Materials:

Do you have following materials available in this health facility?

Sr. #	Description	Y	N
1.	Stethoscope		
2.	BP set		
3.	Examination table		
4.	Functioning examination light		
5.	Functioning Emergency Light		
6.	Emergency Drug Trolley		
7.	Functioning oxygen cylinder		
8.	Protocols for Pakistan pregnancy, Child birth, Postpartum and Newborn care		
9.	Protocols for managing pregnancy complications		
10.	Pregnancy, delivery and post-natal related poster		
11.	FP poster		
12.	Functioning suction machine		
13.	Functioning Bag and Mask		
14.	HBB Poster, timer, cord clamps		
15.	Ventilation table for HBB		
16.	Supplies for preparation of ORS solution (Jug, Cups, Spoons)		
17.	Tongue depressor		
18.	Supplies for functioning EPI center (EPI cards, Syringes, Vaccines for routine EPI)		
19.	Weighing scale		
20.	NG tube		
21.	Functioning Operation theatre for Caesarean Section		
22.	Functioning blood transfusion services in CEmONC facility		

Infection Prevention Practices:

Sr. #	Basic requirements	Y	N
1.	Is there a cleaned environment in the health facility		
2.	Are the soiled instruments are decontaminated with 0.5%chlorine sol		
3.	Are the sharps/needles properly disposed after use		
4.	Is the facility has functional autoclave/ sterilizer/boiler		
5.	Are the sterilized equipment used while dressing		
6.	Are the other wastes from HF disposed properly		
7.	Is there adequate water supply to the facility		
8.	Is there electricity and power supply to the facility		

Availability of MNCH related Essential Drugs:

Sr. #	Basic Drugs	Y	N
1.	Injection Normal Saline/ Ringer lactate		
2.	Inj. Amoxicillin and Gentamicin		
3.	Inj. Metronidazole		
4.	Inj. Syntocinon (Oxytocin)		
5.	Tab. Misoprostol		
6.	Inj. Magnesium sulphate		
7.	7.1% Chlorhexidine gel		
8.	Low osmolality ORS packets		
9.	Zink syrup/tablet		
10.	Oral Amoxicillin		
11.	Paracetamol (Syp/tablet)		
12.	inhaled bronchodilator/Salbutamol		
13.	Dexamethasone		
14.	Tablet Ferrous Sulphate		
15.	Inj. Calcium Gluconate		
16.	Silver nitrate eye drops		

Health Facility support groups/QIT teams:

Sr. #	Questions	Y	N
1.	Does the facility has functional SG/QIT		
2.	Record of SG/QIT meeting conducted in last 2 months course.		
3.	Was an Action Plan developed based on the outcome of the meeting? (observation)		
4.	How many outreach clinics/activities are conducted in last month?	Number ____	

Referral System:

Sr. #	Description	Y	N
1.	Referral slips available		
2.	Ambulance services available		
3.	Feedback of referred case recorded		
4.	SOP who need to be referred present		
5.	List of Emergency contact numbers posted		
6.	Total number of cases referred by LHW/CHWs		
7.	Review meetings on referred cases held.		
8.	List of local transporters displayed		

Capacity Building and management of the facility:

Sr. #	Description	Y	N
1.	Has the female staff being trained in (MNCH) like EOC update trainings		
2.	Does the facility staff is trained in cough, difficult breathing and Diarrhea		
3.	Facility staff trained in HBB		
4.	Is facility staff trained in Misoprostol and chlorhexidine		
5.	Does facility maintain Oxytocin cool chain		
6.	Does facility maintain infection preventions		
7.	Does facility staff trained in FP (Implants , PPIUCD)		

Appendix L: Coaching Visit Report

District Name/Location: _____

Name of Facility: _____

Name of the Provider: _____

Day Month Year
Date of Visit: ☐☐☐☐☐☐☐☐☐☐

Name of the Coach: _____

Type of Visit: ☐ On Job Training (OJT) ☐ Coaching Visit

Topic Covered:

- ☐ Focus Antenatal Care (ANC)
- ☐ Birth Preparedness and Complication Readiness
- ☐ Vaginal Bleeding in Pregnancy
- ☐ Rapid Initial Assessment and Management of Shock
- ☐ Management of Pre-eclampsia/Eclampsia
- ☐ Postpartum Care
- ☐ Newborn Care
- ☐ Infection Prevention
- ☐ Normal Labor Child Birth
- ☐ Use of Partograph
- ☐ Active Management of Third Stage of Labor
- ☐ Normal Child birth: Beneficial Practices
- ☐ Postpartum Hemorrhage
- ☐ Newborn Sepsis
- ☐ Breast Feeding
- ☐ Other: _____

TARGET PERFORMANCE STANDARDS FOR THE CURRENT VISIT

(write number only): _____

Intervention during the Current Visit: See below

Sr. #	Areas using Checklist	Name of health care provider	Standards observed	Gaps identified	Interventions
1					
2					
3					
4					

Take Picture: Record Location:

Reporting Date & Time:

Appendix M:
Routine Service Delivery Reporting Form

District Name: _____ DHIS/Facility Code: _____

Facility Name: _____ Reporting Month: _____

Reporting Person: _____ Designation: _____

Sr. #	Indicators	Achievement	Comments
Output 1: Increased use of MNCH services			
1.	Number of ANC visits	Number	
2.	Number of pregnant women with Hb <10 g/dl	Number	
Number of deliveries conducted			
3.	Normal Vaginal Delivery	Number	
4.	Vacuum / Forcep	Number	
5.	Cesarean	Number	
Complications			
6.	Complications of Abortion	Number	
7.	Postpartum Hemorrhage (PPH)	Number	
8.	Pre-Eclampsia/ Eclampsia	Number	
9.	Prolonged/ Obstructed Labors	Number	
10.	Puerperal Sepsis	Number	
11.	Number of live births in the facility	Number	
12.	Number of live births with LBW	Number	
13.	Number of stillbirths in the facility	Number	
14.	Number of births with asphyxia	Number	
15.	Number of newborn successfully resuscitated	Number	
16.	Number of women provided uterotonics after delivery.	Number	
17.	Number of newborns to whom chlorhexidine gel is applied to umbilical stump	Number	
18.	Number of clorhexidine gels distributed to pregnant women in the community for application to umbilical stump	Number	
19.	Number of misoprostol tablets distributed for PPH prevention to pregnant women in the community	Number	
20.	Number of pregnant women to whom misoprostol prescribed during ANC visit at facility	Number	
21.	Number of PNC visits (within two days)	Number	
22.	Number of maternal deaths reported in DHIS	Number	

Sr. #	Indicators	Achievement	Comments
23.	Number of women received TT-2 Injection	Number	
24.	Number of PPIUCD inserted	Number	
25.	Number of implants inserted	Number	
Output 2: Increased capacity to deliver quality MNCH services			
1.	Facility met **minimum standards** as per bi-annual clinical audit	Yes/No	
2.	Number of deliveries referred to higher level facilities for complications management	Number	
3.	MgSO4 is available in the delivery room	Yes/No	
4.	Number of skilled birth attendants trained in newborn resuscitation	Number	
Output 3: Increased demand for MNCH services			
1.	Number of community support group meetings conducted in reporting month	Number	

Appendix N: Objective Structured Clinical Examination (OSCE)

What is Objective Structured Clinical Examination (OSCE)? The OSCE is a performance-based exam. During the exam, trainees are observed and evaluated as they go through a series of stations where they interview, examine and treat standardized patients presenting with some type of problem.

OSCE Design: An OSCE usually comprises a circuit of short (usual is 5-10 minutes although some use up to 15 minutes) stations, in which each candidate is examined on a one-to-one basis with one or two impartial Trainers /examiner(s) and either real or simulated patients.

Objective: All candidates are assessed using exactly the same stations with the same marking scheme. In an OSCE candidates get marks for each step on the mark scheme that they perform correctly which therefore makes the assessment of clinical skills more objective rather than subjective, where one or two examiners decide whether or not the candidate fails based on their subjective assessment of their skills.

OSCE Marking: Marking in OSCEs is done by the Trainer/Examiner. One of the ways an OSCE is made objective is by having a detailed mark scheme and standard set of questions. Many centers allocate each station an individual pass mark. The sum of the pass marks of all the stations determines the overall pass mark for the OSCE.

Here are some tips for conducting an OSCE before, during and after:

1. **Before**
   a. Prepare all the stations and supplies, the supplies and materials needed are listed for each station. Ensure you have an assessor for each station that requires direct observation.
   b. Ask if the student has any questions about the skill and is ready to be assessed.

2. **During**
   a. Observe and assess the student's performance.
   b. Stand where you can see without intruding and let the student perform the skill.
   c. Do not interfere (Dangerous acts can be discussed with student following the OSCE).
   d. Remember, feedback MUST be delayed until completion of all stations in OSCE. The station rotation is illustrated on the following page.

3. **After**
   a. Score the OSCE and document results.
   b. Give students an opportunity to ask you questions about steps they did not understand or they performed incorrectly.
   c. Instruct students to practice the steps that they performed incorrectly.
   d. If many students had trouble with the same stations, either the teaching methods or materials did not adequately cover that learning objective.

Appendix O: Participant Capacity Building Logbook

PARTICIPANT COMPLETION FORM

Name of Participant _____

Facility _____

Name of Capacity Building Activity	Completion date	Name & Signature of Facilitator
Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC): Group Based Training		
OJT Modules		
Module 1: Focused Antenatal Care		
Module 2: Birth Preparedness and Complication Readiness		
Module 3: Vaginal Bleeding in Pregnancy		
Module 4: Rapid Initial Assessment and Management of Shock		
Module 5: Normal Labour & Child Birth		
Module 6: Use of the Partograph		
Module 7: Active Management of Third Stage of Labor		
Module 8: Normal Child birth and Beneficial Practices		
Module 9: Prevention and Management of Pre-Eclampsia/Eclampsia **Module 10:** Post-Partum Haemorrhage		
Module 11: Management of Postpartum Haemorrhage		
Module 12: Post Partum Care		
Module 13: Puerperal Sepsis		
Module 14: Normal New Born Care		
Module 15: Breast Feeding		
Module 16: Infection Prevention		
Management of Complications in Pregnancy and Childbirth (MCPC): Group Based Training		

Name of Capacity Building Activity	Completion date	Name & Signature of Facilitator
Helping Baby Breathe: Group Based Training		
Client-Centered Family Planning and Contraceptive Implants: Group Based Training FOR DOCTORS ONLY		
Advanced Family Planning for Doctors (Including Intrauterine Contraceptive Device: Group Based training		
Client-Centered Family Planning and Intrauterine Contraceptive Device: Group Based training for CMWs AND MIDLEVEL PROVIDERS		
Postpartum Intrauterine Contraceptive Device (PPIUCD): Group Based Training		
Cough and Difficult Breathing (Pneumonia and Diarrhea): Group Based Training		
Immunization in Practice: Group Based Training		
Nutrition: Group Based Training		

Appendix P: Technical Staff Development Process and e-Learning Requirements

MCHIP/Jhpiego supports self-directed, ongoing adult learning. It is important for all technical staff to stay current with evidence-based best clinical practice and global guidance. Since they are primarily responsible for clinical mentorship to Skilled Birth Attendants at facility level, the district technical team (including Senior Clinical Supervisors and Clinical Officers) are also expected to engage in ongoing learning and continued professional development.

Senior Clinical Supervisors are responsible for maintaining logbooks for the technical team members they support (i.e. Clinical Officers) to track training completion and certification according to program training packages (including e-learning).

Senior Clinical Supervisors will also help develop and standardize the clinical and facilitation skills of their teams. Senior Clinical Supervisors will meet with her district technical team monthly. During the visits, she will conduct at least one technical session OJT/OJC for demonstration and practice in OJT/OJC facilitation. She will also use this opportunity to meet one-on-one with her team members to discuss their learning needs and progress. Following these sessions, Senior Clinical Supervisors will co-sign Clinical Officer Capacity Building logbooks and update staffs learning plans. Senior Clinical Supervisors will also ensure that Clinical Officers complete their e-learning modules as per policy below.

BEMONC eLEARNING MODULES

As part of professional development plan for MCHIP/Jhpiego technical staff (Senior Program Officers, Program Officers, Senior Clinical Supervisors, and Clinical Officers) should complete and pass all six UNFPA e-Learning modules. These e-learning modules use a case-based, interactive approach and include videos and animations. All new and existing staff should complete the modules; new staff members are advised to complete the e-learning modules during their probation period (2 completed course per month, or 6 completed courses in a quarter.) The description of each module is below.

Purpose:	To provide clinical updates for program staff
Target Audience:	Jhpiego district technical staff members
Timeline:	1 March—31 May 2015 for current staff
Module Topics:	Managing Post abortion Care Essential Newborn Care Managing Postpartum Hemorrhage Managing Pre-Eclampsia and Eclampsia Managing Prolonged and Obstructed Labor Managing Puerperal Sepsis

Evidence of successful completion of the e-learning modules (screenshot of passed module quiz) will be included in staff files for review by supervisors at the time of performance appraisal. Individual capacity building logbooks should also be filled according to the completion date of the e-learning module package.

- Head Office supervisors will be responsible for supporting Head Office technical staff (Program Officers and Technical Advisors) to complete e-learning modules, and will ensure that documentation is kept in staff human resource files.
- Senior Clinical Supervisors will be responsible to ensure that she completes the package of e-learning modules. She will also support the Clinical Officers in her district to complete the modules, and document completion in logbooks.

Details on the modules follow below:
Six modules target providers who manage pregnancy and labor in their country contexts, including: nurses, midwives and physicians:

1. **Managing Post-abortion Care** <http://reprolineplus.org/learningopportunities/course/managing-postabortion-care/take-the-coursehttp:/reprolineplus.org/learning-opportunities/course/managing-postabortion-care/take-the-course>
2. **Essential Newborn Care** <http://reprolineplus.org/learning-opportunities/course/essential-newborn-care>
3. **Managing Postpartum Hemorrhage** <http://reprolineplus.org/learning-opportunities/course/managing-postpartum-hemorrhage>
4. **Managing Pre-Eclampsia and Eclampsia** <http://reprolineplus.org/learning-opportunities/course/managing-pre-eclampsia-and-eclampsia>
5. **Managing Prolonged and Obstructed Labor** <http://reprolineplus.org/learning-opportunities/course/managing-prolonged-and-obstructed-labor>
6. **Managing Puerperal Sepsis** <http://reprolineplus.org/learningopportunities/course/managing-puerperal-sepsis>

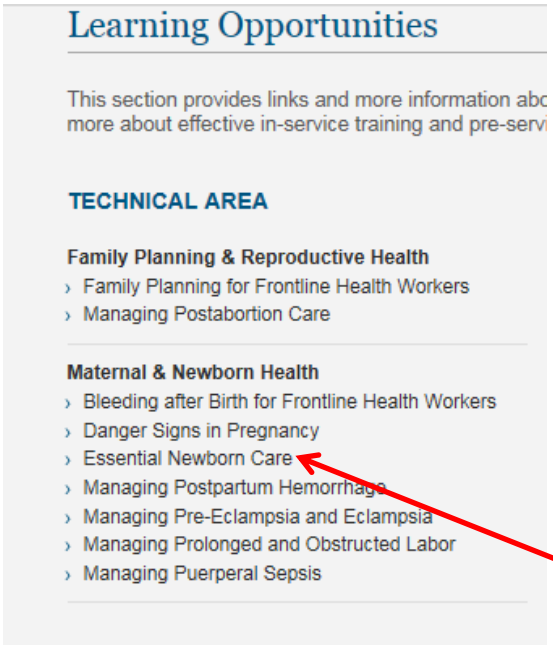
Staff members are encouraged to also complete the three additional modules targeted to community health workers for refresher, if time allows:

1. Family Planning for Frontline Health Workers <http://reprolineplus.org/learningopportunities/course/family-planning-frontline-health-workers>

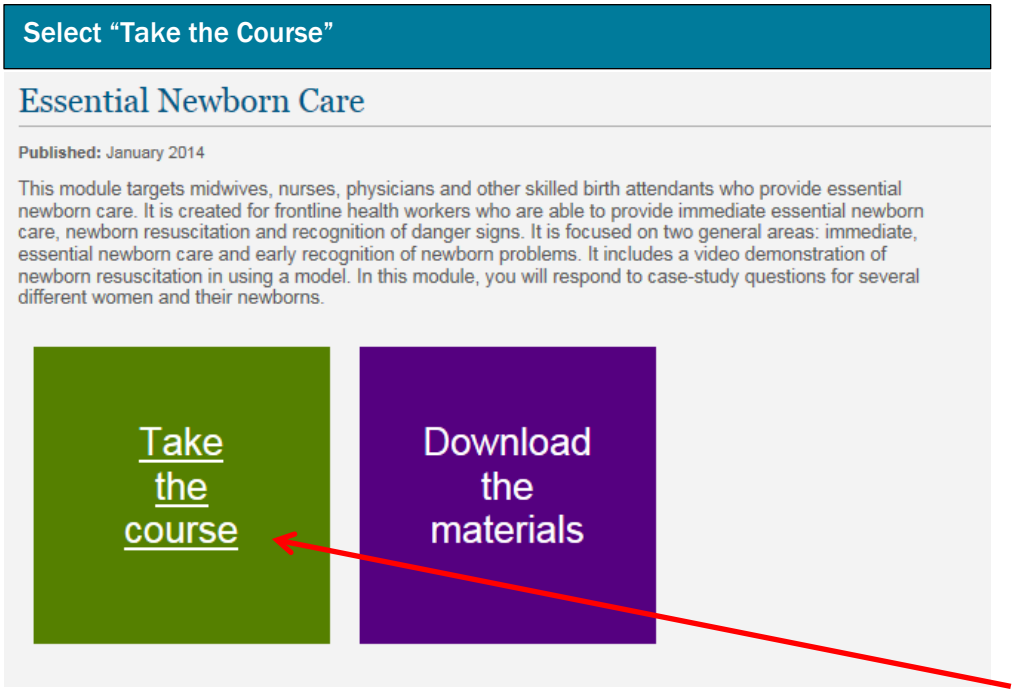
2. Bleeding after Birth for Frontline Health Workers <http://reprolineplus.org/learningopportunities/course/bleeding-after-birth-frontline-health-workers>
3. Danger Signs in Pregnancy <http://reprolineplus.org/learningopportunities/course/danger-signs-pregnancy>

To complete an e-learning module go to the above link and follow these steps:

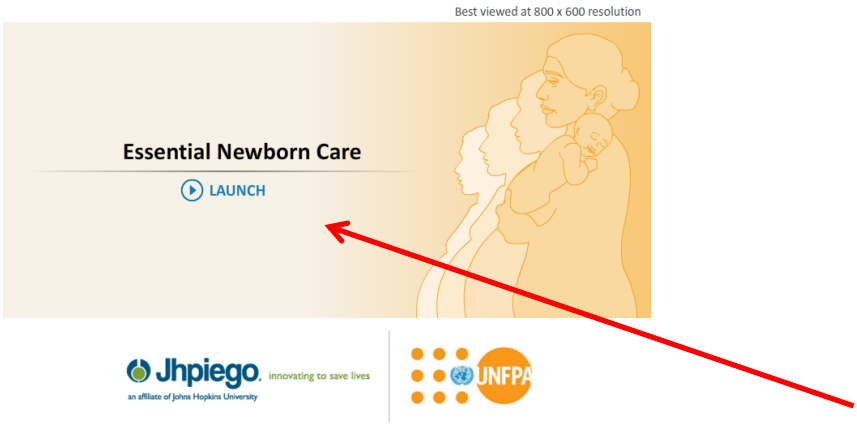
Select the module to take (such as Essential Newborn Care)



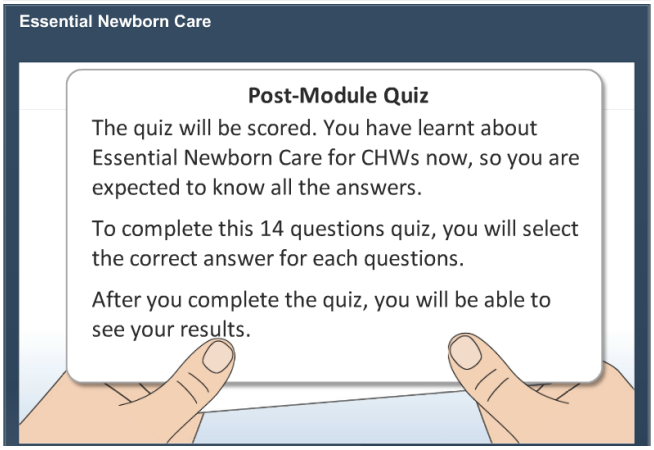
Select "Take the Course"



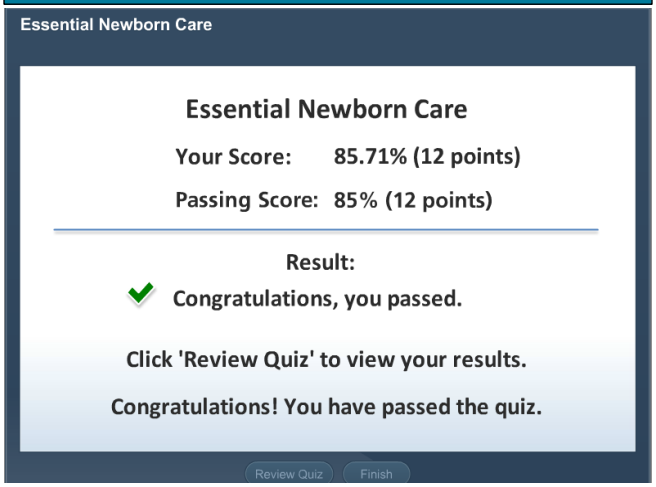
Click Launch "Launch"



At the end of the module, there will be a scored post-module quiz.



Users should document their quiz results by taking a screen shot or printing the results page as a pdf.



Appendix Q: Clinical Performance Support Tools for Focused Antenatal Care

ANTENATAL ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, TESTING) AND CARE CHECKLIST

(To be used by the **Trainer**)

Place a "✓" in case box if task/activity is performed satisfactorily, an "X" if it is not performed satisfactorily, or N/O if the task was 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 participant during evaluation by trainer

CHECKLIST FOR ANTENATAL ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, TESTING) AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	**Cases**				
Getting Ready					
1. Prepare the client care area, necessary supplies, and equipment. Use antiseptic handrub or wash and dry hands.					
2. Greet the woman and her companion respectfully and with kindness, introduce yourself, and offer the woman a seat.					
3. Tell the woman what you are going to do, encourage her to ask questions, and listen to what she has to say.					
4. Perform Quick Check if not done.					
Skill Activity Performed Satisfactorily					
History					
Personal Information (First Visit)					
5. Obtain identifying information from the woman and ask whether she has access to reliable transportation.					
6. Ask if she is currently having a problem, or if she has had any problems during this pregnancy.					
7. Ask if she has received care from another caregiver during this pregnancy.					
Menstrual and Contraceptive History (First Visit)					
8. Obtain her menstrual and contraceptive history and calculate her EDD.					
9. Obtain information on her use of family planning methods and whether she plans to use a family planning method in the future.					
Present Pregnancy (First Visit)					
10. Ask if she has felt the baby move, when the baby first moved, and whether she has felt it move in the last day.					
11. Ask how she and her partner or family feel about this pregnancy.					
Daily Habits and Lifestyle (First Visit)					

CHECKLIST FOR ANTENATAL ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, TESTING) AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	**Cases**				
12. Obtain information about her daily life and work, including her sleeping and eating habits, whether she is currently breastfeeding, whether she uses harmful substances, and whether there is a history of violence or abuse.					
Obstetric History (First Visit)					
13. Ask if she has had any problems during a previous pregnancy or during/following childbirth.					
14. Ask if she has breastfed or had any problems breastfeeding.					
Medical History (First Visit)					
15. Obtain her medical history, including whether she has been tested for HIV, whether she has anemia or any chronic illnesses, and whether she has been hospitalized or had surgery.					
16. Ask if she is taking any drugs/medications (including traditions/local preparations, herbal remedies, over-the-counter drugs, vitamins, or dietary supplements).					
17. Ask if she has had a complete series of five tetanus toxoid (TT) immunizations and when she had her last booster shot.					
Interim History (Return Visits)					
18. Ask if she is having any problems or if there have been significant changes since her last visit.					
19. Ask if she has received care from another caregiver since her last visit.					
20. Ask if there have been any changes in her personal information, daily habits or lifestyle, or medical history since her last visit.					
21. Ask if she taken medications prescribed and followed the advice provided at her last visit.					
Skill Activity Performed Satisfactorily					
Physical Examination					
Assessment Of General Well-Being And Blood Pressure (Every Visit)					
22. Observe her general well-being.					
23. Take woman's weight					
24. Measure blood pressure while the woman is seated and relaxed.					
Preparing for Further Examination					
25. Obtain the woman's consent for the physical examination.					
26. Have the woman empty her bladder.					
27. Provide her with a drape or cloth and help her onto the examination surface.					
Visual Breast Examination (First Visit/As Needed)					
28. Visually inspect the overall appearance of the woman's breasts, and test for nipple protractility if indicated.					
Abdominal Examination (Every Visit)					
29. Ask the woman to uncover her stomach and lie on her back with her knees slightly bent.					
30. Check her abdomen for scars.					
31. Measure the fundal height.					
32. Carry out fundal, lateral, and pelvic palpation.					

CHECKLIST FOR ANTENATAL ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, TESTING) AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	**Cases**				
33. Listen to the fetal heart rate.					
Genital Examination (First Visit/As Needed)					
34. Tell the woman what you are going to do before each step of the examination.					
35. Ask the woman to uncover her genital area and cover her with a cloth or drape.					
36. Use antiseptic handrub or wash and dry hands.					
37. Put gloves on both hands.					
38. Touch the inside of the woman's thigh before touching the genital area.					
39. Separate the labia majora with two fingers and check the labia minora, clitoris, urethral opening, and vaginal opening.					
40. Palpate the labia minora.					
41. Check Skene's and Bartholin's glands for discharge and tenderness.					
42. Check perineum for scars, lesions, inflammation, or cracks in skin.					
After the Examination					
43. Immerse both gloved hands in 0.5% chlorine solution and remove the gloves.					
44. Use antiseptic handrub or wash and dry hands.					
45. Share your findings with the woman.					
Skill/Activity Performed Satisfactorily					
Testing					
46. Do a hemoglobin test (first visit, at about 28 weeks, and as needed based on signs and symptoms).					
47. Refer woman to counseling and testing services for HIV test, if she chooses to be tested.					
48. Test for blood group and Rh, if available.					
49. Test urine for glucose if woman lives in an area with high prevalence of diabetes/gestational diabetes, and refer for treatment if test is positive.					
Skill/Activity Performed Satisfactorily					
Care Provision					
50. Develop a birth plan with the woman, including all preparations for a normal birth and plans in case of emergency.					
51. Provide advice and counseling about common discomforts of pregnancy, as needed.					
52. Provide advice and counseling about use of potentially harmful substances.					
53. Provide advice and counseling about hygiene.					
54. Provide advice and counseling about rest and activity.					
55. Provide advice and counseling about sexual relations and safer sex.					
56. Provide advice and counseling about early and exclusive breastfeeding.					
57. Provide advice and planning about family planning.					
58. Provide advice and counseling about HIV testing.					
59. Encourage the woman to ask questions, and be sure that she understands what is being said.					

CHECKLIST FOR ANTENATAL ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, TESTING) AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	**Cases**				
Immunizations and Other Prophylaxis					
60. Give the woman tetanus toxoid (TT) based on her need.					
61. Give the woman enough iron folate to last until her next visit, and counsel her about nutrition and possible side effects related to iron folate.					
62. Give her appropriate medications.					
Return Visits					
63. Schedule the next antenatal visit, answer any questions, and thank the woman and her family for coming.					
64. Record findings from assessment and care provision on the woman's record.					
Skill/Activity Performed Satisfactorily					

Participant is □ **QUALIFIED** □ **NOT QUALIFIED** to provide antenatal care services based on the following criteria:

Score on Midcourse Questionnaire_% (attach answer sheet)

ANC SKILLS EVALUATION	□ **Satisfactory**	□ **Unsatisfactory**
PROVISION OF SERVICES (PRACTICE)	□ **Satisfactory**	□ **Unsatisfactory**

FOCUSED ANTENATAL CARE

Jhpiego
an affiliate of Johns Hopkins University

G	**Greet** her in a friendly manner
A	**Ask** her if she has any problems and has she made an individual birth plan
T	**Tell** her about danger signs (see back)
H	**Help** her make an individual birth plan
E	**Explain** about malaria, intermittent preventive treatment, insecticide-treated bed nets, tuberculosis (TB) and safer sex
R	**Remind** her about dangers signs, individual birth plan and 4 ANC visit schedule (< 16 weeks; 16–28; 28–32; 32–40)

REMEMBER TO ASK ABOUT HER INDIVIDUAL BIRTH PLAN

- Does your client know when her baby is due?
- Has she identified a skilled birth attendant?
- Has she identified a health facility for delivery/emergency?
- Can she list danger signs in pregnancy and delivery?
- Has she identified a decision-maker in case of emergency?
- Does she know how to get money in case of emergency?
- Does she have a transport plan in case of emergency?
- Does she have a support person for the birth?
- Has she collected the basic supplies for the birth?
- Has she identified a blood donor?

BEFORE THE WOMAN LEAVES YOUR CLINIC, STOP AND ASK HER IF SHE:

- Has a supply of iron and folate tablets
- Has taken her SP and has had her tetanus toxoid injection
- Has a birth plan
- Has a method of postpartum family planning in mind
- Has an ITN
- Knows her appointment for the next ANC visit, 2nd dose of SP and TT
- Knows to return for postpartum care within 3 days of birth
- Knows the signs and symptoms of TB and has been screened if indicated
- Knows her HIV status

You have now prepared your client!

I TREAT PATIENTS AND THEIR FAMILIES IN THE WAY I WOULD LIKE TO BE TREATED!

