



Additional Topic 1: Infection Prevention Review

105 min.

Summary

In this section, important infection prevention (IP) principles will be reviewed, focusing on handwashing, gloving, use of apron, use of needles, waste disposal, and the four steps for processing instruments and supplies. Understanding and using infection prevention practices is important to prevent major infections while providing care and to reduce the risk of transmitting serious diseases such as hepatitis B, hepatitis C, and HIV/AIDS to the woman and to staff, including those who clean up after childbirth.

Consider including some parts or the entire topic in any AMTSL training activities.

Objectives

By the end of this topic, participants will be able to:

- Explain the five basic principles of IP practices.
- Describe ways to protect oneself and others from infection, focusing on handwashing; proper waste disposal; use of gloves, aprons, and other protective gear; and injection safety.
- Describe the four steps for decontaminating instruments.
- Explain how to mix a 0.5 percent chlorine decontamination solution.

Materials/resources needed for the session

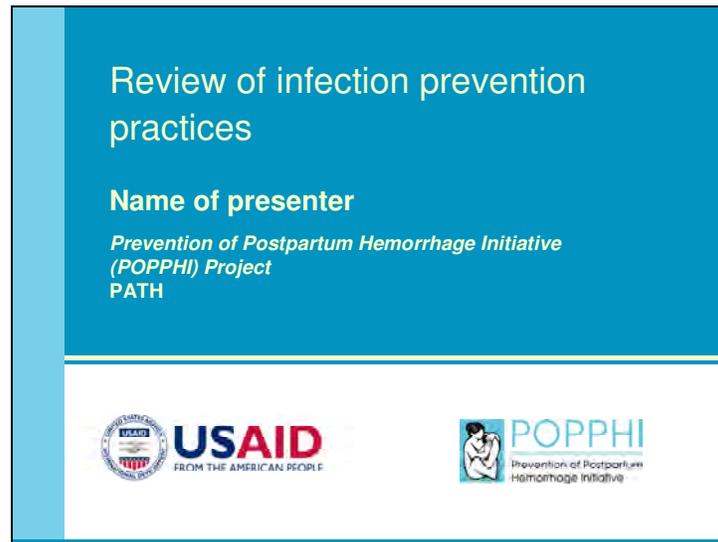
- Reference Manual, Participant's Notebook, and Facilitator's Guide.
- Flipchart, flipchart stand, markers, and flipchart tape.
- Water, 4-5 plastic containers to prepare a chlorine solution in, 4-5 measuring cups, and 4-5 bottles of chlorine (if possible get bottles with different concentrations of chlorine)

Facilitator's Note

The goal of this session is to review IP principles and practices for providers who already have a basic understanding of them. Facilitators may need to add facility-specific information and visuals—for example, types of containers used for sharps, procedures for processing gloves, types of containers used for mixing and storing chlorine decontamination solution, and procedures for sterilization and high-level disinfection.

Facilitators should use their judgment regarding when in the workshop to teach this topic and how much content to include. For example, facilitators may decide to present information on IP just before the classroom or clinical practice sessions or as part of the orientation to the clinical site.

Lesson Plan



Flipchart / Overhead / PowerPoint slide 1

Time: 5 min.

Activities:

- Review objectives of the session.
- Present an overview of the session.

Notes to the facilitator:

- Introduce the session by presenting the objectives: read the objectives, briefly summarize or ask a participant to read them aloud.

Objectives	AT1-1
By the end of this topic, participants will be able to:	
<ul style="list-style-type: none">• Explain 5 principles of infection prevention practices.• Describe ways to protect oneself and others from infection, focusing on handwashing, gloving, use of an apron, use of needles, and proper waste disposal.• Describe the 4 steps for processing instruments and supplies.• Explain how to mix a 0.5% chlorine decontamination solution.	



Flipchart / Overhead / PowerPoint slide 2

Time: 5 min.

Activity: Illustrated lecture.

Objective: Explain five principles of infection prevention practices.

Notes to the facilitator:

- Begin the session by providing an illustrated lecture reviewing the principles of IP practices.
- Ask if participants have any questions before proceeding.

Principles of Infection Prevention Practices	AT1-2
<ul style="list-style-type: none"> • Every person (client or staff) is considered potentially infectious. • Handwashing is the single most important practice for preventing cross-contamination. • Wear gloves before touching anything wet. • Use protective items (aprons, face masks, eye goggles) if splashes or spills of any body fluids are expected. • Use safe work practices. 	

Flipchart / Overhead / PowerPoint slide 3

Time: 5 min.

Activity: Brainstorming to review recommendations for handwashing in the health care setting.

Objective: Describe ways to protect oneself and others from infection, focusing on handwashing, gloving, use of an apron, use of needles, and proper waste disposal.

Brainstorming	AT1-3
<p>When should health care providers wash their hands?</p>	

Notes to the facilitator:

- Facilitate a brainstorming session to make a complete list of when providers need to wash their hands in health care settings. Complete the list from information in the section on handwashing in Additional Topic 1: Infection prevention in the **Reference Manual**.
- Emphasize the fact the providers need to wash their hands for 15–30 seconds for handwashing to be effective.

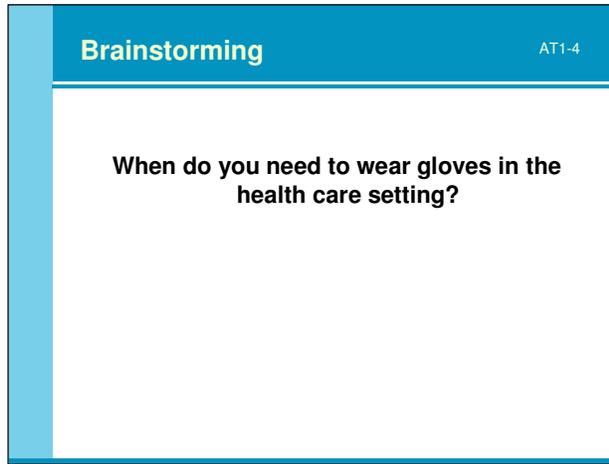
Flipchart / Overhead / PowerPoint slide 4

Time: 5 min.

Activity:

- Brainstorming to review recommendations for wearing gloves in the health care setting.
- Facilitated discussion to review difficulties in decontaminating, cleaning, and sterilizing or HLD processing of gloves.

Objective: Describe ways to protect oneself and others from infection, focusing on handwashing, gloving, use of an apron, use of needles, and proper waste disposal.



Notes to the facilitator:

- Facilitate a brainstorming session to make a complete list of when providers need to wear gloves in health care settings. Complete the list from information in the section on gloves in Additional Topic 1: Infection prevention in the **Reference Manual**.
- Emphasize the fact it is preferable to dispose of gloves after one use rather than trying to reuse them.
- Facilitate a discussion on difficulties in decontaminating, cleaning, and sterilizing or HLD processing of gloves.

- Remind participants of the dangers in using gloves that are cracked, peeling, or have visible tears or holes.

Flipchart / Overhead / PowerPoint slide 5

Time: 5 min.

Activity: Question-and-answer to review protective gear.

Objective: Describe ways to protect oneself and others from infection, focusing on handwashing, gloving, use of an apron, use of needles, and proper waste disposal

Notes to the facilitator:

- Present the flipchart with the different types of protective gear.
- Ask participants to describe:
 - Who (client or provider) is protected by each type of gear.
 - How each type of gear protects either the client or the provider.
- Ask participants which types of protective gear they use regularly at their worksites.



**Flipchart / Overhead / PowerPoint slide 6****Time: 5 min.****Activity:** Illustrated lecture to review handling sharp instruments.**Objective:** Describe ways to protect oneself and others from infection.**Notes to the facilitator:**

Handling sharp instruments	AT1-6
<ul style="list-style-type: none">• Do not leave sharp instruments or needles (sharps) in places other than safe zones.• Use a tray or basin to carry and pass sharp items.• Pass instruments with the handle (not the sharp end) pointing toward the receiver.• Tell other workers before passing sharps to another person.	

- Present an illustrated lecture on handling sharp instruments to prevent injuries in the workplace.
- Ask for questions before proceeding.

Flipchart / Overhead / PowerPoint slide 7**Time: 5 min.****Activity:** Illustrated lecture to review ways to prevent accidental needle sticks.**Objective:** Describe ways to protect oneself and others from infection, focusing on handwashing, gloving, use of an apron, use of needles, and proper waste disposal.**Notes to the facilitator:**

- Present an illustrated lecture on preventing injuries in the workplace due to accidental needle sticks.

Preventing needle sticks	AT1-7
<ul style="list-style-type: none">• Use each needle and syringe only once.• Do not take needle and syringe apart after use.• Do not recap, bend, or break needles before disposal.• Dispose of needles and syringes in a puncture-proof container.	

Flipchart / Overhead / PowerPoint slide 8

Time: 5 min.

Activity: Brainstorming to review how to minimize splashes.

Objective: Describe ways to protect oneself and others from infection when providing maternal and newborn care.

Notes to the facilitator:

BrainstormingAT1-8

How can health workers prevent / minimize splashes of blood or amniotic fluid when providing maternal and newborn care?

- Facilitate a brainstorming session to make a list of how to prevent splashes of blood and body fluids in health care settings. Complete the list from information in the section on preventing splashes in Additional Topic 1: Infection prevention in the **Reference Manual**.
- Review steps to take if blood or body fluids get in the provider's mouth, on the skin, or in the eyes.
- Finish this part of the session by emphasizing the fact that it is much easier to prevent exposure to viruses/microbes than to treat providers with post-exposure prophylaxis.

Flipchart / Overhead / PowerPoint slide 9

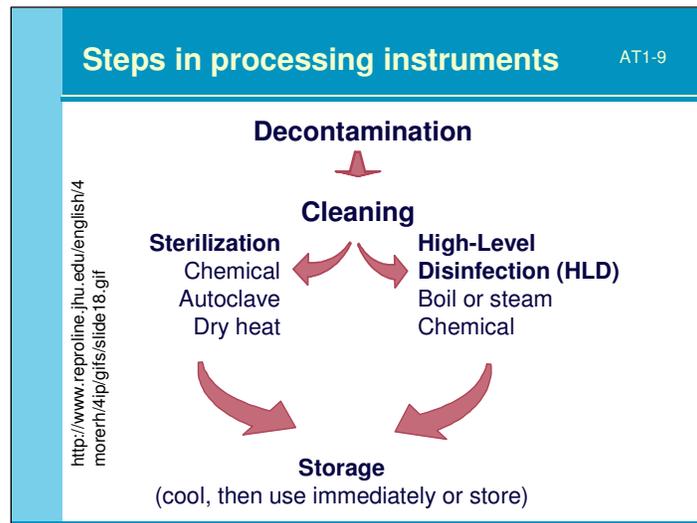
Time: 10 min.

Activity: Question-and-answer to review steps in processing.

Objective: Describe the 4 steps for processing instruments.

Notes to the facilitator:

- Present the diagram showing the four steps for processing instruments.
- Ask participants to refer to Table 6, Steps and benefits for processing instruments for reuse, in the **Reference Manual**.
- For each step, ask a volunteer to explain how the step helps to prevent infection.
- Ask a participant to briefly describe the difference between *high-level disinfected* and *sterile*.



**Flipchart / Overhead / PowerPoint slides 10, 11, and 12****Time: 15 min.****Activity:**

- Illustrated lecture to review preparation of a decontamination solution.
- Mini case studies to practice calculating how to prepare a 0.5% chlorine decontamination solution.

Objective: Explain how to mix a 0.5% chlorine decontamination solution.**Notes to the facilitator:**

- Present and explain how to prepare a 0.5% chlorine solution using liquid household bleach.
- Ask if there are questions.

**Preparing a 0.5% chlorine solution:
Using liquid household bleach** AT1-10

- **[% chlorine in liquid bleach divided by 0.5%] minus 1 = parts of water for each part bleach**
Example: To make a 0.5% chlorine solution from a 3.5% chlorine concentrate, you must use 1 part chlorine and 6 parts water:
 $[3.5\% \text{ divided by } 0.5\%] \text{ minus } 1 = [7] \text{ minus } 1 = 6 \text{ parts water for each part chlorine}$

Water Water Water Water Water Water
Chlorine

EngenderHealth. Online course for Infection Prevention. Available at: www.engenderhealth.org/IP/instrum/in4a.html. Accessed April 2, 2007

Notes to the facilitator:

Mini Case Studies AT1-11

- Calculate the appropriate dilution to prepare a 0.5% chlorine solution using each of the chlorine preparations below:

Chlorine Preparation	Parts Water	Parts Chlorine
2.4%		
5%		
15%		

- Give participants 5 minutes to calculate how to prepare a 0.5% chlorine solution with the chlorine preparations provided in the mini case studies.
- Then ask volunteers to explain how to prepare a 0.5% chlorine decontamination solution using each of the different preparations.

Notes to the facilitator:

- The answers for the calculations are on the slide (also refer to Table 7. Mixing a 0.5 percent chlorine decontamination solution in the **Reference Manual**).
- After going through the calculations, divide the participants into groups of 3-4 people. Give each group a bottle of chlorine, an empty plastic container, and a measuring cup. Ask each group to prepare a 0.5% chlorine solution with the chlorine they were given.

ANSWERS AT1-12

Chlorine Preparation	Parts Water	Parts Chlorine
2.4%	4 parts water	1 part bleach
5%	9 parts water	1 part bleach
15%	29 parts water	1 part bleach

**Flipchart / Overhead / PowerPoint slides 13, 14 and 15****Time: 10 min.****Activity:**

- Illustrated lecture to review preparation of a decontamination solution.
- Mini case studies to practice calculating how to prepare a 0.5% chlorine decontamination solution.

Objective: Explain how to mix a 0.5% chlorine decontamination solution using bleach powder.**Notes to the facilitator:**

- Present and explain how to prepare a 0.5% chlorine solution using bleach powder.
- Ask if there are questions.

**Preparing a 0.5% chlorine solution:
Using bleach powder** AT1-13

- **[% chlorine desired divided by % chlorine in bleach powder] times 1000 = Grams of powder for each liter of water**
- **Example:** To make a 0.5% chlorine solution from calcium hypochlorite powder containing 35% available chlorine:
[0.5% divided by 35%] times 1000 = [0.0143] times 1000 = 14.3
Therefore, you must dissolve 14.3 grams of calcium hypochlorite powder in 1 liter of water in order to get a 0.5% chlorine solution.

