Skills Lab for RMNCH+A Services

Training Manual

November 2013

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

सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Skills Lab for RMNCH+A Services

Training Manual

November 2013

Maternal Health, Child Health & Family Planning Divisions
Ministry of Health & Family Welfare
Government of India

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Preface

Delivering quality health care in a timely manner through public health facilities is one of main goals of National Rural Health Mission. For this to happen, it is of paramount importance to ensure that the personnel providing the health services are trained so that they possess the skill sets required for delivering quality service.

It has been observed that there is a need to augment the knowledge and skills of the health professionals for delivering quality services with adherence to the technical protocols to all clients accessing services at the government health facilities. Opportunities for reorientation and reinforcement of knowledge and skills should be inbuilt in the system so that the health professionals are updated periodically. Periodic assessment and enhancement of the competencies of the ANMs and Staff Nurses who are pillars for rendering quality health care services is critical for achieving NRHM goals.

The decision to augment health professionals training by Skills lab and the assessment and training of these workers who are providing RMNCH+A services in the public health institutions is a major step taken by Government of India. The operational guidelines on the same were released in February 2013, which facilitated establishment of Skills laboratories in the states supported through the National Rural Health Mission.

MH Division has brought out the training manual for the Skill Lab after taking inputs from all the program officers of RCH divisions which needs to be adhered to.

I am sure that the Training Manual on Skills Lab will provide the guidance to the skills lab faculties for undertaking the training and contributing improvement of the service delivery.

Anuradha Gupta
(AS& MD, NRHM)
22.11.2013

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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Foreword

As part of the Government of India's commitment to ensure availability of quality services through public health institutions, NRHM has introduced a system of competency based training and certification programme to be implemented through Skills Laboratories. These Laboratories will provide a platform for augmentation of the skills of health personnels involved in the delivery of RMNCH+A services across public health institutions.

The programme will cover training requirements of Auxiliary Nurse Midwives, Staff Nurses, Medical Officers and Obstetricians, initially the in-service and then covering the pre-service as well. Standardized skill stations comprising of quality mannequins, pedagogy and objective structured clinical examination (OSCE) will be an integral part of these trainings which have been explained in detail in the manual.

The Maternal Health Division has done a commendable job of timely completion of this task, while engaging all the RMNCH+A divisions into this initiative.

I am confident that establishment of the Skills labs will help immensely to ensure that the protocols are practised and adhered to, leading to improving the quality of service delivery in public health institutions in the country.

Rak

(Dr. Rakesh Kumar)
22.11.2013

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Acknowledgement

Ensuring quality of services in public health facilities is one of the important mandates under National Rural Health Mission. To achieve this, it is important that the service providers working at the health facilities are proficient in skills for providing better quality services at health facilities particularly with reference to pregnant women, mothers and new-borns. At present the quality of the pre service teaching and in service trainings is largely focused on knowledge and provides limited opportunities for practicing the skills. So there is a need for creating simulated environment for practicing on mannequins before the trainees are allowed to manage the cases independently.

The operational guidelines on Skills lab will facilitate the States in developing and operationalizing standardized skills station. The Training Manual has been developed for guiding the trainers on how to conduct the trainings as envisaged in the operational guideline. This Manual elaborates session plans giving details in terms of teaching aids, job aids, presentations, videos, checklists required during each session and where the sessions shall be conducted. By using the checklist given in this manual, the trainees will be able to follow and practice the correct steps for demonstrating/practicing the skills. It is hoped that by operationalizing Skills laboratories in every State, we would be able to render knowledge and skills through proficiency based evaluation and this will help both the trainers and trainees in identifying the weaker area which can be strengthened during the mentoring visits by the skill lab trainers.

The initiative and guidance of Ms Anuradha Gupta, AS& MD, NRHM, GOI has helped us in preparing the Operational Guideline and the Training Manual for Skills Laboratories. I would also like to thank Dr Rakesh Kumar, JS (RCH), and MOHFW for his constant technical and administrative support in developing the guidelines for the skills lab.

I would like to acknowledge the support given by Mission Director (NRHM), Govt of Maharashtra and his team for facilitating the deliberations and technical assistance. Dr J.K. Das, Director, NIHFW as the chairperson of the expert group helped us in finalizing the specifications of the mannequins and different skills stations. My sincere thanks to Dr. P. Padmanaban & Mr. K. S. Prasanth from NHSRC who have been instrumental in preparation of the Training manual. I must thank Dr Bulbul Sood, Country Director, JHPIEGO and her team particularly Dr Rashmi Asif, Dr Somesh Kumar, and Ms Princy Fernando from JHPIEGO for their proactive support in framing skill stations.

I would also like to acknowledge the contribution of UNICEF particularly Dr V. K Anand, Dr. Malalay Ahmadzai & Dr Ritu Agarwal for giving their technical inputs. The inputs given by Dr Dinesh Agarwal from UNFPA have been valuable. I must acknowledge the fact that all the National and State experts particularly Dr Aboli Gore, MP TAST, Dr. Archana Mishra, DD(MH),Govt of MP, Dr Manju Chuggani, Principal, Jamia Milia College of Nursing, participated in the deliberations even on holidays and gave valuable inputs.