1. By Using Communication Techniques That Show Respect and Care

- ☐ I introduce myself and address the patient by her name
- ☐ I smile!
- ☐ I look into the patient's eyes when speaking
- ☐ I use understandable language
- ☐ I use a calm, respectful tone of voice
- ☐ I keep body height at same level when talking together (if patient is lying down, I sit in chair beside the bed)
- ☐ I pay attention when the patient talks
- ☐ I include the patient and family in discussions about the patient's situation when doing bedside rounds—a good way to educate and show respect at same time!

2. By Assuring Privacy/Confidentiality

a. I do not discuss personal details about the patient in public
b. During examinations:
   - ☐ I draw curtains between beds if possible
   - ☐ I do appropriate exposure during examinations:
   - ☐ Carefully expose part of body to be examined
   - ☐ Cover parts of body not being examined
   - ☐ Ask family to help provide privacy by holding up cloth during examination

3. By Supporting Patient's Emotional Needs

- ☐ I look for signs of fear, anger, stress, fatigue, and pain
- ☐ I allow the patient to express her feelings
- ☐ I show empathy to the patient by being kind
- ☐ I PRAISE and REASSURE patient's efforts!

4. By Respecting a Patient's Dignity

- ☐ I always explain what I am doing before touching, such as for a vaginal or breast exam, injection, or abdominal exam (I avoid touching sensitive areas, e.g., clitoris)
- ☐ I tell the patient my findings during an examination

5. By Providing Guidance

- ☐ I explain what to expect during labor and birth, etc.
- ☐ I explain what the patient and family can do to help the patient and her labor (positions for labor and birth, drink lots of fluids, empty bladder often, exercises for labor, how to stay cool during labor)

Appendix R: Clinical Performance Support Tools for Birth Preparedness and Complication Readiness

BIRTH PREPAREDNESS INFORMATION NEEDS

1. Expected due date: The woman needs to know her expected due date and understand that it is only an approximate or estimated date. Labor may start before or after the expected due date.
2. Planning and preparation are lifesaving: The woman needs to know that many obstetric complications are unpredictable and can arise suddenly and without warning. Planning or preparing for delivery does not invite such events to happen. Although it is difficult to plan for an event that will happen at an unknown date, planning and preparation can save a woman's life.
3. Obstetric risks and appropriate facility for delivery: - If the woman has a higher-than-average risk of complications, she needs to understand why it is crucial to deliver at a health facility, and she needs to know when she should go (e.g., before her expected due date? When labor starts?) To which facility should she go? Is there a maternity waiting home where she can stay near the facility before delivery? - Even if the woman does not have serious risk factors, she still needs to be able to recognize signs of serious complications. She also needs to know that a health facility is the safest place to deliver. She needs to know which facility she should go to for delivery and whether services are available at night.
4. Basic supplies needed: The woman needs to know basic items that she should have ready for delivery, how much they may cost, and where they can be obtained. If it is not culturally acceptable to make preparations for a baby that is not yet born, counseling should focus mainly on items that the woman herself will need (rather than items for the baby), and the woman and her family should save money to buy necessary items for the baby after it is born.
5. Facility charges for normal delivery and costs of early postpartum care: The woman needs to know what charges she can expect for a normal delivery. She also needs to know the costs associated with a cesarean section, especially if her obstetric history suggests that a cesarean delivery is likely.
6. Available transport options and associated costs: The woman needs to know available options for reaching a facility where she can deliver her baby at night or during the day. She needs to know the approximate travel time to the facility as well as the costs involved.
7. Total anticipated expenses: The woman needs to know the sum total that supplies, service delivery charges, and transport to the facility are likely to cost so she can set aside sufficient funds.
8. Possible sources of funds: The woman needs to realistically assess whether she/her family will be able to put aside the required funds, or brainstorm other possible sources of support, such as relatives, neighbors, and friends. She should also know of/explore other community-level resources, such as emergency loan funds and women's groups.
9. Whom to involve in birth preparations: The woman needs to know that preparing for delivery is a family responsibility and that family dialogue and discussion are essential for obtaining support and the necessary contributions. She needs to assess the roles of various family members in care-related decision-making and involve these key decision-makers in discussing the issue, as well as identify individuals who can be called upon to support her during pregnancy, delivery, and the early postpartum period.

10. When to start birth preparations: Whether she is in her second month or her eighth month of pregnancy, the woman needs to be motivated and empowered to start preparing for skilled care during delivery and the early postpartum period as soon as possible. Given all the preparations that must be made, she should map out a realistic timeframe for making the preparations needed.

Reprinted from *The Skilled Care Initiative. Birth Preparedness: An Essential Part of ANC Counselling. New York: Family Care International.*

Appendix S: Clinical Performance Support Tools for Vaginal Bleeding in Pregnancy

HANDOUT: VAGINAL BLEEDING IN EARLY PREGNANCY

Table S-1 from Managing Complications in Pregnancy and Childbirth

PRESENTING SYMPTOM AND OTHER SYMPTOMS AND SIGNS TYPICALLY PRESENT	SYMPTOMS AND SIGNS SOMETIMES PRESENT	PROBABLE DIAGNOSIS
▪ Light bleeding ▪ Closed cervix ▪ Uterus corresponds to dates	▪ Cramping/lower abdominal pain ▪ Uterus softer than normal	**Threatened abortion**
▪ Light bleeding ▪ Abdominal pain ▪ Closed cervix ▪ Uterus slightly larger than normal ▪ Uterus softer	▪ Fainting ▪ Tender adnexal mass ▪ Amenorrhea ▪ Cervical motion tenderness	**Ectopic pregnancy**
▪ Light bleeding ▪ Closed cervix ▪ Uterus smaller than dates ▪ Uterus softer than normal	▪ Light cramping/lower ▪ abdominal pain • History of expulsion of ▪ products of conception	**Complete abortion**
▪ Heavy bleeding ▪ Dilated cervix ▪ Uterus corresponds to dates	▪ Cramping/lower abdominal pain ▪ Tender uterus ▪ No expulsion of products of conception	**Inevitable abortion**
▪ Heavy bleeding ▪ Dilated cervix ▪ Uterus smaller than dates	▪ Cramping/lower abdominal pain ▪ Partial expulsion of products of conception	**Incomplete abortion**
▪ Heavy bleeding ▪ Dilated cervix ▪ Uterus larger than dates ▪ Uterus softer than normal ▪ Partial expulsion of products of conception, which resemble grapes	▪ Nausea/vomiting ▪ Spontaneous abortion ▪ Cramping/lower abdominal pain ▪ Ovarian cysts (easily ruptured) ▪ Early onset pre-eclampsia ▪ No evidence of a fetus	**Molar pregnancy**

HANDOUT: VAGINAL BLEEDING IN LATER PREGNANCY

Table S-1 from Managing Complications in Pregnancy and Childbirth

PRESENTING SYMPTOM AND OTHER SYMPTOMS AND SIGNS TYPICALLY PRESENT	SYMPTOMS AND SIGNS SOMETIMES PRESENT	PROBABLE DIAGNOSIS
▪ Bleeding after 22 weeks' gestation (may be retained in the uterus) ▪ Intermittent or constant abdominal pain	▪ Shock ▪ Tense/tender uterus ▪ Decreased/absent fetal movements ▪ Fetal distress or absent fetal heart sounds	**Abruptio placentae**
▪ Bleeding (intra-abdominal and/or vaginal) ▪ Severe abdominal pain (may decrease after rupture)	▪ Shock ▪ Abdominal distension/free fluid ▪ Abnormal uterine contour ▪ Tender abdomen ▪ Easily palpable fetal parts ▪ Absent fetal movements and fetal heart sounds ▪ Rapid maternal pulse	**Ruptured uterus**
▪ Bleeding after 22 weeks' gestation	▪ Shock ▪ Bleeding may be precipitated by intercourse ▪ Relaxed uterus ▪ Fetal presentation not in pelvis/lower uterine pole feels empty ▪ Normal fetal condition	**Placenta previa**

Appendix T: Clinical Performance Support Tools for Rapid Assessment and Management of Shock

HANDOUT: EMERGENCY TROLLEY: EQUIPMENT, MEDICINE, AND SUPPLIES

Equipment

1. Oxygen tank with mask/nasal prongs
2. Air way
3. Ambu bag (large size) and mask for adult resuscitation
4. Catheterization set

Medicines

5. IV fluids (1,000 cc drips of normal saline and Ringer's lactate) with IV sets
6. Dexamethasone injection
7. Transamin injection
8. Magnesium sulfate injection
9. Aminophylline injection
10. Atropine sulfate injection
11. Furosemide I injection
12. Hydralazine/aldomet injection
13. Metronidazole injection
14. Hydrocortisone sodium injection
15. Lidocaine injection
16. Calcium gluconate injection
17. Diazepam injection
18. Antiseptic solutions
19. Water for injection
20. Oxytocin injection
21. Misoprostol tab 200 mcg

Supplies

22. IV cannula (18 gauge and different sizes)
23. Syringes (different sizes)
24. Gloves (disposable and sterile)
25. Foley catheter
26. Urine bags
27. Tourniquets
28. Endotracheal tubes
29. Torch
30. Cotton wool
31. Tape
32. Blood collection tubes

Appendix U: Clinical Performance Support Tools for Normal Labor and Childbirth

CHECKLIST: ASSISTING NORMAL DELIVERY

(To be used by the **facilitator/teacher** at the end of the module)

Place a "✓" in case box if step/task is performed **satisfactorily**, an **X** if it is **not** performed **satisfactorily**, or **N/O** if it was 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 participant during evaluation by facilitator/teacher

Participant: _____ Date Observed: _____

CHECKLIST FOR ASSISTING WITH NORMAL DELIVERY (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES				
Getting Ready					
1. Prepare the necessary equipment.					
2. Encourage the woman to adopt the position of her choice and continue spontaneous bearing down efforts.					
3. Place a plastic sheet or clean cloth under the woman's buttocks.					
4. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.					
5. Provide continual emotional support and reassurance, as feasible.					
6. Put on personal protective equipment.					
Assisting the Birth					
7. Wash hands thoroughly with soap and water and dry with a clean, dry cloth, or air dry.					
8. Put high-level disinfected or sterile surgical gloves on both hands. (If sterile towels are not available, put on two pairs of gloves.)					
9. Place one clean/sterile drape from delivery pack over her abdomen.					
Birth of the Head					
10. Clean the woman's perineum with a cloth or compress, wet with antiseptic solution or soap and water, wiping from front to back.					
11. Ask the woman to pant or give only small pushes with contractions as the baby's head is born.					
12. As the pressure of the head thins out the perineum, control the birth of the head with the fingers of one hand, applying a firm, gentle downward (but not restrictive) pressure to maintain flexion. Allow natural stretching of the perineal tissue to prevent tears.					

CHECKLIST FOR ASSISTING WITH NORMAL DELIVERY (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES				
13. Use the other hand to support the perineum using a compress or cloth, and allow the head to crown slowly and be born spontaneously.					
14. Wipe the mucus (and membranes, if necessary) from the baby's mouth and nose with sterile gauze.					
15. Feel around the baby's neck to ensure the umbilical cord is not around the neck: – If the cord is around the neck but is loose, slip it over the baby's head. – If the cord is loose but cannot reach over the baby's head, slip it backward over the shoulders. – If the cord is tight around the neck, clamp the cord with two artery forceps, placed 3 cm apart, and cut the cord between the two clamps.					
Completing the Birth					
16. Allow the baby's head to turn spontaneously.					
17. After the head turns, place a hand on each side of the baby's head, over the ears, and apply slow, gentle pressure downward (toward the mother's spine) and outward until the anterior shoulder slips under the pubic bone.					
18. When the axillary crease is seen, guide the head upward toward the mother's abdomen as the posterior shoulder is born over the perineum.					
19. Lift the baby's head anteriorly to deliver the posterior shoulder.					
20. Move the topmost hand from the head to support the rest of the baby's body as it slides out.					
21. Place the baby on the mother's abdomen. (If the mother is unable to hold the baby, ask her birth companion or an assistant to care for the baby.)					
22. Note the time of birth and the sex of the baby and tell the mother.					
23. Thoroughly dry the baby and cover with a clean, dry cloth: – Assess breathing while drying the baby, and if it does not breathe immediately, begin resuscitative measures (see **Learning Guide: Newborn Resuscitation**).					
24. Wait 2–3 minutes and clamp and cut the umbilical cord: – Apply umbilical clamp (or tie) – Cut the cord					
25. Ensure the baby is kept warm in skin-to-skin contact on the mother's chest and cover the baby with a cloth or blanket, including the head (with hat if possible).					
26. Palpate the mother's abdomen to rule out the presence of an additional baby(ies) and proceed with active management of third stage of labor.					
Active Management of Third Stage of Labor					
27. Give oxytocin 10 units IM					
28. Clamp the cord close to the perineum and hold the clamped cord and the end of the clamp in one hand.					
29. Place the other hand just above the pubic bone and gently apply counter traction (push upward on the uterus) to stabilize the uterus and prevent uterine inversion.					

CHECKLIST FOR ASSISTING WITH NORMAL DELIVERY (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES				
30. Keep tight tension on the cord and wait for a strong uterine contraction (2–3 minutes).					
31. When the cord lengthens, very gently pull downward on the cord to deliver the placenta.					
32. Continue to apply counter traction with the other hand.					
33. If the placenta does not descend during the 30 to 40 seconds of controlled cord traction, relax the tension and repeat with the next contraction.					
34. As the placenta delivers, hold it with both hands and twist slowly so the membranes are expelled intact: – If the membranes do not slip out spontaneously, gently twist them into a rope and move up and down to assist separation without tearing them.					
35. Slowly pull to complete delivery.					
36. **Immediately** check fundal tone through abdomen. If soft, massage until well contracted.					
Examination of Placenta					
37. Hold placenta in palms of hands, with maternal side facing upward: – Check whether all lobules are present and fit together.					
38. Now hold cord with one hand and allow placenta and membranes to hang down: – Insert fingers of other hand inside membranes, with fingers spread out, and inspect membranes for completeness. – Note position of cord insertion.					
39. Inspect cut end of cord for presence of two arteries and one vein.					
40. Dispose of placenta in bucket lined with a plastic bag.					
Examination of Vagina and Perineum for Tears					
41. (If two gloves are worn, remove top pair of gloves after immersing in 5% chlorine solution) – Gently separate the labia and inspect vagina for lacerations/tears.					
42. Inspect the perineum for lacerations/tears.					
43. Gently cleanse the perineum with warm water and a clean cloth or gauze.					
44. Apply a clean pad or cloth to the vulva.					
Post-Procedure Tasks					
45. Place any contaminated items (i.e., swabs) in a plastic bag or leakproof, covered waste container.					
46. Decontaminate instruments by placing in a container with 0.5% chlorine solution for six minutes.					
47. Decontaminate needles and/or syringes: – If disposing of needle and syringe, hold the needle under the surface of a 0.5% chlorine solution, fill the syringe, and push out (flush) three times; then place in a puncture-resistant sharps container.					

CHECKLIST FOR ASSISTING WITH NORMAL DELIVERY (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES				
48. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out: – If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container.					
49. Wash hands thoroughly with soap and water, and dry them with a clean, dry cloth, or air dry.					
50. After cleaning umbilical cord area, apply chlorhexidine gel with index finger at the umbilical stump and area around umbilical cord.					
Immediate Postpartum and Newborn Care					
51. Observation of the baby: – Monitor baby's temperature, heart rate, and respirations every 15 minutes for the first hour – If cold, make sure that the baby is kept warm by maintaining skin-to-skin contact (if that's not possible, re-wrap the baby, including the head) – Continue to monitor vital signs every 30 minutes for the second hour and on an hourly basis for 4 hours or until temperature stabilizes – Check the cord; if there is bleeding from the cord, retie it if necessary – Encourage and support the mother in initiating breastfeeding within the first hour after birth – Explain the importance of colostrum and exclusive breastfeeding – Encourage the mother to ask questions and respond using easy-to-understand language					
52. After the baby has breastfed: – Weigh the baby and record weight – Ensure the baby is dressed warmly and with the mother – Explain to mother importance of delayed bathing, and not to apply anything to the skin or cord. – Ensure Application of chlorhexidine on Umbilical cord					

CHECKLIST FOR ASSISTING WITH NORMAL DELIVERY (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES				
52. Care of the mother: – Encourage the woman to stay in the facility to be monitored for at least six hours after the birth. – Monitor the woman every 15 minutes in the first hour, every 30 minutes in the second hour, and every hour for 4 hours, checking: a. Fundal firmness b. Vaginal bleeding (number of pads used) c. Blood pressure d. Pulse e. Respirations f. Hydration – Ask the woman if she has urinated and encourage her to do so whenever she wishes. – Encourage the woman to eat and drink. – Explain all findings to the mother, including newborn examination – Counsel on danger signs and complication readiness; self-care; rest; nutrition; care of newborn; immunization of newborn; family planning; and resuming sexual relations. – Record the information on the woman's clinical record. – Advise the woman to visit for further postpartum and newborn care within the next 3 days.					
53. Wash hands thoroughly with soap and water and dry with clean, dry cloth, or air dry.					

VAGINAL EXAMINATION CHECKLIST

(To be used by the facilitator/teacher at the end of the module)

Place a "✓" 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 participant during evaluation by facilitator/teacher

Participant: _____ Date Observed: _____

CHECKLIST FOR VAGINAL EXAMINATION (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES			
Getting Ready				
1. Prepare the necessary equipment.				
2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns.				
3. Complete an abdominal examination, including: – Lie and presentation – Frequency and length of contractions – Station of the fetal head – Fetal heart rate				
Genital Examination				
4. Ask the woman to uncover her genital area, and cover her to provide privacy and respect modesty.				
5. Ask the woman to separate her legs while continuing to bend her knees slightly.				
6. Turn on a light and direct it toward genital area.				
7. Wash hands thoroughly with soap and water and dry with a clean, dry cloth, or air dry.				
8. Put new examination or high-level disinfected gloves on both hands.				
9. Touch the inside of the woman's thigh before touching any part of her genital area.				
10. Separate labia majora with two fingers; check labia minora, clitoris, urethral opening, and vaginal opening, noting any abnormality, protrusion from the vagina, blood or foul-smelling discharge, or urine or stool coming from vaginal opening.				
11. Look at the perineum, noting scars, lesions, inflammation, or cracks in skin.				
12. Separate labia with gloved hand and observe introitus for visible bulging of membranes or fetal head/parts.				
Vaginal Examination				
13. Gently insert index and middle fingers of exam hand into vagina, maintaining light downward pressure and moving fingers toward cervix: – Palpate mucosa and structural integrity along vaginal walls. – Insert middle and index fingers into open cervix and gently open them to cervical rim (the distance between the outer aspects of both fingers is the dilation in centimeters).				

CHECKLIST FOR VAGINAL EXAMINATION (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)	CASES			
14. Assess condition of amniotic fluid and membranes: – With middle and index fingers still inserted into cervix, evaluate if bag of water is intact or ruptured: a. The presence of a smooth membrane palpated over the presenting part indicates an intact bag of waters. b. If the bag of waters is ruptured, the presenting part will be felt directly. c. If the bag of waters is ruptured, check the color (green, yellow) of the meconium				
15. Assess presentation and position of fetus and molding: – With index fingers still inserted into cervix: a. Feel fetal skull to confirm cephalic presentation and assess molding, noting whether bones touch or overlap. b. Withdraw examination hand and inspect glove for blood and/or meconium.				
16. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove gloves by turning them inside out. – If disposing of gloves (examination gloves and surgical gloves that will not be reused), place in a plastic bag or leakproof, covered waste container.				
17. Wash hands thoroughly with soap and water and dry with a clean, dry cloth, or air dry.				
18. Document findings on: – History-taking sheet – Hospital admission book – Partograph sheet, if dilated at least 4 cms, including: a. Patient's name, gravida, date & time of admission, rupture of membranes b. Labor status (time, cervical dilatation and descent of head, strength and frequency of contractions, drugs and fluids) c. Fetal status (fetal heart rate, amniotic fluid, molding) d. Maternal status (pulse; blood pressure; temperature; urine protein, acetone, and volume)				

Appendix V: Clinical Performance Support Tools for Use of the Partograph

USE OF THE WORLD HEALTH ORGANIZATION PARTOGRAPH

The partograph is a **tool**, not an end in itself. The partograph accomplishes the following:

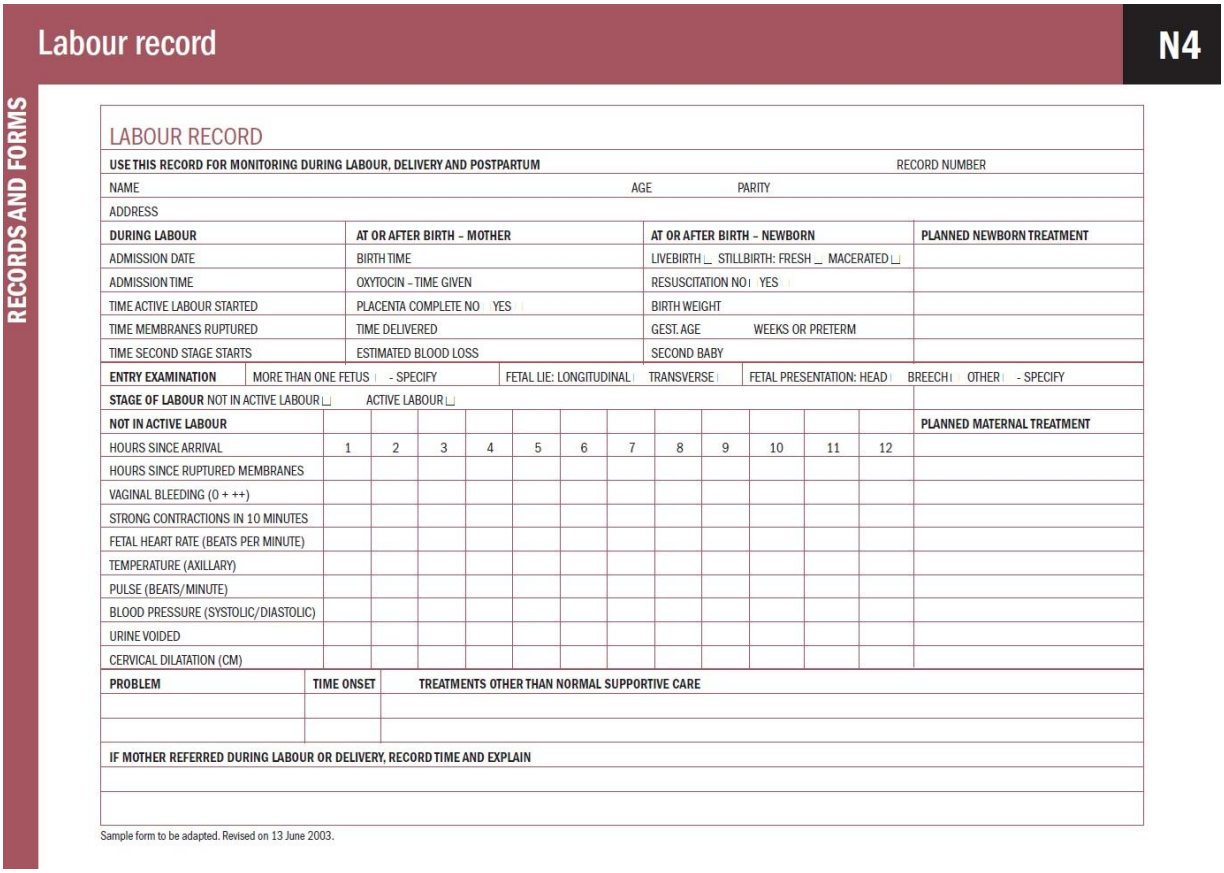
- Provides a graphic representation of labor progress and the condition of the mother and fetus
- Guides early detection of prolonged or obstructed labor
- Informs decision-making in the management of labor
- Improves the detection of complications in a timely manner
- Provides legal protection to the care provider, the institution, and the client

Guidance on the use of the partograph:

- Label the partograph with patient-identifying information.
- Note the fetal heart rate, color of amniotic fluid, presence of molding, contraction pattern, and medications.
- Plot cervical dilation on alert line: in normal labor, after 4 cm dilatation.
- Action line: if the plotted line crosses the action line, intervention is required.
- **Onset of labor:** Determine the onset of labor through obtaining a complete client history. Ask for symptoms such as regular contractions that are 3–5 minutes apart, blood-stained mucous, or rupture of membrane. Note approximate time of onset of labor.
- **Client information:** Fill out the client name, gravida, para, date of booking, date and time of admission, rupture of membranes if at home, and time of rupture.
- **Liquor:** Record the color of the amniotic fluid at every vaginal examination as follows:
  - I: Intact
  - C: Clear fluid
  - M: Meconium
  - B: Blood-stained fluid
- **Fetal heart sound:** Record fetal heart sounds. Chart for one full minute every hour.
- **Cervical dilation:** Assess at every vaginal examination and mark with an *x*. Vaginal exams should be performed every four hours.
- **Hours in labor:** Record the time passed since active labor started, or from 4 cm dilation.
- **Time:** Record actual time.
- **Contractions:** Record the number of contractions in 10 minutes, every hour in the first stage of labor, for strength and duration.
- **Medication:** Record any medication given orally, IV, or IM needs to be recorded, as well as the time administered.

- **Pulse:** Record every hour.
- **Blood pressure and temperature:** Record every 4 hours or more often if abnormal.
- **Urine volume:** Record every time urine is passed.

Sample Partograph Chart



Labour record N4

RECORDS AND FORMS

LABOUR RECORD

USE THIS RECORD FOR MONITORING DURING LABOUR, DELIVERY AND POSTPARTUM													RECORD NUMBER
NAME								AGE		PARITY			
ADDRESS													
DURING LABOUR	**AT OR AFTER BIRTH – MOTHER**							**AT OR AFTER BIRTH – NEWBORN**					**PLANNED NEWBORN TREATMENT**
ADMISSION DATE	BIRTH TIME							LIVEBIRTH ⌊_ STILLBIRTH: FRESH ⌊_ MACERATED ⌊⌋					
ADMISSION TIME	OXYTOCIN – TIME GIVEN							RESUSCITATION NO ⌊ YES ⌊					
TIME ACTIVE LABOUR STARTED	PLACENTA COMPLETE NO ⌊ YES ⌊							BIRTH WEIGHT					
TIME MEMBRANES RUPTURED	TIME DELIVERED							GEST. AGE WEEKS OR PRETERM					
TIME SECOND STAGE STARTS	ESTIMATED BLOOD LOSS							SECOND BABY					
ENTRY EXAMINATION	MORE THAN ONE FETUS ⌊ – SPECIFY			FETAL LIE: LONGITUDINAL ⌊ TRANSVERSE ⌊				FETAL PRESENTATION: HEAD ⌊ BREECH ⌊ OTHER ⌊ – SPECIFY					
STAGE OF LABOUR NOT IN ACTIVE LABOUR ⌊⌋ ACTIVE LABOUR ⌊⌋													
NOT IN ACTIVE LABOUR													**PLANNED MATERNAL TREATMENT**
HOURS SINCE ARRIVAL	1	2	3	4	5	6	7	8	9	10	11	12	
HOURS SINCE RUPTURED MEMBRANES													
VAGINAL BLEEDING (0 + ++)													
STRONG CONTRACTIONS IN 10 MINUTES													
FETAL HEART RATE (BEATS PER MINUTE)													
TEMPERATURE (AXILLARY)													
PULSE (BEATS/MINUTE)													
BLOOD PRESSURE (SYSTOLIC/DIASTOLIC)													
URINE VOIDED													
CERVICAL DILATATION (CM)													

PROBLEM	TIME ONSET	TREATMENTS OTHER THAN NORMAL SUPPORTIVE CARE

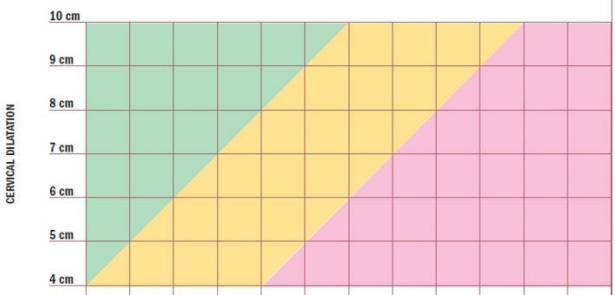
IF MOTHER REFERRED DURING LABOUR OR DELIVERY, RECORD TIME AND EXPLAIN

Sample form to be adapted. Revised on 13 June 2003.

RECORDS AND FORMS

PARTOGRAPH

USE THIS FORM FOR MONITORING ACTIVE LABOUR



FINDINGS	TIME											
Hours in active labour	1	2	3	4	5	6	7	8	9	10	11	12
Hours since ruptured membranes												
Rapid assessment 83-87												
Vaginal bleeding (0 + ++)												
Amniotic fluid (meconium stained)												
Contractions in 10 minutes												
Fetal heart rate (beats/minute)												
Urine voided												
T (axillary)												
Pulse (beats/minute)												
Blood pressure (systolic/diastolic)												
Cervical dilatation (cm)												
Delivery of placenta (time)												
Oxytocin (time/given)												
Problem-note onset/describe below												

Sample form to be adapted. Revised on 13 June 2003.

Partograph N5

Postpartum record N6

RECORDS AND FORMS

POSTPARTUM RECORD

MONITORING AFTER BIRTH	EVERY 5-15 MIN FOR 1ST HOUR				2 HR	3 HR	4 HR	8 HR	12 HR	16 HR	20 HR	24 HR
TIME												
RAPID ASSESSMENT												
BLEEDING (0 + ++)												
UTERUS HARD/ROUND?												
MATERNAL: BLOOD PRESSURE												
PULSE												
URINE VOIDED												
VULVA												
NEWBORN: BREATHING												
WARMTH												

NEWBORN ABNORMAL SIGNS (LIST)

TIME FEEDING OBSERVED ☐ FEEDING WELL ☐ DIFFICULTY

COMMENTS

PLANNED TREATMENT	TIME	TREATMENT GIVEN
MOTHER		
NEWBORN		

IF REFERRED (MOTHER OR NEWBORN), RECORD TIME AND EXPLAIN:

IF DEATH (MOTHER OR NEWBORN), DATE, TIME AND CAUSE:

Sample form to be adapted. Revised on 25 August 2003.