Notes to the facilitator:

Mini Case Studies AT1-14

Calculate the appropriate dilution to prepare a 0.5% chlorine solution using each of the chlorine preparations below :

Preparation	% Active Chlorine	Gms / Liter
Calcium hypochlorite	70%	
Calcium hypochlorite	35%	

- Give participants 5 minutes to go through the calculations.
- Then ask volunteers to explain how to prepare a 0.5% chlorine decontamination solution using each of the different preparations.

Notes to the facilitator:

- The answers for the calculations are on the slide (also refer to Table 7. Mixing a 0.5 percent chlorine decontamination solution in the **Reference Manual**).

Preparing a 0.5% chlorine solution: Answers AT1-15

Preparation	% Active Chlorine	Gms / Litre
Calcium hypochlorite	70%	7.1 grams per liter
Calcium hypochlorite	35%	14.2 grams per liter



Flipchart / Overhead / PowerPoint slide 16

Time: 30 min.

Activities:

- Summary.
- Review content by playing the IP interactive knowledge game.

Interactive Game: Infection Prevention (IP) knowledge interactive game
AT1-16

Turn to classroom learning activities for Additional Topic 1: Infection Prevention in the **Participant's Notebook**.



Notes to the facilitator:

- Refer to the following pages of the **Facilitator's Guide** for instructions on how to play this game. Refer to the pages following instructions for the game to find answers to the questions. The questions, without the answers, are located in the **Participant's Notebook**.

Flipchart / Overhead / PowerPoint slide 17

Notes to the facilitator:

- Encourage participants to work on learning activities found in the **Participant's Notebook** for Additional Topic 1.
- Participants may work individually or in groups on the learning activities during breaks, in the evening, or in the clinical area when there are no clients.
- Participants may correct their learning activities by referring to suggested answers found in the **Participant's Notebook**. Facilitators should make themselves available to work with the participants to review answers for learning activities.

Learning activities
AT1-17

- Please complete learning activities found in the **Participant's Notebook** for Additional Topic 1.
- You may work individually or in groups on the learning activities during breaks, in the evening, or in the clinical area when there are no clients.
- You may correct your answers individually or with another participant or the facilitator.
- See a facilitator if you have questions.

Infection Prevention (IP) knowledge interactive game

Purpose	To present basic information on IP in an easy and enjoyable way while allowing participants an opportunity to demonstrate what they know.
Duration	30 minutes
Introduction	<p>Set up round tables that will accommodate 4–6 participants at each table. Divide the group into two to four teams of equal size, depending on the size of the group and the amount of time you have. The more teams there are, the longer the game will take.</p> <p>Distribute the groups somewhat evenly by discipline, so that each group has the same number of nurses, doctors, and so on. Number the teams 1, 2, 3, and 4 and ask the participants to sit with their teams.</p> <p>Prepare a flipchart that has a circle divided into 6 parts for each team. Write a team’s number on top of each circle.</p> <p>Start the exercise by explaining that the objective is to be the first team to complete the circle. Each team can fill in one-sixth of the circle each time the team gets a correct answer in six of the following categories:</p> <ul style="list-style-type: none"> ▪ Handwashing ▪ Protective gear ▪ Handling sharps ▪ Preventing splashes ▪ Waste disposal ▪ Instrument processing <p>Ask participants to turn to classroom learning activities for Additional Topic 1: Infection Prevention in the Participant’s Notebook that has a copy of the questions without the answer key.</p>
Activities	<p>Give the participants 15–20 minutes to answer the questions, working together in their teams.</p> <p>Remind the teams to record their answers on the question sheet. Suggest that they keep the answers simple and not linger on any one question.</p> <p>To begin play, the first team chooses a category and a question, then reads the question aloud and gives the answer. The team has 10 seconds to answer.</p> <p>If correct, the team colors in one-sixth of its circle and records next to the circle the name of the category from which the question came.</p> <p>A team may only answer one question per category.</p>



Infection Prevention (IP) knowledge interactive game

	<p>If incorrect, the next team gets to answer that question or another question of its choosing.</p> <p>Once a team correctly answers a question, no other team may use it. The facilitator should clarify any misconceptions that may have surfaced during the discussion once a team has answered a question. The next team takes a turn.</p> <p><i>The first team to fill its circle by coloring in all six pieces (representing six correct answers in six different categories) is the winner and receives the prize.</i></p>
Debriefing	<p>Point out that each participant brings a great deal of knowledge and expertise to the training activity and that by working together, they are able to respond correctly to many of the IP questions in the Knowledge Game.</p>

Answers to IP Knowledge Game

Category 1: Handwashing

For each practice or situation described below, select whether it is an acceptable or unacceptable handwashing practice.

Practice	Answer (circle one)
1. A doctor washes his hands by dipping them in a basin of water before examining a patient.	Unacceptable: Hands can be contaminated by dipping them in a basin of water. Standing water can easily become contaminated even if antiseptic is added.
2. If there is no running water at a clinic, one staff member pours water over the other's hands for handwashing.	Acceptable: If there is no running water, this practice is an acceptable substitute, as long as the water being poured is clean.
3. A large bar of soap is kept in a saucer for use by all personnel in the examination room.	Unacceptable: Small pieces of soap kept in a dish that allows drainage are best. A large bar of soap in a dish with no drainage can become contaminated easily.
4. Staff members wash their hands for approximately five seconds.	Unacceptable: Staff must wash their hands for 10–15 seconds.
5. A staff member arrives at the clinic to find many people waiting for her, so she immediately begins seeing clients without washing her hands.	Unacceptable: Staff should wash their hands when they arrive and before they leave a health facility.



Category 2: Protective gear

For each practice or situation described below, select whether it is an acceptable or unacceptable infection prevention practice.

Practice	Answer (circle one)
1. Put gloves in the labor room sink after use.	Unacceptable: Gloves should be decontaminated immediately after use and then cleaned and high level disinfected or sterilized.
2. Rub the fundus after delivery of the placenta without using gloves.	Unacceptable: The woman's abdomen can be contaminated by body fluids and blood during countertraction and skin-to-skin contact with the newborn and exam gloves should be worn to protect the provider.

In the space provided, circle *true* or *false* for each statement.

3. Protective gear should be worn when handling a baby after delivery, before the infant is bathed.	True
4. Gloves provide a barrier against possible infectious microorganisms that can be found in blood, other body fluids, and waste.	True: Gloves act as a barrier.
5. Even when gloves are decontaminated, cleaned, and high level disinfected, they should not be used if there are holes in them.	True

Category 3: Handling sharps

In the space provided, circle *true* or *false* for each statement.

Practice	Answer (circle one)
1. Injuries with sharp objects occur when sharps are left on surgical drapes or bed linens.	<i>True: Sharp objects left on drapes or bed linen can cause injuries.</i>
2. To reduce the risk of a needlestick, recap a needle by holding the syringe in one hand and holding the needle in the other hand.	<i>False: You should avoid recapping needles.</i>
3. Housekeeping staff are rarely at risk of injury or infections caused by sharps—such as hypodermic needles or scalpel blades—because they are not directly involved in client-care activities.	<i>False: Housekeeping staff are often at risk of injury or infection by sharps.</i>

For each of the practices described below, select whether it is an acceptable or unacceptable infection prevention practice:

4. Break a hypodermic needle before disposal.	<i>Unacceptable: Providers are at risk when breaking a needle after using it and before disposal. Sharps can cause injury and transmission of serious infections, including HIV and hepatitis B.</i>
5. Wash a needlestick or cut with soap and water.	<i>Acceptable: A needlestick or cut may be washed with soap and water.</i>



Category 4: Preventing splashes

For each practice or situation described below, select whether it is an acceptable or unacceptable infection prevention practice.

Practice	Answer (circle one)
1. The provider drops instruments into a bucket with decontamination solution to avoid contact with the solution.	<i>Unacceptable: Place items in the decontamination bucket without splashing the solution.</i>
2. The provider artificially ruptures membranes during a contraction to prevent splashes.	<i>Unacceptable: Avoid rupturing membranes during a contraction to prevent splashes.</i>
3. Irrigate eyes well with water when blood or body fluids splash in them.	<i>Acceptable</i>
4. If you accidentally get blood or body fluids on your hands, wash with a 0.5 percent chlorine solution.	<i>Unacceptable: If blood or body fluids get in your mouth or on your skin, wash with plenty of water and soap as soon as it is possible and safe for the woman and baby. Chlorine is very abrasive and can cause small wounds on your hands which increase your risk of exposure to blood-borne pathogens.</i>
5. Hold contaminated instruments under the water while scrubbing.	<i>Acceptable: Holding instruments and other items under the surface of the water while scrubbing and cleaning will help prevent splashing.</i>

Category 5: Waste disposal

In the space provided, circle *true* or *false* for each statement.

Practice	Answer
1. Everyone who handles medical waste—from the point generated until final disposal—is at risk of infections and injury.	<i>True: A large percentage of staff report having experienced waste-related injuries and infection.</i>
2. If medical waste is stored at the health facility before being burned, it can be placed in a pile behind the clinic.	<i>False: Place waste in a container in a closed area that is minimally accessible, and make sure all containers have lids.</i>
3. Liquid medical waste can be disposed down a sink, drain, toilet, or latrine.	<i>True: If this is not possible, bury it along with solid medical waste.</i>
4. Burial sites for medical waste should not be located near water sources because of the potential to contaminate the water.	<i>True</i>
5. Scavenging of medical waste is rarely a problem in low-resource settings.	<i>False</i>



Category 6: Instrument processing

In the space provided, circle *true* or *false* for each statement.

Practice	Answer (circle one)
1. Decontamination kills all microorganisms on soiled instruments and other items.	<i>False: Decontamination kills viruses such as HIV and many—but not all—other microorganisms.</i>
2. When preparing a chlorine solution for decontamination, it is important to know the amount of active chlorine in the product used.	<i>True: It is important to know the amount of active chlorine in order to make a solution of the correct strength for decontamination.</i>
3. Cleaning instruments before sterilizing them is not necessary if they were soaked in a 0.5 percent chlorine solution for 10 minutes.	<i>False: Although decontamination makes items safer to handle, cleaning is still necessary to remove organic material, dirt, and other matter that can interfere with further processing.</i>
4. Sterilizing may not be effective if blood and other organic material are not cleaned from instruments before sterilizing.	<i>True: It is important to clean items before sterilization; microorganisms trapped in blood and other matter can survive the sterilization process.</i>
5. High-level disinfection kills all microorganisms.	<i>False: High-level disinfection does not reliably kill all bacterial endospores.</i>



Additional Topic 2: Birth Preparedness and Complication Readiness

45 min.

Summary

The following session discusses how to develop a birth-preparedness plan (BPP) and a Complication-Readiness Plan (CRP). Because all pregnancies are at risk for complications, providers must work with all pregnant women and their families to develop a BPP which will help ensure that women receive high-quality, timely care for both normal and complicated pregnancy, labor, and childbirth.

Objectives

After completing this session, participants will be able to:

- Identify the components of the BPP and the CRP.
- Describe how preparation of these plans can prevent maternal and newborn deaths.

Materials/resources needed for the session

- Reference Manual, Participant's Notebook, and Facilitator's Guide.
- Flipchart, flipchart stand, markers, and flipchart tape.

Facilitator's Note

This topic is not part of the core curriculum, but facilitators may choose to add it to the Prevention of Postpartum Hemorrhage training program if there is a particular need or interest in the country to have a session on developing birth-preparedness and complication-readiness plans.

Lesson Plan



Flipchart / Overhead / PowerPoint slide 1

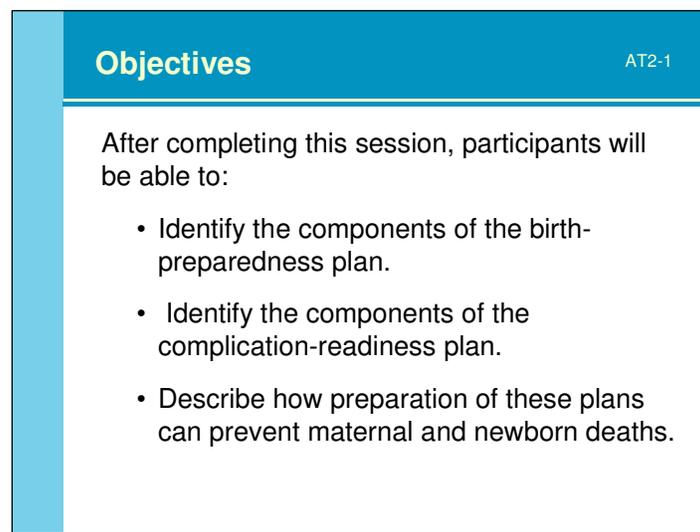
Time: 5 min.

Activities:

- Review objectives of the session.
- Present an overview of the session.

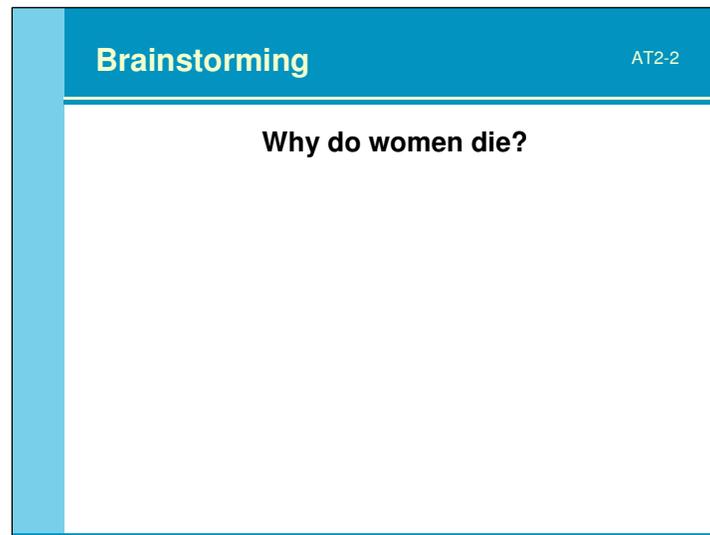
Notes to the facilitator:

- Introduce the session by presenting the objectives: read the objectives, briefly summarize, or ask a participant to read them aloud.



**Flipchart / Overhead / PowerPoint slide 2****Time: 5 min.****Activity:** Question-and-answer to review reasons why women die from pregnancy-related complications.**Notes to the facilitator:**

- Ask participants to list the reasons why women and newborns do not receive timely, high-quality care and how this affects mortality. Write the findings on a flipchart and complete the list with the following information.
- The factors that prevent women from getting the lifesaving health care they need include:
 - Distance from health services;
 - Cost (direct fees as well as the cost of transportation, drugs, and supplies);
 - Multiple demands on women's time;
 - Women's lack of decision-making power within the family;
 - Poor quality services, including poor treatment by health providers, which makes women reluctant to use services.