ADVISE AND COUNSEL

MOTHER

- ☐ Postpartum care and hygiene
- ☐ Nutrition
- ☐ Birth spacing and family planning
- ☐ Danger signs
- ☐ Follow-up visits

BABY

- ☐ Exclusive breastfeeding
- ☐ Hygiene, cord care and warmth
- ☐ Special advice if low birth weight
- ☐ Danger signs
- ☐ Follow-up visits

PREVENTIVE MEASURES

FOR MOTHER

- ☐ ☐ Iron/folate
- ☐ ☐ Vitamin A
- ☐ ☐ Mebendazole
- ☐ ☐ Sulphadoxine-pyrimethamine
- ☐ ☐ Tetanus toxoid immunization
- ☐ ☐ RPR test result and treatment
- ☐ ☐ ARV

FOR BABY

- ☐ Risk of bacterial infection and treatment
- ☐ BCG, OPV-0, Hep-0
- ☐ RPR result and treatment
- ☐ TB test result and prophylaxis
- ☐ ARV

Appendix W: Clinical Performance Support Tools for Active Management of the Third Stage of Labor

MODULE 7: ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR

GUIDELINES FOR STORAGE OF OXYTOCIN	
If there is:	**Do this:**
Cold chain during transit*	Keep oxytocin at 2–8 degrees C (maintain proper temperature from manufacturer to distributor, to provider, and to patient at the end).
No cold chain during transit	Keep the oxytocic drug in the dark, away from direct sunlight, during transit. If kept in the dark, oxytocic drugs can be kept out of the cold chain (at temperatures of no more than 40 degrees C) for two weeks during transit.
Reliable refrigeration upon arrival at facility, including: • Temperature of 2–8 degrees C • A functional thermometer • Sufficient storage	• Store oxytocin at 2–8 degrees C. • Keep ampules in a closed box away from sunlight. • Periodically remove the ampules as per weekly client load calculated on the restocking worksheet. • Keep the ampules in the dark when removing them from the refrigerator.
No refrigeration available at facility: • No electricity • No reliable refrigeration	• Keep oxytocin in closed boxes away from sunlight, and remove it only when needed. • Keep one week's supply of ampules and syringes in the labor/delivery room.
Identify a focal person (and an alternate) from the labor ward to be responsible for oxytocin storage and supply.	
Determine a day of the week to check and refresh the oxytocin supply.	
Label boxes of oxytocin ampules with the date of receipt and entry into the refrigerator (first in, first out).	
Oxytocin kept at room temperature in the labor ward should be limited to a week's supply.	
Oxytocin stock should be rotated so that ampules that have been exposed to room temperature for a longer period of time are used first.	
Calculate a three-month supply of oxytocin, as follows: Average number of deliveries per month x 3.8 = approximate number of 10 IU ampules needed for three months	
Oxytocin may be stored outside the refrigerator at 30 degrees C or less for no more than three months. Oxytocin is more stable than ergometrine and is not sensitive to light.	
Oxytocin is the drug of choice for active management of the third stage of labor.	

*Cold chain: The cold chain begins with the cold storage unit at the vaccine manufacturing plant, extends through the transfer of vaccine to the distributor and then to the provider's office, and ends with the administration of the vaccine to the patient. Proper storage temperatures must be maintained at every link in the chain.

Source: Improving the Quality of Oxytocin for Use in the Prevention and Management of Postpartum Hemorrhage. Maternal and Child Health Integrated Program.

CHECKLIST: ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR

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

Place a "✓" in case box if step/task is performed **satisfactorily**, an **X** if it is **not** performed **satisfactorily**, or **N/O** if it is 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 participant during evaluation by facilitator/teacher

Participant: _____ Date Observed: _____

CHECKLIST FOR ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	**Cases**				
Active Management of the Third Stage of Labor					
1. After ensuring that there is not another baby, give oxytocin 10 units IM within 1 minute after birth.					
2. Clamp and cut the cord approximately 3 minutes after birth.					
3. Wait for a uterine contraction.					
4. With one hand above the pubic bone, apply pressure in an upward direction (toward the woman's head) to apply counter-traction and stabilize the uterus.					
5. At the same time, with the other hand, pull with a firm, steady tension on the cord in a downward direction (follow direction of the birth canal).					
6. Deliver placenta slowly, with both hands, gently turning the entire placenta and lifting it up and down until membranes deliver.					
7. Immediately after the placenta delivers, massage the uterus if it is not firm. Note the time of delivery of the placenta.					
8. Examine the placenta, membranes, and cord.					
9. Inspect the vulva, perineum, and vagina for lacerations/tears and carry out appropriate repair as needed.					
10. Cleanse perineum and apply a pad or cloth to vulva.					
11. Assist the mother to a comfortable position and perform essential newborn care.					
12. During the first two hours after delivery of the placenta, monitor the woman every 15 minutes: – Measure her vital signs. – Massage her uterus to make sure it is contracted. – Check for excessive vaginal bleeding.					

CHECKLIST: OXYTOCIN STORAGE AT THE HEALTH FACILITY

(To be used by the **facilitator/teacher** at the end of the module)

Place a "✓" in case box if step/task is performed **satisfactorily**, an **X** if it is **not** performed **satisfactorily**, or **N/O** if it is 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 participant during evaluation by facilitator/teacher

Participant:_____ Date Observed:_____

CHECKLIST FOR OXYTOCIN STORAGE AT THE HEALTH FACILITY (MANY OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	Cases				
Calculate the facility's weekly, monthly, and yearly delivery numbers. Whenever possible, procurement of oxytocin should be based on actual client volume.					
Determine a day of the week (suggest the first day of the week) as the day to check and refresh the oxytocin supply on the labor ward.					
Identify a focal person (and an alternate) from the labor ward to be responsible for oxytocin storage.					
The focal person should calculate oxytocin needs and restock the supply in the labor room accordingly.					
Oxytocin available at room temperature in the labor ward should be limited to a week's supply.					
Label boxes of oxytocin ampules with the date of receipt and entry of boxes into refrigeration.					
Oxytocin stock should be rotated so that ampules that have been exposed to room temperature for longer periods of time are used first.					
The health facility has at least a three-month supply of oxytocin.					

Appendix X: Clinical Performance Support Tools for Normal Childbirth: Beneficial Practices

HANDOUT: WOMAN'S CHOICE OF POSITION DURING LABOR AND BIRTH

Lying on side

Kneeling

Sitting backwards

Hands and knees

Squatting

Standing

Walking

Sitting

Using birth stool

Appendix Y: Clinical Performance Support Tools for Prevention and Management of Pre-eclampsia/ Eclampsia

CHECKLIST FOR GIVING MAGNESIUM SULFATE INJECTION

(To be used by the facilitator at the end of module)

Place a "✓" in case box if task/activity is performed **satisfactorily**, an **X** if it is **not** performed **satisfactorily**, or **N/O** if it is 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 participant during evaluation by trainer

CHECKLIST FOR ADMINISTRATION OF MAGNESIUM SULFATE ($MGSO_4$)		
Observe the following tasks/steps being carried out:		
Ask patient permission as appropriate		
Place patient in comfortable position		
Clean area where injection is to be given with alcohol swab		
Recheck name/expiry date of injection vial/ampule of $MgSO_4$ to be given		
Prepare $MgSO_4$ injection given in quantity and dilution as given in PCPNC guide B13 **For IM injection:** Add 1 mL of 2% lignocaine to 10 mL of 50% $MgSO_4$ solution in 10 mL syringe. **For IV injection:** Make 20% solution by adding 8 mL (4 g) of 50% solution to 12 mL sterile water, in a 20 mL syringe.		
IV/IM combined loading dose: Give either 20 mL of 20% $MgSO_4$ IV slowly over 15 to 20 minutes.		
If 20% solution is not available, make 20% solution by above method. Never give undiluted 50% solution by IV.		
Then give 5 g of $MgSO_4$ IM (preparation given above) in upper outer quadrant of each buttock.		
If unable to give IV, give IM-only loading dose: Add 1 mL of 2% lignocaine to 10 mL of 50% $MgSO_4$ solution in 10 mL syringe.		
While giving IV loading dose, watch immediate for effects of flushing/feeling heat.		
Rub the area followed by IM injection in both buttocks.		
Dispose of the syringe properly.		
Thank and cover the patient.		
Wash your hands properly		

- ☐ Perform the procedure of giving MgSO4 on a mannequin in the skills lab.
- ☐ Inform your facilitator when you complete this task.
- ☐ Please observe standard precautions and communication.

Appendix Z: Clinical Performance Support Tools for Prevention and Management of Postpartum Hemorrhage

CHECKLIST: FEMALE CATHETERIZATION

Place a "✓" in case box if task/activity is performed **satisfactorily**, and "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 participant during evaluation by trainer

CHECKLIST FOR DEMONSTRATION OF FEMALE CATHETERIZATION		
Observe the following tasks/steps being carried out correctly:		
Wash hands thoroughly with soap and water and dry with a clean, dry cloth, or air dry		
Greet patient and ask permission		
Place woman in comfortable position		
Put new examination or high-level-disinfected surgical gloves on both hands		
Clean the external genitalia		
Insert catheter into the urethral orifice, allow urine to drain into a sterile receptacle, and measure and record amount		
Secure catheter and attach it to urine drainage bag		
Immerse both gloved hands in 0.5% chlorine solution; remove gloves by turning them inside out		
Wash hands thoroughly with soap and water and dry with a clean, dry cloth, or air dry		

- ☐ Perform the procedure of female catheterization on a mannequin in the skills lab.
- ☐ Inform your facilitator when you complete this task.
- ☐ Please observe standard precautions and communication skills while performing this task.

CHECKLIST: GIVING IM INJECTION

Place a "✓" in case box if task/activity is performed **satisfactorily**, and "X" if it is **not** performed satisfactorily, or **N/O** if it is 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 participant during evaluation by trainer

CHECKLIST FOR DEMONSTRATION OF GIVING IM INJECTION		
Observe the following tasks /steps being carried out:		
Wash hands thoroughly with soap and water and dry with a clean, dry cloth, or air dry		
Greet patient and ask permission		
Place in comfortable position		
Recheck name and expiry of injection vial of ampule to be given		
Put syringe needle into vial (do not touch outside of container)		
Draw required amount of medicine into syringe		
Hold syringe upright pointing toward roof		
Remove bubble from syringe by lightly tapping the side		
Push the syringe plunger until air comes out and medicine begins to spill from the tip of needle		
Put the syringe on a prepared tray or container		
Clean area where injection is to be given with alcohol swab		
IM injection in buttock given in upper outer quadrant		
IM injection on arm given in upper outer quadrant of deltoid		
Before injecting medicine, pull back on plunger to see if blood enters syringe ▪ If no, inject the medicine slowly ▪ If yes, withdraw slowly and start again		
Dispose of syringe properly		
Thank and cover the patient		

- ☐ Perform the procedure of IM Injection on mannequin in the skills lab.
- ☐ Inform your facilitator when you complete this task.
- ☐ Please observe standard precautions and communication skills while performing this task.

CHECKLIST: INTERNAL BIMANUAL COMPRESSION OF THE UTERUS

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

Place a "✓" in case box if step/task is performed **satisfactorily**, an **X** if it is **not** performed **satisfactorily**, or **N/O** if it was 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 participant during evaluation by facilitator/teacher

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 equipment.					
Skill/Activity Performed Satisfactorily					
Bimanual Compression					
1. Wash your hands thoroughly and put on high-level-disinfected or sterile surgical gloves.					
2. Clean the vulva and perineum with antiseptic solution.					
3. Insert your fist into the anterior vaginal fornix and apply pressure against the anterior wall of the uterus.					
4. Place the other hand on abdomen behind the uterus, press the hand deeply into the abdomen, and apply pressure against posterior wall of the uterus.					
5. Maintain compression until the bleeding is controlled and uterus contracts.					
Skill/Activity Performed Satisfactorily					
Post-Procedure Tasks					
1. Remove the gloves and discard them in leakproof container or plastic bag, or decontaminate them in 0.5% chlorine solution if they will be reused.					
2. Wash your hands thoroughly.					
3. Monitor vaginal bleeding, take the woman's vital signs, and make sure the uterus is firmly contracted.					
Skill/Activity Performed Satisfactorily					

CHECKLIST: MANUAL REMOVAL OF PLACENTA

(To be used by the **facilitator/teacher** at the end of the module)

Place a "✓" in case box if step/task is performed **satisfactorily**, an **X** if it is **not** performed **satisfactorily**, or **N/O** if it was 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 participant during evaluation by facilitator/teacher

Participant:_____ Date Observed:_____

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA (MANY OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)						
Step/Task	Cases					
Getting Ready						
1. Prepare the necessary equipment.						
2. Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.						
3. Provide continual emotional support and reassurance, as feasible.						
4. Ask the woman to empty her bladder, or insert a catheter.						
5. Give anesthesia (diazepam 5 mg injection) to the woman.						
6. Start an IV line (normal saline injection).						
7. Give prophylactic antibiotics (ampicillin 2 gm stat + 500 mg metronidazole IV) to the woman.						
8. Put on personal protective equipment.						
Skill/Activity Performed Satisfactorily						
Manual Removal Of Placenta						
1. Wash your hands and forearms thoroughly and put on sterile surgical gloves (use elbow-length gloves, if available).						
2. Hold the umbilical cord with a clamp and pull the cord gently.						
3. Place the fingers of one hand into the uterine cavity and locate the placenta.						
4. Support/stabilize the fundus while detaching the placenta.						
5. Move the hand back and forth in a smooth lateral motion until the whole placenta is separated from the uterine wall.						
6. Withdraw the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally.						
7. Give oxytocin 20 IU IV in 1 L of normal saline at a rate of 60 drops/minute.						
8. Have an assistant massage the fundus to encourage atonic uterine contraction.						
9. If there is continued heavy bleeding, give ergometrine 0.2 mg by IM injection or prostaglandins sublingually (misoprostol 800 mcg).						
10. Examine the uterine surface of the placenta to ensure that it is complete.						

CHECKLIST FOR MANUAL REMOVAL OF PLACENTA (MANY OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY.)					
Step/Task	Cases				
11. Examine the woman carefully and repair any tears to the cervix or vagina, or repair episiotomy.					
Skill/Activity Performed Satisfactorily					
Post-Procedure Tasks					
1. Remove gloves and discard them in a leakproof container or plastic bag, or decontaminate them in 0.5% chlorine solution if they will be reused.					
2. Wash your hands thoroughly.					
3. Monitor vaginal bleeding, take the woman's vital signs, and make sure that the uterus is firmly contracted every 30 minutes for six hours.					
Skill/Activity Performed Satisfactorily					

Appendix AA: Clinical Performance Support Tools for Postpartum Care

CHECKLIST: POSTPARTUM ASSESSMENT AND CARE

(To be used by the **facilitator/teacher** at the end of the module)

Place a "✓" in case box if step/task is performed **satisfactorily**, an "**X**" if it is **not** performed **satisfactorily**, or **N/O** if it was 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 participant during evaluation by facilitator/teacher

Participant_____Date observed__

CHECKLIST FOR POSTPARTUM ASSESSMENT AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY)					
Step/Task	Cases				
Getting Ready					
1. Prepare the necessary equipment.					
2. Greet the woman respectfully and with kindness.					
3. Listen to her attentively and respond to her questions and concerns.					
4. Provide continual emotional support and reassurance, as feasible.					
History Note: Ask the following questions if the information is not available on the woman's record. Ask at every visit for items followed with an asterisk (*) and only at the first visit for other items.					
Personal Information					
5. What are your name and age, and what is the name of your baby?					
6. What are your address and phone number?					
7. Do you have access to reliable transportation?					
8. How many times have you been pregnant, and how many children have you had?					
9. Are you having a particular problem at present?* (If the woman answers "yes," find out what the problem is and ask the additional questions below.) – When did the problem first start? – Did it occur suddenly or develop gradually? – When and how often does the problem occur? – Did anything unusual occur before it started? – Are you eating, sleeping, and doing other things normally? – Has the problem become more severe? – Are there other signs and conditions related to the problem? If yes, ask what they are. – Have you received treatment for the problem? If yes, ask who provided the treatment, what it involved, and whether it helped.					

CHECKLIST FOR POSTPARTUM ASSESSMENT AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY)					
Step/Task	**Cases**				
10. Have you received care from another caregiver?* (If the woman answers "yes," ask the additional questions below.) – Who provided the care? – Why did you seek care from another caregiver? – What did the care involve? – What was the outcome of the care?					
Daily Habits and Lifestyle					
11. Do you work outside the home?*					
12. Do you walk long distances, carry heavy loads, or do physical labor?*					
13. Do you get enough sleep/rest?*					
14. What do you normally eat in a day?*					
15. Do you smoke or use any other possibly harmful substances?					
16. Who do you live with?					
17. Has anyone ever prevented you from seeing family or friends, stopped you from leaving your home, or threatened your life?					
18. Have you ever been injured, hit, or forced to have sex by someone?					
19. Are you frightened of anyone?					
Present Pregnancy and Childbirth (First Visit)					
20. When did you have your baby?					
21. Where did you have your baby, and who attended the birth?					
22. Did you have vaginal bleeding during this pregnancy?					
23. Did you have any convulsions (or pre-eclampsia/eclampsia) during this pregnancy or birth?					
24. Did you have any complications during this childbirth (for example, cesarean section or other uterine surgery, vaginal or perineal tears, or episiotomy)?					
25. Were there any complications with the baby?					
Present Postpartum Period (Every Visit)					
26. Have you had any heavy bleeding since you gave birth?					
27. What color is your vaginal discharge, and how often do you need to change your pad/cloth?					
28. Have you had any problems with bowel or bladder function (for example, incontinence, leakage of urine/feces from vagina, burning on urination, inability to urinate when urge is felt, or constipation)?					
29. Do you feel good about your baby and your ability to take care of him/her? (If the woman answers "no," ask the additional questions below.) – Are you feeling sad or overwhelmed? – Are you not eating or sleeping well? – Have you been crying or feeling more irritable than usual?					
30. Is your family adjusting to the baby?					
31. Do you feel that breastfeeding is going well?					

CHECKLIST FOR POSTPARTUM ASSESSMENT AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY)					
Step/Task	**Cases**				
Contraceptive History (First Visit)					
32. How many more children do you plan to have?					
33. Have you used a family planning method before? (If the woman answers "yes," ask the additional questions below.) – Which method(s) have you used? – Did you like the method(s), and why or why not? – Which method did you like the most and why (if more than one method used)? – Would you like information about other methods?					
34. Are you going to use family planning in the future?					
Physical Examination					
Assessment of General Well-Being (Every Visit)					
35. Observe gait and movements, and behavior and facial expressions. – If not normal for the woman's culture, ask if she has: a. Been without food or drink for a prolonged period b. Been taking drugs/medications c. Had an injury					
36. Observe general cleanliness, noting visible dirt and odor.					
37. Check skin, noting lesions and bruises.					
38. Check conjunctiva for pallor.					
Vital Signs Measurements (Every Visit)					
39. Have the woman remain seated and relaxed.					
40. Measure her blood pressure, temperature, and pulse.					
Breast Examination (Every Visit)					
41. Explain the next steps in the physical examination to the woman and obtain her consent to proceed.					
42. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth, or air dry.					
43. Ask the woman to uncover her body from the waist up, and have her lie comfortably on her back.					
44. Gently palpate breasts, noting tenderness, swelling, and any areas that are red and hot.					
45. Check nipples, noting pus or bloody discharge, cracks, fissures, or other lesions, and whether nipples are inverted.					
Abdominal Examination (Every Visit)					
46. Ask the woman to uncover her stomach.					
47. Have her lie on her back with her knees slightly bent.					
48. Look for old or new incisions on the abdomen: – If there is an incision (sutures) from a cesarean section or other uterine surgery, look for signs and symptoms of infection.					
49. Gently palpate the abdomen between umbilicus and symphysis pubis, noting size and firmness of uterus.					
50. Check whether bladder is palpable above the symphysis pubis.					

CHECKLIST FOR POSTPARTUM ASSESSMENT AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY)					
Step/Task	**Cases**				
Leg Examination (Every Visit)					
51. Grasp the woman's foot with one hand and gently but firmly move the foot upward toward the woman's knee: – Observe whether this causes pain in the calf. – Repeat the procedure with the other leg.					
Genital Examination (Every Visit – not required if perineum intact)					
52. Ask the woman to uncover her genital area, and cover or drape her for privacy and modesty.					
53. Ask the woman to separate her legs while continuing to bend her knees slightly.					
54. Turn on the light and direct it toward genital area.					
55. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth, or air dry.					
56. Put new examination or high-level disinfected gloves on both hands.					
57. Look at the perineum, noting scars, lesions, inflammation, or cracks in skin, bruising, and color, odor, and amount of lochia.					
58. Immerse both gloved hands briefly in a container filled with 0.5% chlorine solution; then remove the gloves by turning them inside out: – If disposing of gloves (examination gloves and surgical gloves that will not be reused), place them in a plastic bag or leakproof, covered waste container.					
59. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth, or air dry.					
Breastfeeding and Breast Care					
60. Based on the woman's breastfeeding history, provide information about the following: – Exclusive breastfeeding on demand – Comfortable positions for breastfeeding and use of both breasts – Adequate rest and sleep – Extra fluid and food intake – Breast care					
Complication Readiness					
61. Review the woman's complication readiness plan with her (or develop one if she does not have one), covering: – Arrangements made since last visit – Changes – Obstacles or problems encountered					
Family Planning					
62. Introduce the concepts of birth spacing and family planning: – Discuss the woman's previous experience with and beliefs about contraception, as well as her preferences. – Advise the woman on the availability and accessibility of family planning services.					

CHECKLIST FOR POSTPARTUM ASSESSMENT AND CARE (SOME OF THE FOLLOWING STEPS/TASKS SHOULD BE PERFORMED SIMULTANEOUSLY)					
Step/Task	**Cases**				
Nutritional Support					
63. Provide advice and counseling about diet and nutrition: – All postpartum women should eat a balanced diet and a variety of foods rich in iron, vitamin A, calcium, magnesium, and vitamin C. – Women who are breastfeeding should: a. Eat two additional servings of staple food per day b. Eat three additional servings of calcium-rich foods c. Drink at least eight glasses of fluid (2 liters) each day (including milk, water, juices) d. Eat smaller, more frequent meals, if necessary e. Try to decrease amount of heavy work and increase rest time					
Self-Care and Other Healthy Behaviors					
64. Provide advice and counseling about: – Prevention of infection and good hygiene – Rest and activity – Sexual relations and safer sex					
Immunizations and Other Prophylaxis					
65. Give tetanus toxoid based on the woman's need.					
66. Dispense a sufficient supply of iron/folate to last until next visit and counsel the woman about the following: – Eating food rich in vitamin C – Avoiding tea, coffee, and colas – Possible side effects and management					
67. Dispense medications as follows: – Vitamin A (based on region/population-specific need) – Iron folic acid tablets					
Return Visits					
68. Schedule the next postnatal visit: – Make sure the woman knows when and where to come. – Answer any additional questions or concern. – Advise her to bring her records with her to each visit. – Make sure she understands that she can return any time before the next scheduled visit if she has a problem. – Review danger signs and key points of the complication readiness plan. – Thank the woman for coming.					

Appendix AB: Clinical Performance Support Tools for Normal Newborn Care

HANDOUT: PROCEDURE FOR NEWBORN BATHING

Before bathing and before the baby is undressed:

- Prepare equipment and supplies.
- Ensure that the room is warm (25 °C or more) and free from drafts.
- Ensure that the water is warm to the touch, but not hot.

Until the cord has fallen off and the stump is completely healed, bathe the baby according to the following guidelines to ensure that the cord is kept dry:

- Lay the baby on a clean towel on a flat surface, or have somebody else hold the baby.
- First, undress the baby's head and upper body.
- Bathe the baby's head and upper body (do not use soap on the baby's face):
  - Begin by washing the baby's head and face, using clean water and clean cloths.
  - Clean the eyes using separate clean cloths or cotton balls, wiping each eye from the inside to the outside edge.
  - Then wash the neck, arms, and rest of upper body.

Note: Wash around the cord and do not immerse it in water!

- Immediately dry and dress the baby's head and upper body, including a hat.
- Next, undress the baby's lower body (remember to properly dispose of the diaper/napkin).
- Bathe the baby's lower body:
- Begin by washing the baby's legs.
- Then wash the baby's bottom, from the groin/genitals toward the buttocks.
- Immediately dry and dress the baby's lower body (remember to fold the diaper/napkin so that it does not cover the cord).

After the cord has fallen off and the stump is completely healed, the baby can be bathed in a shallow pan of water while being held upright, and the upper body and lower body do not have to be bathed, dried, and clothed separately.

Immediately after bathing, the baby should be:

- Thoroughly dried;
- Dressed and/or wrapped in a clean, dry blanket/covering; and
- Put in close contact with the woman.

Put no lotions, powders, or other products on the baby's skin.

If the baby becomes chilled during bathing, rewarm the baby by placing her/him in skin-to-skin contact with the woman and covering with a clean, dry blanket.

HANDOUT: PHYSICAL EXAMINATION OF THE NEWBORN

Complete the following steps before performing the physical examination:

- Inform the woman of what you are going to do. Encourage her to ask questions, and listen to what she has to say.
- Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth, or allow them to air dry.
- Wear examination gloves if the baby has not been bathed since birth, or if the cord is touched or there is blood, urine, and/or stool present.
- Place the baby on a clean, warm surface or examine her/him in the woman's arms.
- Have clean clothes or blankets/coverings ready to dress the baby immediately after the examination.

ELEMENT	NORMAL
Weight	▪ Normal birth weight is 2.5–4.0 kg ▪ Be wary if the baby's weight is less than 2.5 kg and look closely for danger signs.
Respiration	▪ Normal respiratory rate is 30–60 breaths per minute ▪ No gasping ▪ No chest in-drawing ▪ No grunting on expiration ▪ If any of the above or fast breathing is present, refer urgently.
Temperature (axillary)	▪ Normal temperature is 36.5–37.5°C ▪ If baby feels too hot, unwrap the baby for 10 minutes and then rewrap and check again if too hot
Color	▪ Baby's lips, tongue, nails, palms of hands, and soles of feet are pink ▪ No central cyanosis (blue tongue and lips) ▪ No jaundice (yellowness) ▪ No pallor ▪ Normal variation: Cyanosis (blueness) of hands or feet in the first 12 hours
Movements and posture	▪ Movements are regular and symmetrical (i.e., equal on both sides of the body) ▪ No convulsions ▪ No spasms ▪ No opisthotonos (extreme hyperextension of the body, with the head and heels bent backward and the body arched forward) ▪ If there are irregular or asymmetrical arm or leg movements, facilitate non-urgent referral/transfer.
Level of alertness and muscle tone	▪ Responds actively to handling and other stimuli ▪ Can easily be roused from sleep ▪ Not floppy or lethargic ▪ Can be consoled when upset; not overly irritable ▪ If the baby is nonresponsive, floppy or lethargic, or inconsolable, act immediately! Facilitate urgent referral/transfer.
Skin	▪ The normal color of a newborn's skin is pinkish. ▪ In case of cyanosis, respond immediately.
Head	▪ Head is symmetrical in shape ▪ Fontanels are soft and flat ▪ Distance between sutures is within normal range (i.e., they are not widely separated)

ELEMENT	NORMAL
	▪ Size of the head is proportionate to the body ▪ Common concerns: – Swelling on the head that does not cross suture lines and feels firm to the touch (cephalohematoma); may take 12 weeks to resolve – Edematous swelling (caput succedaneum) over the part of the head that came first through the birth canal; unless excessive, usually resolves within 24 hours – Misshapen head caused by molding; usually resolves within two to three days ▪ If any of the following signs are observed, act now! Facilitate urgent referral/transfer: – Anterior fontanel is bulging – Sutures are abnormally wide – Swelling on the head crosses suture lines – Circumference of head appears to be increasing – Edematous swelling or misshapen head (caused by birth/molding) that is not resolved by 72 hours after birth
Face and Mouth	**First Visit** ▪ Facial features and movements are regular and symmetrical. ▪ The lips, gums, and palate are intact. ▪ If any of the following signs are observed, facilitate non-urgent referral/transfer: – Cleft lip (split in lip) or cleft palate (hole in upper palate connecting mouth and nasal passages) – Unable to wrinkle forehead or close eye on one side – Angle of mouth is pulled to one side – Other features/movements are not within normal range
Eyes	The baby's eyes have no swelling, redness, or pus draining from them.
Chest	▪ Chest movements are regular and symmetrical ▪ No chest in-drawing
Abdomen and cord stump	▪ The abdomen should be rounded, but not distended, with no protrusions. ▪ The stump is dry. ▪ There is no blood or pus oozing from cord stump. ▪ There is no red, inflamed, swollen, or hardened skin around umbilicus. ▪ There is no offensive smell. ▪ If there is a distended abdomen or any abnormal protrusion, particularly from the base of the cord or through a defect in the abdominal wall, ACT NOW. Cover exposed protrusion with clean, moist cloth (if applicable) and facilitate urgent referral/ transfer. ▪ If the cord stump is bleeding, retie the cord. ▪ If bleeding continues after 15 minutes, and foul smell or pus is draining from umbilicus, facilitate urgent referral.
External genitalia and anus	▪ The genitals are regular and symmetrical. ▪ In boys, the urethral orifice is at end of the penis. ▪ The anus appears patent/intact. **Note:** Do not insert anything into the anus to confirm patency. Patency of the anus is confirmed when meconium is passed.
Back	Spine should be free of swelling, lesions, dimples, or hairy patches. If the spine is not within normal range, facilitate urgent referral/transfer.