Flipchart / Overhead / PowerPoint slide 3

Time: 10 min.

Activity: Illustrated lecture to explain the four delays in receiving lifesaving health care.

Notes to the facilitator:

- Explain that the factors that prevent women from getting the lifesaving health care have been translated into the following delays:
 - **Delay in recognizing the problem:** When a woman experiences a danger sign, she must recognize that she is experiencing a problem. If pregnant women, their families, and women caring for them do not know the danger signs that indicate the woman is experiencing a complication, they will not know when they need to seek care.
 - **Delay in deciding to seek care:** When a problem arises, the woman and her family have to decide to seek care. If the primary decision-maker is not present, it may mean that the woman is not allowed to seek care, or seeking care is delayed.
 - **Delay in arriving at the appropriate facility:** Once the woman, family, and partner make a decision to seek care, they must find a means of transport and the necessary funds to go to the appropriate facility. If there is no means of transport and/or the woman and her family do not have the necessary funds, the woman will not seek care in a timely fashion.
 - **Delay in receiving high-quality care:** Once the woman has reached the appropriate level, she must receive high-quality care for whatever obstetric emergency she has suffered. If the care she receives is not high-quality or appropriate care, then the woman will have reached the appropriate facility in vain.

The slide is titled "Four Delays" in a blue header. The text "AT2-3" is in the top right corner of the header. Below the header, there is a list of four bullet points: "Delay in recognizing the problem", "Delay in deciding to seek care", "Delay in arriving at the appropriate facility", and "Delay in receiving quality care".

**Flipchart / Overhead / PowerPoint slides 4 and 5****Time: 10 min.****Activity:** Question-and-answer and illustrated lecture to describe elements of the birth-preparedness plan.**Objective:** Identify the components of the birth-preparedness plan.**Notes to the facilitator:**

- Ask participants to describe what they do to assist women and their families to prepare for birth during antenatal visits.
- Write the findings on a flipchart and complete the list with the information on preparing a birth-preparedness plan found in Additional Topic 2: Birth preparedness and complication readiness in the **Reference Manual**.

Brainstorming	
	AT2-4
How do you assist women and their families to prepare for birth?	

Notes to the facilitator:

- Present information on elements of a birth-preparedness plan using information found in Additional Topic 2: Birth preparedness and complication readiness in the **Reference Manual**.

Elements of a birth-preparedness plan	
	AT2-5
<ul style="list-style-type: none">• Make plans for the birth.• Decide birth plan issues.• Prepare what is needed for birth.• Save money.	

Flipchart / Overhead / PowerPoint slides 6 and 7

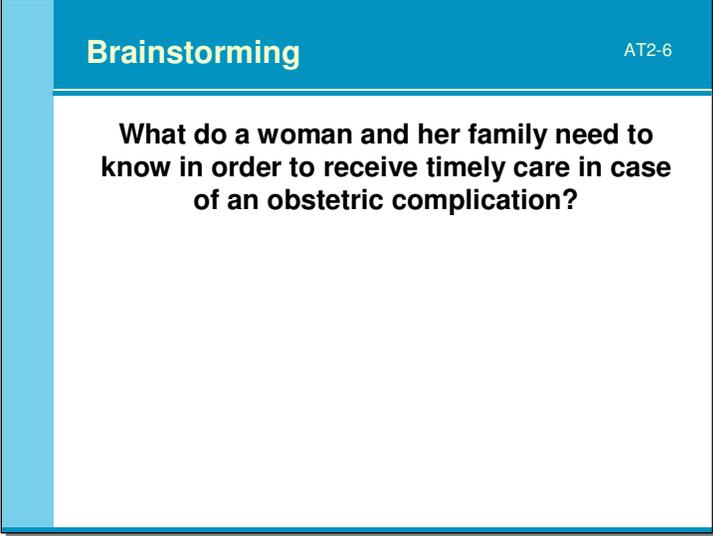
Time: 10 min.

Activity: Brainstorming and illustrated lecture to describe elements of the complication-readiness plan.

Objective: Identify the components of the complication-readiness plan.

Notes to the facilitator:

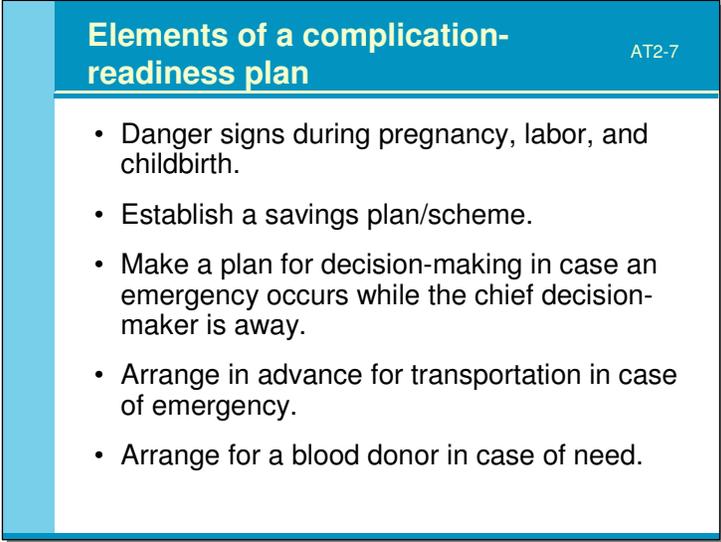
- Ask participants to describe what they do to assist women and their families to prepare for any complications that may occur during pregnancy, childbirth, in the immediate postpartum, and for the newborn.
- Write the findings on a flipchart and complete the list with the information on preparing a complication-readiness plan found in Additional Topic 2: Birth preparedness and complication readiness in the **Reference Manual**.



A slide titled "Brainstorming" with the code "AT2-6" in the top right corner. The main text asks: "What do a woman and her family need to know in order to receive timely care in case of an obstetric complication?"

Notes to the facilitator:

- Present information on elements of a complication-readiness plan using information found in Additional Topic 2: Birth preparedness and complication readiness in the **Reference Manual**.



A slide titled "Elements of a complication-readiness plan" with the code "AT2-7" in the top right corner. The slide lists five key elements:

- Danger signs during pregnancy, labor, and childbirth.
- Establish a savings plan/scheme.
- Make a plan for decision-making in case an emergency occurs while the chief decision-maker is away.
- Arrange in advance for transportation in case of emergency.
- Arrange for a blood donor in case of need.

**Flipchart / Overhead / PowerPoint slide 8****Time: 5 min.****Activity:** Summary.**Notes to the facilitator:**

- Review the most important points of the session. Involve participants as much as possible in the summary.
- Emphasize that preparation of birth-preparedness and complication-readiness plans can:
 - **Prevent PPH.** If the woman gives birth with a skilled attendant, she can benefit from interventions that prevent PPH, such as monitoring labor using a partograph, AMTSL, etc.

AND

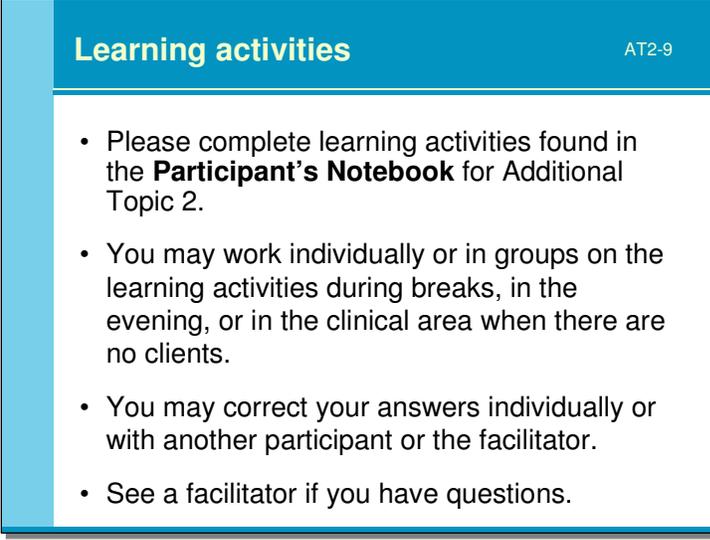
- **Prevent deaths due to PPH.** If the woman gives birth with a skilled attendant, she can benefit from close monitoring during the immediate postpartum, which will assist in early diagnosis of PPH, and will be treated by a skilled attendant who can appropriately manage PPH.

Summary		AT2-8
Preparation of birth-preparedness and complication-readiness plans can:		
1) prevent PPH		
AND		
2) prevent deaths due to PPH		

Flipchart / Overhead / PowerPoint slide 9

Notes to the facilitator:

- Encourage participants to work on learning activities found in the **Participant's Notebook** for Additional Topic 2.
- Participants may work individually or in groups on the learning activities during breaks, in the evening, or in the clinical area when there are no clients.
- Participants may correct their learning activities by referring to suggested answers found in the **Participant's Notebook**. Facilitators should make themselves available to work with the participants to review answers for learning activities.



Learning activities AT2-9

- Please complete learning activities found in the **Participant's Notebook** for Additional Topic 2.
- You may work individually or in groups on the learning activities during breaks, in the evening, or in the clinical area when there are no clients.
- You may correct your answers individually or with another participant or the facilitator.
- See a facilitator if you have questions.



Additional Topic 3: Management of selected complications during the third stage of labor

5 hours

Summary

This section provides some guidance on how to manage the most common problems that may occur during the third stage of labor. It is very rare for problems to happen if AMTSL is performed correctly. However, some problems may happen regardless of how the birth attendant manages the third stage of labor. If problems occur, providers must recognize and manage them.

Objectives

By the end of this topic, participants will be able to describe the immediate medical management of the following complications that may occur during the third stage of labor:

- The woman begins to bleed excessively after childbirth.
- The woman is in shock.
- The uterus does not contract adequately.
- There are genital tears.
- There is a cervical tear.
- The placenta is retained.
- The cord tears off (ruptured cord) during controlled cord traction.
- The uterus inverts.

Materials/resources needed for the session

- Reference Manual, Participant's Notebook, and Facilitator's Guide.
- Flipchart, flipchart stand, markers, and flipchart tape.
- Obstetric and newborn models, two cloths for the newborn, one cloth for the woman's abdomen, delivery kit (one pair of scissors, two clamps), and cord ties or clamps.
- Infection prevention equipment and supplies: protective gear, bucket, chlorine, water, gloves, soap, towels, and waste bin.
- Oxytocin, syringe, needle, and sharps disposal box.
- Light source.
- Blood pressure machine, stethoscope, thermometer, and wall clock.
- Bedpan, urinary catheter, and test tube.
- Material for starting an IV, IV pole, and compresses.

Facilitator's Note

This topic is not part of the core curriculum, but facilitators may choose to add it to the Prevention of Postpartum Hemorrhage training program if there is a particular need or interest in the country to have a session on management of complications that may occur during the third stage of labor. The steps for management are based on recommendations from the World Health Organization. Facilitators will need to compare these protocols to national protocols for management of obstetric emergencies and, where needed, adapt them to the local context.

Evidence has confirmed that these problems are NOT caused by AMTSL (if it is implemented properly), but may happen just before, during, or just after third stage.

Lesson Plan



Management of selected complications during the third stage of labor

Name of presenter

Prevention of Postpartum Hemorrhage Initiative (POPHI) Project
PATH

 **USAID**
FROM THE AMERICAN PEOPLE

 **POPHI**
Prevention of Postpartum Hemorrhage Initiative

Flipchart / Overhead / PowerPoint slide 1

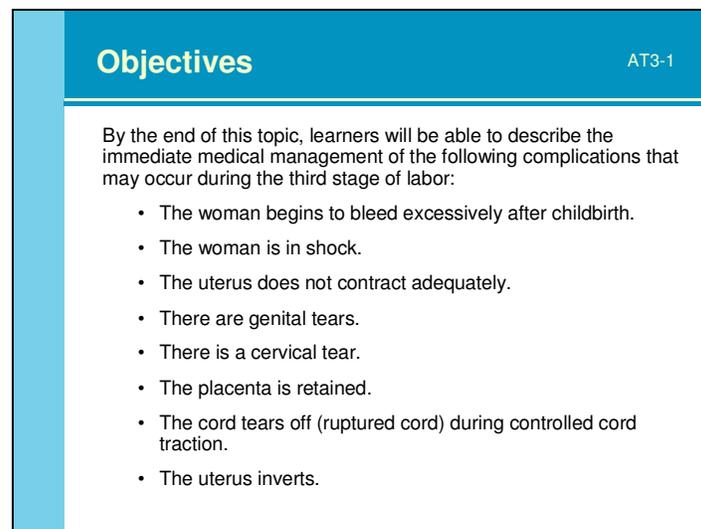
Time: 5 min.

Activities:

- Review objectives of the session.
- Present an overview of the session.

Notes to the facilitator:

- Introduce the session by presenting the objectives: read the objectives, briefly summarize, or ask a participant to read them aloud.



Objectives AT3-1

By the end of this topic, learners will be able to describe the immediate medical management of the following complications that may occur during the third stage of labor:

- The woman begins to bleed excessively after childbirth.
- The woman is in shock.
- The uterus does not contract adequately.
- There are genital tears.
- There is a cervical tear.
- The placenta is retained.
- The cord tears off (ruptured cord) during controlled cord traction.
- The uterus inverts.

**Flipchart / Overhead / PowerPoint slide 2****Time: 5 min.****Activity:** Illustrated lecture to review the principles to follow when managing an obstetric emergency.**Notes to the facilitator:**

- Begin the session by reviewing the principles of care when providing care to a woman experiencing an obstetric complication.

Principles for management of obstetric emergencies	
	AT3-2
<ol style="list-style-type: none">1. It is impossible to predict which women will have an obstetric emergency.2. The rapidness of the diagnosis will influence the outcome for the woman experiencing a complication.3. The responsibility of the birth attendant is to:<ul style="list-style-type: none">• Put the initial steps of emergency care into practice and• Ensure that the woman receives further care as soon as possible by the most appropriate health care provider.	

Flipchart / Overhead / PowerPoint slide 3

Time: 15 min.

Activities:

- Illustrated lecture to present immediate management in the case of an obstetric emergency.
- Simulation of immediate management in the case of an obstetric emergency.

Notes to the facilitator:

- Present the flipchart/slide describing immediate management of an obstetric emergency (if possible, perform a simulation of the steps). Ask participants to turn to the job aid for immediate management of an obstetric emergency found in Additional Topic 3: Managing complications during the third stage of labor in the **Participant's Notebook**. Review the first steps in management of an obstetric emergency.
- Explain the purpose of each of the steps in general management:
 - **Shout for help:** Management of any emergency requires that many health care providers work together to do all of the necessary steps.
 - **Initial rapid evaluation** assists the provider in making a decision to treat the woman for shock and provides a baseline for evaluation of any treatment provided.
 - **Starting an IV infusion** will ensure that the woman has an IV line for perfusing medications or fluids before her veins collapse.
 - **Begin specific evaluation and management for the obstetric emergency.** Any management should be based on a clear identification of the problem being treated.
- Ask for questions before proceeding.

Immediate management in case of an obstetric emergency	
	AT3-3
<ol style="list-style-type: none">1. SHOUT FOR HELP.2. Urgently mobilize all available personnel.3. Rapidly evaluate vital signs (pulse, blood pressure, respiration, temperature).4. Start an IV infusion (two if possible) using a large-bore (16-gauge or largest available) cannula or needle. Collect blood just before infusion of fluids. Rapidly infuse IV fluids.5. Begin specific evaluation and management for the obstetric emergency.	

**Flipchart / Overhead / PowerPoint slides 4 and 5****Time: 5 min.****Activity:** Illustrated lecture to present signs and symptoms of shock.**Notes to the facilitator:**

- Present the flipchart/slide listing the most common signs and symptoms of shock.

Symptoms and signs of shock that are usually present: AT3-4	
<ul style="list-style-type: none">• Fast, weak pulse (110 per minute or more)• Low blood pressure (systolic less than 90 mm Hg)	

Notes to the facilitator:

- Present the flipchart/slide listing other signs and symptoms of shock.

Other symptoms and signs of shock include: AT3-5	
<ul style="list-style-type: none">• Pallor (especially of inner eyelid, palms or around mouth)• Sweatiness or cold clammy skin• Rapid breathing (rate of 30 breaths per minute or more)• Anxiousness, confusion, or unconsciousness• Scanty urine output (less than 30 mL per hour)	

Flipchart / Overhead / PowerPoint slides 6, 7, 8, and 9

Time: 15 min.

Activity: Mini case studies to review signs and symptoms of shock.

Notes to the facilitator:

- Ask participants to refer to classroom learning activity 1: Assessing shock for Additional Topic 3: Managing complications during the third stage of labor in the **Participant's Notebook**.
- Ask a participant to read the case study aloud, then ask participants to decide if the woman is in shock or not.
- Ask participants to provide an explanation for their response. Facilitate a discussion if not all of the participants had the same answers.
- Complete as many of the mini case studies as possible.

Mini case studies (Classroom learning activity 1: Assessing shock)	AT3-6
<ul style="list-style-type: none">• Ms. A gave birth at home about 4 hours ago. She has come to your health center because she has heavy vaginal bleeding. Vital signs: Pulse: 96 beats/min; BP: 110/70; Respirations: 21/min; Temperature: 37°C; her conjunctivae are pale; her extremities are warm; she is conscious; she just passed a "large amount" of urine.	

- Correct answer: Ms. A is not in shock.

- Correct answer: Ms. B is in shock.

Mini case studies (Classroom learning activity 1: Assessing shock)	AT3-7
<ul style="list-style-type: none">• You assisted Ms. B during childbirth. Labor was prolonged and she received an IV drip of oxytocin to augment uterine contractions. Ms. B gave birth soon after the IV was started and you did AMTSL. Thirty minutes after delivery of the placenta, Ms. B is still bleeding heavily. Vital signs: Pulse: 112 beats/min; BP: 80/40; Respirations: 36/min; Temperature: 36°C; her conjunctivae are pale; her extremities are cold; Ms. B is very anxious; you can't remember when she last passed urine.	



Mini case studies
(Classroom learning activity 1: Assessing shock)

AT3-8

- Ms. C is 38 weeks pregnant. She has come to the health center because she is having vaginal bleeding, severe abdominal pain, and she thinks she is in labor. Vital signs: Pulse: 82 beats/min; BP: 130/90; Respirations: 24/min; Temperature: 37,5°C; Fetal heart tones: absent; her conjunctivae are pale; her extremities are cold; Ms. C is very anxious; she can't remember when she last passed urine.

- Correct answer: Ms. C is not in shock.

- Correct answer: Ms. D is in shock.
- Remind participants that an early diagnosis of obstetric emergencies will only be possible if health care providers closely monitor the woman during labor, childbirth, and immediately after giving birth.

Mini case studies
(Classroom learning activity 1: Assessing shock)

AT3-9

- Ms. D gave birth in the health center last night. When you are doing rounds, you find: Vital signs: Pulse: 132 beats/min; BP: 70/-; Respirations: 32/min; Temperature: 36°C; her conjunctivae are pale; Ms. D is confused and has cold, clammy skin; she last urinated before giving birth.

Flipchart / Overhead / PowerPoint slides 10 and 11

Time: 15 min.

Activities:

- Illustrated lecture to present general management of shock.
- Simulation of general management of shock.

Objective: Describe the immediate medical management if the woman presents with shock.

Notes to the facilitator:

- Present the flipchart describing general management of shock (if possible, perform a simulation of the steps). Ask participants to turn to job aids found in the **Participant's Notebook** to review the algorithm for immediate management of shock.
- Explain the importance of each step:
 - **Shout for help:** Management of any emergency requires that many health care providers work together to do all of the necessary steps.
 - **Initial rapid evaluation** assists the provider in making a decision to treat the woman for shock and also provides a baseline for evaluation of any treatment provided.
 - **Turn the woman onto her side** to minimize the risk of aspiration if she vomits and to ensure that an airway is open.
 - **Keep the woman warm but do not overheat her**, as this will increase peripheral circulation and reduce blood supply to the vital centers.
 - **Elevate the legs** to increase return of blood to the heart (if possible, raise the foot end of the bed).

Immediate management of shock

(Slide 1 / 2) AT3-10

- 1. SHOUT FOR HELP.**
2. Urgently mobilize all available personnel.
3. Rapidly evaluate vital signs (pulse, blood pressure, respiration, temperature).
4. Turn the woman onto her side.
5. Keep the woman warm but do not overheat her.
6. Elevate the legs.

**Notes to the facilitator:**

- Start an IV infusion (two, if possible); collect blood for estimation of hemoglobin, immediate cross-match, and bedside clotting, just before infusion of fluids; and rapidly infuse IV fluids to replace fluid volume that has been lost.
- Start two IVs: one site to replace fluid loss and the other to give medications.
- Catheterize the bladder. This allows the health care provider to keep track of fluid intake and urine output and monitor the woman's response to fluids.
- **If available, give oxygen.** Giving oxygen will improve oxygenation of vital organs at a time when the circulatory system is not able to.
- Ask for questions before proceeding.

Immediate management of shock
(Slide 2 / 2)

AT3-11

7. Start an IV infusion (two if possible) and rapidly infuse IV fluids.
8. Catheterize the bladder and monitor fluid intake and urine output.
9. If available, give oxygen at 6–8 L per minute by mask or nasal cannulae.
10. Continue to monitor vital signs (every 15 minutes) and blood loss.
- 11. Determine the cause of shock and begin treatment.**

Flipchart / Overhead / PowerPoint slides 12 and 13

Time: 15 min.

Activities:

- Illustrated lecture to present general management of vaginal bleeding after childbirth.
- Simulation of general management of vaginal bleeding after childbirth.

Objective: Describe the immediate medical management if the woman begins to bleed excessively after childbirth.

Notes to the facilitator:

- Present the flipchart describing general management of vaginal bleeding after childbirth (if possible, perform a simulation of the steps). Ask participants to turn to the job aid for immediate management of vaginal bleeding after childbirth.
- Explain that the steps in general management provide emergency management and assist the provider in making a diagnosis of PPH:
 - **Initial rapid evaluation** assists the provider in making a decision to treat the woman for shock and also provides a baseline for evaluation of any treatment provided.
 - When providing **uterine massage** the provider can assess if the uterus is atonic, expel any blood clots that may prevent the uterus from contracting effectively, and stimulate uterine contractions.
 - **Administering oxytocin** ensures an early start to treatment for uterine atony (the leading cause of PPH).

Vaginal bleeding after childbirth (Slide 1 / 2)		AT3-12
1. SHOUT FOR HELP.		
2. Urgently mobilize all available personnel.		
3. Make a rapid evaluation of the general condition of the woman, including vital signs (pulse, blood pressure, respiration, temperature).		
4. If shock is suspected, immediately begin treatment. Even if signs of shock are not present, keep shock in mind,		
5. Massage the uterus to expel blood and blood clots,		
6. Give oxytocin 10 units IM.		

**Notes to the facilitator:**

- An **IV infusion** prevents and/or treats shock and maintains blood volume.
- Examining the **bladder** and assisting the woman to empty it will assist the provider in deciding if a full bladder is contributing to uterine atony and will prevent uterine atony by ensuring the bladder is empty.
- **Examining the placenta** will assist the provider in deciding if retained placenta or placental fragments is the cause of PPH.
- **Examining the vagina and perineum** for tears will assist the provider in deciding if genital lacerations are the cause of PPH (examination of the cervix should only occur if there are no identified vaginal or perineal lacerations, the uterus is well contracted, and the placenta is complete).
- Ask for questions before proceeding.

Vaginal bleeding after childbirth AT3-13
(Slide 2 / 2)

6. Start an IV infusion and infuse IV fluids.
7. Help the woman empty her bladder.
8. Check to see if the placenta has been expelled and examine the placenta to be certain it is complete.
9. Examine the vagina, perineum, and cervix for tears.
10. Determine the cause of bleeding and begin treatment.

Flipchart / Overhead / PowerPoint slide 14**Time: 5 min.****Activity:** Illustrated lecture to review the principal causes of PPH.**Notes to the facilitator:**

- Briefly review the principal causes of PPH.

Principal causes of PPH AT3-14

- Uterine atony (cause 70-90% of PPH)
- Genital lacerations
- Retained placenta
- Uterine rupture or inversion
- Disseminated intravascular coagulopathy (blood-clotting disorders)

Flipchart / Overhead / PowerPoint slides 15 and 16

Time: 15 min.

Activity: Individual work to review signs and symptoms associated with the most common causes of PPH.

Mini case studies	AT3-15
<ul style="list-style-type: none">• Find learning activity 2: <i>Assessing excessive vaginal bleeding after childbirth</i>, found in the classroom learning activities for Additional Topic 3: <i>Managing complications during the third stage of labor</i> in the Participant's Notebook.• Read through each mini case study and decide on the most probable cause of each woman's postpartum hemorrhage.• You may refer to Table 8 in Additional Topic 3: <i>Managing complications during the third stage of labor</i> in the Reference Manual.	

Notes to the facilitator:

- Ask participants to turn to classroom learning activity 2: *Assessing excessive vaginal bleeding after childbirth* for Additional Topic 3: *Managing complications during the third stage of labor* in the **Participant's Notebook**.
- They should also refer to Table 8 in Additional Topic 3 in the **Reference Manual**.
- Give participants 5 minutes to read the mini case studies and write in their answers.

Notes to the facilitator:

- After they have had time to review the mini case studies, put the correct answers up (remember that the answer provides the MOST probable diagnosis).
- Ask participants if their answers agree with yours. Facilitate a discussion if there are questions about the probable diagnosis.
- Answer any questions.

Mini case studies	AT3-16
Answers	
<ul style="list-style-type: none">• Ms. A: Retained placenta• Ms. B: Genital lacerations• Ms. C: Cervical tear• Ms. D: Retained placental fragments + uterine atony• Ms. E: Inverted uterus• Ms. F: Uterine atony	



Flipchart / Overhead / PowerPoint slides 17 and 18

Time: 15 min.

Activity: Illustrated lecture to review management of uterine atony.

Objective: Describe the immediate medical management of the woman whose uterus does not contract adequately.

Notes to the facilitator:

- Ask participants to turn to the section *What if the uterus does not adequately contract?* in Additional Topic 3 of the **Reference Manual** and refer to management of uterine atony.
- Present the steps to follow when a woman presents with uterine atony (if possible, perform a simulation of the steps as presented in the **Reference Manual**).
- Remind participants that uterine atony is the leading cause of PPH.
- Emphasize that uterine atony may coexist with genital lacerations, retained placental fragments, retained placenta, and clotting disorders.
- Emphasize that packing the uterus is ineffective and wastes precious time.

Uterine Atony: Management AT3-17

- Continue to massage the uterus
- Use uterotonic drugs
- Perform bimanual compression
- Perform aortic compression
- Surgical management

At all times:

- Anticipate need for blood and transfuse as necessary.
- Consider other causes / contributing factors – genital lacerations, retained placenta, clotting disorder.

Packing the uterus is ineffective and wastes precious time.

Notes to the facilitator:

- Review uterotonic drugs to administer to manage uterine atony (see Table 9 in the **Reference Manual**).

Uterotonics for treatment of PPH AT3-18			
	<i>Oxytocin</i>	<i>Ergometrine</i>	<i>Misoprostol</i>
<i>Dose and route</i>	IV: Infuse 20 units in 1 L IV fluids at 60 drops per minute IM: 10 units	IM: give 0.2 mg	1,000 mcg rectally
<i>Continuing dose</i>	IV: Infuse 20 units in 1 L IV fluids at 40 drops per minute	Repeat 0.2 mg IM after 15 minutes If required, give 0.2 mg IM every 4 hours	Not known
<i>Maximum dose</i>	Not more than 3 L of IV fluids containing oxytocin	5 doses (total 1.0 mg)	Oral dose should not exceed 600 mcg because of risk of fever

Flipchart / Overhead / PowerPoint slide 19

Time: 10 min.

Activity: Demonstration of a bedside clotting test.

Notes to the facilitator:

- Demonstrate how to perform a bedside clotting test to rule out a blood clotting disorder.
- Remind participants that they should also consider the possibility that the woman has a clotting disorder any time a woman has PPH.

Bedside clotting testAT3-19

- Take 2 mL of venous blood into a small, dry, clean plain glass test tube (approximately 10 mm x 75 mm).
- Hold the tube in your closed fist to keep it warm (+37°C).
- After 4 minutes, tip the tube slowly to see if a clot is forming. Then tip it again every minute until the blood clots and the tube can be turned upside down.
- Failure of a clot to form after 7 minutes or a soft clot that breaks down easily suggests a blood-clotting disorder.

Flipchart / Overhead / PowerPoint slides 20 and 21

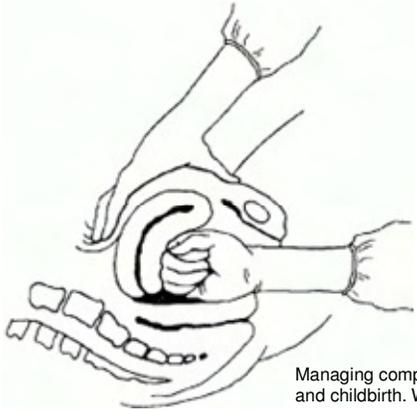
Time: 20 min.