ELEMENT	NORMAL
Limbs	▪ Position and appearance of limbs, hands, and feet normal and symmetrical ▪ Movement of limbs is regular and symmetrical ▪ No swelling over any bone ▪ No crying when arm, shoulder, or leg is touched If limbs are not within the normal range, facilitate non-urgent referral/transfer after providing basic care.

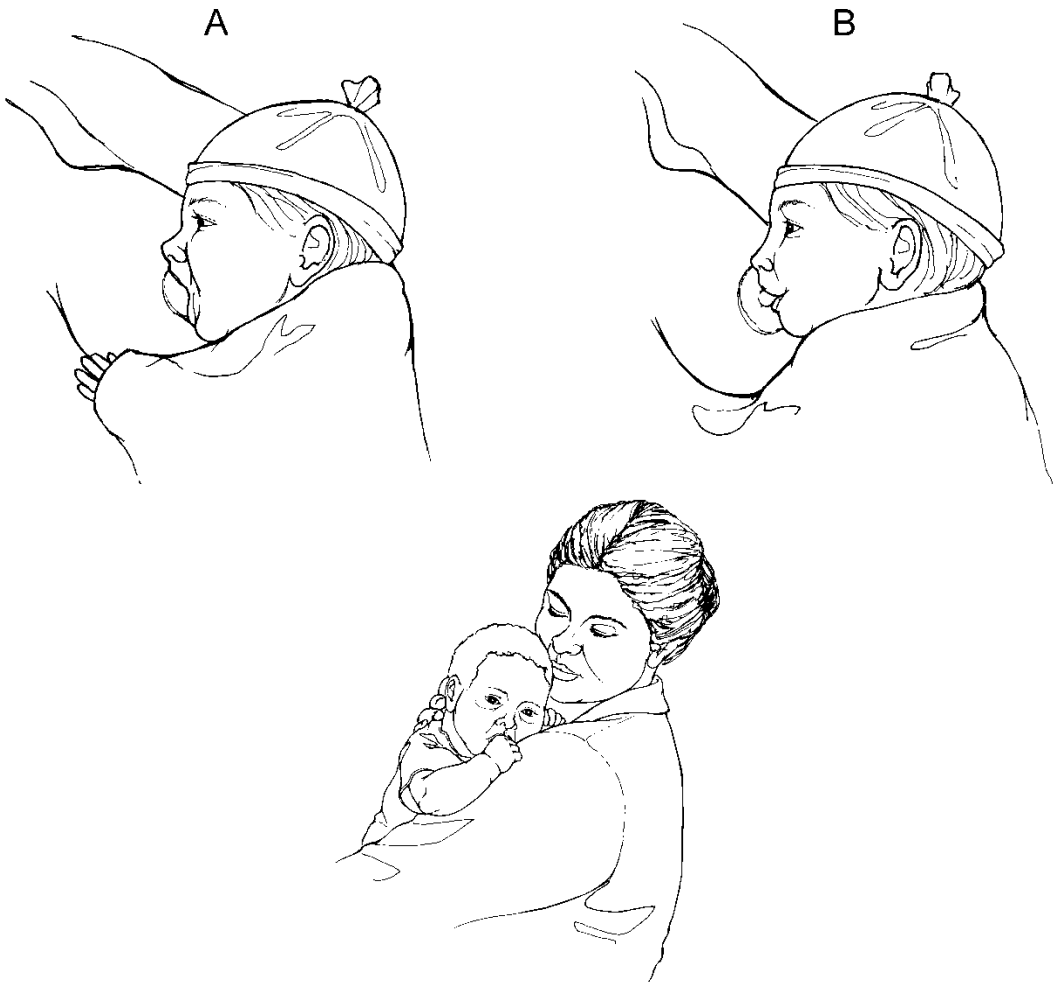
Reprinted from *Kinzie B and Gomez G. Basic Maternal and Newborn Care—Basic Antenatal Care: Course Notebook for Trainers*. Baltimore: Jhpiego, 2004.

Appendix AC: Clinical Performance Support Tools for Breastfeeding

HANDOUT: BREASTFEEDING

POSITIONING	▪ The woman is comfortable, with back and arms supported. ▪ The baby's head and body are aligned; baby's abdomen is turned toward the woman. ▪ The baby's face is facing the breast with nose opposite nipple. ▪ The baby's body is held close to the woman. ▪ The baby's whole body is supported. ▪ The baby is brought to nipple height.
HOLDING	▪ The woman may support the weight of her breast with her hand and shape her breast by putting her thumb on the upper part, so that the nipple and areola are pointing toward the baby's mouth; OR ▪ She may support the breast by placing her fingers flat against the chest wall, while bringing the baby to her breast to suckle.
ATTACHMENT AND SUCKLING	▪ The nipple and areola, rather than only the nipple, are drawn into the baby's mouth. ▪ The baby's mouth is wide open; lower lip is curled back below base of nipple. ▪ The baby takes slow, deep sucks, often with visible or audible swallowing. ▪ The baby pauses from time to time. ▪ The baby may make "smacking" sounds. ▪ See figure below.
WOMAN'S COMFORT	▪ The woman does not complain of or appear to have nipple/breast pain during breastfeeding.
FINISHING THE BREASTFEEDING	▪ The newborn should release the breast her/himself rather than being pulled from the breast. ▪ Feeding may vary in length, anywhere from 4 to 40 minutes per breast. ▪ Breasts are softer at the end of the feed compared to the beginning, when they are full and firm. ▪ The newborn looks sleepy and satisfied at the end of a feeding.

Correct (A) and Incorrect (B) Attachment of the Newborn to the Breast



ELEMENT	NORMAL
Physical contact and communication	• The woman appears to enjoy physical contact with her newborn and appears contented with the newborn. • She caresses, talks to, and makes eye contact with the newborn. • When holding or feeding the newborn, she and the newborn are turned toward each other. • She responds with active concern to the newborn's crying or need for attention.

CHECKLIST: SUPPORTING SUCCESSFUL BREASTFEEDING

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

(Some of the following steps/tasks should be performed simultaneously)

Place a "✓" in case box if step/task is performed satisfactorily, an X if it is not performed satisfactorily, or N/O if it is 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 participant during evaluation by facilitator/teacher

Participant: _____ Date Observed: _____

STEP/TASK	Cases			
Getting Ready				
1. Greet the mother.				
2. Include family in discussion of breastfeeding if possible.				
3. Ask the mother if there is any reason she cannot breastfeed.				
4. Explain why it is important to breastfeed soon after birth: – Baby is usually awake and ready to suck – Baby sucking stimulates mother to produce breast milk – Baby benefits from colostrum – Helps placental separation – Helps mother/baby bonding				
5. Wash hands with soap and water and dry with clean cloth/air dry.				
Help the Mother and Baby Start Breastfeeding				
6. Explain each step as you do it so the mother can do it herself.				
7. Mother's position: – Help the mother into a comfortable position.				
8. Baby's position: – Place baby close to the mother – Head and body are in a straight line – Baby is facing breast with nose close to nipple – Whole body is fully supported; put baby on a blanket or pillow, if needed, so baby and breast are at the same level				
9. Help the baby attach: – Ask mother to hold her breast in a "C" hold (thumb on top and other fingers below breast), with fingers away from areola – Touch the outer edge of the baby's lips with the nipple – Wait for the mouth to open wide – Move baby onto breast with baby's lower lip below the nipple; do not move baby's head, but support back of the neck and move the whole body – Look at how baby is attached and sucking; explain to mother how she can tell if baby is sucking well				

STEP/TASK	Cases			
10. Attachment: – Chin is touching the breast – Baby's mouth is wide open – Baby's lower lip is averted – More areola is visible above than below the breast				
11. Baby's sucking: – Slow, deep sucks – Some pauses – You can hear the baby swallow when feeding – If baby is not attached or sucking well, take the baby off the breast by pressing down on the baby's chin; then try again – Let baby suck as long as s/he wants or until s/he releases the breast				
12. Switch breasts: – Repeat steps 16–30 to help mother switch baby to other breast – After breastfeeding, burp the baby				
Advice and Information				
13. Advise the mother to: – Give only breast milk in the first six months – Feed the baby on demand – Alternate which breast is used to start feeding (e.g., if left breast was given at last feed, start with right breast) – If baby still wants to feed more after the first breast, give the second breast – Empty first breast before starting the other (this provides hind milk) – Use comfortable and different positions – Get enough rest – Drink a large glass of fluid with every breastfeed. Mother should not drink more than 1–2 cups of fluids containing caffeine – Eat one extra meal a day				
14. Signs that baby is getting enough milk: – Baby passes urine at least six times in 24 hours – The mother's breast feels softer after feeding – Baby gains weight over time (after the first week) – Baby seems content after feeding and may sleep				
15. Other information: – Continue to breastfeed a sick baby – Breastfeed more often during periods of rapid growth – Breastfeed for at least two years				

Appendix AD: Clinical Performance Support Tools for Infection Prevention and Control

HANDOUT: STANDARD PRECAUTIONS

To Use Standard Precautions Means to Always

- Consider every person potentially infectious (even babies and medical staff).
- Wash your hands.
- Wear protective clothing when needed (gloves, eye protection, aprons, closed shoes).
- Use an antiseptic as appropriate.
- Prevent injuries with sharps.
- Process patient care instruments and equipment safely.
- Keep the environment clean.
- Dispose of waste safely.

Always Wash Your Hands

1. When arriving at/leaving the workplace;
2. Before/after caring for or examining a mother/baby;
3. Before/after using gloves;
4. After having contact with blood/body fluids from instruments, supplies, or splashes; and
5. Before eating and after using the toilet, coughing, or blowing your nose.

Antiseptic Hand rub

What is it?

Cleaning hands with an antiseptic such as alcohol (60–90% ethyl or isopropyl), chlorhexidine 2–4%, iodine preparations 3%, betadine 7.5–10%, or Savlon greater than 1%; or using hand sanitizer

Advantages

- Inhibits or kills most gram-negative and gram-positive bacteria, TB, viruses (HIV), and fungi
- More effective than handwashing, which removes dirt, blood, and some transient germs, but not all
- If used with hand softeners like glycerin or propylene glycol, protects and softens skin

How to make it

Mix 100 mL 60–90% ethyl or isopropyl alcohol with 2 mL skin softener (glycerin, propylene glycol, sorbitol)

How to Use It

- Pour about 5 mL into hands.
- Rub solution into hands; clean the palms, back of hands, and especially between fingers and under nails, until dry.
- Do not use if hands are contaminated with body fluids, but wash hands with soap and water.
- Wash hands with soap and water after every 5–10 uses to reduce the build-up of hand softeners.

PERSONAL PROTECTIVE EQUIPMENT/CLOTHING

MASK AND EYE PROTECTION	Used for: ▪ Sorting and cleaning instruments and linens ▪ Attending a vaginal delivery ▪ Cutting umbilical cord *Note: Eye protection can include goggles, face shields, or plain glasses.*
APRON OR GOWN	Used for: ▪ Sorting and cleaning instruments and linens ▪ Attending a vaginal delivery
FOOT PROTECTION	Closed shoes or boots made from rubber or leather protect the wearer from: ▪ Injury by sharps or heavy items ▪ Blood or other body fluids on the floor
GLOVES	**Utility or heavy-duty gloves:** Use when touching dirty instruments, linens, and waste; doing housekeeping; and cleaning contaminated surfaces and disposing of contaminated waste **Single-use examination gloves:** Use if having contact with intact mucous membranes and when at risk of exposure to blood or other body fluids **Surgical gloves:** For all procedures having contact with tissues under the skin or with the blood stream

RECOMMENDED CLEANING FOR HEALTH FACILITY

FREQUENCY	WHAT TO CLEAN
Clean with disinfectant cleaning solution (mix 0.5% chlorine solution with a soap or detergent that does not contain an acid, ammonia, or ammonium chloride):	
Following discharge of a patient	▪ Mattress, bed frame, cot, incubator ▪ Any other equipment used for the patient's care
Immediately	▪ Furniture, floors, rooms, and equipment (after a procedure or after a delivery) ▪ Spills
Daily	▪ Delivery and examination rooms ▪ Floors ▪ Furniture and equipment used daily (exam table, table tops, counters, weighing scales) ▪ Sinks, toilets and latrines, and waste containers—use separate mop, cloth, or brush
Clean with detergent and water solution:	
Weekly	Clean doors (including door handles), windows, walls, ceilings, and ceiling fixtures

Double Bucket Technique: This technique helps the disinfectant cleaning solution last longer. Use two buckets, one with disinfectant cleaning solution and the second bucket with rinse water. Always rinse and wring out the mop before dipping it into the disinfectant cleaning solution. When rinse water becomes very dirty, dispose of it and replace it with clean rinse water. (Providers are encouraged to use metal trolleys with wheels and holders for two buckets.)

WAYS TO DISPOSE OF CONTAMINATED WASTE	
Sink, Toilet, Or Latrine	Before pouring liquid waste into a sink or toilet, think about where the drain empties. It is dangerous for liquid medical waste to run through open gutters or sewers. To dispose of blood and blood bags, empty the blood into the sink and incinerate bags with contaminated waste.
Bury	Burying contaminated waste is another option. The pit must be in a safe location and correctly filled in and covered. A safely located pit: ▪ Has a fence around it, ▪ Is at least 50 meters [155 feet] from any water source, ▪ Is downhill from any wells, ▪ Is not in an area that floods, and ▪ Has a water level more than 4 meters (12 feet) below the surface.
Burn	This is the best method for disposing of contaminated waste. It prevents people and animals from collecting used supplies and reusing.
Encapsulate	Seal the container that has the waste in it by filling it completely with cement, plastic foam, or clay; and wait until it dries. Then either bury the sealed container or dispose of it in a landfill. This method can be used for disposal of sharps and other hazardous materials.
Placenta and other body tissues	Dispose of in the placental pit, as tissues and placenta are highly contaminated.

4 STEPS FOR PROCESSING INSTRUMENTS AND SUPPLIES

STEP 1	Decontaminate	▪ Kills viruses and many other germs ▪ Makes items safer to handle during cleaning ▪ Makes items easier to clean
STEP 2	Clean	▪ Removes blood, other body fluids, tissue, and dirt ▪ Reduces the number of germs ▪ Makes sterilization or high-level disinfection effective (If blood clot remains on instrument, germs in clot may not be completely killed by sterilization or high-level disinfection.)
STEP 3	Sterilization OR High-Level Disinfection (HLD)	▪ Sterilization kills all germs, including endospores ▪ May not be possible to do in all settings ▪ Can be done by dry heat or wet heat (autoclave) ▪ HLD kills all germs except some endospores ▪ Use for items having contact with broken skin or intact mucous membranes
		▪ If sterilization is not possible, HLD is only other choice ▪ Can be done by steaming, boiling, or chemical disinfection (soak in 0.1% chlorine solution for 20 minutes)
STEP 4	Store or Use	▪ Sterilized: If sterilized instruments/equipment are wrapped, they are good for at least 30 days unless something causes the package to become contaminated (tear in package or becomes wet). ▪ HLD: Store in a high-level disinfected or sterile covered tray for up to 1 week.

HANDOUT: DECONTAMINATION AND CLEANING

Quick References for Mixing Bleach

Preparing Dilute Chlorine Solutions from Liquid Bleach (Sodium Hypochlorite Solution) for Decontamination and High-Level Disinfection (HLD)

TYPE OR BRAND OF BLEACH (BY COUNTRY)	CHLORINE % available	PARTS WATER TO 1 PART BLEACH[a]	
		0.5%	0.1%[b]
Chlorine	2.4%	4	23
Robin Bleach	3.5%	6	34
12 °chlorum[c]	3.6%	6	35
Household bleach (USA, Indonesia), ACE (Turkey), Eau de Javel (France) (15 °chlorum[c])	5%	9	49
Blanquedor, Cloro (Mexico)	6%	11	59
Lavandina (Bolivia)	8%	15	79
Chloros (UK)	10%	19	99
Chloros (UK), Extrait de Javel (France) (48 °chlorum[c])	15%	29	149

[a] Read as one part (e.g., cup or glass) concentrated bleach to x parts water (e.g., JIK [0.5% solution]—mix 1 cup bleach with 6 cups water for a total of 7 cups).

[b] Use boiled water when preparing a 0.1% chlorine solution for HLD because tap water contains microscopic organic matter that inactivates chlorine.

[c] In some countries, the concentration of sodium hypochlorite is expressed in chlorometric degrees (°chlorum); one °chlorum is approximately equivalent to 0.3% available chlorine.
Adapted from: World Health Organization (WHO). 1989. *Guidelines on Sterilization and High-Level Disinfection Methods Effective Against Human Immunodeficiency Virus (HIV).* AIDS Series 2. WHO: Geneva.

Formula for Making a Dilute Solution from a Concentrated Solution

Check concentration (% concentrate) of the chlorine product you are using.
Determine total parts water needed using the formula below.

$$\textit{Total Parts (TP) water} = \left[\frac{\%\ \text{Concentrate}}{\%\ \text{Dilute}}\right] - 1$$

Mix 1 part concentrated bleach with the total parts water required.

Example: Make a dilute solution (0.5%) from 5% concentrated solution.

STEP 1: Calculate TP water: $\left[\frac{5.0\%}{0.5\%}\right] - 1 = 10 - 1 = 9$

STEP 2: Take 1 part concentrated solution and add to 9 parts water.

Double the chlorine as water increases in liters.

Preparing Dilute Chlorine Solutions from Dry Powders

AVAILABLE CHLORINE REQUIRED	0.5%	0.1%[b]
Calcium hypochlorite (70% available chlorine)	7.1 g/L[a]	1.4 g/L
Calcium hypochlorite (35% available chlorine)	14.2 g/L	2.8 g/L
NaDCC[c] (60% available chlorine)	8.3 g/L	1.5 g/L
Chloramine tablets[d] (1 g of available chlorine per tablet)	20 g/L (20 tablets/liter)[d]	4 g/L (4 tablets/liter)[d]
NaDCC-based tablets (1.5 g of available chlorine per tablet)	4 tablets/liter	1 tablet/liter

[a] For dry powders, read x grams per liter (example: calcium hypochlorite—7.1 grams mixed with 1 liter water).

[b] Use boiled water when preparing a 0.1% chlorine solution for HLD because tap water contains microscopic organic matter that inactivates chlorine.

[c] Sodium dichloroisocyanurate

[d] Chloramine releases chlorine at a slower rate than does hypochlorite. Before using the solution, be sure the tablet is completely dissolved.

Adapted from: World Health Organization (WHO). 1989. *Guidelines on Sterilization and High-Level Disinfection Methods Effective Against Human Immunodeficiency Virus (HIV).* AIDS Series 2. WHO: Geneva.

Formula for Making Chlorine Solutions from Dry Powders

Check concentration (% concentrate) of the powder you are using.
Determine grams bleach needed, using the formula below.

$$\textit{Grams/Liter} = \left[\frac{\%\ \text{Dilute}}{\%\ \text{Concentrate}}\right] \times 1000$$

Mix measured amount of bleach powder with 1 liter of water.

Example: Make a dilute chlorine-releasing solution (0.5%) from a concentrated powder (35%).

STEP 1: Calculate grams/liter: $\left[\frac{0.5\%}{35\%}\right] \times 1000 = 14.2\ \text{g/L}$

STEP 2: Add 14.2 grams (☐14 g) to 1 liter of water.

Appendix AE: Clinical Performance Support Tools for Family Planning

FAMILY PLANNING METHODS COUNSELING

Participant:_____ Date Observed:_____

TASK: NOTE DO NOT NEED TO BE COMPLETED IN EXACTLY THIS ORDER		Safe/Effective Completion of Task	
		YES	No
1.	Uses appropriate communication skills: speaks clearly and simply, encourages questions and assesses understanding when needed	1	0
2.	Is professional: Greets the woman/client politely, maintains/ensures confidentiality, speaks politely to the woman		
3.	Determines if the woman has a method in mind or no method in mind	1	0
4.	Determines woman's reproductive goals and other desired method attributes	1	0
5.	Assesses woman's perception of need for STI protection, and addresses appropriately	1	0
6.	Assesses woman's baseline understanding of family planning method of interest or methods appropriate based on reproductive goals	1	0
7.	Counsels based on reproductive goals or method of interest, does not review methods that are not of interest or not in line with the woman's desired spacing and method attributes	1	0
Using available visual aids, provides general information about a selected contraceptive method including:			
8.	How it prevents pregnancy and its effectiveness	1	0
9.	How it is used	1	0
10.	Advantages, disadvantages and possible danger signs associated with complications	1	0

Pass Score *8/10*
Student Score _____

Pass ____ Fail ____

Comments/ Remediation Plan:

_____

_____

_____

_____

Examiner Signature _____

Resource List

- Contraceptive flip chart or other job aid for counseling (Counseling Desk Reference is preferred)
- Condoms, OC, Implant, IUD, etc. (wide range of sample methods)
- Markers
- Two chairs
- Table
- Woman to role play client

Examiner Instructions

- Ask participant to speak directly to woman role playing client
- Ensure that participant does not have any unanswered questions about station before she or he begins

Participant Instructions

- Interact directly with the woman that you are counseling
- 15 minutes to complete station

Standardized Patient Instructions

- You are 25 years old
- You are married
- You do not desire another child for at least two years, effectiveness is the most important method attribute for you
- You have had one baby delivered vaginally without complications one year ago
- You are still breastfeeding
- You have never had an STI and are not concerned about them
- You are not currently using contraceptives, other than withdrawal
- You are sexually active in a monogamous relationship with your husband

Appendix AF: Counseling Guide for PPFP/PPIUCD Counseling

Based on the GATHER Technique, this guide provides a "framework" for counseling—both general and specific to women interested in the PPIUCD.

Place a **"tick"** in case box if task/activity is performed **satisfactorily,** a **"cross"** if it is **not** performed **satisfactorily**, or **N/O** if not observed. Provide comments to the learner to allow him or her to improve her performance.

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, task or skill not performed by learner during evaluation by trainer

Learner: _____ Date Observed: _____

	ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
GREET—Establish good rapport and initiate counseling on PPFP.						
1.	Establishes a supportive, trusting relationship	☐ Greets the woman, using her name and introducing self.				
		☐ Shows respect for the woman and helps her feel at ease.				
2.	Allows the woman to talk and listens to her	☐ Encourages the woman to explain her needs and concerns and ask questions.				
		☐ Listens carefully and supports the woman's informed decisions				
3.	Engages woman's family members.	☐ Includes woman's partner or important family member in the discussion, as the woman desires and with her consent.				
ASK—Determine reproductive intentions, knowledge of pregnancy risk and use of various contraceptives.						
4.	Determines any previous experiences with family planning.	☐ Explores woman's knowledge about the return of fertility and the benefits of pregnancy spacing or limiting (as desired).				
		☐ Asks whether she has had prior experience with family planning methods, any problems, reasons for discontinuing, etc.				
5.	Assesses partner/family attitudes about family planning.	☐ Explores partner's/family's knowledge about the return of fertility and the benefits of pregnancy spacing/limiting.				

	ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
6.	Assesses reproductive intentions.	☐ Asks about desired number of children, desire to space or limit births, desire for long-term family planning, etc.				
COUNSELING AND PPIUCD SERVICES						
7.	Assesses need for protection against sexually transmitted infections (STIs).	☐ Explores woman's need for protection from STIs, including HIV.				
		☐ Explains and supports condom use, as a method of dual protection				
8.	Determines interest in a particular family planning method.	☐ Asks whether she has a preference for a specific method, based on prior knowledge or the information provided.				
TELL—Provide the woman with information about PPFP methods.						
9.	Provides general information about benefits of healthy pregnancy spacing (or limiting, if desired).	☐ Advises that to ensure her health and the health of her baby (and family), she should wait at least 2 years after this birth before trying to get pregnant again.				
		☐ Advises about the return of fertility postpartum and the risk of pregnancy. Advises how LAM and breastfeeding are different.				
		☐ Advises about the health, social and economic benefits of healthy pregnancy spacing (or limiting, if desired).				
10.	Provides information about PPFP methods.	Based on availability and on woman's prior knowledge and interest, briefly explains the advantages, limitations and use of the following methods:				
		☐ LAM				
		☐ Condoms				
		☐ POPs, COCs				
		☐ DMPA (injections)				
		☐ PPIUCD				
		☐ No-scalpel vasectomy (male sterilization)				
		☐ Postpartum tubal ligation (female sterilization)				
		☐ Shows the methods (using poster or wall chart) and allows the woman to touch or feel the items, including the IUCD, using a contraceptive tray.				
		☐ Corrects any misconceptions about family planning methods.				

	ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
HELP—Assist the woman in making a choice; give her additional information that she might need to make a decision.						
11.	Helps the woman to choose a method.	☐ Gives woman additional information that she may need and answer any questions.				
		☐ Assesses her knowledge about the selected method; provides additional information as needed.				
12.	Supports the woman's choice.	☐ Acknowledges the woman's choice and advises her on the steps involved in providing her with her chosen method.				
13.	Evaluates the woman's health and determine if she can safely use the method.	☐ Asks the woman about her medical and reproductive history.				
14.	Provides key information about the PPIUCD with the woman:	☐ Effectiveness: Prevents almost 100% of pregnancies				
		☐ Mechanism for preventing pregnancy: Causes a chemical change that damages the sperm BEFORE the sperm and egg meet				
		☐ Duration of IUCD efficacy: Can be used as long (or short) as woman desires, up to 12 years (for the Copper T 380A)				
		☐ Removal: Can be removed at any time by a trained provider with immediate return to fertility				
15.	Discusses advantages of the PPIUCD:	☐ Simple and convenient IUCD placement, especially immediately after delivery of the placenta				
		☐ No action required by the woman after IUCD placement (although one routine follow-up visit is recommended)				
		☐ Immediate return of fertility upon removal				
		☐ Does not affect breastfeeding or breast milk				
		☐ Long-acting and reversible (as described above)				

	ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
16.	Discusses limitations of the PPIUCD:	☐ Heavier and more painful menses for some women, especially first few cycles after interval IUCD (less relevant or noticeable to postpartum women)				
		☐ Does not protect against STIs, including HIV				
		☐ Higher risk of expulsion when inserted postpartum (though less with immediate postpartum insertion)				
17.	Discusses warning signs; explains that she should return to the clinic as soon as	☐ Bleeding or foul-smelling vaginal discharge (different from the usual lochia)				
		☐ Lower abdominal pain, especially if the first 20 days after insertion—accompanied by not feeling well, fever or chills				
		☐ Concerns she might be pregnant				
18.	Confirms that the woman understands	☐ Encourages the woman to ask questions.				
		☐ Asks the woman to repeat key pieces of information.				
RETURN—Plan for next steps and for when she will arrive to hospital for delivery.						
19	Plans for next steps refers to a subsequent visit after an initial PPFP/PPIUCD counseling session, but before birth and IUCD insertion. "Return," as a part of post-insertion counseling, is addressed in the insertion checklists, following.]	☐ Makes notation in the woman's medical record about her PPFP choice or which methods interest her.				
		☐ If the woman cannot arrive at a decision at this visit, asks her to plan for a follow-up discussion at her next visit; advises her to bring partner/family member with her.				
		☐ Provides information about when the woman should come back, as appropriate.				