Activity: Demonstration and return demonstration of internal bimanual compression of the uterus.

Notes to the facilitator:

- Ask participants to stand around the model to observe the demonstration of internal bimanual uterine compression. Make sure that everyone can see.

Internal bimanual compressionAT3-20



Managing complications in pregnancy and childbirth. WHO. 2003

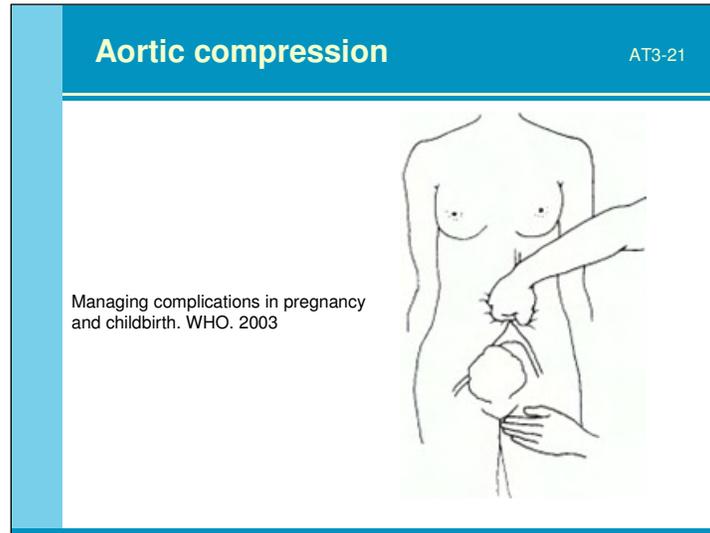
- Follow steps for internal bimanual uterine compression as listed in the **Reference Manual**. Ask participants to refer to the **Reference Manual** and follow along as you provide the demonstration.
- Ask for questions before proceeding. Repeat any steps that may be unclear.
- Give participants time to practice internal bimanual uterine compression on the obstetric model.



Activity: Demonstration and return demonstration of aortic compression.

Notes to the facilitator:

- Ask participants to stand around the model to observe the demonstration of aortic compression. Make sure that everyone can see.
- Follow steps for aortic compression as listed in the **Reference Manual**. Ask participants to refer to the **Reference Manual** and follow along as you provide the demonstration.
- Ask for questions before proceeding. Repeat any steps that may be unclear.
- Give participants time to practice aortic compression on the obstetric model.



Flipchart / Overhead / PowerPoint slide 22

Time: 20 min

Activity: Small group work to review management of genital tears, retained placental fragments, retained placenta.

Objective: Describe the immediate medical management of the woman whose uterus does not contract adequately.

Small Group Work

AT3-22

- **Group 1:** Develop a job aid that describes management of genital tract tears (refer to Additional Topic 3 in the **Reference Manual**).
- **Group 2:** Develop a job aid that describes management of retained placenta (refer to Additional Topic 3 in the **Reference Manual**).
- **Group 3:** Develop a job aid that describes management of retained placental fragments (refer to Additional Topic 3 in the **Reference Manual**).

Notes to the facilitator:

- Divide the group in three smaller groups. Assign each group the task of preparing a job aid that describes management of genital tears (group 1), management of retained placenta (group 2), management of retained placental fragments (group 3).
- Give each group 10 minutes to work on their task.
- Circulate around the room and assist participants as they work on their task.
- Each group should present their job aid to the large group.

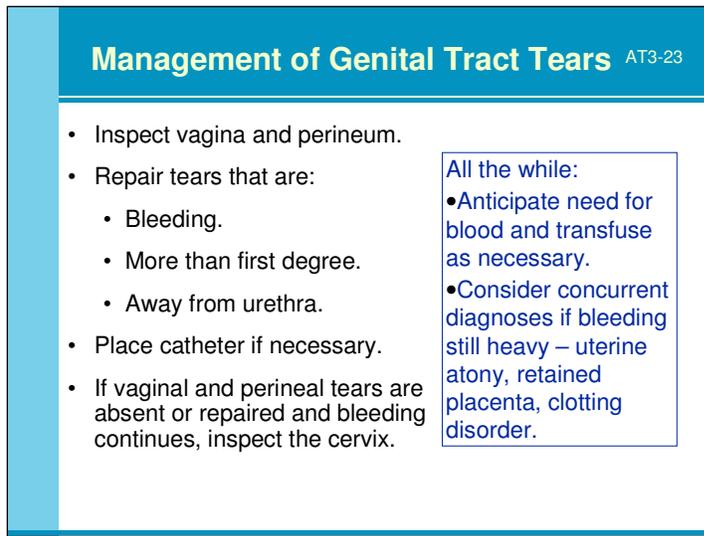
Flipchart / Overhead / PowerPoint slide 23

Time: 10 min.

Activity: Provide a summary of management of genital tract tears after the group has presented their job aid.

Notes to the facilitator:

- After Group 1 has presented their job aid on management of genital tears, present the flipchart/overhead/PowerPoint slide summarizing management of genital tract tears.



Management of Genital Tract Tears AT3-23

- Inspect vagina and perineum.
- Repair tears that are:
 - Bleeding.
 - More than first degree.
 - Away from urethra.
- Place catheter if necessary.
- If vaginal and perineal tears are absent or repaired and bleeding continues, inspect the cervix.

All the while:

- Anticipate need for blood and transfuse as necessary.
- Consider concurrent diagnoses if bleeding still heavy – uterine atony, retained placenta, clotting disorder.

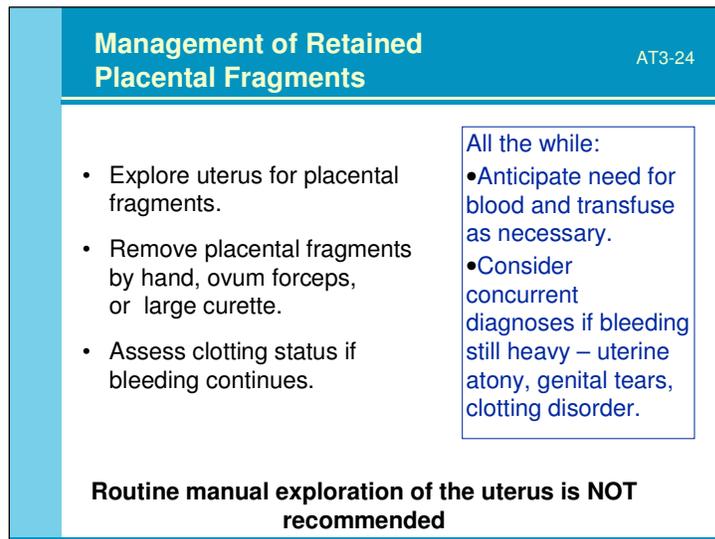
Flipchart / Overhead / PowerPoint slide 24

Time: 10 min.

Activity: Provide a summary of management of retained placental fragments after the group has presented their job aid.

Notes to the facilitator:

- After Group 2 has presented their job aid on management of retained placental fragments, present the flipchart/overhead/PowerPoint slide summarizing management of retained placental fragments.



Management of Retained Placental Fragments AT3-24

- Explore uterus for placental fragments.
- Remove placental fragments by hand, ovum forceps, or large curette.
- Assess clotting status if bleeding continues.

All the while:

- Anticipate need for blood and transfuse as necessary.
- Consider concurrent diagnoses if bleeding still heavy – uterine atony, genital tears, clotting disorder.

Routine manual exploration of the uterus is NOT recommended

**Flipchart / Overhead / PowerPoint slide 25****Time: 10 min.****Activity:** Provide a summary of management of retained placenta after the group has presented their job aid.**Notes to the facilitator:**

- After Group 3 has presented their job aid on management of retained placenta, present the flipchart/overhead/PowerPoint slide summarizing management of retained placenta.

Management of Retained Placenta AT3-25	
<ul style="list-style-type: none">• If placenta is seen, ask woman to push; if in vagina, remove.• Ensure bladder is empty; catheterize if necessary.• Give oxytocin 10 units IM if not already done.• Attempt controlled cord traction.• If not successful, manually remove placenta (give one dose of prophylactic antibiotics if manual removal of placenta).• Assess clotting status if bleeding continues.	<p>All the while:</p> <ul style="list-style-type: none">• Anticipate need for blood and transfuse as necessary.• Consider concurrent diagnoses if bleeding still heavy – uterine atony, genital tears, clotting disorder.

Flipchart / Overhead / PowerPoint slides 26 and 27

Time: 10 min.

Activity: Illustrated lecture to review management of inverted uterus.

Objective: Describe the immediate medical management of the woman whose uterus has inverted.

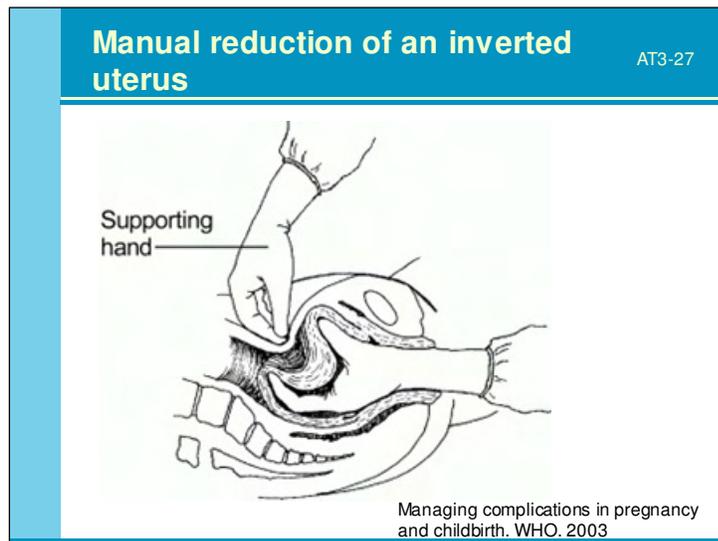
Notes to the facilitator:

- Ask participants to turn to the section *What if the uterus inverts?* found in Additional Topic 3 of the **Reference Manual**.
- Remind participants that uterine inversion is very rare and that AMTSL is not associated with increased rates of uterine inversion when it is performed according to standards
- Provide an illustrated lecture on management of inverted uterus.
- Emphasize that the provider should not administer uterotonic drugs or attempt placental removal until the inversion is corrected.
- Ask for questions before proceeding.

Management of Inverted Uterus AT3-26

<ul style="list-style-type: none">• Act quickly.• Assess clotting status.• Reposition uterus.• Hold oxytocics until uterus is repositioned.• Give antibiotics as for metritis if signs of infection are present.• Refer for surgical intervention if necrosis is suspected.	<p>All the while:</p> <ul style="list-style-type: none">• Give IV fluids.• Anticipate need for blood and transfuse as necessary.• Give pain medication and antibiotics.• Consider concurrent diagnoses if bleeding still heavy.
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Do not give uterotonic drugs until the inversion is corrected. If the placenta has not separated from the uterine wall when inversion occurs, do not attempt removal of the placenta until the inversion is corrected



Notes to the facilitator:

- Ask participants to stand around the model to observe the demonstration of manual reduction of an inverted uterus. Make sure that everyone can see.
- Follow steps for manual reduction of an inverted uterus as listed in the **Reference Manual**. Ask participants to refer to the **Reference Manual** and follow along as you provide the demonstration.
- Ask for questions before proceeding.



Flipchart / Overhead / PowerPoint slides 28 and 29

Time: 10 min.

Activity: Question-and-answer to review management of ruptured cord.

Objective: Describe the immediate medical management of the woman whose uterus has inverted.

Notes to the facilitator:

- Ask participants to turn to the section *What if the cord tears off during controlled cord traction?* found in Additional Topic 3 in the **Reference Manual**.
- Ask participants to suggest ways to manage ruptured cord. Write their responses on a flipchart.

Brainstorming
AT3-28

Steps for managing ruptured cord

Management of ruptured cord
AT3-29

- Have the woman empty her bladder or ensure that the bladder is empty; catheterize the bladder only if necessary.
- If the placenta has separated and is in the vagina:
 - Ask the woman to squat.
 - With a contraction, ask the woman to push the placenta out.
- If the placenta has not separated, consider manual removal of the placenta.

Notes to the facilitator:

- When all responses are exhausted, show the slide describing management of a ruptured cord.
- Remind participants that AMTSL is not associated with increased rates of ruptured cords when it is performed according to standards
- Ask for questions before proceeding.

Flipchart / Overhead / PowerPoint slide 30

Time: 30 min.

Activity: Case study to review management of PPH.

Notes to the facilitator:

- Divide participants into groups of 3 to 4 people (try to ensure that there is a mix of cadres of providers in each group).
- Facilitate group work.
- After 20 minutes, facilitate a discussion about the answers in a plenary. Answers to the case study are in the **Facilitator's Guide** and the **Participant's Notebook**.

Small Group Work (Groups of 3-4 people)

AT3-30

- Turn to classroom learning activity 3 for *Additional Topic 3* in the **Participant's Notebook**.
- Carefully read the case study and then respond to the questions (refer to *Additional Topic 3* in the **Reference Manual**).
20 minutes
- Discuss responses in the plenary.
10 minutes

Flipchart / Overhead / PowerPoint slide 31

Time: 60 min.

Activity: Clinical simulation to summarize key points in the session.

Clinical simulation: Management of vaginal bleeding after childbirth

AT3-31



Notes to the facilitator:

- Refer to the **Facilitator's Guide** for instructions on how to facilitate the clinical simulation.
- Answers for the clinical simulation are on the pages following instructions for facilitating the clinical simulation.
- The questions, without the answers, are located in the **Participant's Notebook**.

**Flipchart / Overhead / PowerPoint slide 32****Notes to the facilitator:**

- Encourage participants to work on learning activities found in the **Participant's Notebook** for Additional Topic 3.
- Participants may work individually or in groups on the learning activities during breaks, in the evening, or in the clinical area when there are no clients.
- Participants may correct their learning activities by referring to suggested answers found in the **Participant's Notebook**. Facilitators should make themselves available to work with the participants to review answers for learning activities.

Learning activities	AT3-32
<ul style="list-style-type: none">• Please complete learning activities found in the Participant's Notebook for Additional Topic 3• You may work individually or in groups on the learning activities during breaks, in the evening, or in the clinical area when there are no clients• You may correct your answers individually or with another participant or the facilitator.• See a facilitator if you have questions.	

Case study: Vaginal bleeding after childbirth—Answer Key

Read and carefully analyze this case study.* Consider the steps in clinical decision-making as you answer the questions.

Case study: Mrs. B is a 30-year-old, para four, who just gave birth at the health center to a full-term, healthy newborn weighing 4.2 kg. She was given ergometrine 0.2 mg IM after birth of the newborn. The placenta was delivered 5 minutes later, without complications. However, half an hour after childbirth, Mrs. B reports heavy vaginal bleeding.

Assessment (history, physical examination, screening procedures, and laboratory tests)

1. What will you do in your initial assessment of Mrs. B, and why?
 - **Mrs. B. should be told what is going to be done and listened to carefully. In addition, her questions should be answered in a calm and reassuring manner.**
 - **At the same time, a rapid assessment should be done to check for signs of shock (rapid, weak pulse, systolic blood pressure less than 90 mm Hg, pallor and sweatiness, rapid breathing, confusion).**
 - **The placenta should be checked thoroughly for completeness.**
2. What aspects of Mrs. B's physical examination will help you make an immediate diagnosis or identify her problems/needs, and why?
 - **Mrs. B's uterus should be checked immediately to see whether it is contracted. If the uterus is contracted and firm, the most likely cause of bleeding is genital trauma. If the uterus is not contracted and the placenta is complete, the most likely cause of bleeding is an atonic uterus. The most important causes of bleeding can be suspected by palpating the uterus.**
 - **Her perineum, vagina, and cervix should be examined carefully for tears.**

Diagnosis (identifying problems and/or needs)

You have completed your assessment of Mrs. B, and your main findings include the following:

Mrs. B's **vital signs**: pulse: 88 beats/minute; blood pressure: 110/80 mm Hg; respiration: 18 breaths/minute; temperature: 37°C. Her uterus is firm and well-contracted. The placenta is complete, and she doesn't have perineal trauma. Examination of the vagina and cervix is difficult because she continues to have heavy vaginal bleeding; therefore, tears of the cervix and vagina are possible.

3. Based on these findings, what is Mrs. B's diagnosis, and why?
 - **Mrs. B's symptoms and signs (e.g., immediate postpartum hemorrhage, placenta complete, uterus well contracted) are consistent with genital trauma.**

* Case study adapted from JHPIEGO/Maternal & Neonatal Health. *Managing Complications in Pregnancy and Childbirth Learning Resource Package: A Guide for Teachers.*



Care provision (Planning and Intervention)

4. Based on your diagnosis, what is your plan of care for Mrs. B, and why?
- ***An IV should be started using a large-bore needle to replace fluid loss, using Ringer's lactate or normal saline.***
 - ***A careful speculum examination of the vagina and cervix should be conducted without delay, as tears of either the cervix and/or the vagina are the most likely cause of Mrs. B's bleeding.***
 - ***Any tears should be repaired immediately.***
 - ***Mrs. B's vital signs and fluid intake and output should be monitored.***
 - ***Her uterus should also be checked to make sure that it remains firm and well contracted.***
 - ***Blood should be drawn for hemoglobin and cross-matching, and blood for transfusion should be made available as soon as possible, in the event that it is needed.***
 - ***The steps taken to manage the complication should be explained to Mrs. B. She should be encouraged to express her concerns, listened to carefully, and provided emotional support and reassurance.***

Evaluation

One hour after childbirth, Mrs. B has a cervical tear repaired.

5. Based on these findings, what is your continuing plan of care for Mrs. B, and why?
- ***Mrs. B's vital signs and blood loss should continue to be monitored—every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 4 hours for 24 hours. Her uterus should be checked to make sure that it remains firm and well contracted. In addition, she should be encouraged to breastfeed her newborn.***
 - ***Twenty-four hours after the bleeding has stopped, check her hemoglobin and hematocrit to assess for anemia.***
 - ***If Mrs. B's hemoglobin is below 7 g/dL, or her hematocrit is below 20% (indicating severe anemia), she should be given ferrous sulfate or ferrous fumarate 120 mg by mouth plus folic acid 400 µg by mouth once daily for 3 months. A blood transfusion is not needed if her vital signs are stable and no further bleeding occurs.***
 - ***If Mrs. B's hemoglobin is between 7 to 11 g/dL, she should be given ferrous sulfate or ferrous fumarate 60 mg by mouth plus folic acid 400 µg by mouth once daily for 6 months.***
 - ***The steps taken for continuing management of the complication should be explained to Mrs. B. She should be encouraged to express her concerns, listened to carefully, and provided continuing emotional support and reassurance.***
 - ***Mrs. B. should remain at the health center for an additional 24 hours, and before discharge, counseling should be provided about danger signs in the postpartum period (bleeding, fever, headache, blurred vision) and about compliance with iron/folic acid treatment and the inclusion in her diet of locally available foods rich in iron. In addition, counseling about breastfeeding and newborn care should be provided.***

REFERENCES

WHO. *Managing complications in pregnancy and childbirth: A guide for midwives and doctors*. Geneva: WHO, 2000. (pages S-25 to S-31)

Clinical Simulation: Management of Vaginal Bleeding After Childbirth

Purpose: The purpose of this clinical simulation* is to help training participants practice problem-solving and decision-making skills in the management of vaginal bleeding after childbirth, emphasizing quick recognition and appropriate management.⁶

Time: 60 minutes

Instructions: The activity should be carried out in the classroom, the labor and delivery area of a hospital, or clinic or maternity center. Make sure that the necessary equipment and supplies are available during the simulation activity.

- One participant should play the role of patient and a second participant the role of skilled provider. Other participants may be called on to assist the provider.
- The facilitator will give the participant playing the role of provider information about the patient's condition and ask pertinent questions, as indicated in the left-hand column of the chart below.
- The participant will be expected to assess the situation and react (intervene) rapidly when the facilitator provides information and asks questions. Key reactions/responses expected from the participant are provided in the right-hand column of the chart below.
- Procedures such as starting an IV and bimanual examination should be role-played, using the appropriate equipment.
- Initially, the facilitator and participant will discuss what is happening during the simulation in order to develop problem-solving and decision-making skills. The italicized questions in the simulation are for this purpose. Further discussion may take place after the simulation is completed.
- As the participant's skills become stronger, the focus of the simulation should shift to providing appropriate care for the life-threatening emergency in a quick, efficient, and effective manner. All discussion and questioning should take place after the simulation is over.

Resources: *Reference Manual, blood pressure machine, stethoscope, equipment for starting an IV infusion, oxygen cylinder, mask and tubing, syringes and vials, speculum, sponge forceps, high-level disinfected or sterile surgical gloves.*

* Adapted from *Managing Complications in Pregnancy and Childbirth. Learning Resource Package: Guide for Teachers*; JHPIEGO/Maternal & Neonatal Health.⁶



Scenario 1	
Information provided and questions asked by the facilitator	Key reactions and responses from participants
<p>1. Mrs. B is 24 years old and has just given birth to a healthy baby girl after seven hours of labor. The provider performed AMTSL, and the placenta and membranes were complete. The midwife who attended the birth left the hospital at the end of her shift, shortly after the birth. About 30 minutes later, a nurse rushes to tell you that Mrs. B is bleeding profusely.</p> <p>What will you do?</p>	<ul style="list-style-type: none"> • Shouts for help to urgently mobilize all available personnel. • Makes a rapid evaluation of Mrs. B’s general condition, including vital signs (pulse, blood pressure and respiration rate), level of consciousness, color and temperature of skin. • Explains to Mrs. B what is going to be done, listens to her, and responds attentively to her questions and concerns.
<p>2. During the examination, Mrs. B’s blood pressure is 102/72 mm Hg and pulse 102 beats/minute and weak. Her skin is not cold and clammy.</p> <p>What is Mrs. B’s likely diagnosis?</p> <p>What will you do now?</p>	<ul style="list-style-type: none"> • States that Mrs. B is not in shock from postpartum bleeding. • Palpates the uterus for firmness. • Asks one of the staff that responded to her shout for help to start an IV infusion, using a large-bore cannula and normal saline or Ringer’s lactate at a rate of 1 L in 15–20 minutes with 10 units oxytocin. • While starting the IV, collects blood for appropriate tests (hemoglobin, blood typing, and cross-matching, and bedside clotting test for clotting disorder).
<p>Discussion Question 1: How would you know when a woman is in shock?</p>	<p><i>Expected Responses: Pulse is greater than 110 beats/minute; systolic blood pressure less than 90 mm Hg; cold, clammy skin; pallor; respiration rate greater than 30 breaths/minute; anxious and confused or unconscious.</i></p>
<p>3. You find that Mrs. B’s uterus is soft and not contracted.</p> <p>What will you do now?</p>	<ul style="list-style-type: none"> • Massages the uterus to expel blood and blood clots and stimulate a contraction. • Starts oxygen at 6–8 L/minute. • Catheterizes bladder. • Covers Mrs. B to keep her warm. • Continues to monitor (or has assistant monitor) blood pressure, pulse, and blood loss.

Scenario 1	
Information provided and questions asked by the facilitator	Key reactions and responses from participants
<p>4. After five minutes, Mrs. B's uterus is well contracted, but she continues to bleed heavily.</p> <p>What will you do now?</p>	<ul style="list-style-type: none"> • Examines the cervix, vagina, and perineum for tears. • Asks one of staff assisting to locate placenta and examines for missing pieces.
<p>5. On further examination of the placenta, you find that it is complete. On examination of Mrs. B's cervix, vagina, and perineum, you find a cervical tear. She continues to bleed heavily.</p> <p>What will you do now?</p>	<ul style="list-style-type: none"> • <i>Prepares to repair the cervical tear.</i> • Tells Mrs. B what is happening, listens to what she has to say, and provides reassurance. • Has a staff member assisting check Mrs. B's vital signs.
<p>Discussion Question 2: <i>What would you have done if examination of the placenta had shown a missing piece (placenta incomplete)?</i></p>	<p><i>Expected Responses:</i></p> <ul style="list-style-type: none"> • <i>Explain the problem to Mrs. B and provide reassurance.</i> • <i>Give pain medications and prophylactic antibiotics.</i> • <i>Use sterile or high-level disinfected gloves to explore the uterus for placental fragments and remove with hand, ovum forceps, or large curette.</i>
<p>6. Forty-five minutes have passed since treatment for Mrs. B was started. You have just finished repairing Mrs. B's cervical tear. Her blood pressure is now 110/78 mm Hg, pulse 98 beats/minute, and respiration rate 24 breaths/minute. She is resting quietly.</p> <p>What will you do now?</p>	<ul style="list-style-type: none"> • Adjusts rate of IV infusion to 1 L in 6 hours. • Continues to check for vaginal blood loss. • Continues to monitor blood pressure and pulse. • Checks that urine output is 30 mL/hour or more. • Continues with routine postpartum care, including breastfeeding of newborn.



Checklists for Facilitators

The **following checklists*** can be used by facilitators to assess their own clinical teaching skills or to provide feedback to other facilitators.

Checklist for Classroom Presentation Skills (To be completed by Facilitator)

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 standard procedure or guidelines.

Unsatisfactory: Does not perform the step or task according to standard procedure or guidelines.

Not Observed: Step or task not performed by participant during evaluation by facilitator.

Checklist for Classroom Presentation Skills					
STEP/TASK	OBSERVATIONS				
1. Presents an effective introduction.					
2. States the objective(s) as part of the introduction.					
3. Asks questions of the entire group.					
4. Targets questions to individuals.					
5. Asks questions at a variety of levels.					
6. Uses participant names.					
7. Provides positive feedback.					
8. Responds to participant questions.					
9. Follows facilitator's notes and/or a personalized reference manual.					
10. Maintains eye contact.					
11. Projects voice so that all participants can hear.					
12. Moves about the room.					
13. Uses audiovisuals effectively.					
14. Displays a positive use of humor.					
15. Presents an effective summary.					
16. Provides for application or practice of presentation content.					
Delivered an effective classroom presentation					

* Checklists from www.reproline.jhu.edu, the website of the JHPIEGO Corporation.⁷

Checklist for Clinical Coaching Skills⁷ (To be completed by Facilitator)

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 standard procedure or guidelines.

Unsatisfactory: Does not perform the step or task according to standard procedure or guidelines.

Not Observed: Step or task not performed by facilitator during evaluation by a peer facilitator.

Checklist for Clinical Coaching Skills					
STEP/TASK	OBSERVATIONS				
Before practice session					
1. Greets participant.					
2. Asks the participant to review her/his performance in previous practice sessions.					
3. Asks the participant which steps or tasks s/he would like to work on during the practice session.					
4. Reviews any difficult steps or tasks in the checklist that will be practiced during the session.					
5. Works with the participant to set specific goals for the practice session.					
During practice session					
1. Observes the participant as s/he practices the procedure.					
2. Provides positive reinforcement and suggestions for improvement as the participant practices the procedure.					
3. Refers to the checklist during observation.					
4. Records notes about participant performance on the checklist during the observation.					
5. Is sensitive to the client when providing feedback to the participant during a clinical session with clients.					
6. Provides corrective comments only when the comfort or safety of the client is in doubt.					



Checklist for Clinical Coaching Skills					
STEP/TASK	OBSERVATIONS				
After practice feedback session					
1. Greets the participant.					
2. Asks the participant to share feelings about the practice session.					
3. Asks the participant to identify those steps performed well.					
4. Asks the participant to identify those steps where performance could be improved.					
5. Refers to notes on the learning guide.					
6. Provides positive reinforcement regarding those steps or tasks the participant performed well.					
7. Offers specific suggestions for improvement.					
8. Works with the participant to establish goals for the next practice session.					
Used effective coaching skills					

Checklist for Clinical Demonstration Skills (To be completed by Facilitator)

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 standard procedure or guidelines.

Unsatisfactory: Does not perform the step or task according to standard procedure or guidelines.

Not Observed: Step or task not performed by facilitator during evaluation by a peer facilitator.