Appendix AG: IUCD Insertion and Pelvic Exam

Participant: _____ Date Observed: _____

TASK		Safe/Effective Completion of Task	
		Yes	No
1.	Prepare the necessary equipment.	1	0
2.	Greets client with respect/introduces self	1	0
3.	Confirms contraceptive choice	1	0
4.	Offers anticipatory guidance prior to insertion	1	0
5.	Washes hands to standard	1	0
6.	Explain steps needed for immediate preparation of woman (empty bladder, cleanse genitals, comfortable positioning, etc.)	1	0
7.	Performs bimanual pelvic examination: ▪ Determines size, shape and position of the uterus ▪ Checks for enlargement or tenderness of the adnexa and cervical motion tenderness ▪ Checks for any uterine abnormalities that would interfere with the IUCD	1	0
8.	Inserts speculum and visualizes cervix ▪ Looks for any abnormal discharge ▪ Looks for any ulcers, lesions or sores ▪ Looks for any cervical stenosis or other abnormalities	1	0
9.	Gently grasps cervix with tenaculum	1	0
10.	Determines depth of uterus and sets depth gauge on IUD appropriately	1	0
11.	Appropriately inserts IUD	1	0
12.	Performs post-insertion infection prevention: places equipment in decontamination solution, disposes of waste appropriately, washes hands	1	0
13.	Assess woman to ensure that she has tolerated insertion	1	0
14.	Provides post procedure education including: ▪ possible side effects ▪ warning signs (PAINS), ▪ string check, ▪ when to return to clinic (3-6 weeks)	1	0

Pass Score *11/14*
Student Score _____

Pass Fail

Comments/ Remediation Plan:

_____
_____
_____

Examiner Signature _____

MEDICAL EQUIPMENT & SUPPLIES LIST

- Pelvic model
- Speculum
- Tenaculum
- Uterine Sound
- Sterile Gloves
- Antiseptic solution
- Cotton balls
- IUD - Copper T 380A
- Light source
- Basin marked (.05% bleach solution), biohazardous and regular waste containers

EXAMINER INSTRUCTIONS

- Ask participant to explicitly explain actions throughout simulation
- Step #6 – Ask participant to briefly explain what s/he will do to prepare woman for insertion
- Step #7 – Ask participant to explain what they are looking for during the bimanual exam
- Step #8-Ask participant to explain what they are looking for during the speculum exam
- Step #14- Ask participant to provide IUCD post-insertion education

PARTICIPANT INSTRUCTIONS

- Treat the anatomic model as they would a woman. Simulate the presence of a woman seeking services.
- Consider that counseling has already been provided, and the woman has been identified as appropriate for IUCD insertion
- The woman has been identified as 'low personal risk' of an STI, so perform the pelvic exam immediately prior to insertion
- Post-insertion education should also be provided
- 15 minutes to complete station

Appendix AH: IUCD Loading and No Touch Technique

Participant: _____ Date Observed: _____

TASK		Safe/ Effective Completion of Task	
		Yes	No
1	Partially opens package on a flat surface.	1	0
2	Pick up package with open end up and bend back white backing flaps.	1	0
3	Grasp white solid rod and insert into insertion tube to almost touch bottom of "T."	1	0
4	Stabilize Safe Load device, and with other hand push inserter tube with "T" into Safe Load device.	1	0
5	When arms touch sides of inserter tube, manipulate the tube to catch the tips of the arms in the tube.	1	0
6	Push folded arms into inserter tube to keep them fixed in the tube.	1	0
7	Rotate the loaded IUCD 90° to release it from the Safe Load device.	1	0
8	Sets the IUCD at 8 cm	1	0
9	Able to state the IUCD should not be loaded more than 5 minutes before insertion	1	0
10	Does not contaminate the IUCD during loading	1	0
11	Able to state at least 2 components of no-touch technique: ▪ Load the IUCD in the sterile package ▪ The uterine sound and/or IUCD are not allowed to touch the vaginal walls or blades of the speculum ▪ The uterine sound and/or IUCD pass through the cervical os only once	1	0

Pass Score *_8_/11*
Student Score _____
Pass Fail

Comments/ Remediation Plan:

_____

_____

_____

Examiner Signature _____

MEDICAL EQUIPMENT & SUPPLIES LIST

- Clean Gloves
- IUD - Safeload

EXAMINER INSTRUCTIONS

- Tell the participant that the uterus was sounded at 8cm
- Ask participant to explicitly explain actions throughout simulation
- Step # 9– Ask participant to tell you how long the IUCD can be loaded before it is inserted
- Step # 11 – Ask participant to describe what the no-touch technique is

PARTICIPANT INSTRUCTIONS

- You have sounded the uterus and it is 8cm, load the IUCD appropriately in the sterile package for insertion.
- 15 minutes to complete station

Appendix AI: Early Postpartum Insertion of the IUCD (Copper T 380A)

(To Be Used by Learners and Trainers)

Learner: _____ Date Observed: _____

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUCD						
STEP/TASK	CASES					
Tasks to Perform in Postpartum Ward (prior to Procedure)						
1. Reviews the woman's record to ensure that she has chosen the IUCD.						
2. Ensures that she has been appropriately counseled and screened for PPIUCD insertion.						
3. Greets the woman with kindness and respect.						
4. If she has not been counseled and assessed for postpartum IUCD, provides that service now.						
5. **Confirms** that the woman still wants IUCD.						
6. Briefly describes procedure. Answers any question the woman might have.						
7. Confirms that correct sterile instruments, supplies and light source are available for early postpartum insertion; obtains PPIUCD kit/tray.						
8. Confirms that IUCDs are available on labor ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to insertion.						
Pre-Insertions Tasks (in Procedure Room)						
Note: For early postpartum insertion, the procedure is very similar to postplacental (instrumental) insertion. There are some differences, however, especially due to the postpartum changes that are already occurring in the woman's body. For example, depending on how much uterine involution has taken place, the provider may consider using a regular ring forceps for insertion, as it may be long enough to reach the fundus.						
9. Confirms that there are no delivery-related conditions that preclude insertion of IUCD now:						
☐ Rupture of membranes for greater than 18 hours						
☐ Chorioamnionitis						
☐ Puerperal sepsis						
☐ Continued excessive postpartum bleeding						
☐ Genital trauma so severe that repairs would be disrupted by postpartum placement of an IUCD (confirmed by inspection of genitalia, Step 15)						
10. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).						
11. Ensures that woman has recently emptied her bladder.						
12. Helps the woman onto table. Drapes her lower abdominal/pelvic area.						
13. Determines level/length of uterus and confirms that there is good uterine tone.						
14. Performs hand hygiene and puts HLD or sterile surgical gloves on both hands.						

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUCD					
STEP/TASK	CASES				
15. Inspects genitalia for trauma/repairs.					
Insertion of the IUCD					
16. **Confirms** that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if needed.					
17. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.					
18. Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.					
19. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.					
20. Gently grasps anterior lip of the cervix with the ring forceps. (Note: Slightly more pressure may be needed to close forceps than with postplacental insertion because cervix has become firmer and begun to resume its pre-pregnancy state.) (Speculum may be removed at this time, if necessary.)					
21. Leaves forceps aside, still attached to cervix.					
22. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.					
23. With nondominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.					
24. With dominant hand, uses placental forceps to grasp IUCD inside sterile package. Holds IUCD by the edge, careful not to entangle strings in the forceps.					
25. Gently lifts anterior lip of cervix using ring forceps.					
26. **Gently inserts and slowly advances IUCD** (this step overlaps with Step 27):					
☐ While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUCD—through cervix into lower uterine cavity. (Note: If difficult to pass placental forceps through the cervix, it may be necessary to use a second ring forceps to help widen cervical opening.)					
☐ Gently moves IUCD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus.					
☐ Keeping placental forceps firmly closed, lowers ring forceps and gently removes them from cervix; leaves them on sterile towel.					
27. **"Elevates" the uterus** (this step overlaps with Steps 26 and 28):					
☐ Places base of nondominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and					
☐ Gently pushes uterus upward in abdomen to extend lower uterine segment.					
28. **Passes IUCD through vagino-uterine angle** (this step overlaps with Step 27):					
☐ Keeping forceps closed, gently moves IUCD upward toward uterine fundus, in an angle toward umbilicus.					
☐ Lowers the dominant hand (hand holding placental forceps) down, to enable forceps to easily pass vagino-uterine angle and follow contour of uterine cavity. Takes care not to perforate uterus. (Note: Although this step may be more difficult in the early postpartum period, it is essential that the IUCD reach the fundus.)					

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUCD					
STEP/TASK	CASES				
29. Continues gently advancing forceps until uterine fundus is reached, when provider feels a resistance. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the IUCD has reached the fundus.					
30. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.					
31. Keeping forceps slightly open, slowly removes them from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus. Takes particular care not to dislodge IUCD or catch IUCD strings as forceps are removed.					
32. Keeps stabilizing uterus until forceps are completely withdrawn. Places forceps aside on sterile towel.					
33. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, removes IUCD using same forceps used for first insertion; positions same IUCD in forceps inside sterile package and reinserts.					
34. Checks any repairs made, as necessary, to ensure that they have not been disrupted.					
35. Removes all instruments used and places them open in 0.5% chlorine solution so they are totally submerged.					
Post-Insertion Tasks					
36. Allows the woman to rest a few minutes. Continues routine postpartum and newborn care.					
37. Disposes of waste materials appropriately.					
38. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
39. Performs hand hygiene.					
40. Tells woman that IUCD has been successfully placed; reassures her and answer any questions she may have. Tells her that detailed instructions will be provided prior to discharge, and provides the following instructions:					
☐ Reviews IUCD side effects and normal postpartum symptoms					
☐ Tells woman when to return for IUCD/postnatal/newborn checkup					
☐ Emphasizes that she should come back any time she has a concern or experiences warning signs					
☐ Reviews warning signs for IUCD (PAINS[1])					
☐ Reviews how to check for expulsion and what to do in case of expulsion					
☐ Ensures that the woman understands post-insertion instructions					
☐ Gives written post-insertion instructions, if possible					
☐ Provides card showing type of IUCD and date of insertion					
41. Records information in the woman's chart or record. Attaches IUCD card (which women will be given at discharge) to woman's record.					
42. Records information in the appropriate register(s).					

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	☐ Yes ☐ No	☐ Yes ☐ No
Signed:		
Date:		

Appendix AK: Checklists for Contraceptive Implants

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)] COUNSELING AND CLINICAL SKILLS: INSERTION

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)] COUNSELING AND CLINICAL SKILLS: *INSERTION*						
STEP/TASK	CASES					
PRE-INSERTION COUNSELING						
1. Greet the client respectfully and with kindness.						
2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.						
3. Display the Balanced Counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: – Does the client want more children in the future? – Is she breastfeeding an infant < 6 months? – Will her partner use condoms? – Has she not tolerated an FP method in the past?						
4. Continue with Balanced Counseling, using the cards to: – Give information about the methods on the cards that are left. – Discuss side effects and efficacy. – Help the client to choose a method. – Confirm method choice.						
5. Review medical eligibility: – Read from the client brochure in language the client understands (e.g., "Method not advised if you ....").						
6. Review Client Screening Checklist to determine if two-rod implants are an appropriate choice for the client.						
7. Perform (or refer for) further evaluation, if indicated.						
8. Assess the woman's knowledge about implants' major side effects: – Confirm that the client accepts possible menstrual changes with implants.						
9. Describe insertion procedure and what to expect.						
INSERTION OF TWO-ROD IMPLANTS						
Getting Ready						
1. Determine that required sterile or high-level disinfected instruments and two implant rods are present.						

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)] COUNSELING AND CLINICAL SKILLS: *INSERTION*						
STEP/TASK	**CASES**					
2. Wash hands thoroughly and dry them.						
3. Check to be sure that the client has thoroughly washed and rinsed her entire arm.						
4. Tell the client what is going to be done and encourage her to ask questions.						
5. Position the woman's arm and place a clean, dry cloth under her arm.						
6. Mark position on arm for insertion of rods 6 cm to 8 cm above the elbow folder (this should form a "V" pattern).						
7. Put on sterile pair of hand gloves.						
Pre-Insertion Tasks						
1. Set up sterile field and place implant rods and trocar on it.						
2. Prep insertion site with antiseptic solution.						
3. Place sterile or high-level disinfected drape over arm (optional).						
4. Inject 2 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.						
5. Advance needle about 4–5 cm and inject 1 ml of local anesthetic in each of two subdermal tracks.						
6. Check for anesthetic effect before making skin incision.						
Insertion						
1. Insert trocar directly subdermally superficially.						
2. While tenting the skin, advance trocar and plunger to mark (1) nearest hub of trocar.						
3. Remove plunger and load first rod into trocar with gloved hand or forceps.						
4. Reinsert plunger and advance it until resistance is felt.						
5. Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.						
6. Withdraw trocar and plunger together until mark (2) nearest trocar tip, just clear of incision (do not remove trocar from skin).						
7. Move tip of trocar away from end of rod and hold rod out of the path of the trocar.						
8. Redirect trocar about 15□□and advance trocar and plunger to mark (1).						
9. Insert the second rod using the same technique.						
10. Palpate rods to check that two rods have been inserted in a V-distribution.						
11. Palpate incision to check that both rods are 5 mm clear of incision.						
12. Remove trocar only after insertion of second rod.						
13. Optionally ask the client to palpate the two rods prior to dressing.						
Post-Insertion Tasks						
1. Remove drape and wipe the client's skin with alcohol.						
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band- Aid or tape on a sterile gauze (2x2).						
3. Apply pressure dressing snugly.						

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)] COUNSELING AND CLINICAL SKILLS: *INSERTION*					
STEP/TASK	**CASES**				
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.					
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.					
6. Wash hands thoroughly and dry them.					
7. Complete client record, including drawing position of rods.					
POST-INSERTION COUNSELING					
1. Instruct the client regarding wound care and make return visit appointment, if necessary.					
2. Discuss what to do if the client experiences any problems following insertion or side effects.					
3. Assure the client that she can have rods removed at any time if she desires.					
4. Ask the client to repeat instructions and answer the client's questions.					
5. Complete client card indicating which implant she received and by when she needs to return for removal.					
6. Observe the client for at least 15–20 minutes before sending her home.					

Comments:

_____

_____

_____

_____

_____

Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes___No _____ NA ___	Clinical practice satisfactory Yes_____No _____
Competent in two-rod implants ____	Not competent in two-rod implants ___
Action Plan – Check all that apply	
____Could become competent with additional experience (more cases) supervised by a competent	
____Follow-up visit in 3–6 months	
____Other (specify)	
Assessor's name	
Assessor's signature	Date

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: INSERTION

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK ACTIVITYSTEPS	CASES			
PRE-INSERTION COUNSELING				
1. Greet the client respectfully and with kindness.				
2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.				
3. Display the Balanced Counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: – Does the client want more children in the future? – Is she breastfeeding an infant < 6 months? – Will her partner use condoms? – Has she not tolerated an FP method in the past?				
4. Continue with Balanced Counseling, using the cards to: – Give information about the methods on the cards that are left. – Discuss side effects and efficacy. – Help the client to choose a method. – Confirm method choice.				
5. Review medical eligibility: – Read from the client brochure in language the client understands (e.g., "Method not advised if you ....").				
6. Review Client Screening Checklist to determine if a one-rod implant is an appropriate choice for the client.				
7. Perform (or refer for) further evaluation, if indicated.				
8. Assess the woman's knowledge about implants' major side effects. – confirm that the client accepts possible menstrual changes with implants.				
9. Describe insertion procedure and what to expect.				
INSERTION OF ONE-ROD IMPLANT				
Getting Ready				
1. Determine that required materials and the one-rod implant are present.				
2. Wash hands thoroughly and dry them.				

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK ACTIVITYSTEPS	CASES			
3. Check to be sure that the client has thoroughly washed and rinsed her arm.				
4. Tell the client what is going to be done and encourage her to ask questions.				
5. Position the woman's arm and place a clean, dry cloth under her arm.				
6. Mark position on arm for insertion of rod 6-8 cm above the elbow fold.				
7. Put on a pair of clean examination gloves.				
Pre-Insertion Tasks				
1. Prep insertion site with antiseptic solution.				
2. Inject 1 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.				
3. Check for anesthetic effect before applying the sharp needle.				
Insertion				
1. Using no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)				
2. Visually verify the presence of the implant inside the metal part of the needle.				
3. Stretch the skin around the insertion site with thumb and index finger **or alternatively**, stretch the insertion site skin by slightly pulling with thumb.				
4. Using the needle, puncture the skin at a 20° angle and insert only up to the bevel of the needle.				
5. Release the skin. Lower the applicator to a horizontal position.				
6. Gently advance, while lifting the skin, forming a tent, until inserting the full length of the needle without using force. Keep the applicator parallel to the surface of the skin.				
7. Break the seal of applicator. Turn the obturator 90 degrees.				
8. Fix the obturator with one hand against the arm and with the other hand slowly pull the needle out of the arm; never push against the obturator.				
9. Remove the needle, and apply pressure to the opening site.				
10. Palpate to check that the rod is I place. Optionally ask the client to palpate the implant prior to dressing.				
Post-Insertion Tasks				
1. Wipe the client's skin with alcohol.				
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).				
3. Apply pressure dressing snugly.				
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.				

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK ACTIVITYSTEPS	**CASES**			
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.				
6. Wash hands thoroughly and dry them.				
7. Complete client record, including drawing position of rod.				
POST-INSERTION COUNSELING				
1. Instruct the client regarding wound care and make return visit appointment, if necessary.				
2. Discuss what to do if the client experiences any problems following insertion or side effects.				
3. Assure the client that she can have implant removed at any time if she desires.				
4. Ask the client to repeat instructions and answer client's questions.				
5. Complete client card indicating which implant she received and by when she needs to return for removal.				
6. Observe the client for at least 15–20 minutes before sending her home.				

Comments:

_____

_____

_____

_____

_____

Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes___No _____ NA ___	Clinical practice satisfactory Yes_____No _____
Competent in one-rod implants (Implanon) ___	Not competent in one-rod implants (Implanon) ___
Action Plan – Check all that apply	
____Could become competent with additional experience (more cases) supervised by a competent	
____Follow-up visit in 3–6 months	
____Other (specify)	
Assessor's name	
Assessor's signature	Date

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: INSERTION

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK	CASES			
PRE-INSERTION COUNSELING				
1. Greet the client respectfully and with kindness.				
2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.				
3. Display the Balanced Counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: – Does the client want more children in the future? – Is she breastfeeding an infant < 6 months? – Will her partner use condoms? – Has she not tolerated an FP method in the past?				
4. Continue with Balanced Counseling, using the cards to: – Give information about the methods on the cards that are left. – Discuss side effects and efficacy. – Help the client to choose a method. – Confirm method choice.				
5. Review medical eligibility: – Read from the client brochure in language the client understands (e.g., "Method not advised if you ....").				
6. Review Client Screening Checklist to determine if two-rod implants are an appropriate choice for the client.				
7. Perform (or refer for) further evaluation, if indicated.				
8. Assess the woman's knowledge about implants' major side effects. – Confirm that the client accepts possible menstrual changes with implants.				
9. Describe the insertion procedure and what to expect.				
INSERTION OF ONE-ROD IMPLANT				
Getting Ready				
1. Determine that required materials and the one-rod implant are present.				
2. Wash hands thoroughly and dry them.				
3. Check to be sure that the client has thoroughly washed and rinsed her arm.				
4. Tell the client what is going to be done and encourage her to ask questions.				
5. Position the woman's arm and place a clean, dry cloth under her arm.				

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK	**CASES**			
6. Mark position on arm for insertion of rod 6–8 cm above the elbow fold.				
7. Put on a pair of clean examination gloves.				
Pre-Insertion Tasks				
1. Prep the insertion site with antiseptic solution.				
2. Inject 1 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.				
3. Check for anesthetic effect before applying the sharp needle.				
Insertion				
1. Using no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)				
2. Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap from the needle containing the implant.				
3. Visually verify the presence of the implant inside the metal part of the needle.				
4. Stretch the skin around the insertion site with thumb and index finger, *or alternatively*, stretch the insertion site skin by slightly pulling with thumb				
5. Using the needle, puncture the skin at a 30° angle and insert only up to the bevel of the needle.				
6. Lower the applicator to the horizontal position so that it is parallel to the surface of the skin while continuing to tent or lift the skin with the needle tip.				
7. While lifting the skin with the tip of the needle, slide the needle to its full length toward the guide mark. Make sure that the entire length of the needle is inserted under the skin.				
8. While keeping the applicator in the same position and the needle inserted to its full length with one hand, unlock the purple slider by pushing it slightly down using the other free hand.				
9. Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator.				
10. Remove the applicator.				
11. Palpate to check that one rod is in place. Optionally ask the client to palpate the implant prior to dressing.				
Post-Insertion Tasks				
1. Wipe the client's skin with alcohol.				
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).				
3. Apply pressure dressing snugly.				
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.				
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.				

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK	**CASES**			
6. Wash hands thoroughly and dry them.				
7. Complete client record, including drawing position of rod.				
POST-INSERTION COUNSELING				
1. Instruct the client regarding wound care and make return visit appointment, if necessary.				
2. Discuss what to do if the client experiences any problems following insertion or side effects.				
3. Assure the client that she can have implant removed at any time if she desires.				
4. Ask the client to repeat instructions and answer client's questions.				
5. Complete client card indicating which implant she received and by when she needs to return for removal.				
6. Observe the client for at least 15–20 minutes before sending her home.				

Comments:

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Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes___No _____ NA ___	Clinical practice satisfactory Yes_____No _____
Competent in one-rod implants (Implanon NXT) ___	Not competent in one-rod implants (Implanon NXT) __
Action Plan – Check all that apply	
____Could become competent with additional experience (more cases) supervised by a competent	
____Follow-up visit in 3–6 months	
____Other (specify)	
Assessor's name	
Assessor's signature	Date

CHECKLIST FOR IMPLANT COUNSELING AND CLINICAL SKILLS: REMOVAL

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR IMPLANT COUNSELING AND CLINICAL SKILLS: *REMOVAL*						
STEP/TASK	CASES					
PRE-REMOVAL COUNSELING						
1. Greet the client respectfully and with kindness.						
2. Listen carefully to the client's response for reason for removal to determine if she wants another method, is hoping to get pregnant, or wants to replace her implant.						
3. Confirm with the client what her intentions are. Provide FP counseling if appropriate.						
4. Describe the removal procedure and what to expect. If she intends to have another implant, discuss with her where it will be inserted.						
5. Ensure that the client is not allergic to the topical antiseptic or the local anesthetic that is available.						
REMOVAL OF IMPLANT ROD(S)						
Getting Ready						
1. Determine that sterile instruments and other required materials for removal are available. Make sure a new implant is available if reinserting a new implant.						
2. Check that the client has thoroughly washed and rinsed her arm.						
3. Tell the client what is going to be done and encourage her to ask questions.						
4. Position the woman's arm and place a clean, dry cloth under her arm.						
5. Palpate the rod(s) to determine point for removal.						
6. With a waterproof marker, mark the client's arm where the tip of the rod(s) is palpated.						
Pre-Removal Tasks						
1. Wash hands thoroughly and dry them.						
2. Put sterile gloves on both hands.						
3. Arrange instruments and supplies.						
4. Prep removal site with antiseptic solution twice.						
5. Inject small amount of local anesthetic (1% without epinephrine) at the incision site and under the end of the rod(s).						

CHECKLIST FOR IMPLANT COUNSELING AND CLINICAL SKILLS: *REMOVAL*					
STEP/TASK	**CASES**				
6. Check for anesthetic effect before making skin incision.					
Removal					
1. Push down the proximal end of the implant to stabilize it; a bulge may appear indicating the distal end of the implant.					
2 Make a small (2 mm) incision below ends of rod(s).					
3. Push end of rod toward the incision to remove it.					
4. Grasp end of rod with curved (mosquito or Crile) forceps.					
5. Clean off fibrous tissue sheath that covers tip of rod with sterile gauze (or scalpel—dull side).					
6. Grasp exposed end of rod with second forceps, gently remove and inspect to ensure that the rod is intact before placing rod in bowl containing 0.5% chlorine solution for decontamination.					
7. Ensure that the complete rod has been removed; show to the client.					
8. If this is a two-rod system, repeat steps 1–7.					
Re-Inserting Implant (one or two rods)					
1. The new implant rod(s) can be re-inserted along the same track as the recently removed implant (if the woman chose to have a new implant inserted).					
2. Provide additional local anesthesia by infiltrating 1% lignocaine along the track(s) of the previously removed implant(s).					
3. Wait for 1-2 minutes for the anesthetic to take effect.					
4. Insert the one- or two-rod implant as per insertion steps (including post-insertion steps and post-insertion counselling).					
Post-Removal Tasks					
1. Wipe the client's skin with alcohol.					
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).					
3. Apply pressure dressing snugly.					
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.					
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.					
6. Wash hands thoroughly and dry them.					
7. Complete client record.					
POST-REMOVAL COUSELING					
1. Instruct the client regarding wound care and make return visit appointment, if needed.					
2. Discuss what to do if any problems occur and answer any questions.					
3. Counsel the client regarding new contraceptive method and provide one, if desired.					
4. Observe the client for at least 15–20 minutes before sending her home.					

Comments:

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Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes_____No _____ NA Clinical practice satisfactory Yes_____No _____

_____

Competent in implants removal _____ Not competent in implants removal _____

Action Plan – Check all that apply

_____Could become competent with additional experience (more cases) supervised by a competent

_____Follow-up visit in 3–6 months

_____Other (specify)

Assessor's name

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Assessor's signature Date

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CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II) COUNSELING AND CLINICAL SKILLS: INSERTION

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR TWO-ROD IMPLANTS [JADELLE AND SINO-IMPLANT (II)] COUNSELING AND CLINICAL SKILLS: *INSERTION*						
STEP/TASK	CASES					
PRE-INSERTION COUNSELING						
1. Greet the client respectfully and with kindness.						
2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.						
3. Display the Balanced Counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: – Does the client want more children in the future? – Is she breastfeeding an infant < 6 months? – Will her partner use condoms? – Has she not tolerated an FP method in the past?						
4. Continue with Balanced Counseling, using the cards to: – Give information about the methods on the cards that are left. – Discuss side effects and efficacy. – Help the client to choose a method. – Confirm method choice.						
5. Review medical eligibility: – Read from the client brochure in language the client understands (e.g., "Method not advised if you ....").						
6. Review Client Screening Checklist to determine if two-rod implants are an appropriate choice for the client.						
7. Perform (or refer for) further evaluation, if indicated.						
8. Assess the woman's knowledge about implants' major side effects: – Confirm that the client accepts possible menstrual changes with implants.						
9. Describe insertion procedure and what to expect.						
INSERTION OF TWO-ROD IMPLANTS						
Getting Ready						
1. Determine that required sterile or high-level disinfected instruments and two implant rods are present.						
2. Wash hands thoroughly and dry them.						
3. Check to be sure that the client has thoroughly washed and rinsed her entire arm.						
4. Tell the client what is going to be done and encourage her to ask questions.						

5.	Position the woman's arm and place a clean, dry cloth under her arm.					
6.	Mark position on arm for insertion of rods 6 cm to 8 cm above the elbow folder (this should form a "V" pattern).					
7.	Put on sterile pair of hand gloves.					
Pre-Insertion Tasks						
1.	Set up sterile field and place implant rods and trocar on it.					
2.	Prep insertion site with antiseptic solution.					
3.	Place sterile or high-level disinfected drape over arm (optional).					
4.	Inject 2 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.					
5.	Advance needle about 4–5 cm and inject 1 ml of local anesthetic in each of two subdermal tracks.					
6.	Check for anesthetic effect before making skin incision.					
Insertion						
1.	Insert trocar directly subdermally superficially.					
2.	While tenting the skin, advance trocar and plunger to mark (1) nearest hub of trocar.					
3.	Remove plunger and load first rod into trocar with gloved hand or forceps.					
4.	Reinsert plunger and advance it until resistance is felt.					
5.	Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.					
6.	Withdraw trocar and plunger together until mark (2) nearest trocar tip, just clear of incision (do not remove trocar from skin).					
7.	Move tip of trocar away from end of rod and hold rod out of the path of the trocar.					
8.	Redirect trocar about 15□□ and advance trocar and plunger to mark (1).					
9.	Insert the second rod using the same technique.					
10. Palpate rods to check that two rods have been inserted in a V-distribution.						
11. Palpate incision to check that both rods are 5 mm clear of incision.						
12. Remove trocar only after insertion of second rod.						
13. Optionally ask the client to palpate the two rods prior to dressing.						
Post-Insertion Tasks						
1.	Remove drape and wipe the client's skin with alcohol.					
2.	Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).					
3.	Apply pressure dressing snugly.					
4.	Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.					
5.	Remove gloves by turning inside out and place in leak-proof container or plastic bag.					
6.	Wash hands thoroughly and dry them.					
7.	Complete client record, including drawing position of rods.					

POST-INSERTION COUNSELING					
1. Instruct the client regarding wound care and make return visit appointment, if necessary.					
2. Discuss what to do if the client experiences any problems following insertion or side effects.					
3. Assure the client that she can have rods removed at any time if she desires.					
4. Ask the client to repeat instructions and answer the client's questions.					
5. Complete client card indicating which implant she received and by when she needs to return for removal.					
6. Observe the client for at least 15–20 minutes before sending her home.					

Comments:

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Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes ___ No ___ NA ___	Clinical practice satisfactory Yes ____ No ____
Competent in two-rod implants ____	Not competent in two-rod implants ___
Action Plan – Check all that apply	
____Could become competent with additional experience (more cases) supervised by a competent provider/trainer	
____Follow-up visit in 3–6 months	
____Other (specify)	
Assessor's name	
Assessor's signature	Date

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: INSERTION

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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

Observed Step, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK ACTIVITYSTEPS	CASES			
PRE-INSERTION COUNSELING				
1. Greet the client respectfully and with kindness.				
2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.				
3. Display the Balanced Counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: – Does the client want more children in the future? – Is she breastfeeding an infant < 6 months? – Will her partner use condoms? – Has she not tolerated an FP method in the past?				
4. Continue with Balanced Counseling, using the cards to: – Give information about the methods on the cards that are left. – Discuss side effects and efficacy. – Help the client to choose a method. – Confirm method choice.				
5. Review medical eligibility: – Read from the client brochure in language the client understands (e.g., "Method not advised if you ....").				
6. Review Client Screening Checklist to determine if a one-rod implant is an appropriate choice for the client.				
7. Perform (or refer for) further evaluation, if indicated.				
8. Assess the woman's knowledge about implants' major side effects. – Confirm that the client accepts possible menstrual changes with implants.				
9. Describe insertion procedure and what to expect.				
INSERTION OF ONE-ROD IMPLANT				
Getting Ready				
1. Determine that required materials and the one-rod implant are present.				
2. Wash hands thoroughly and dry them.				
3. Check to be sure that the client has thoroughly washed and rinsed her arm.				
4. Tell the client what is going to be done and encourage her to ask questions.				

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK ACTIVITYSTEPS	**CASES**			
5. Position the woman's arm and place a clean, dry cloth under her arm.				
6. Mark position on arm for insertion of rod 6-8 cm above the elbow fold.				
7. Put on a pair of clean examination gloves.				
Pre-Insertion Tasks				
1. Prep insertion site with antiseptic solution.				
2. Inject 1 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.				
3. Check for anesthetic effect before applying the sharp needle.				
Insertion				
1. Using no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)				
2. Visually verify the presence of the implant inside the metal part of the needle.				
3. Stretch the skin around the insertion site with thumb and index finger **or alternatively**, stretch the insertion site skin by slightly pulling with thumb.				
4. Using the needle, puncture the skin at a 20° angle and insert only up to the bevel of the needle.				
5. Release the skin. Lower the applicator to a horizontal position.				
6. Gently advance, while lifting the skin, forming a tent, until inserting the full length of the needle without using force. Keep the applicator parallel to the surface of the skin.				
7. Break the seal of applicator. Turn the obturator 90 degrees.				
8. Fix the obturator with one hand against the arm and with the other hand slowly pull the needle out of the arm; never push against the obturator.				
9. Remove the needle, and apply pressure to the opening site.				
10. Palpate to check that the rod is I place. Optionally ask the client to palpate the implant prior to dressing.				
Post-Insertion Tasks				
1. Wipe the client's skin with alcohol.				
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).				
3. Apply pressure dressing snugly.				
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.				
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.				
6. Wash hands thoroughly and dry them.				
7. Complete client record, including drawing position of rod.				
POST-INSERTION COUNSELING				
1. Instruct the client regarding wound care and make return visit appointment, if necessary.				

CHECKLIST FOR ONE-ROD (IMPLANON) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK ACTIVITYSTEPS	CASES			
2. Discuss what to do if the client experiences any problems following insertion or side effects.				
3. Assure the client that she can have implant removed at any time if she desires.				
4 Ask the client to repeat instructions and answer client's questions.				
5. Complete client card indicating which implant she received and by when she needs to return for removal.				
6. Observe the client for at least 15–20 minutes before sending her home.				