Checklist for Clinical Demonstration Skills					
STEP/TASK	OBSERVATIONS				
1. Uses facilitator's notes or a personalized reference manual.					
2. States the objective(s) as part of the introduction.					
3. Presents an effective introduction.					
4. Arranges demonstration area so that participants are able to see each step in the procedure clearly.					
5. Never demonstrates an incorrect procedure or shortcut.					
6. Communicates with the model or client during demonstration of the skill/activity.					
7. Asks questions and encourages participants to ask questions.					
8. Demonstrates or simulates appropriate infection prevention practices.					
9. When using model, positions model as an actual client.					
10. Maintains eye contact with participants as much as possible.					
11. Projects voice so that all participants can hear.					
12. Provides participants opportunities to practice the skill/activity under direct supervision.					
Presented an effective clinical demonstration					



Administrative Documents

POPPHI: ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR TRAINING PROGRAM

Registration Form

General Information

Name _____

Surname

First

Middle

Title: Mrs. () Miss () Ms. () Mr. () Dr. ()

Sex: Male _____ Female _____

Contact Address _____

Home or mobile telephone _____ E-mail _____

Place of work _____

Address _____

Telephone _____ Work E-mail _____

Professional Qualification

Please tick all that apply

Registered Nurse _____ Registered Midwife _____ Public Health Nurse _____

Obstetrical Nurse _____

Obstetrician/Gynecologist _____ Physician _____ Clinical Officer _____

Medical Assistant _____

Other (please specify) _____

AMTSL Training Registration Form

- Page 2 -

Job Title/Designation _____

Position _____

Primary Responsibility

Clinical teaching _____

Clinical practice _____

Administration _____

Other (please specify) _____

Main area of clinical work or teaching (tick the area where you spend most of your time as a provider or tutor/facilitator)

Antenatal clinic _____

Labor ward _____

Postpartum ward _____

Family planning clinic _____

Other (please specify) _____

Number of births you have attended in the last 3 months:

None () 0-10 births () 11-20 births () >20 births ()

Experience with active management of third stage of labor (AMTSL)

Previous training in AMTSL: Yes () No ()

If yes: Date of training in AMTSL: ____/____ (mm/yyyy)

Organization that provided training in AMTSL:

Pre-Service Education () MOH () NGO () UNICEF ()

UNFPA () Other (please specify) _____ ()

Number of times you have practiced AMTSL: Never practiced ()

0-10 times () 11-20 times () >20 times ()



Final Evaluation Form

Please evaluate the following by ticking (✓) how you feel about each statement.
 Feel free to comment below and use the back for more writing space.

Statement	Strongly Agree	Agree	Not Decided	Disagree	Strongly Disagree
1. For the work I do, training was appropriate.					
2. For the work I do, training was helpful.					
3. Training facilities and arrangements were satisfactory.					
4. The Participant's Manual and other reading materials were easy to understand.					
5. The reference manual and other reading materials helped me to learn.					
6. Teaching aids were useful (films, charts, models).					
7. The methods used for teaching were helpful (case studies, role-plays, clinical).					
8. The facilitators were knowledgeable and skilled.					
9. The facilitators were fair and friendly.					
10. The facilitators communicated clearly and simply.					
11. The objectives of the training were met.					

12. What 3 topics were most useful to you?

13. What 3 topics were not useful to you?

14. What 3 things would you change about the training?

Other comments (please use back of paper if needed):



Pre-Course Questionnaire: AMTSL

Instructions:

Read each question carefully before choosing a response. Write the letter "T" for True or "F" for False in the space provided after each statement.

If you do not understand a question, ask one of the facilitators to assist you before you respond to the question. Each question is worth 1 point.

Instructions:

Read each question carefully before choosing a response. Write the letter "T" for True or "F" for False in the space provided after each statement.

If you do not understand a question, ask one of the facilitators to assist you before you respond to the question. Each question is worth 1 point.

Scientific evidence

1. Active management of third stage of labor reduces the length of the third stage of labor.

2. The **only** difference between active and physiologic management of third stage of labor is that oxytocin is administered within a minute after birth of the baby in AMTSL.

Causes and prevention of PPH

3. When a portion of the placenta—one or more lobes—is retained, it prevents the uterus from contracting effectively.

4. Immediate PPH is most commonly due to uterine atony (failure of the uterus to contract properly after the infant is born).

5. The best way to prevent PPH is to carefully identify risk factors in women during pregnancy and at the beginning of labor.

6. Monitoring labor using the partograph may help prevent PPH.

Review of uterotonic drugs

7. Ergometrine is less stable than oxytocin when exposed to heat and light.

8. Temporary storage of oxytocin outside the refrigerator at a maximum of 30°C is acceptable for no more than three months.

9. Oxytocin should never be given to women with preeclampsia, eclampsia, or high blood pressure because it increases the risk of convulsions and cerebrovascular accidents.

10. Misoprostol is a uterotonic that can be used to treat PPH.

11. In the context of active management of the third stage of labor, if oxytocin is not available, skilled attendants should offer ergometrine/methylergometrine or the fixed drug combination of oxytocin and ergometrine to women without hypertension or heart disease for prevention of PPH.
-

AMTSL

12. Active management of the third stage of labor should be practiced only on women who have a history of postpartum hemorrhage.
-
13. Delayed clamping and cutting of the umbilical cord is helpful to both term and preterm babies.
-
14. Controlled cord traction should only be done in between contractions to prevent uterine inversion.
-
15. Controlled cord traction should never be applied without applying countertraction (push) to the uterus above the pubic bone with the other hand.
-
16. In the context of prevention of PPH, if oxytocin is not available or birth attendants' skills are limited, misoprostol should be administered soon after the birth of the baby.
-
17. Active management decreases the need for uterotonic drugs to manage postpartum hemorrhage.
-
18. The provider should wait for signs of placental separation before beginning controlled cord traction.
-

Monitoring during the immediate postpartum period

19. Ms. A gave birth to a healthy baby girl 30 minutes ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. You estimate that she lost about 300 mL of blood. Because the birth and third stage were normal, it is only necessary to monitor Ms. A's uterus and vaginal bleeding every hour.
-
20. To ensure that the uterus remains contracted after delivery of the placenta, the provider should instruct the woman how the uterus should feel and how she can massage it herself.
-



KEY Pre-Course Questionnaire: AMTSL

Instructions:

Read each question carefully before choosing a response. Write the letter "T" for True or "F" for False in the space provided after each statement.

If you do not understand a question, ask one of the facilitators to assist you before you respond to the question. Each question is worth 1 point.

Scientific evidence

1. Active management of third stage of labor reduces the length of the third stage of labor.
True
2. The **only** difference between active and physiologic management of third stage of labor is that oxytocin is administered within a minute after birth of the baby in AMTSL.
False

Causes and prevention of PPH

3. When a portion of the placenta—one or more lobes—is retained, it prevents the uterus from contracting effectively.
True
4. Immediate PPH is most commonly due to uterine atony (failure of the uterus to contract properly after the infant is born).
True
5. The best way to prevent PPH is to carefully identify risk factors in women during pregnancy and at the beginning of labor.
False
6. Monitoring labor using the partograph may help prevent PPH.
True

Review of uterotonic drugs

7. Ergometrine is less stable than oxytocin when exposed to heat and light.
True
8. Temporary storage of oxytocin outside the refrigerator at a maximum of 30°C is acceptable for no more than three months.
True
9. Oxytocin should never be given to women with preeclampsia, eclampsia, or high blood pressure because it increases the risk of convulsions and cerebrovascular accidents.
False
10. Misoprostol is a uterotonic that can be used to treat PPH.
True
11. In the context of active management of the third stage of labor, if oxytocin is not available, skilled attendants should offer ergometrine/methylergometrine or the fixed drug combination of oxytocin and ergometrine to women without hypertension or heart disease for prevention of PPH.
True

AMTSL

12. Active management of the third stage of labor should be practiced only on women who have a history of postpartum hemorrhage.
False
13. Delayed clamping and cutting of the umbilical cord is helpful to both term and preterm babies.
True
14. Controlled cord traction should only be done in between contractions to prevent uterine inversion.
False
15. Controlled cord traction should never be applied without applying countertraction (push) to the uterus above the pubic bone with the other hand.
True
16. In the context of prevention of PPH, if oxytocin is not available or birth attendants' skills are limited, misoprostol should be administered soon after the birth of the baby.
True
17. Active management decreases the need for uterotonic drugs to manage postpartum hemorrhage.
True
18. The provider should wait for signs of placental separation before beginning controlled cord traction.
False

Monitoring during the immediate postpartum period

19. Ms. A gave birth to a healthy baby girl 30 minutes ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. You estimate that she lost about 300 mL of blood. Because the birth and third stage were normal, it is only necessary to monitor Ms. A's uterus and vaginal bleeding every hour.
False
20. To ensure that the uterus remains contracted after delivery of the placenta, the provider should instruct the woman how the uterus should feel and how she can massage it herself.
True



Mid-Course Questionnaire: AMTSL

Instructions:

Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the facilitators to assist you before you respond to the question.

MULTIPLE CHOICE

Circle the best response for each question. Each question is worth 1 point.

Scientific evidence

- 1) Which of the following statements describes an **advantage** of physiologic management of the third stage of labor?
 - a) It increases the length of the third stage of labor.
 - b) It does not interfere with the normal process of labor and childbirth.
 - c) It reduces the risk of PPH.
 - d) It reduces average amount of blood loss.
- 2) Which of the following statements describes a **disadvantage** of AMTSL?
 - a) It requires the presence of a skilled birth attendant who can administer injections.
 - b) It increases the amount of blood loss after childbirth.
 - c) It increases the risk of PPH during the third stage of labor.
 - d) It increases the length of the third stage of labor.

Review of uterotonic drugs

- 3) Which of the following statements about oxytocin is not true?
 - a) Oxytocin acts within 6 to 7 minutes.
 - b) Oxytocin has few or no side effects.
 - c) Oxytocin is more stable than ergometrine when exposed to heat.
 - d) Oxytocin is more stable than ergometrine when exposed to light.
- 4) Uterotonic drugs...
 - a) can be used to stimulate contractions
 - b) are used to treat postpartum hemorrhage
 - c) help prevent uterine atony after childbirth
 - d) All of the above
- 5) If the health facility does not have a refrigerator:
 - a) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than two weeks.
 - b) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than three months.
 - c) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than one week.
 - d) None of the responses is correct.

- 6) If a skilled birth attendant is not present at the birth:
- a) Oxytocin or misoprostol may be administered in the absence of AMTSL
 - b) AMTSL should still be practiced because it prevents PPH
 - c) Physiologic management of the third stage of labor should be practiced
 - d) (a) and (c)
- 7) WHO recommends oxytocin as the uterotonic drug of choice because:
- a) It is fast-acting
 - b) It is inexpensive
 - c) In most cases, it has no side effects or contraindications for use during the third stage of labor
 - d) It is more stable than ergometrine in hot climates and light
 - e) All of the above

Prevention of PPH

- 8) Which of the following can prevent the uterus from contracting properly?
- a) Clamping of the cord too quickly after childbirth
 - b) Emptying the bladder before placenta separation
 - c) Failure of the placenta to separate from the uterus
 - d) Failure to wait at least 15 minutes before massaging the uterus after the placenta has delivered
- 9) Up to two-thirds of PPH cases:
- a) can be predicted if women's risk factors are identified during pregnancy
 - b) occur in women who have no risk factors
 - c) can be predicted if a thorough history is taken when the woman comes to the health facility in labor
 - d) can be predicted by experienced skilled birth attendants
- 10) The most important factor in determining a woman's chances of surviving PPH is:
- a) the woman's parity
 - b) early diagnosis and management of PPH
 - c) identification of risk factors during pregnancy
 - d) identification of risk factors when a woman comes to the health facility to give birth
- 11) Screening for, preventing, and treating anemia during pregnancy can:
- a) prevent PPH
 - b) reduce the risk of dying from PPH
 - c) make AMTSL less risky
 - d) all of the responses are correct

**AMTSL**

- 12) Active management of the third stage of labor includes all of the following EXCEPT:
 - a) Massage the uterus
 - b) Apply upward pressure on the uterus with a contraction
 - c) Wait for signs of placenta separation (e.g., lengthening of the cord)
 - d) Give a uterotonic drug within one minute after birth
- 13) The main risk in performing active management of the third stage is:
 - a) Retained placenta
 - b) Pulling the cord off
 - c) Causing uterine atony
 - d) None of the above
- 14) Controlled cord traction is only applied when countertraction is applied simultaneously because:
 - a) Countertraction helps the placenta descend into the vagina.
 - b) Countertraction supports the uterus and helps prevent uterine inversion during controlled cord traction.
 - c) Countertraction reduces pain caused when controlled cord traction is applied.
 - d) Countertraction reduces the risk of maternal-to-child transmission of HIV.
- 15) If the placenta does not descend during 30–40 seconds of controlled cord traction:
 - a) Consider placenta accreta and prepare the patient for a surgical intervention.
 - b) Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well contracted again.
 - c) Administer a second injection of oxytocin 10 IU IM.
 - d) Administer a different uterotonic because the first uterotonic was not effective.
- 16) Performing AMTSL:
 - a) will prevent all cases of PPH
 - b) cannot prevent all cases of PPH
 - c) may increase the risk of PPH due to uterine inversion
 - d) will only prevent PPH in women with risk factors for PPH
- 17) Active management decreases:
 - a) the incidence of postpartum hemorrhage
 - b) the length of third stage of labor
 - c) the percentage of third stages of labor lasting longer than 30 minutes
 - d) all of the responses are correct

- 18) The umbilical cord should be cut:
- a) As soon as possible after birth of the baby to facilitate AMTSL and immediate newborn care
 - b) Immediately after birth of the baby if the newborn requires resuscitation
 - c) After the placenta is delivered to ensure transfer of blood to the newborn
 - d) At a time determined by cultural beliefs

Monitoring during the immediate postpartum period

- 19) Ms. A gave birth to a healthy baby girl one hour ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. How often should you monitor her uterus and vaginal bleeding during the second hour after delivery of the placenta?
- a) Every 10 minutes
 - b) Every 15 minutes
 - c) Continuously
 - d) Every 60 minutes
- 20) Baby A was born at 3:15 pm. She did not require resuscitation and has already begun breastfeeding. It is now 6:30 pm. How often will you monitor her temperature?
- a) Every 10 minutes
 - b) Every 15 minutes
 - c) Continuously
 - d) Every 60 minutes



KEY Mid-Course Questionnaire: AMTSL

Scientific evidence

- 1) Which of the following statements describes an **advantage** of physiologic management of the third stage of labor?
 - a) It increases the length of the third stage of labor.
 - b) **It does not interfere with the normal process of labor and childbirth.**
 - c) It reduces the risk of PPH.
 - d) It reduces average amount of blood loss.
- 2) Which of the following statements describes a **disadvantage** of AMTSL?
 - a) **It requires the presence of a skilled birth attendant who can administer injections.**
 - b) It increases the amount of blood loss after childbirth.
 - c) It increases the risk of PPH during the third stage of labor.
 - d) It increases the length of the third stage of labor.

Review of uterotonic drugs

- 3) Which of the following statements about oxytocin is not true?
 - a) **Oxytocin acts within 6 to 7 minutes.**
 - b) Oxytocin has few or no side effects.
 - c) Oxytocin is more stable than ergometrine when exposed to heat.
 - d) Oxytocin is more stable than ergometrine when exposed to light.
- 4) Uterotonic drugs...
 - a) can be used to stimulate contractions
 - b) are used to treat postpartum hemorrhage
 - c) help prevent uterine atony after childbirth
 - d) **All of the above**
- 5) If the health facility does not have a refrigerator:
 - a) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than two weeks.
 - b) **Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than three months.**
 - c) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than one week.
 - d) None of the responses is correct.

- 6) If a skilled birth attendant is not present at the birth:
- a) Oxytocin or misoprostol may be administered in the absence of AMTSL
 - b) AMTSL should still be practiced because it prevents PPH
 - c) Physiologic management of the third stage of labor should be practiced
 - d) **(a) and (c)**
- 7) WHO recommends oxytocin as the uterotonic drug of choice because:
- a) It is fast-acting
 - b) It is inexpensive
 - c) In most cases, it has no side effects or contraindications for use during the third stage of labor
 - d) It is more stable than ergometrine in hot climates and light
 - e) **All of the above**

Prevention of PPH

- 8) Which of the following can prevent the uterus from contracting properly?
- a) Clamping of the cord too quickly after childbirth
 - b) Emptying the bladder before placenta separation
 - c) **Failure of the placenta to separate from the uterus**
 - d) Failure to wait at least 15 minutes before massaging the uterus after the placenta has delivered
- 9) Up to two-thirds of PPH cases:
- a) can be predicted if women's risk factors are identified during pregnancy
 - b) **occur in women who have no risk factors**
 - c) can be predicted if a thorough history is taken when the woman comes to the health facility in labor
 - d) can be predicted by experienced skilled birth attendants
- 10) The most important factor in determining a woman's chances of surviving PPH is:
- a) the woman's parity
 - b) **early diagnosis and management of PPH**
 - c) identification of risk factors during pregnancy
 - d) identification of risk factors when a woman comes to the health facility to give birth
- 11) Screening for, preventing, and treating anemia during pregnancy can:
- a) prevent PPH
 - b) **reduce the risk of dying from PPH**
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**AMTSL**

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- Massage the uterus
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 - Give a uterotonic drug within one minute after birth
- 13) The main risk in performing active management of the third stage is:
- Retained placenta
 - Pulling the cord off
 - Causing uterine atony
 - None of the above**
- 14) Controlled cord traction is only applied when countertraction is applied simultaneously because:
- Countertraction helps the placenta descend into the vagina.
 - Countertraction supports the uterus and helps prevent uterine inversion during controlled cord traction.**
 - Countertraction reduces pain caused when controlled cord traction is applied.
 - Countertraction reduces the risk of maternal-to-child transmission of HIV.
- 15) If the placenta does not descend during 30–40 seconds of controlled cord traction:
- Consider placenta accreta and prepare the patient for a surgical intervention.
 - Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well contracted again.**
 - Administer a second injection of oxytocin 10 IU IM.
 - Administer a different uterotonic because the first uterotonic was not effective.
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 - b) **Immediately after birth of the baby if the newborn requires resuscitation**
 - c) After the placenta is delivered to ensure transfer of blood to the newborn
 - d) At a time determined by cultural beliefs

Monitoring during the immediate postpartum period

- 19) Ms. A gave birth to a healthy baby girl one hour ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. How often should you monitor her uterus and vaginal bleeding during the second hour after delivery of the placenta?
- a) Every 10 minutes
 - b) **Every 15 minutes**
 - c) Continuously
 - d) Every 60 minutes
- 20) Baby A was born at 3:15 pm. She did not require resuscitation and has already begun breastfeeding. It is now 6:30 pm. How often will you monitor her temperature?
- a) Continuously
 - b) Every 15 minutes
 - c) Every 30 minutes
 - d) **Every 60 minutes**



Alternate Mid-Course Questionnaire: AMTSL

Instructions:

Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the facilitators to assist you before you respond to the question.

MULTIPLE CHOICE

Circle the best response for each question. Each question is worth 1 point.

Scientific evidence

- 1) Which of the following statements describes a **disadvantage** of physiologic management of the third stage of labor?
 - a) It increases the length of the third stage of labor.
 - b) It does not interfere with the normal process of labor and childbirth.
 - c) It reduces the risk of PPH.
 - d) It reduces average amount of blood loss.
- 2) Which of the following statements describes an **advantage** of AMTSL?
 - a) It requires the presence of a skilled birth attendant who can administer injections.
 - b) It reduces the amount of blood loss after childbirth.
 - c) It increases the risk of PPH during the third stage of labor.
 - d) It increases the length of the third stage of labor.

Review of uterotonic drugs

- 3) Under ideal condition, oxytocin should be stored :
 - a) In a refrigerator, between 2–8°C
 - b) In an open kidney dish in the delivery room
 - c) In a drawer in the midwife's office
 - d) in a coat pocket to facilitate its use
- 4) Which of the following statements about augmentation of labor is **false** :
 - a) Labor should be augmented only if clear emergency or obstetric conditions are present, and a physician is readily available to perform a cesarean delivery should complications arise.
 - b) If a woman requires augmentation of labor, she should be immediately referred to a health care facility with the capacity to perform a cesarean operation.
 - c) Oxytocin can be safely administered IM in labor if accompanied by an antispasmodic medication
 - d) If oxytocin is used for labor augmentation, it should be administered by controlled IV drip in a health facility that has an operating theater and qualified physician to perform an emergency caesarean operation

- 5) Which of the following statements about oxytocin is true :
- a) Oxytocin acts within 6 to 7 minutes.
 - b) Oxytocin is associated with the following side effects: chills and elevated temperature
 - c) Oxytocin is less stable than ergometrine when exposed to heat or light.
 - d) Oxytocin has no known contraindications for postpartum use
- 6) If the health facility does not have a refrigerator:
- a) Oxytocin may be stored outside the refrigerator at a maximum of 40°C for no more than three months.
 - b) Unrefrigerated transport of oxytocin is possible if no more than six weeks at 30-50°C
 - c) Unrefrigerated transport of ergometrine is possible if kept **in the dark** and for no more than one month at 30°C.
 - d) None of the responses is correct
- 7) Which of the following elements need to be checked to ensure that oxytocin has not lost its effectiveness:
- a) The expiry date written on the ampoule
 - b) The color of the product
 - c) The drug company that produced it
 - d) The route of administration as written on the ampoule

Prevention of PPH

- 8) The most important factor in determining a woman's chances of surviving PPH is:
- a) the woman's parity
 - b) early diagnosis and management of PPH
 - c) identification of risk factors during pregnancy
 - d) identification of risk factors when a woman comes to the health facility to give birth
- 9) Which of the following statements is **true**:
- a) The majority (two-thirds) of PPH cases can be predicted by screening for risk factors during pregnancy
 - b) The majority (two-thirds) of PPH cases can be predicted by conducting a thorough history when women present at the health care facility in labor
 - c) The majority (two-thirds) of women who have PPH have no risk factors
 - d) The majority (two-thirds) of PPH cases can be predicted if the provider has enough labor and delivery experience
- 10) Which of the following care should be provided routinely to all women to prevent PPH and ensure its early diagnosis and management:
- a) Using the risk factor approach to identify women at high risk of suffering PPH
 - b) Developing a birth preparedness and complication readiness plan during pregnancy
 - c) Augmenting labor when the cervical dilatation is to the left of the alert line
 - d) Applying AMTSL at all births



- 11) Which of the following statements about PPH is **true**:
- a) The importance of a given volume of blood loss varies with the woman's hemoglobin level
 - b) Nearly half of women who deliver vaginally often lose at least 1000 mL of blood
 - c) Blood loss estimates made by providers are usually extremely accurate
 - d) Blood loss of less than 1000 mL will have not effect on women who are not anemic.

AMTSL

- 12) Controlled cord traction is **not recommended** if :
- a) The provider has not been trained to apply it
 - b) The woman did not receive a uterotonic drug after birth of the baby
 - c) Labor was induced using oxytocin
 - d) (a) and (b)
- 13) Controlled cord traction should never be applied except if countertraction is applied simultaneously because:
- a) Countertraction helps the placenta descend into the vagina.
 - b) Countertraction supports the uterus and helps prevent uterine inversion during controlled cord traction.
 - c) Countertraction reduces pain caused when controlled cord traction is applied.
 - d) Countertraction reduces the risk of maternal-to-child transmission of HIV.
- 14) Active management of the third stage of labor includes which of the following elements:
- a) Wait for signs of placental separation (e.g., lengthening of the cord)
 - b) Administer a uterotonic drug after delivery of the placenta
 - c) Immediately clamp the cord after birth of the baby
 - d) Controlled cord traction with simultaneous countertraction
- 15) If the placenta does not descend after 2 attempts of controlled cord traction:
- a) Consider placenta accreta and prepare the patient for a surgical intervention.
 - b) Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well contracted again.
 - c) Administer a second injection of oxytocin 10 IU IM.
 - d) Administer a different uterotonic because the first uterotonic was not effective.
- 16) What should a skilled birth attendant rule out before administering a uterotonic drug?
- a) Pulsation of the umbilical cord
 - b) Uterine contractedness
 - c) The presence of another baby
 - d) Signs of placenta separation (e.g., lengthening of the cord)

- 17) Which of the following statements about cutting the cord is **true**:
- a) Delaying cord clamping will interfere with the application of AMTSL
 - b) The practice of waiting to clamp the cord until at least 2 to 3 minutes after birth of the baby has proven beneficial to the baby as it results in higher hemoglobin and hematocrit values and possibly lower levels of early childhood anemia and greater iron stores.
 - c) Cutting the cord assists with separation of the placenta from the uterine wall
 - d) Waiting more than 30 seconds to cut the cord is only helpful for premature infants
- 18) In the context of prevention of PPH, if the birth attendant cannot administer oxytocin then management of the third stage of labor will include the following elements:
- a) Wait for signs of placental separation (e.g., lengthening of the cord)
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Monitoring in the immediate postpartum period

- 19) Ms A just gave birth to a health baby boy. Her perineum is intact. How often should the provider monitor the woman's vaginal bleeding during the third hour after giving birth?
- a) every 10 minutes
 - b) every 15 minutes
 - c) every 30 minutes
 - d) every 60 minutes
- 20) If a woman gave birth at 1:00 pm and it is now 1:15 pm, how often should the provider monitor her new baby's temperature?
- a) every 10 minutes
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Facilitator's Tools

Training report form

Participants and Results

Training Dates: ___/___/___ - ___/___/___

Name	Profession	Previous experience with AMTSL	Place of work	Knowledge Assessment		Skill Assessment	
				Pre-Course	Final	Pre-Clinical	Final



Documents, Forms, and Equipment Needed for 3-Day AMTSL Training

TOPIC	WHEN NEEDED	DOCUMENT / FORM / EQUIPMENT	NUMBER OF COPIES		
			Participants	Facilitators	Total
Preparation/ registration	Before training begins	Notepad, pencil, pen, ruler, eraser			
		Name tags			
		Registration forms			
		Pre-course questionnaire			
		Mid-course questionnaire			
		Schedule			
		AMTSL Training Objectives			
		AMTSL Reference Manual			
		AMTSL Participant’s Notebook			
		AMTSL Facilitator’s Guide			
		Flipchart and markers			
		Extra flipchart paper if presenting on charts			
		Overhead or LCD projector			
Supplies for each topic	Before the topic is presented	Core Topic 1: Review of third stage of labor and evidence for AMTSL			
		Core Topic 2: Causes and prevention of PPH			
		Core Topic 3: Uterotonic drugs			
		Core Topic 4: Steps in AMTSL			
		Additional Topic 1: Infection prevention			
		Additional Topic 2: Birth-preparedness and complication-readiness plans			
		Additional Topic 3: Management of selected complications during the third stage of labor			



Facilitator responsibility list

AMTSL Training Program

RESPONSIBILITY	FACILITATOR(S)
<i>Preparation</i>	
1. Prepare staff in clinical site (ideally done several weeks before the training is to occur).	
a. Give information on class dates, size, when on ward, focus of clinical time.	
b. Ask for assistance/cooperation.	
c. Ensure sufficient supplies for participants when on the units.	
d. Work with staff to ensure high-quality care provided (so staff role models skills/protocols taught in training program).	
2. Do inventory of teaching equipment, supplies, and documents and replace as needed.	
3. Arrange meals, snacks, accommodation.	
4. Prepare classroom (clean, enough desks/chairs, whiteboard/pens, overhead/video machines available).	
5. Make copies of all learning materials needed: Reference Manuals, Participant's Notebooks, Facilitator's Guides, Pre- and Mid-Course Questionnaires, answers to learning activities.	
6. Prepare materials needed for demonstrations.	
<i>Administrative and evaluation responsibilities</i>	
1. Welcome participants as they arrive.	All
2. Pass out registration form, Participant's Notebook, Reference Manual.	
3. Pre-/mid-course knowledge assessment.	
4. Skill evaluations (first day, before clinical, and last day).	All

RESPONSIBILITY	FACILITATOR(S)
5. Orientation	
a. Opening, welcome	
b. Registration	
c. Introductions	
d. Workshop ground rules	
e. Training objectives	
f. Orientation to learning materials	
g. Schedule	
h. Team system	
i. Using checklists	
6. Arrange certificates.	
7. Review participant training evaluation and closing.	All
8. Write Training Report.	
9. Arrange/attend Facilitator Meeting every _____ months.	All
Teaching responsibilities	
Core topic 1: Review of the third stage of labor and evidence for AMTSL	
Core Topic 2: Causes and Prevention of PPH	
Core Topic 3: Uterotonic Drugs	
Core Topic 4: Steps in AMTSL	1 facilitator per 4 participants during practice session



RESPONSIBILITY	FACILITATOR(S)
Additional Topic 1: Infection Prevention	
Additional Topic 2: Birth-Preparedness and Complication-Readiness Plans	
Additional Topic 3: Management of Selected Complications During the Third Stage of Labor	
Orientation to clinical areas	
Clinical sessions	1 facilitator per 2–4 participants during clinical sessions
<i>Facilitators</i>	
Overall responsibility for Day 1	
Overall responsibility for Day 2	
Overall responsibility for Day 3	
Overall responsibility for clinical practice	
Overall responsibility for administrative documents	

Slide References

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- CT1-2:

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- CT4-5, CT4-7, CT4-8, CT4-13

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- CT4-6, CT4-9, CT4-11, CT4-12

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- CT1-3, CT1-4, CT4-10

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- AT1-9

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- AT1-10

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- AT3-20, AT3-21, AT3-27

Text References

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