Comments:

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Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes____ No ___ NA ___	Clinical practice satisfactory Yes_____No _____
Competent in one-rod implants (Implanon) ___	Not competent in one-rod implants (Implanon) ___
Action Plan – Check all that apply	
____Could become competent with additional experience (more cases) supervised by a competent	
____Follow-up visit in 3–6 months	
____Other (specify)	
Assessor's name	
Assessor's signature	Date

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: INSERTION

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK	**CASES**			
PRE-INSERTION COUNSELING				
1. Greet the client respectfully and with kindness.				
2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.				
3. Display the Balanced Counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client's response: – Does the client want more children in the future? – Is she breastfeeding an infant < 6 months? – Will her partner use condoms? – Has she not tolerated an FP method in the past?				
4. Continue with Balanced Counseling, using the cards to: – Give information about the methods on the cards that are left. – Discuss side effects and efficacy. – Help the client to choose a method. – Confirm method choice.				
5. Review medical eligibility: – – Read from the client brochure in language the client understands (e.g., "Method not advised if you ....").				
6. Review Client Screening Checklist to determine if two-rod implants are an appropriate choice for the client.				
7. Perform (or refer for) further evaluation, if indicated.				
8. Assess the woman's knowledge about implants' major side effects. – Confirm that the client accepts possible menstrual changes with implants.				
9. Describe the insertion procedure and what to expect.				
INSERTION OF ONE-ROD IMPLANT				
Getting Ready				
1. Determine that required materials and the one-rod implant are present.				
2. Wash hands thoroughly and dry them.				
3. Check to be sure that the client has thoroughly washed and rinsed her arm.				

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK	**CASES**			
4. Tell the client what is going to be done and encourage her to ask questions.				
5. Position the woman's arm and place a clean, dry cloth under her arm.				
6. Mark position on arm for insertion of rod 6–8 cm above the elbow fold.				
7. Put on a pair of clean examination gloves.				
Pre-Insertion Tasks				
1. Prep the insertion site with antiseptic solution.				
2. Inject 1 ml of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.				
3. Check for anesthetic effect before applying the sharp needle.				
Insertion				
1. Using no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)				
2. Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap from the needle containing the implant.				
3. Visually verify the presence of the implant inside the metal part of the needle.				
4. Stretch the skin around the insertion site with thumb and index finger, *or alternatively*, stretch the insertion site skin by slightly pulling with thumb				
5. Using the needle, puncture the skin at a 30° angle and insert only up to the bevel of the needle.				
6. Lower the applicator to the horizontal position so that it is parallel to the surface of the skin while continuing to tent or lift the skin with the needle tip.				
7. While lifting the skin with the tip of the needle, slide the needle to its full length toward the guide mark. Make sure that the entire length of the needle is inserted under the skin.				
8. While keeping the applicator in the same position and the needle inserted to its full length with one hand, unlock the purple slider by pushing it slightly down using the other free hand.				
9. Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator.				
10. Remove the applicator.				
11. Palpate to check that one rod is in place. Optionally ask the client to palpate the implant prior to dressing.				
Post-Insertion Tasks				
1. Wipe the client's skin with alcohol.				
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).				
3. Apply pressure dressing snugly.				
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and				

CHECKLIST FOR ONE-ROD (IMPLANON NXT) IMPLANTS COUNSELING AND CLINICAL SKILLS: *INSERTION*				
STEP/TASK	**CASES**			
– Placing waste materials in leak-proof container or plastic bag.				
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.				
6. Wash hands thoroughly and dry them.				
7. Complete client record, including drawing position of rod.				
POST-INSERTION COUNSELING				
1. Instruct the client regarding wound care and make return visit appointment, if necessary.				
2. Discuss what to do if the client experiences any problems following insertion or side effects.				
3. Assure the client that she can have implant removed at any time if she desires.				
4. Ask the client to repeat instructions and answer client's questions.				
5. Complete client card indicating which implant she received and by when she needs to return for removal.				
6. Observe the client for at least 15–20 minutes before sending her home.				
5. Complete client card indicating which implant she received and by when she needs to return for removal.				
6. Observe the client for at least 15–20 minutes before sending her home.				

Comments:

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Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes____ No ___ NA ___	Clinical practice satisfactory Yes_____No _____
Competent in one-rod implants (Implanon NXT) ___	Not competent in one-rod implants (Implanon NXT) __
Action Plan – Check all that apply	
____Could become competent with additional experience (more cases) supervised by a competent provider/trainer	
____Follow-up visit in 3–6 months	
____Other (specify)	
Assessor's name	
Assessor's signature	Date

CHECKLIST FOR IMPLANT COUNSELING AND CLINICAL SKILLS: REMOVAL

Rate the performance of each step or task observed using the following rating scale:

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

CHECKLIST FOR IMPLANT COUNSELING AND CLINICAL SKILLS: *REMOVAL*						
STEP/TASK	CASES					
PRE-REMOVAL COUNSELING						
1. Greet the client respectfully and with kindness.						
2. Listen carefully to the client's response for reason for removal to determine if she wants another method, is hoping to get pregnant, or wants to replace her implant.						
3. Confirm with the client what her intentions are. Provide FP counseling if appropriate.						
4. Describe the removal procedure and what to expect. If she intends to have another implant, discuss with her where it will be inserted.						
5. Ensure that the client is not allergic to the topical antiseptic or the local anesthetic that is available.						
REMOVAL OF IMPLANT ROD(S)						
Getting Ready						
1. Determine that sterile instruments and other required materials for removal are available. Make sure a new implant is available if reinserting a new implant.						
2. Check that the client has thoroughly washed and rinsed her arm.						
3. Tell the client what is going to be done and encourage her to ask questions.						
4. Position the woman's arm and place a clean, dry cloth under her arm.						
5. Palpate the rod(s) to determine point for removal.						
6. With a waterproof marker, mark the client's arm where the tip of the rod(s) is palpated.						
Pre-Removal Tasks						
1. Wash hands thoroughly and dry them.						
2. Put sterile gloves on both hands.						
3. Arrange instruments and supplies.						
4. Prep removal site with antiseptic solution twice.						
5. Inject small amount of local anesthetic (1% without epinephrine) at the incision site and under the end of the rod(s).						
6. Check for anesthetic effect before making skin incision.						

CHECKLIST FOR IMPLANT COUNSELING AND CLINICAL SKILLS: *REMOVAL*					
STEP/TASK	**CASES**				
Removal					
1. Push down the proximal end of the implant to stabilize it; a bulge may appear indicating the distal end of the implant.					
2. Make a small (2 mm) incision below ends of rod(s).					
3. Push end of rod toward the incision to remove it.					
4. Grasp end of rod with curved (mosquito or Crile) forceps.					
5. Clean off fibrous tissue sheath that covers tip of rod with sterile gauze (or scalpel—dull side).					
6. Grasp exposed end of rod with second forceps, gently remove and inspect to ensure that the rod is intact before placing rod in bowl containing 0.5% chlorine solution for decontamination.					
7. Ensure that **the complete** rod has been removed; show to the client.					
8. If this is a two-rod system, repeat steps 1–7.					
Re-Inserting Implant (one or two rods)					
1. The new implant rod(s) can be re-inserted along the same track as the recently removed implant (if the woman chose to have a new implant inserted).					
2. Provide additional local anesthesia by infiltrating 1% lignocaine along the track(s) of the previously removed implant(s).					
3. Wait for 1-2 minutes for the anesthetic to take effect.					
4. Insert the one- or two-rod implant as per insertion steps (including post-insertion steps and post-insertion counselling).					
Post-Removal Tasks					
1. Wipe the client's skin with alcohol.					
2. Bring edges of incision together and close it using surgical tape, then cover it with a Band-Aid or tape on a sterile gauze (2x2).					
3. Apply pressure dressing snugly.					
4. Before removing gloves, dispose materials by: – Placing used needle (without capping) and trocar in sharps container, and – Placing waste materials in leak-proof container or plastic bag.					
5. Remove gloves by turning inside out and place in leak-proof container or plastic bag.					
6. Wash hands thoroughly and dry them.					
7. Complete client record.					
POST-REMOVAL COUSELING					
8. Instruct the client regarding wound care and make return visit appointment, if needed.					
9. Discuss what to do if any problems occur and answer any questions.					
10. Counsel the client regarding new contraceptive method and provide one, if desired.					
11. Observe the client for at least 15–20 minutes before sending her home.					

Comments:

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Observation Summary *(Tick as appropriate)*:

Model practice satisfactory Yes ____ No ____ NA ____	Clinical practice satisfactory Yes _____ No _____
Competent in implants removal ____	Not competent in implants removal ____
Action Plan – Check all that apply	
_____Could become competent with additional experience (more cases) supervised by a competent	
_____Follow-up visit in 3–6 months	
_____Other (specify)	
Assessor's name	
Assessor's signature	Date

Appendix AL: Clinical Performance Support Tools for Manual Vacuum Aspiration

CHECKLIST FOR PREPARING MANUAL VACUUM ASPIRATION (MVA) EQUIPMENT

To be used by the Participant for practice and by the Trainer at the end of the course

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

Satisfactory Perform 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, task, or skill not performed by the learner during evaluation by clinical trainer

Participant:_____ Date Observed:_____

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CASES				
	1	2	3	4	5
SELECT CANNULA AND SYRINGE					
1. Assess uterine size.					
2. Select cannula appropriate to uterine size and cervical dilations.					
3. Inspect cannula for cracks or signs of weakness. Discard if any seen.					
4. Select syringe and adapter (if required).					
5. Inspect syringe and adapter for cracks or signs of weakness. Discard if any seen.					
ASSEMBLE CANNULA AND SYRINGE					
1. Attach adapter (if required) to end of syringe or cannula.					
2. Check that the plunger is positioned fully within the barrel of the syringe, with the pinch valve open and the valve button out.					
3. Grasp the barrel of the syringe and pull back on the plunger until the arms of the plunger snap outward.					
4. Check that the plunger cannot move forward without being released.					
5. Check the syringe for vacuum tightness by leaving the syringe for a couple of minutes once the vacuum is established then open the pinch valve and listen for a rush of air into the syringe.					
6. Place the prepared equipment on sterile cloth and cover until procedure begins.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

Appendix AM: Clinical Performance Support Tools for Vacuum Assisted Delivery

LEARNING CHECKLIST: VACUUM EXTRACTION

To be completed by **students/participants**
(Some of the following steps/tasks should be performed simultaneously)

Rate the performance of each step or task observed using the following rating scale:

1. Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. Competently Performed: Step or task performed correctly in proper sequence (if necessary) but learner does not progress from step to step efficiently

3. Proficiently Performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

STEP/TASK	CASES				
GETTING READY					
1. Prepare and check the necessary equipment					
2. Tell the woman and her support person what is going to be done, listen to her and respond attentively to her questions and concerns					
3. Be Prepare and make arrangements for the referral immediately if the vacuum extraction fails					
4. Provide continual emotional support and reassurance, as feasible					
5. Review to ensure that the following conditions for vacuum extraction are present: – Adequate contractions – Term fetus – Vertex presentation – Cervix fully dilated – Head at least at 0 station or no more than 0/5 palpable above the symphysis pubis – Membranes are ruptured					
6. Make sure an assistant is available					
7. Put on personal protective barriers					
PRE-PROCEDURE TASKS					
8. Wash hands thoroughly with soap and water. Dry with a clean, dry cloth or air dry					
9. Put high-level disinfected or sterile surgical gloves on both hands					
10. Clean the vulva with antiseptic solution					
11. Empty the bladder, if necessary					
12. Check all connections on the vacuum extractor and test the vacuum on a gloved hand					
VACUUM EXTRACTION					
13. Assess position of fetal head by feeling the sagittal suture line and fontanelles. If position of fetal head is posterior, do not proceed unless posterior cup is available					

STEP/TASK	CASES				
14. Identify the posterior fontanelle					
15. Apply the cup, with the center of the cup over the flexion point, 3 cm anterior to the posterior fontanel					
16. Check the application and ensure that there is no maternal soft tissue (cervix or vagina) within the rim of the cup. If necessary, reapply cup					
17. Create a vacuum of 0.2 kg/cm^2 negative pressure with the pump and check application of cup again					
18. Increase vacuum to 0.8 kg/cm^2 negative pressure					
19. After maximum negative pressure has been applied, start traction in the line of the pelvic axis and perpendicular to the cup					
20. With each contraction, apply traction in a line perpendicular to the plane of the cup rim: – Place the thumb on the cup and a gloved finger on the scalp next to the cup during traction to apply countertraction and assess potential slippage and descent of the vertex					
21. Between contractions, have assistant check: – Fetal heart rate					
22. With progress, and in the absence of fetal distress, continue the "guiding" pulls for a maximum of 20 minutes if pressure is reduced between contractions. Continue for a maximum of 10 minutes if pressure is not reduced between contractions					
23. Perform episiotomy (only if necessary) when fetal head is crowning					
24. When the head has been delivered, release the vacuum, remove the cup and complete the delivery. Continue with active management of third stage of labor					
25. Check the birth canal for tears following delivery and repair if necessary					
26. Repair the episiotomy, if one was performed					
27. Provide immediate postpartum and newborn care, as required.					
POST-PROCEDURE TASKS					
28. Before removing gloves, dispose of waste materials in a leak-proof container or plastic bag					
– Place all instruments, silicone cup, and tubing (after flushing with 0.5% chlorine) in 0.5% chlorine solution for 10 minutes for decontamination. – Do not immerse the pumps. Wipe off pump with 0.5% chlorine immediately followed by wiping off with soapy water and then clean water. – Sterilize or HLD instruments. Autoclave silicone cup at 123 deg C for 3 minutes – For any particular cup, follow manufacturer's directions for cleaning and sterilization					
29. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out. – If disposing of gloves, place them in a leak-proof container or plastic bag					
30. Wash hands thoroughly with soap and water and dry with a clean, dry cloth or air dry					

Appendix AN: Guidelines for Quality Improvement and Patient Safety Review in Maternal and Newborn Care for Health Centers

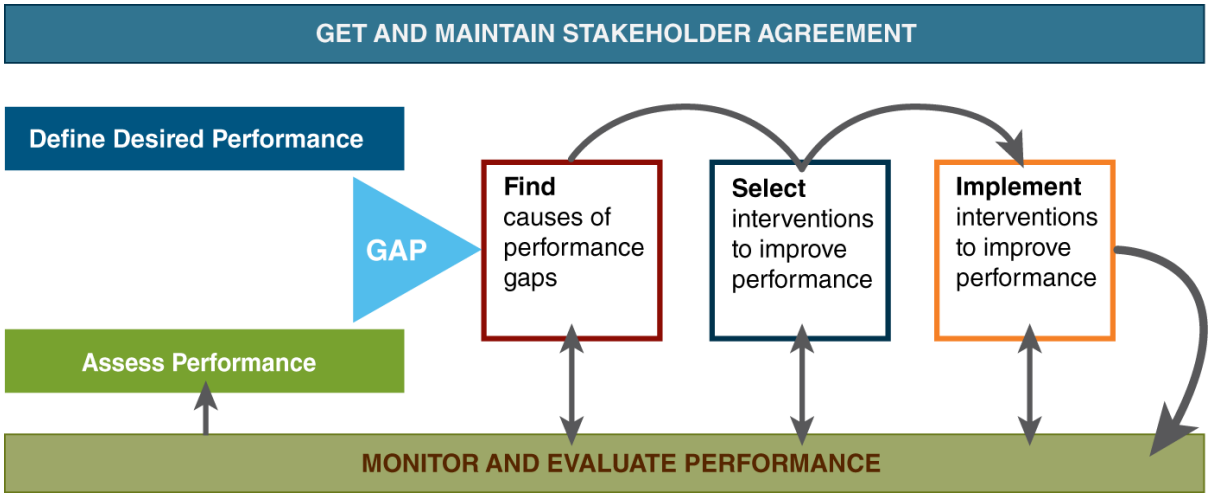
INTRODUCTION

The Quality Improvement and Patient Safety (QIPS) tool is a practical management approach for improving the performance and quality of maternal, newborn and child health (MNCH) services. It consists of the systematic utilization of performance standards as the basis for the organization and functioning of these services and the rewarding of compliance through recognition mechanisms. QIPS follows four basic steps:

- Setting standards of performance in an operational way
- Implementing the standards through a streamlined and systemic methodology
- Measuring progress to guide the improvement process
- Recognizing achievements made

This process begins with the development of high-impact, evidence-based operational standards in a specific area of health service delivery, in this case, for those related to MNCH. The performance standards developed are included in an assessment tool that can be used for self, peer, internal and external assessments at the facility level.

Figure 1: Cycle of Performance Improvement



The implementation of the assessment tool leads to the identification of performance gaps that need to be reduced or eliminated. Local health managers, health care providers and facility staff as a team (where applicable) can then analyze the causes of the gaps. They can then identify and implement appropriate interventions to correct any lack of knowledge and skills, an inadequate enabling environment (including resources and policies) and/or lack of motivation to close these gaps.

Facility staff and managers are encouraged to take action, beginning with simple interventions (the "low hanging fruit") to achieve early results, create momentum for change and gradually acquire change management skills to address more complex gaps.

Partial improvements are rewarded during the process through a combination of measures such as by providing feedback and social recognition (e.g., recognition ceremonies, symbolic rewards). The global achievement of compliance with standards by the facility is acknowledged through a recognition mechanism that should involve institutional authorities and the community.

DESCRIPTION OF THE ASSESSMENT TOOL AND IMPLEMENTATION INSTRUCTIONS

Description of the Tool

The QIPS performance assessment tool:

- Lists key performance standards organized by program areas for MNCH services; each performance standard has verification criteria easily observable with "YES" and "NO" responses
- Objectively establishes the desired level of performance
- Measures actual level of performance when applied to a health facility or MNCH center
- Helps identify performance gaps

Sections	Areas	# of Standards	Pages #
1.	Focused Antenatal Care	6	
2.	Labor and Delivery	13	
3.	Postnatal Care	5	
4.	Cough or Difficult Breathing And Diarrhea	3	
5.	Postpartum Family Planning	8	
6.	Infection Prevention	4	
7.	Linkages and Referrals	1	
General Total		**40**	

How to use the Assessment Tool

The QIPS assessment tool should be used to conduct assessments of the health facility. In each area, the performance standards have specific instructions on how and where to collect and verify the information needed, and the number of observations required. These four methods are used for data collection:

- Direct structured observation
- Document review
- Interviews
- Skill observations on anatomical models

Internal/self-assessment approach:

- Introduce yourself as the observer and explain the reason for the QIPS assessment
- The QIPS assessment tool should be used to guide the observation

- Feedback should not be provided during the assessment
- Be objective and respectful during the assessment

When doing document review:

- Introduce yourself and explain the reason for the QIPS assessment
- Identify correct sources of information (e.g., administrative forms, statistical records, service records)
- Review the documents using the assessment tool
- Question individuals responsible for these areas to provide additional information and/or clarify information
- Be objective and respectful during the assessment

When conducting interviews:

- Introduce yourself and explain the reason for the QIPS assessment
- Identify the staff who typically carry out the particular activities or procedures
- Interview staff using the assessment tool
- Ask probing questions to get the precise information, do not make assumptions about responses
- Ask the staff member to show documents, equipment or materials as appropriate
- Be objective and respectful during the assessment

How to Fill Out the QIPS Tool

The QIPS tool is organized around six MNCH service areas. Below is one example of a performance standard related to AMTSL.

Performance Standard	Verification Criteria	Mark Yes/No				
		Case 1 Y/N	Case 2 Y/N	Case 3 Y/N	Case 4 Y/N	Case 5 Y/N
AMTSL-1: AMTSL is performed for all women during childbirth	Check medical records to see if the following are performed during labor:					
	Provide uterotonic drugs within one minute after the baby is born					
		YES	NO	N/A		
	If oxytocin is the uterotonic used for AMTSL at this facility, is reliable refrigeration available and used for oxytocin storage?					
	Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.					

Instructions:

- Review five cases at the facility and evaluate each case against the given standard. Mark "Y" in the respective case column if answer to the standard is affirmative and mark "N" if answer to the standard is negative.
- For instance: If the case 1 answer to the standard is negative, mark N in the respective column, as shown below. Similarly if the answer to the standard is Y for case 2, then mark Y in the respective case column as mentioned below:

Case 1 Y/N	Case 2 Y/N	Case 3 Y/N	Case 4 Y/N	Case 5 Y/N
N	Y			

- Immediately fill in the information to be collected as part of QIPS.
- Mark "Y" and "N" in the correspondent column, as appropriate. Do not leave any verification criteria blank.
- In the comments column, write down all pertinent comments in a concise form, highlighting any relevant issues and potential causes.
- Mark "Y" if the procedure was performed correctly or the item exists as described.
- Mark "N" if the procedure is not performed or it is performed incorrectly or if a required item does not exist.

In the example below, the first verification criterion is marked "Y" because during the observation the provider checked to see that the placenta was complete.

Standard	Verification Criteria	Y/ N	Comments
The provider adequately performs immediate postpartum care.	Observe two women during their deliveries and determine whether the provider (in the labor or delivery rooms):		1 point
	▪ Checks to see whether the placenta is complete (maternal and fetal sides, plus membranes)	Y	
	▪ Informs the woman what she is going to do before proceeding, then carefully examines the vagina and perineum	Y	
	▪ Gently cleanses the vulva and perineum with clean water (warm if possible) or a nonalcoholic antiseptic solution	Y	
	▪ Sutures tears if necessary	Y	
	▪ Covers the perineum with a clean sanitary pad	Y	
	▪ Makes sure that the woman is comfortable (clean, hydrated and warmly covered)	Y	
	▪ Ensures that the baby is well-covered, is with the mother and has begun to suckle	Y	

Initial identification of gaps:
Identify gaps by marking "N" for:

- Practice not performed
- Practice performed incorrectly or incompletely

In the comments column:

- If possible, summarize potential reasons why the criterion was not done correctly
- Be very direct: just fill in an appropriate response

HOW TO SCORE THE ASSESSMENT TOOL AND SUMMARIZE THE RESULTS

Scoring using the assessment tool:

- Each standard is worth one point
- For each standard to be met, all of the verification criteria should be "Yes."

Examples: In this first standard, the site is awarded 0 points because the first criterion was not met.

Standard	Verification Criteria	Y, N, or NA	Comments
The provider properly manages the neonate	Observe if the provider:		0 Points
	▪ Washes hands with soap and water and dries them with a clean towel or uses an alcohol-based solution	N	
	▪ Demonstrates the proper positioning and attachment of the baby on the breast	Y	
	▪ Gives immunizations according to MOH policy	Y	

- => 4 "YES" marking against reviewed cases will result in a ranking score of 1, and < 4 "Y" marking will result in a ranking score of 0

Example for ranking 1:

Case 1 Y/N	Case 2 Y/N	Case 3 Y/N	Case 4 Y/N	Case 5 Y/N	Score
Y	Y	Y	Y	N	1

Example for ranking 0:

Case 1 Y/N	Case 2 Y/N	Case 3 Y/N	Case 4 Y/N	Case 5 Y/N	Score
Y	Y	Y	N	N	0

How to summarize the results:

- Summarize the results at the end of each section
- Write the number of standards achieved per area and in total

- Calculate and write the percentage of standards achieved per area and in total by dividing the number of standards achieved by the total number of standards in each area, and multiplying the results by 100 (e.g., 7/14 x 100=50%). Apply the same process for the general total, divide total number of standards achieved by the total number of standards (e.g., 32/59 x 100=54%)

Areas	Number of Standards	Number of Standards Observed	Criteria Achieved	
			Number	%
Focused Antenatal Care	6	6	4	67
Labor and Delivery	13	13	10	77
Postnatal Care	5	5	3	60
Cough or Difficult Breathing and Diarrhea	3	3	3	100
Postpartum Family Planning	8	8	4	50
Infection Prevention	4	4	3	75
Linkages and Referrals	1	1	0	0
General Total	**40**	**40**	**27**	**68**

Usually, for a facility to obtain recognition it should reach at least 80% of compliance with the standards.

TYPES OF ASSESSMENTS

A baseline assessment and then a continuous measurement of progress are used as mechanisms to guide the process, inform managerial decisions and reinforce the momentum for change. Through continuous measurement, managers, providers and communities can monitor the process, assess success of interventions, identify new gaps and introduce necessary adjustments to their plans. Measurement also makes it possible to present managers and providers with quantitative targets. Achieving the targets and making sustained progress on them have an important motivating effect for those involved in the improvement process.

Continuous measurement is based on the periodic implementation of assessments using the performance assessment tool. The assessments can be:

- Self-assessments are those conducted by the individual providers on their own work. The provider uses the performance assessment tool as a job aid to verify if she/he is following the recommended standardized steps during the provision of care. These assessments can be performed as frequently as desired or needed. It is recommended that they be performed at least monthly as part of the performance review.
- Internal assessments are those implemented internally by facility staff. These can be in the form of peer assessments when facility staff use the assessment tool to mutually assess the work among colleagues or internal monitoring assessments when managers and/or providers use the QIPS tool to periodically assess the services being improved. It is recommended that this latter assessment occur monthly.
- External assessments are those implemented by persons external to the facility. These assessments are usually conducted by those from the central, regional and district levels of ministries of health. The assessments can take the form of facilitative supervision when the purpose of the visit is to provide support for identification of performance gaps and interventions, or verification assessments when the purpose of the visit is to confirm compliance with recommended standards of care for recognition purposes. In the case of verification assessments, it is desirable that representatives of the clients and communities

served are involved in the process in an appropriate way. For instance, they could have representatives on the team conducting the facility assessment. It is recommended that this latter assessment take place every six months.

DEVELOPMENT OF ACTION PLANS AND ORGANIZATION OF TEAMS

After every assessment, facility staff should develop operational plans to implement the improvement process. These plans are relatively simple tools that outline the gaps and the causes that need to be eliminated, the specific intervention to be conducted, the person(s) in charge, the deadline for the task and any potential support that may be needed. Identifying the responsible person(s) and setting deadlines are extremely important because they allow better follow-up of activities included in the plan. Operational plans should be developed upon analysis of the results of the baseline or follow-up monitoring assessments by teams of facility providers/managers working in the different areas of service provision being improved.

It is important to understand that such a process is usually initiated by a small group of committed persons because it is not common to find widespread support for a new improvement initiative. It is, therefore, key to identify dedicated champions for the initiative and involve them in initial improvement efforts.

A key task of this initial group is to organize teams to implement the improvement process. Most service delivery processes do not depend on the action of single providers, they are the result of team efforts; therefore, it is important to expand the group of committed people beyond champions. Teams should be organized by specific areas of the assessment tool. Each area team should analyze the results of the performance assessment in their respective area, develop an operational plan accordingly, and implement and monitor improvement activities.

It is desirable to work with networks of services rather than isolated services. Working in networks of similar services or facilities, which can exchange experiences and provide mutual support, usually favors the achievement of positive changes.

The process emphasizes bottom-up action and client and community involvement. A key purpose of the QIPS process is to provide local health workers and the clients and communities they serve with practical tools that empower them and increase their influence on the health delivery process. Clients and communities are not seen as passive recipients of health activities, but as essential partners in the health care process. To the maximum extent possible, client and community representatives should be part of the improvement teams, plans and activities.

In addressing the identified gaps, the teams should remember that there are:

- Gaps that do not require significant cause analysis because the solution is obvious and simple (e.g., designation of a person in charge of a task, minor purchases to replace broken pieces of equipment, minor relocation of supplies and equipment to make them more available at point of use)
- Gaps that are likely caused by factors under local/facility control and could be eliminated with the mobilization of local resources (e.g., modification of some internal procedures, redistribution of workload within the facility, internal reallocation of resources, some types of training, implementation of some types of incentives)
- Gaps that are likely caused by factors outside of local/facility control and that usually require the mobilization of significant external resources (e.g., changes in policies, salary increases, increases in the number of staff, provision of additional budgets, physical plant remodeling/construction).

As mentioned above, teams should begin with the easier gaps and gradually undertake more complex ones.

In developing action plans, the teams should remember that the cause(s) of gaps are categorized as follows:

- Gaps related to resources (equipment/supplies)
- Gaps that require staff training to perform skills correctly
- Gaps that require refresher training to improve knowledge of facility team
- Gaps related to staff/team motivation factor

QIPS Guidelines Annexure 1: Index of the QIPS Assessment Tool

Areas	Criteria	Pages
1. Focused Antenatal Care	6	
2. Labor and Delivery	13	
3. Postnatal Care	5	
4. Cough or Difficult Breathing and Diarrhea	3	
5. Postpartum Family Planning	8	
6. Infection Prevention	4	
7. Linkages and Referrals	1	

QIPS Guidelines Annexure 2: Summary Sheet for Health Centers

Region: _____ **Facility Name:** _____

Assessors: _____

Assessment Type: (Baseline ☐ / Internal 1 ☐ 2 ☐ / External ☐)

Date: _____

Areas	Number of Standards	Number of Standards Observed	Criteria Achieved	
			Number	%
Focused Antenatal Care	6			
Labor and Delivery	13			
Postnatal Care	5			
Cough or Difficult Breathing and Diarrhea	3			
Postpartum Family Planning	8			
Infection Prevention	4			
Linkages and Referrals	1			
General Total	**40**			

QIPS Guidelines Annexure 3: Action Plan

Standard	Gap	Intervention	Responsible Person	Support Required	Timeline
1.					
2.					
3.					
4.					

QIPS Guidelines Annexure 4: Role Plays

1. FOCUSED ANTENATAL CARE

The assessor should ensure that the following items are available before starting the role play: gestational age calendar, sphygmomanometer, adult stethoscope, thermometer, measuring tape and examination gloves.

The provider receives and greets the pregnant woman cordially and respectfully.
Shabana is 23 years old and 20 weeks pregnant. She did not receive any antenatal care (ANC) during this pregnancy and this is her first FANC visit at the facility. The Lady Health Worker (LHW) in her community counseled Shabana and convinced her to come to the facility for ANC in order to be assessed for the possibility of a high-risk pregnancy.

Shabana has not yet experienced any general danger signs related to high-risk pregnancy. She is gravida 3 para with two sons. Her last child is about 2 years old and was born in December 2012. Her last delivery was conducted at home by a 'Dai' and she did not attend any focused antenatal care (FANC) visits during that pregnancy. She never had a TT vaccination during any of her past pregnancies. She has no history of any allergies and is not taking any medicine at the moment.

The provider properly gives individualized counseling based on findings.
Shabana comes to the facility with a complaint of mild abdominal discomfort and weakness. She also asks the provider how long she needs to abstain from intercourse. She expresses her concerns about whether routine housework could affect her baby.

The provider records all of Shabana's history and findings on an antenatal card. She also makes a follow-up appointment for the pregnant woman.
Shabana asks when she has to come back for another checkup. When the provider inquires about the general danger signs, Shabana forgets one or two signs so the provider repeats them to ensure that she remembers all of them.

2. COUGH OR DIFFICULT BREATHING AND DIARRHEA

The provider makes san initial identification of the problem
Shabana brings her baby boy for follow up visit on 14th day of her delivery. She brought him to the facility with the complaint of high grade fever since the night before. Her baby weighs 3.5 kg, temp of 39.8 C and the respiratory rate is 70/min. The baby's posture/ movement is normal.

The provider will now examine the baby (a model will be used for this) telling what he is doing. The mother tells the provider that the baby vomits everything and also had convulsions last night and is not able to breastfeed.

The provider will now prescribe treatment based on the national guidelines for the classification he has made.

The provider assesses the immunization status
The provider asked Shabana about baby BCG at birth and had no other vaccination after that. He could also write the information that baby needs DPT1 on the card as per guidelines.

The provider advises the mother about danger signs
The provider will advise the mother about the danger signs and about exclusive breast feeding

3. IMPLANTS

Scenario

The assessor plays the role of a 29-year-old client named Naheed. She has been using the withdrawal method for last two years and now wants to use a family planning (FP) method other than pills for a longer-lasting method. She is on the fourth day of her regular menstrual cycle and heard that implants are a new and good longer-lasting family planning method. However, Naheed is concerned about the insertion of the implant and wants to know more about it. She wants to know whether the insertion of an implant is painful like an injection or if it is even more painful.

The provider describes for whom an implant is an appropriate method.
After listening to the provider, Naheed thinks it over and asks the following question, "I have also heard that the implant does not suit everyone and causes bleeding in between the periods. Is this true?"

Naheed then asks about the available range of IUCDs in the facility and decides to get an implant.

Does the provider prepare the clinical area and the woman for the procedure?
Before proceeding with the insertion, the assessor should give the provider some instructions, encouraging her to try to use good verbal communication do all the steps as if she is dealing with the actual client, including assisting the client in stepping up to the table, using the flip chart that shows a sink with running water, etc. The assessor then needs to observe.

Does the provider give instructions about return or follow-up visits?
If the provider does not end the session with return or follow-up instructions, the assessor can ask leading questions to ask when she should return for follow-up.

4. IUCD INSERTION

Scenario

The assessor plays the role of a 31-year-old client named Fatima. She had been taking pills (COCs) for the past two years for birth control and now she wants to use a FP method other than pills for a longer-lasting method. She is on the fourth day of her regular menstrual cycle and heard that an IUCD is effective as a longer-lasting method, but she is frightened about the use of an IUCD and its insertion. She is also confused about how it is going to be used, and whether it will be painful like an injection or will insertion of the IUCD be more painful.

The provider describes the IUCD and shares specific and relevant information.
After listening to the provider's explanation, Fatima now thinks it over and asks, "Is the IUCD suitable for everyone?"

5. POSTPARTUM CARE FOR MOTHER AND NEWBORN

Scenario

Shaista is 24 years old and delivered a baby girl, weighing 2.8 kg, two days ago at home with a TBA at her side. She has come to the facility with her husband and mother-in-law. Shaista is having severe abdominal pain with heavy bleeding and has changed pads 10 times. The client's hygienic condition is poor and she is feeling weak. She tells the provider that her mother-in-law is a bit stern and is giving her three meals a day made up of just one *chapati* and tea. She tells the provider that she has no knowledge of family planning. Culturally, Shaista is expected to resume household work a week after delivery.

If the provider does not perform a physical examination of the baby then the assessor needs to ask leading question while taking on the role of the mother, asking the provider if her baby is alright. She explains that the baby has been crying since the night before. Otherwise the baby is breastfeeding well. The assessor needs to observe the provider while she is examining the newborn.

Observations:

- Conduct an initial assessment.
- Conduct a routine physical examination of the newborn.
- Counsel the mother, husband and family.
- Record all findings in the Maternal Health Register/OPD register.

Appendix AO: QUALITY IMPROVEMENT AND PATIENT SAFETY (QIPS) ASSESSMENT TOOL

AREA 1: FOCUSED ANTENATAL CARE (FANC)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
FANC-01: The provider receives and treats the pregnant woman cordially and respectfully	Verify by direct observation (or role play if no clients) whether the provider:	☐ Direct observation ☐ Role play					
	1. Greets the woman and her companion (if present) in a cordial manner						
	2. Explains to the woman what she/he is going to do and encourages her to ask questions						
	SCORE						
FANC-02: Pregnant women are attending FANC according to recommended schedule of ANC visits	Check and verify from (Maternal Health Register) record/antenatal cards for documentation of each visit						
	Verify by direct observation or by role play whether the Provider Explains to the women about the following WHO-recommended schedule of ANC visits:	☐ Direct observation ☐ Role play					
	▪ 1st visit: <16 weeks						
	▪ 2nd visit: 24–28 weeks						
	▪ 3rd visit: 30–32 weeks						
	▪ 4th visit: 36–38 weeks						
	SCORE						
FANC-03: The provider takes a FANC history, including screening for danger signs	Verify by direct observation or by role play whether the provider(Annexure 4)	☐ Direct observation ☐ Role play					
	1. Asks about and records danger signs that the woman may have, or has had:						
	– Vaginal bleeding						
	– Respiratory difficulty						
	– Fever						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	– Severe headache						
	– Blurred vision						
	– Severe abdominal pain						
	– Convulsions/loss of consciousness						
	2. Provider calculates the estimated date of delivery according to her last menstrual period at her first antenatal visit and documents it						
	SCORE						
FANC-04: The provider properly conducts obstetric physical exam of the pregnant woman	Verify by direct observation (or if no clients, by role play in Annexure 4) whether the provider:	☐ Direct observation ☐ Role play					
	1. Measures vital signs (blood pressure, temperature, pulse and respiration)						
	2. Measures fundal height (after 12 weeks)						
	3. Listens to fetal heart sounds (after 20 weeks)						
	4. Determines fetal lie and presentation (after 36 weeks)						
	SCORE						
FANC-05: The provider requests laboratory tests according to the FANC package	Verify by direct observation (or role play if no clients) whether the provider requests or checks the following laboratory tests:	☐ Direct observation ☐ Role play					
	1. Routine investigation (blood group and Rh factor, hemoglobin, blood glucose)						
	2. Specific investigation if needed (i.e., hepatitis B, hepatitis C and urine analysis for proteinuria)						
	SCORE						
FANC-06: The provider gives immunization to all pregnant women according to national guidelines	Check immunization record (from Vaccination Register/Maternal Health Register) to verify whether the provider:						
	Verifies tetanus toxoid vaccine provided to all pregnant women (TT2 among pregnant women)						
	SCORE						
	Review five medical records from the last month of cases during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.						

Total of Standards	6
Total Observed	
Total Achieved	

AREA 2: LABOR AND DELIVERY

Facility Name: _____

Assessor: _____ Date: _____

PREMATURE RUPTURE OF MEMBRANE (PROM)							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PROM-1: Medical record documents appropriate management for each woman with rupture of membrane > = 18 hours and women with any early signs of infection	Check the medical record (from Labor Register/Partograph Record) to determine if the provider did the following:						
	1. Administered appropriate prophylactic antibiotics to women with prolonged rupture of membranes: appropriate choice, dose and length of therapy (Annexure 1)						
	2. Administered antibiotics to women with early signs of infection (temp > 38 degrees C or foul-smelling amniotic fluid/vaginal discharge)						
	SCORE						
	Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.						
PROM-02: Antibiotics for prevention and treatment of chorioamnionitis are available in the health facility	Observe and verify that the following medicines are available and accessible at facility:	☐ Direct observation ☐ Role play					
	1. Injection of ampicillin 2g IV every 6 hours PLUS						
	2. Injection of gentamicin 5mg/kg body weight IV every 24 hours (7days) (Annexure 1)						
	SCORE						

PARTOGRAPH (PG)							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PG-1: All women in labor are monitored with a partograph that is complete and accurate	Verify by checking record(Partograph Register/Labor Register) that the partograph is filled in completely and in a timely manner:						
	1. Fetal heart rate						
	2. Labor progress: cervical dilatation						
	3. Strength and frequency of contractions						
	4. Oxytocin, when used						
	5. Maternal pulse and blood pressure						
	SCORE						
	Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.						
PG-2: Every woman has a support person of her choice throughout labor and delivery	Verify by direct observation in the labor room whether:	☐ Direct observation ☐ Role play					
	1. Women were assisted by a support person of their choice during all stages of labor						
	SCORE						

ACTIVE MANAGEMENT OF THIRD STAGE OF LABOR (AMTSL)							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
AMTSL-1: AMTSL is performed for all women during childbirth	Check medical records(Labor Register/Partograph Register) to see if the following are performed during labor:	☐ Direct observation ☐ Role play					
	1. Provide uterotonic*within one minute after the baby is born						
	2. If oxytocin is the uterotonic used for AMTSL at this facility, is reliable refrigeration available and used for oxytocin storage?						
	SCORE						
	Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column. **Uterotonic drugs (oxytocin/misoprostol/ergotamine) (Annexure 1)*						

IMMEDIATE NEWBORN CARE (INC)							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
INC-01: Routine immediate care of a newborn is properly performed	Check and observe that provider:	☐ Direct observation ☐ Role play					
	1. Thoroughly dries baby, stimulates baby and covers baby's head immediately						
	2. Places baby on mother's chest in skin-to-skin contact						
	3. Assesses breathing						
	4. Delays cord cutting until pulsation stops (2–3 minutes)						
	5. Applies CHX to the cord stump						
	6. Encourages mother to start breastfeeding within one hour of delivery						
	SCORE						

HELPING BABIES BREATHE							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
HBB-01: Equipment and supplies are available at delivery side and ready to use	Check and verify that:	☐ Direct observation ☐ Role play					
	1. Labor room has resuscitation/ventilation area with all HBB equipment and supplies						
	2. HBB action plan displayed in labor room						
	SCORE						
HBB-2: Provider has correct knowledge and skills to resuscitate baby	1. Provider successfully performs 7 steps of bag/mask use (Annexure 2)						
	2. Provider successfully performs at least 10 out of 13 OSCE steps (Annexure 3)						
	SCORE						
HBB-3: Provider properly maintains resuscitation record in District Health Information System (DHIS) obstetric register	1. HBB data are available and maintained in DHIS obstetric register						
	SCORE						

POSTPARTUM HEMORRHAGE (PPH)							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PPH-01: Provider can appropriately manage women diagnosed with PPH	Check whether medical records contain:						
	1. Notes on IV installation						
	2. Causes of PPH						
	Observe or check and verify that PPH case managed as follows:	☐ Direct observation ☐ Role play					
	1. Administers oxytocin 20 IU in 1L of saline solution, 60 drops/minute, then 40 drops/minute, up to a maximum of 3L of solution with oxytocin /misoprostol (Annexure 4)						
	2. If bleeding continues after administration of uterotonic drugs, provider manages woman using additional measures to control bleeding (i.e., bimanual compression)						
	3. If bleeding continues despite above management, the provider refers the woman promptly, and documents referral						
	Note for the assessor: Review five medical records from the last month of cases. If it is not possible to review five medical records, please explain the reason in the notes column.						
	SCORE						

PRE-ECLAMPSIA AND ECLAMPSIA							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PE-01: Medical record documents appropriate management for each woman with severe pre-eclampsia/ eclampsia	List of specific observations documented:						
	1. Vital signs (BP, pulse)						
	2. Tendon reflex						
	3. Danger signs						
	4. Urine output						
	5. IV line is attached						
	6. Test for urine proteinuria						
	7. Monitor and evaluate blood pressure						
	8. Any medication for pre-eclampsia/eclampsia administered, dose and timing						
	SCORE						

PRE-ECLAMPSIA AND ECLAMPSIA							
Performance Standard	**Verification Criteria**	**Yes/ No**	**Yes/ No**	**Yes/ No**	**Yes/ No**	**Yes/ No**	**Comments**
	Review five medical records from the last month of cases or of women who are in labor in the delivery room during the assessment. If it is not possible to review these medical records, please document the reason in the notes column.						
PE-02: Appropriate drugs and equipment are always available and accessible for management of severe pre-eclampsia/ eclampsia	The following should be available, accessible and ready for use at the health facility:	☐ Direct observation ☐ Role play					
	1. Magnesium sulfate 20%						
	2. IV set						
	3. 10% calcium gluconate						
	4. Nifedipine or labetalol or atenolol or methyldopa						
	SCORE						
PE-03: The provider correctly manages severe pre-eclampsia/ eclampsia	Verify that the provider correctly manages severe pre-eclampsia/eclampsia	☐ Direct observation ☐ Role play					
	Loading dose:						
	1. Administers 4g of 20% solution of magnesium sulfate in IV solution (20ml) slowly over a 20-minute period						
	2. Administers 5g of 50% magnesium sulfate solution (20ml), with 1ml of 2% lidocaine IM deep in each buttock (total 10g)						
	In case of convulsion, continue the management of eclampsia/severe pre-eclampsia:						
	3. If convulsions reoccur after 15 minutes, gives 2g (10 ml of 20% magnesium sulfate) slowly in IV over 20 minutes						
	Maintenance dose:						
	4. Plan 1: Hydralazine 5mg IV slowly/nifedipine 5mg orally, repeating the dose if the diastolic BP is still more than 110 after 10 minutes						
	5. Rapid evaluation of condition and if needed refer						
	SCORE						

Total Standards	13
Total Observed	
Total Achieved	

AREA 3: POSTNATAL CARE (PNC)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PNC-01: The provider conducts a routine physical exam of the postnatal woman within 48 hours of delivery	Observe that the provider performs the following:	☐ Direct observation ☐ Role play					
	1. Washes hands with soap and water and dries them						
	2. Takes vital signs						
	3. Examines the breasts for establishment of lactation, engorgement and/or tenderness						
	4. Examines abdomen for involution of uterus, tenderness or distension						
	5. Assesses amount of bleeding and healing of laceration/episiotomy (if needed)						
	SCORE						
PNC-02: The provider properly counsels the postpartum mother and manages care according to the assessment findings	Determine by observation whether the provider counsels on the following areas:						
	1. Family planning						
	2. Nutrition/iron folic supplementation						
	3. Explains to the mother AND her husband or another family member the need to report to the health facility when the following danger signs are observed:						
	– Excessive vaginal bleeding						
	– Severe headache						
	– Severe abdominal pains						
	– Offensive vaginal discharge						
	– Fever						
	– Convulsions						
	– Blurred vision						
	– Extreme fatigue						
	SCORE						
	Verify by direct observation or by role play (Annexure 4) that the provider correctly manages the situation.						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
CARE FOR THE NEWBORN							
Instructions to the assessor: Observe one or more providers giving care to newborn in the postpartum ward.							
PNC-03: The provider properly conducts a newborn exam	Observe and verify or by role play for the situation	☐ Direct observation ☐ Role play					
	1. Whether the provider conducts a thorough physical exam of the newborn:						
	– Washes hands before and after drying them, puts on gloves						
	– Weighs the baby						
	– Counts respiration (normal 30 to 50 per minute)						
	– Measures axillary temperature (36.5–37.2)						
	– Performs head-to-toe examination of baby						
	– Checks application of chlorhexidine on umbilical stump						
	SCORE						
PNC-04: The provider properly counsels and demonstrates to mother the importance of newborn care	Observe whether the provider:	☐ Direct observation ☐ Role play					
	1. Demonstrates how to keep the baby warm and dry (proper wrapping)						
	2. Encourages the mother to breastfeed exclusively						
	3. Counsels the mother and family member on the importance of completing child immunizations according to schedule						
	SCORE						
PNC-05: The provider advises the mother about danger signs	Observe whether the provider advises the mother and other family member about the following danger signs and in case any of the danger signs is present, immediately seeks help:	☐ Direct observation ☐ Role play					
	1. The infant has convulsions						
	2. The infant vomits everything or is not able to feed or is sucking or feeding poorly						
	3. The infant is not able to feed or is sucking or feeding poorly						
	4. Any problems with breathing						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	5. The infant is lethargic or unconscious						
	6. Any oozing from the umbilical stump (pus, clear or blood)						
	7. The infant feels hot to touch or very cold to touch						
	SCORE						
	Note for assessor: Verify by direct observation or by using model and role play.(Annexure 4)						

AREA 4: COUGH & DIFFICULT BREATHING AND DIARRHEA

Facility Name: _____

Assessor: _____ Date: _____

COUGH OR DIFFICULT BREATHING AND DIARRHEA							
Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
Pneumonia and diarrhea (PD)-01: The provider assesses, classifies, treats and counsels caregiver on home care for a child who has a cough or difficulty breathing	Observe and verify from medical record (by using IMNCI chart in the manual) whether the provider:	☐ Direct observation ☐ Role play					
	1. Assesses, classifies and refers child with general danger signs						
	2. Assesses child presenting with cough and/or difficult breathing						
	3. Recognizes main clinical signs						
	4. Classifies the child as per protocol						
	5. Treats/refers the child as per protocol						
	6. Provides counseling on medication and home care						
	SCORE						
PD-02: The provider assesses, classifies, treats and counsels caregiver on home care for a child who has diarrhea	Observe and verify from medical record (by using IMNCI chart in the manual) whether the provider:	☐ Direct observation ☐ Role play					
	1. Assesses diarrhea and dehydration in sick child.						
	2. Classifies diarrhea and dehydration in sick child						
	3. Treats diarrhea as per protocol						
	4. Counsels caregiver on four rules of home treatment						
	SCORE						

PD-03: Facility has an adequate stock of essential commodities for management of cough or for difficulty breathing and diarrhea	1. Checks and verifies commodities available for management of cough and/or difficulty breathing:						
	– Oral amoxicillin						
	– Inhaled bronchodilator/salbutamol						
	– Injectable antibiotics (for comprehensive and basic emergency obstetric care [CEmONC and BEmONC])						
	– Oxygen (for CEmONC and BEmONC)						
	2. Checks and verifies commodities for management of diarrhea:						
	– Low osmolality ORS packets						
	– Zinc syrup/tablets						
	– IV fluids preferably Ringer's lactate solution/Nasogastric (NG) tube						
	– Jug, cups, spoon						
	– Scale						
	SCORE						

Total of Standards	8
Total Observed	
Total Achieved	

AREA 5: POSTPARTUM FAMILY PLANNING (PPFP)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
PPFP-01: Statistical data are recorded	Verify that the following reports have been completed accurately and sent to the District Health Officer (OR record maintained in cases of a private clinic/hospital):	☐ Direct observation ☐ Role play					
	1. Daily registry of services						
	2. If public hospital, CLR6 form is available and in use						
	SCORE						
PPFP-02: The provider gives information about long–acting contraceptive methods available in the clinic and confirms client's choice	Observe whether the provider explains:	☐ Direct observation ☐ Role play					
	1. All long-acting contraceptive methods available at facility						
	2. The contraceptive method that client wants to use or helps the client to choose an appropriate method						
	3. Provider informs the client of the effectiveness of IUCD/implant						
	SCORE						
	Verify by direct observation or by role play. (Annexure 4)						
PPFP-03: The provider performs the insertion using the sterile technique PPIUCD/implant	Observe that the provider performs the following:	☐ Direct observation ☐ Role play					
	1. Ensures that she has been appropriately counseled on immediate PPIUCD insertion and still wants an IUCD						
	2. Confirms that correct sterile instruments, IUCD supplies and light source are available in the labor room for immediate post-placental insertion						
	3. Palpates the uterus to evaluate the height of the fundus and the size and degree of contraction of the uterus						
	4. Observes that PPIUCD inserted by using the placental forceps or the ring forceps, following the non-touch technique						
	5. Ensures that the IUCD is placed at the uterine fundus and visually examines the cervix following insertion						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	6. Removes all instruments used and places them (they should be open) in 0.5% chlorine solution and ensures that they are totally submerged						
	SCORE						
PPFP-4: The provider performs the IUCD insertion using sterile technique	Observe that the provider performs the following:	☐ Direct observation ☐ Role play					
	Performs pre-insertion tasks:						
	1. Asks the client to empty her bladder						
	2. Performs bimanual examination with HLD, sterile or disposable gloves						
	Performs insertion task by using "no-touch" technique:						
	1. Gently applies antiseptic solution two times to cervix and grasps the cervix with tenaculum/vulsellum						
	2. Sounds the uterus using "no-touch" technique						
	3. Inserts the Copper T 380A using the "withdraw" technique after setting depth gauge						
	4. Removes the tenaculum and speculum and places them in 0.5% chlorine solution for 10 minutes for decontamination						
	Performs post-insertion tasks:						
	1. Explains **PAINS** signs to clients						
	2. Completes her record						
	SCORE						
IMPLANT							
Assessor needs to check the skills of the service provider for all long-acting contraceptive methods.							
PPFP-5: The provider assesses client's eligibility for use of Implants	Observe that the provider verifies whether client has any condition that could affect her use of the implant by asking about the following:	☐ Direct observation ☐ Role play					
	1. Severe liver disease, infection or tumor						
	2. Breastfeeding a baby less than 6 weeks old after delivery						
	3. Currently has blood clot in legs or lungs						
	4. Unexplained vaginal bleeding						
	5. Had breast cancer more than 5 years ago, and it has not returned						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
	SCORE						
PPFP-6:The provider performs the pre-insertion task	Observe that the provider performs the following steps:	☐ Direct observation ☐ Role play					
	1. Checks that the client has washed her arm before procedure						
	2. Checks that the instrument tray is ready						
	SCORE						
PPFP-7: The provider correctly inserts the implant	1. Drapes the autoclave sheet over the arm and ensures that the hole in sheet is over the insertion site						
	2. Administers an injection of local anesthetic under the skin of the insertion site to prevent pain while the implants are being inserted						
	3. Inserts the implants just under the skin using an inserter, Closes the incision with an adhesive bandage.						
	SCORE						
PPFP-8: The provider gives instructions about the return and/or follow-up visits	Verify by direct observation or by role play that the provider:						
	1. Discusses return visits and follow-up according to the selected method (after 7 days)						
	SCORE						

Total of Standards	8
Total Observed	
Total Achieved	

AREA 6: INFECTION PREVENTION (IP)

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
IP-01: Hospital or other health facilities look clean	Check that the following areas are clean (*no dust, blood, trash, used needles and syringes, or spider webs*):	☐ Direct observation ☐ Role play					
	1. Observation/examination room for the first stage of labor						
	2. Delivery room						
	3. Postpartum room						
	4. Washing area for used instruments/sterilization and HLD processing area						
	SCORE						
IP-02: Ensure availability and use of personnel protective equipment	Observe that the following equipment is available, accessible and ready for use:	☐ Direct observation ☐ Role play					
	1. Personal protective equipment available during procedure(delivery and in instrument processing:						
	– Gloves/utility gloves						
	– Eye protection, mask, goggles						
	– Apron and closed shoes						
	SCORE						
IP-03: Instruments processing for decontamination and other articles (immediately after use)	Verify by observation whether the following is performed:	☐ Direct observation ☐ Role play					
	1. Decontamination of instruments immediately after procedure (delivery/IUCD insertion and implant insertion) with **0.5% chlorine solution for 10 minutes**						
	2. Cleaning of instruments with brush and soapy water after decontamination						
	3. High level disinfection (HLD): instruments are boiled for 20 minutes starting from the time a rolling boil begins OR using autoclave						
	4. HLD/sterilized packs stored properly with expiration dates on them						
	SCORE						

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
IP-04: Waste is collected and disposed of properly to avoid injuries and contamination	Observe and verify whether:	☐ Direct observation ☐ Role play					
	1. Containers with sharps are incinerated						
	2. Solid waste (used dressings and other materials contaminated with blood and organic matter) are incinerated/buried in incineration pit						
	3. Contaminated liquid waste (blood, urine and other body fluids) are disposed into a toilet or sink and sink is rinsed with water						
	4. Placenta is disposed in placenta pit						
	SCORE						

Total of Standards	4
Total Observed	
Total Achieved	

AREA 7: LINKAGES AND REFERRALS

Facility Name: _____

Assessor: _____ Date: _____

Performance Standard	Verification Criteria	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Comments
Linkages and referrals: Effective systems of linking and referring clients for higher level care is in place, and effectively used.	Check and verify by record (from referral register)or by staff interview:						
	1. MCH facility has a system in place for referring women/child in case of complication						
	2. Facility has linkage for provision of emergency blood supply						
	SCORE						

Total of Standards	1
Total Observed	
Total Achieved	

Total of Standards	40
Total Observed	
Total Achieved	

Placeholder: Area 7:

QIPS ASSESSMENT TOOL APPENDIX 1: Use of Uterotonic Drugs

Drug	Dose and Administration	Further Dose	Maximum Dose	Caution and Contraindication
Oxytocin	IV: 20 IU IV in 1 liter of fluid with 60 drips/minutes IM: 10 U	IV: 20 U IV in 1 liter of fluid with 40 drips/minute	Not more than 3 liters of IV solution containing oxytocin	Do not give in IV bolus
Ergometrin/methyl-ergometrin	IM or IV (slow drip) 0.2 mg	Repeated 0.2 IM after 15 minutes If necessary, give 0.2 mg IM or IV (slow drip) every 4 hours	5 doses (total of 1.0 mg)	Hypertension, pre-eclampsia, cardiac diseases

Adapted from: World Health Organization. 2008. *Managing complications in pregnancy and childbirth: A guide for midwives and doctors (IMPAC).*

First-Line Antibiotics Therapy Regimen for Severe Infection/Maternal Sepsis

Reference	Severe Infection	Sepsis
WHO. 2003. *IMPAC.*	Ampicillin 2 g IV every 6 hours + gentamycin 5 mg/kgbw IV every 24 hours + metronidazole 500 mg IV every 8 hours until 48 hours fever free	Penicillin G 2 mil. unit or ampicillin 2 g IV every 6 hours + gentamycin 5 mg/kgbw IV every 24 hours + metronidazole 500 mg IV every 8 hours until 48 hours fever free
WHO. 2006. *IMPAC.*	Ampicillin 2 g IV/IM continued by 1 g IV/IM every 8 hours + metronidazole 500 mg IV every 8 hours until 48 hours fever free	

QIPS Assessment Tool Appendix 2: Bag and Mask Ventilation—Skills Check

Name of trainee/provider_____Date _____

Complete this evaluation with learners before they attempt the OSCE evaluations. Use the comments below the numbered steps to score the performance. Note the number of steps done correctly on the first attempt. Give feedback to the learner.

Repeat the evaluation until all steps are done correctly.

	DONE	NOT DONE
1. Check equipment and select the correct mask Test function of bag and mask. Make sure mask fits the baby's face.	☐	☐
2. Apply the mask to make a firm seal Extend the head, place mask on the chin, then over the mouth and nose. A firm seal permits chest movement when the bag is squeezed.	☐	☐
3. Ventilate at 40 breaths per minute The rate should not be less than 30 or more than 50 breaths per minute.	☐	☐
4. Look for chest movement Check that every ventilation breath produces chest movement.	☐	☐
5. Improve ventilation if the chest does not move a. Head—reapply mask and reposition head b. Mouth—clear secretions and open the mouth c. Bag—squeeze the bag harder	☐	☐

Score on first attempt_____ of 7

All steps done correctly_____(facilitator name and initials)

QIPS Assessment Tool Appendix 3: Helping Babies Breathe

OSCE – Station A

Instructions to the facilitator:
Read aloud to the learner the following instructions and the case. Provide prompts where shown in ***red***. As you observe the learner, tick ☑ the boxes "Done" or "Not Done" for each activity. Indicate the baby's response to the learner's actions using the neonatal simulator or words if using a mannequin. For example, when the learners evaluate crying, show or say that the baby is not crying.

"I am going to read a role play case. Please listen carefully, and then show me the actions you would take. I will indicate the baby's response with the simulator (OR in words), but I will provide no other feedback until the end of the case."

"You are called to assist the delivery of a term baby. There are no complications in the pregnancy. The baby will be born in less than 10 minutes. Introduce yourself and prepare for the birth and care of the baby."

Prepares for birth	**Done**	**Not Done**
Identifies a helper and makes an emergency plan.	☐	☐
Prepares the area for delivery	☐	☐
Cleans hands and maintains clean technique throughout.	☐	☐
Prepares an area for ventilation and checks equipment	☐	☐
Prompt: After 5-7 minutes give baby to learner and say, "The amniotic fluid is clear. Show how you will care for the baby."		
DRIES THOROUGHLY	☐ *	☐
Removes wet cloth.	☐	☐
Evaluates crying		
Prompt: Show or say the baby is not crying.		
RECOGNIZES BABY IS NOT CRYING	☐ *	☐
Clears airway and stimulates breathing		
Keeps warm	☐	☐
POSITIONS HEAD AND CLEARS AIRWAY	☐ *	☐
Stimulates breathing by rubbing the back	☐	☐
Evaluates breathing		
Prompt: Show or say the baby is breathing well.		
Recognizes baby is breathing well.	☐	☐
Clamps or ties and cuts the cord.	☐	☐
Positions skin-to-skin on mother's chest and communicates with mother	☐	☐

SCORING:
Successful completion requires a total score of 10 correct of 13 and "Done" must be ticked for ***DRIES THOROUGHLY, RECOGNIZES BABY IS NOT CRYING, AND POSITIONS HEAD AND CLEARS AIRWAY*** (boxes indicated by *).

Number Done Correctly ..... *Facilitator initials* .....

Appendix AP: MCHIP/Jhpiego Strategy for Prevention of Postpartum Hemorrhage

WHAT IS POSTPARTUM HEMORRHAGE?

Postpartum Hemorrhage (PPH) is the leading cause of maternal mortality in Pakistan. According to the WHO guidelines in 2012, uterotonic is the single most important intervention in the prevention of PPH, regardless of the location of the delivery. In health care facilities with refrigeration capacity, the first line uterotonic which should be used is Oxytocin. However, in Pakistan the quality of available Oxytocin is of serious concern and impractical at facilities without reliable electricity. It is also out of reach of the 32% women in Sindh who deliver at home. Misoprostol is the appropriate uterotonic choice of community based births.

WHAT IS THE TARGETED INTERVENTION AND ADVOCACY FOR MCHIP/JHPIEGO?

MCHIP/Jhpiego is introducing misoprostol to prevent PPH in five target districts. Misoprostol will be distributed through **1) Advanced Antenatal Care (ANC) distribution through ANC** clinics for all MNCH target Centers and **2) Community based distribution through Lady Health Workers (LHWs) or Community Health Workers (CHWs) or Traditional Birth Attendants (TBAs)** (where LHWs are not available). To meet this target, following resources was developed by MCHIP/Jhpiego at the central level:

- Training materials for misoprostol was reviewed and adapted and approved by the Department of Health (DOH) for use by health care providers, LHW program trainers and LHWs.
- Trainers developed and available at the province level who can train health care providers and LHWs to distribute misoprostol at the districts.
- IEC materials developed for distribution through ANC clinics: 1) Flip book for counselling; 2) Poster for display in ANC clinic; and 3) Brochure to be given to women (still under design).
- IEC materials developed for distribution at the community level 1) Flip book for LHWs for counselling and use during the support group meetings; 2) Misoprostol poster to be displayed in the health house of LHWs and 3) Brochure to be given to women(still under design).

WHAT IS OUR STRATEGY FOR MAKING MISOPROSTOL AVAILABLE?

Misoprostol is currently not available at the facilities or for community based distribution. MCHIP/Jhpiego is working through the following channels to make misoprostol available.

- DOH: MCHIP/Jhpiego will work with the Director General office through Public Sector Coordinator to issue letter to the District Health office (DHO) to procure misoprostol and provide a share of the procurement to the LHW Program.
- District Health office (DHO): MCHIP/Jhpiego will coordinate to with the DHO to procure locally and provide misoprostol to the facilities and the LHW program.
- LHW Program: The LHW program currently does not have funds to procure misoprostol. MCHIP/Jhpiego will coordinate with the PPHI and DHO to make misoprostol available to the LHW program.
- People's Primary Healthcare Initiative (PPHI): PPHI has procured misoprostol for their network of facilities. PPHI will distribute the misoprostol through the ANC at their

facilities. MCHIP/Jhpiego will discuss with PPHI l to provide the misoprostol to the LHWs that are working in the PPHI facilities for community based distribution.

While the discussion on the procurement through the government channels is being finalized, MCHIP/Jhpiego as a short term strategy will ask the women to purchase the misoprostol from commercial medical stores. Misoprostol is easily available over the counter at the medical stores and at a low cost of 30 Rupees for three tablets.

WHAT IS THE PLAN FOR THE DISTRICT LEVEL ROLL OUT OF MISOPROSTOL?

Advanced distribution through ANC Clinics		
Misoprostol available at all ANC clinics for advance distribution	District Coordinators (DCs) to coordinate with DHOs and District Support Managers (PPHI)	Approval letter from the DOH
Health facility staff trained on misoprostol distribution	HQ technical team and Field team	See the training plan and IEC material (Annex 1 & 2)
Health facility staff receive refresher training and on the job training on a periodic basis	Clinical supervisors and clinical officers	
Health facility display poster at the ANC clinic	Health facility and the clinical officers and clinical supervisors	ANC Posters
Health facility records the ANC distribution of misoprostol and reports on a monthly basis	District coordinator, Subawardee, M&E officer	District Health Information System OPD register and Stock register for both Public and private providers
Pregnant women coming for ANC visits in their last trimester should receive: ▪ Counseling for misoprostol and delivery with a skilled birth attendant using the misoprostol flip book from the ANC Provider ▪ Misoprostol tablets 3 tablets of 200 ug each combined 600 ug ▪ A brochure on prevention of PPH using misoprostol ▪ Small zip folder for women to keep misoprostol tablets and brochure safe ▪ Prescription of misoprostol if not available at facility to buy from medical store delivery	Health facility and ANC provider and the clinical officers and clinical supervisors and Technical team and Program team	Flip book, Brochure, Small Zip folder
Community Based Distribution through LHWs or CHWs		
LHWs and CHWs trained on misoprostol distribution	HQ technical team and Field team	See the training plan (Annex 1)
LHWs and CHWs receive refresher training and on the job training on a periodic basis	Clinical supervisors and clinical officers	
CHWs and LHWs display poster at home	Clinical Officers and clinical supervisors	ANC posters
TBAs identified and trained for counselling and distribution of misoprostol using flip book	DCs/Community mobilization Officers	Misoprostol flip book
LHWs, CHWs, and TBAs record and report data on misoprostol distribution	DCs/subawardees & M&E assistant	LHW Management Information System /separate reporting format
Pregnant women at home should receive: ▪ Counseling for misoprostol and delivery with SBA using the misoprostol flip book from the LHW or CHW ▪ Misoprostol tablets 3 tablets of 200 ug each combined 600 ug ▪ A brochure on prevention of PPH using	LHW/ CHW, the clinical officers and clinical supervisors and Technical team and Program team	Flip Book, Brochure, small zip folder

misoprostol ▪ Small zip folder for women to keep misoprostol tablets and brochure safe ▪ Prescription of misoprostol if not available at facility to buy from medical store delivery		

Appendix AQ: Distribution and Use of Chlorhexidine

Introduction to Chlorhexidine and its Importance

- Chlorhexidine is an antiseptic
- This antiseptic gel is to be used only on the umbilical area of neonates and is to be used immediately after cord cutting in the umbilical stump and surrounding area.
- Application of Chlorhexidine gel helps prevent bacterial infection for a long period of time (24–48 hours).
- Once-a day application for up to seven days after birth or separation of cord, whichever comes first
- Use of Chlorhexidine gel has no side effects.
- It is easy to use.
- Use of Chlorhexidine is helpful in replacing other harmful traditional cord care practices.

Application Procedure of Chlorhexidine

- Wash hands properly with soap and water before piercing the tube, following all 11 steps of proper hand washing.
- Use sharp protuberance of the lid to pierce tube. Before applying Chlorhexidine, ensure the baby is warm and is wrapped properly exposing only the naval area.
- Apply Chlorhexidine immediately after cord cutting. Use Chlorhexidine gel on umbilical stump and spread it using index finger around the abdominal area that comes in contact with umbilical stump.
- Apply Chlorhexidine gel once -a day up to seven days after birth or separation of cord, whichever comes first.
- Gel takes 2–3 minutes to dry. Cover it with light clothes to avoid wiping.

Role and Responsibilities of SBAs

- Participate in the Chlorhexidine training program.
- Provide information regarding Chlorhexidine to all relevant labor room and delivery staff.
- During ANC visits provide information on Chlorhexidine and counsel on avoiding harmful umbilical cord practices to pregnant women and their families.
- Distribute IEC materials to pregnant women during ANC visit in the last trimester.
- Ensure availability of Chlorhexidine in the labor and delivery room.
- If present during delivery (at home or in a health facility), apply Chlorhexidine on umbilical cord stump of newborn baby soon after birth.
- Educate mothers to continue to apply gel up to seven days after birth or separation of cord, whichever comes first;
- Keep record of births and Chlorhexidine application in DHIS/OBS Register
- Track stock of Chlorhexidine.

Role and Responsibilities of Lady Health Workers (LHWs)

- Participate in Chlorhexidine training program.
- Identify and follow all pregnant women in her catchment area.
- Conduct sessions on importance of Chlorhexidine and avoidance of harmful umbilical cord practices in women's support group meetings.
- Provide counseling to pregnant woman and her family regarding Chlorhexidine during home visits.
- Provide Chlorhexidine gel tubes and IEC material to pregnant women during counselling sessions / regular home visits preferably during third trimester of pregnancy.
- If present during delivery, apply Chlorhexidine on umbilical cord stump of newborn baby soon after birth.
- If a delivery is not attended by a skilled attendant, then the LHW should make a home visit to the new mother within 24 hours and check the umbilical cord and use of Chlorhexidine.
- Record Chlorhexidine distribution data in the pregnant women register
- Regularly replenish Chlorhexidine from health facility to prevent stock out.
- Submit Chlorhexidine distribution/use data in LHW monthly report on time.

CHLORHEXIDINE DISTRIBUTION MECHANISM

Facility- level distribution:

- DHOs will receive Chlorhexidine tubes on quarterly basis upon submission of quarterly consumption/demand report.
- Upon receipt of Chlorhexidine the DHO will ensure entry in stock register and distribute the Chlorhexidine to selected health facilities as per requisition on monthly basis.
- Chlorhexidine will be kept in the labour room for application on the umbilical stump of every newborn soon after birth

Community- level distribution:

- District Coordinator LHW Program will submit a requisition on quarterly basis and upon receipt of Chlorhexidine will ensure entry in DPIU stock register.
- DPIU will distribute Chlorhexidine to LHW through Lady health supervisors (LHSs) on the basis of monthly requisition submitted by LHWs.
- The LHS will maintain medicine stock register as per LHW program protocol.
- LHWs will distribute CHX to pregnant women during third trimester of pregnancy.

Note: The distribution mechanism at both levels is based upon supplies to be provided by USAID/MCHIP. Once the local manufacturing will be started and DoH will procure directly than proposed mechanism will be replaced by DoH existing supply system.

CHLORHEXIDINE RECORDING AND REPORTING MECHANISM

Facility –level:

- Chlorhexidine consumption and demand record will be maintained in following DHIS tools.
- DHIS Obstetric register

- DHIS Daily Medicine Expense Register
- DHIS Stock Register (Medicine/Supplies)
- Health Facility Monthly Report Form

Community- level:

- The LHW will maintain the distribution and use of Chlorhexidine record in "Hamla Khawaten List" in Daily Diary of LHW.
- LHWs will report the number of Chlorhexidine tubes distributed and balance in their monthly report.
- The LHS will submit the distribution and balance of Chlorhexidine in compiled monthly report to DPIU.
- The DPIU will submit the monthly report to PPIU and DHO.

FREQUENTLY ASKED QUESTIONS

When and where Chlorhexidine is used?

- Chlorhexidine is applied on the umbilical cord stump of a newborn after birth.
- It can be used in any setting where a birth occurs: at home after a home birth or after a delivery in a health facility.

What are its advantages?

- It is preventative. It works before the infection begins.
- It is simple to use. The instructions are simple and have been shown to be easy to follow by mothers, families, community health workers and health care providers (such as skilled birth attendants). It is important to wash hands before use.
- It does not require special storage, such as refrigeration.
- It is equitable all newborns should receive Chlorhexidine immediately after birth.
- It is safe. Chlorhexidine has been used for umbilical cord care in developed countries for 40 years.
- The concentration of Chlorhexidine digluconate was selected because it is strong enough to work as an antiseptic, but at a low enough concentration not to have other effects (i.e, absorption into the bloodstream).
- This formulation of Chlorhexidine is water-based. Many other antiseptics are alcohol-based, which are not recommended for premature babies.
- As with many medicines intended for topical use, avoid contact with eyes or ears.
- It is very effective, more than other antiseptics. It reduces infections and prevents newborn deaths.

What is its correct application procedure?

- Please refer to the Chlorhexidine job aid (Appendix C) to follow the correct steps.
- Apply immediately after birth, following these five steps:
  1. Wash hands properly with soap and water before applying Chlorhexidine to the baby.
  2. Open the tube by pressing the sharp tip of the lid to break the inner shield of the tube. Apply the Chlorhexidine gel on the umbilical cord stump and the surrounding areas of the cord.
  3. Spread the gel gently on the stump and surrounding areas using your index finger.

4. After applying Chlorhexidine, apply nothing else to the cord stump and keep it clean.
5. Apply Chlorhexidine gel once-day for seven days after birth or separation of cord, whichever comes first.

Are there any side effects of Chlorhexidine?

- No, there are no side effects of Chlorhexidine use for cord care. It has been noted, however, that using Chlorhexidine can delay cord separation; however, delayed cord separation with the use of Chlorhexidine does not harm the baby.

Appendix AR: Recommendations for Healthcare Waste Management at Maternity Units in Sindh

MCHIP/Jhpiego is responsible for establishing an effective healthcare waste management system at all these facilities to ensure that patients, providers, and community members are not exposed to any increased risk of infections due to improper waste management.
Studies have shown that in Pakistan on an average 2 kg of waste is generated per day per bed. Incineration is the most common final waste disposal method but is not carried out properly and sometimes the waste is burned incompletely in the open.
An effective healthcare waste management system consists of following steps.

1. Minimize waste
2. Segregation of waste the point of care.
3. Proper storage and transportation at the final disposal site.
4. Proper final disposal.

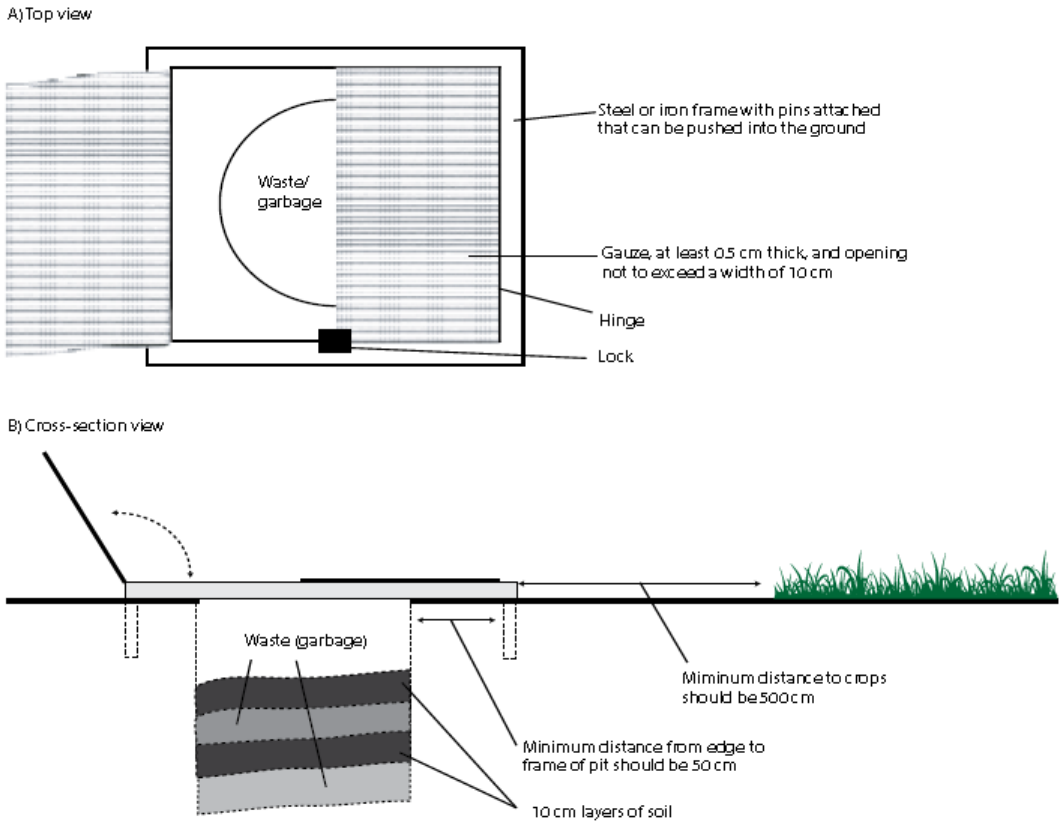
FINAL WASTE TREATMENT OPTIONS

Safe burial on hospital premises

Minimal approaches to health-care waste management need to be used in remote health-care facilities and underdeveloped areas. In addition, minimal practices may also be necessary in temporary refugee encampments and areas experiencing exceptional hardship. Consequently, the safe burial of waste on hospital premises may be the only viable option available at that time. Even in these difficult circumstances, the hospital management can establish the following basic principles:

- Access to the disposal site should be restricted to authorized personnel only.
- The burial site should be lined with a material of low permeability, such as clay, dung and river silt, if available, to prevent pollution of shallow groundwater and nearby wells.
- New water wells should not be dug near the disposal pit.
- Only infectious health-care waste should be buried (if general hospital waste were also buried on the premises, available space would be quickly filled).
- Larger quantities (<1 kg) of chemical wastes should not be buried at one time; however, burying small quantities occasionally is less likely to create adverse pollution.
- The burial site should be managed as a landfill, with each layer of waste covered by a layer of soil to prevent odors and contact with the decomposing waste, and to deter rodents and insects.

The design and use of a burial pit is illustrated in Figure 8.7. Once the pit is constructed, the safe burial of waste in minimal circumstances depends critically on staff following sensible operational practices. This must be insisted upon, and the local health-care manager must realize their responsibility for making an organized waste-disposal system work properly.



Source: COSsen Zuid-Holland (2006)

Safe onsite burial is practicable only for relatively limited periods (i.e. 1–2 years), and for relatively small quantities of waste (i.e. 5–10 tonnes in total). Where these conditions are exceeded, a longer term solution, probably involving disposal at a land-disposal site away from the health-care facility, should be found.

Key points to remember

Many health-care waste-treatment systems are commercially available today. The choice of technology depends on the characteristics of the waste of the health-care facility, the capabilities and requirements of the technology, environment and safety factors, and costs. Treatment technologies employ thermal, chemical, irradiative, biological or mechanical processes. The common types of treatment technologies are:

- autoclaves
- integrated or hybrid steam-based treatment systems
- microwave treatment technologies
- dry-heat treatment technologies
- chemical treatment technologies
- incinerators

These technologies could be supplemented by post-treatment shredders, grinders and compactors. For most technologies, except incinerators, validation testing is needed to ensure that a minimum level of disinfection can be achieved. Autoclaves come in a wide range of sizes and can be classified according to the method of air removal. Integrated steam-based treatment technologies incorporate various mechanical processes to improve the treatment efficiency. Incinerators can range from small batch units to large complex treatment plants. Incinerators should have flue gas cleaning systems to minimize pollutant releases and meet national or international emission limits. Small-scale incineration is a transitional means of disposal for healthcare waste. When investing in new technologies, priority consideration should be given to technologies that do not produce dioxins or furans. Regardless of the technology, the healthcare facility should have an annual budget for periodic maintenance and repair.

Health-care facilities can work with municipal authorities and other stakeholders to gradually improve the disposal of waste in landfills. Among the desirable features of a landfill are:

- restricted access to prevent scavenging
- daily soil cover to prevent odours, and regular compaction
- organized deposit of wastes in small work areas
- isolation of waste to prevent contamination of groundwater and surrounding areas
- trained staff

In circumstances where sanitary or engineered landfills are not available, various options are possible to minimize the transmission of infections and adverse impacts on the environment from hazardous health-care waste.

The following waste categories should not be incinerated:

- mercury thermometers (preferably collect for mercury recovery);
- pressurized containers (safe burial in pits);
- polyvinyl chloride (PVC) plastics such as intravenous sets, catheters and PVC containers for sharps (safe burial in pits);
- vials of vaccines (safe burial in pits);
- anatomical wastes or body parts (safe burial in pits).

Onsite burial in pits

Dig a pit 1–2 m wide and 2–3 m deep. The bottom of the pit should be at least 2 m above the groundwater. Line the bottom of the pit with clay or permeable material. Construct an earth mound around the mouth of the pit to prevent water from entering. Construct a fence around the area to prevent unauthorized entry. Inside the pit, place alternating layers of waste, covered with 10 cm of soil (if it is not possible to layer with soil, alternate the waste layers with lime). When the pit is within about 50 cm of the ground surface, cover the waste with soil and permanently seal it with cement and embedded wire mesh (Figure 14.1).

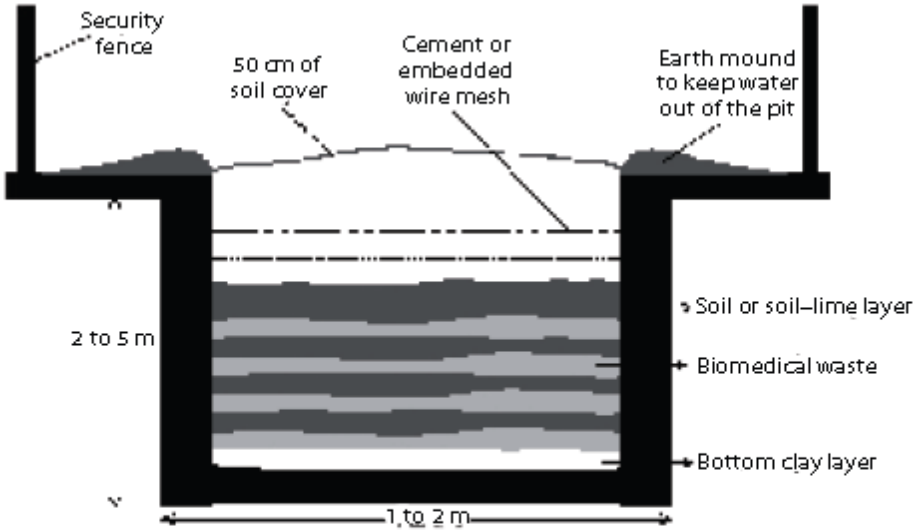


Figure 14.1 Construction of a pit for onsite waste burial

Disposal of Placenta and other pathological waste

Note: This annex is adapted from Medecins Sans Frontieres (2010).

Treating and disposing of biodegradable pathological waste is a critical problem for many health-care facilities. The general approach for managing this type of waste is outlined in Chapter 8. This annex describes some alternative approaches, which may be relevant if incineration, cremation and advanced non-incineration technologies applicable to pathological waste (such as alkaline digestion and hybrid steam treatment systems with internal shredding) are not available, and if the pathological waste must be treated or disposed of within the compound of the health-care facility. Under no circumstances should live cultures be treated in this manner. Instead, live cultures should be disinfected in the laboratory before being sent for disposal.

Organic waste often contains too many liquids to be suitable for incineration with volume reducers or batch autocombustion incinerators. The temperature reduction due to the evaporation of the liquids will result in formation of more toxic gases, survival of potential thermoresistant pathogens or even bringing the combustion to a halt.

Much research has focused on the elimination of enteric or waterborne pathogens in various types of composting system, both aerobic and anaerobic. As yet, there has been no comparable research for bloodborne pathogens or pathogens involved in hospital-acquired infections; however, the risk appears to be lower than that for enteric infections. Firstly, the likelihood of bloodborne or hospital-acquired pathogens surviving composting is lower than that for waterborne infectious agents. Viruses and bacteria that cannot form spores are likely to be inactivated in a short period, although bacterial spores are more resistant. Biodigestion processes with higher temperatures and longer residence times are considered to be the best at eliminating pathogens.

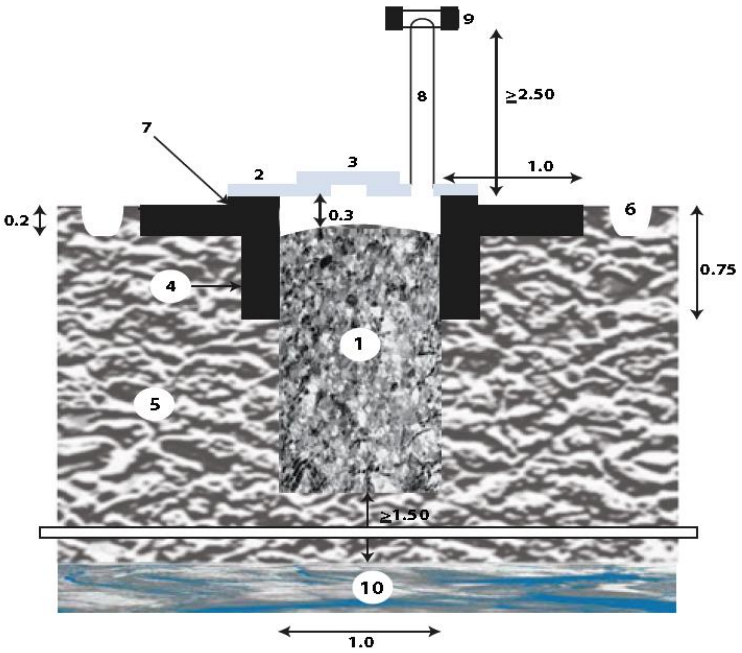
In any waste-disposal approach, care should be taken to prevent contact with untreated waste, such as through skin contact or splashes during collection and placement of the waste into pits, composters, digesters, and so on. Enteric pathogens can cause infection through the usual cycle of infection – for example, someone handling compost from a digestion process may get material on their hands and then spread it to their mouth. Conversely, bloodborne pathogens are unlikely to be spread via this usual cycle of infection; it is very unlikely that someone would pick up any bloodborne pathogen by handling compost or biodigester slurry unless the worker has cuts or breaks in the skin, or there are sharps in the waste causing injury to the workers.

Placenta Pit

In many communities, burying placentas is an important ritual and one option for disposal. If it is done safely, burial can protect the community from pathogens while respecting cultural norms and religious traditions.

One disposal option is to dispose of placentas in concrete pits (Figure A6.1). The site of the pits should be as far away as possible from publicly accessible areas and from hygienically critically areas (e.g. water wells, kitchens). Placenta pits should not be built too close to buildings due to possible odours.

The dimensions of the pit will be context specific, and will depend on the average number of births and infiltration rate of the soil. In principle, allow 0.5 litres of soil infiltration per placenta, and a maximum of 5 litres of total space per placenta if all the bloody liquids are collected and no infiltration is occurring.
The liquid proportion of placentas can leach into the soil through the unsealed sides of the pit. However, the pit should be designed to prevent the waste from contaminating the surrounding groundwater. A safety distance of at least 1.5 m from the bottom of the pit to the groundwater level is recommended. Placenta pits are not recommended in sites where the water table is near the surface or in areas prone to flooding.



Source: Medecins Sans Frontieres (2010)
The top 50 cm (or more) of the pit should be reinforced with concrete to prevent surface water infiltration. The base of the pit should be made from concrete to stabilize the structure and to slow the downward movement of liquid towards the water table. Placenta pits can be also constructed from a standard concrete ring with a diameter of about 1 m. The top slab should be above ground level and made from watertight concrete to prevent surface water infiltration. The top should be closed by a lockable hatch and a vent pipe installed to ensure that the generated gases can escape and air can get in. Where soil is particularly sandy,
extra precautions may need to be taken to protect the water table and to prevent the pit from collapsing: the sides may be reinforced with bricks, laid with gaps between them so that the liquids can still escape.
1. Pit: string line, sticks and measuring tape, 2. Slab: shovel, hoe, pick axe, miner's bar, 3. Lid: fired bricks or cement blocks
4. Base or lining: sand, cement, gravel and clean water., 5. Permeable soil: reinforcement bars (diameter 8 mm)
6. Drainage channel: tools to prepare and cast concrete; masons' tools, 7. Mortar layer (at least 10 mm thick): jute sacking or plastic sheeting
8. Ventilation pipe: prefabricated slab with lid, 9. Tee with mosquito netting: protective clothing for operators
10. Water table: polyvinyl chloride (PVC) pipe (preferably diameter 150 mm), piece of stainless steel or nylon mosquito net
Dimensions are indicated in metres; labour requirements are for an experienced mason and one or two labourers

It is recommended that two placenta pits are built so that the second one is available as soon as the first is filled. Once a pit is filled up, it should be closed. Any sealed pits should be marked and their locations recorded. However, it may be possible to reopen pits after enough time has passed and the material has been degraded. When pits are reopened, it may be necessary to remove some of the degraded material. In this case, the concrete bottom of the pit has the added advantage that it will prevent workers digging too deeply and either destabilizing the pit or getting too close to the water table.

The process of biodegradation in the pit can destroy pathogenic microorganisms as the waste is subjected to changes in temperature, pH and a complex series of chemical and biological reactions. The degradation processes in a pit are anaerobic, with some aerobic decomposition in the upper layers where oxygen is available for aerobic bacteria. The waste should not be treated with chemical disinfectants such as chlorine before being disposed of, because these chemicals destroy the microorganisms that are important for biological decomposition.

At present, few data are available on how long it will take for all pathogens and eggs to die – particularly because the decomposition process depends on the local conditions (e.g. surrounding temperatures). Therefore, it is recommended that placenta pits should remain for at least two years before reopening. More research is needed on this subject.

Ash or charcoal helps reduce odours without adversely affecting the decomposition. Although adding lime will help to reduce odours, it will increase the pH of the soil and thereby slow the rate of decomposition, and therefore is not recommended. Adding ash will also reduce odours and decrease soil pH. It will also correct the carbon to nitrogen (C:N) ratio and speed up decomposition.
The operation of a placenta pit is based on the following steps and principles (MSF, Technical Brief 6.08):

- Dispose of the organic waste into the pit immediately when it arrives at the waste zone. Use only one pit at the time. Make sure that the pits are always closed with the slab's lid.
- Disinfect the empty organic waste bins with a 0.1% chlorine solution, rinse them with clean water, and finally clean them with water and soap. Never mix chlorine and soap together.
- Close the pit down when the level of the organic waste is about 0.5 m underneath the slab. Put a thick layer of wood ash on top of the organic waste and top up with compacted soil if the pit is closed permanently. Do not use ash from burnt soft waste for this purpose. Most organic waste will decompose into harmless matter, so it is normally possible to empty a pit that has been closed down for at least two years. However, be aware that bones of amputated limbs will still be intact. The general public may find the removal of these remainders offensive. Take particular care to avoid injuries with sharps that have accidentally been discarded in the organic waste pit. A new permanent burial place should be found for the organic waste remainders, potentially a controlled tip or a sanitary landfill.