I would like to appreciate the contribution given by Dr S.K. Sikdar, DC (FP) and Dr P. K. Prabhakar, DC(CH) for their active contribution in framing these guidelines. The technical support given by Dr. Manisha Malhotra, DC(MH), Dr Dinesh Baswal, DC(MH), Dr Renu Srivastava, Dr Ravinder Kaur, Dr Pushkar Kumar, & Dr Rajeev Agarwal, Senior Consultants in CH and MH Division, helped in firming the technical components and also in bringing final edited version of this document.

It is my earnest request to all the State Mission Directors and Program Officers to take personal initiative in creation of skills lab both for in-service and pre service trainings in order to ensure that the service providers have a platform for harnessing their skills for provision of quality RMNCH services.

(Dr H. Bhushan)
DC (MH I/c)
22.11.2013

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PART I

PRE-REQUISITES

INTRODUCTION

The RMNCH+A strategy of GoI is based on the concept of Continuum of Care approach encompassing the health and well being of women, newborn and children managed through convergent efforts under NRHM. To strengthen the services for ensuring Continuum of care approach, competencies of service providers is essential.

Presently Medical Officers, SNs and ANMs are being trained on skills to provide the required services, however, practicing of these skills is being compromised due to various reasons. It is observed that inadequate follow-up and mentoring of personnel for proficiency of skills learnt during the trainings and absence of enabling environment to practice the gained skills has resulted in poor delivery of quality of services.

Skill is the ability of an individual to perform the task, however, competence is, possessing the knowledge, skill and attitude required to perform the task. It has been observed that trainings have to be need-based for acquisition and upgradation of skills of health care providers to provide RMNCH+A services. Introduction of skills lab is the need based training concept in the present scenario.

The Skills Lab: operational guidelines released by GOI in February 2013, deals with establishment of Skills lab, training plan, job responsibilities of designated officers, monitoring & evaluation methods and budget for these activities.

This training manual deals with training methodology, session plan, skills checklist, OSCE method of evaluation, record keeping and Certification. The manual is common for facilitator (trainer) and learner (trainee).

TRAINERS & TRAINEES

Every skills lab will have 6 dedicated trainers and among them one will be designated as in-charge or skills lab coordinator. 16 trainees can be trained in every batch.

The job responsibilities of trainer and skills lab coordinator is mentioned in the operational guidelines. A few other specific roles to ensure that:

a The schedule of training as per GOI guidelines is strictly followed

b Individual attention is provided to all learners

c Skills lab is available for practice after the days' session is over if any learner requests for it

d At the end of each day, the trainer should discuss the day's proceedings and inform about the next day.

e All learners to be grouped for housekeeping of the skills lab during the training days to help them develop ownership and sense of belonging and responsibility towards the equipment and training material in the skills lab. At the end of each day, the assigned group will assist the trainer to clean up the skills station, make them ready for the next day and remove any waste scattered in the skills lab and collect it in the waste bin in the lab for the cleaning staff, arrange the table and chairs in order so that the lab looks neat for use for the personnel wanting to come for practice after the training hours.

HOW TO USE THE MANUAL?

The training manual is intended to be used by the trainer as well as trainee. The skills lab training is to be conducted strictly according to the steps given in the manual.

The manual has two parts. The first part is general introduction, part two deals with basic skills. Manual for Add-on skills is a separate document. To conduct a session, the skill lab and the seminar hall has to be ready with the set of teaching-learning aids (Video, Powerpointpresentations ,demonstrations) prescribed in the manual. It is the responsibility of the trainers to ensure that the skill lab is ready to receive the trainees. It is the responsibility of the DNO to ensure that all support is provided to trainers in this regard.

Sessions for both the batches (basic and add-on) starts in the seminar hall. The sessions in the skill stations are conducted as per a prefixed schedule and adherence to this schedule is important to timely and correctly conduct the sessions. The manual gives details on 'how to set up the stations for conducting the sessions' with the list of mannequins, equipments and consumables. Before start of session, a pre-test (consisting of Knowledge and OSCE components) is conducted to understand the baseline knowledge/skills level of the trainees.

In the session plan, the trainees will be grouped into 4 teams for conduct of session. Once session starts, do not allow change of group since this can result in some trainees missing some of the sessions. For doing knowledge assessment, the trainer picks up two sets of questions (from the 5 sets provided in the CD), one for pretest and another for post test. The questions are accompanied by an answer key also. Trainees should be encouraged to ask questions for further clarifications. For case scenarios/role plays, trainer must assign the roles to trainees and conduct session in a natural manner.

After the conduct of the training a post test (consisting of Knowledge and OSCE components) is carried out to understand the improvements from baseline on 'knowledge/skills level' of the trainees. The checklists which indicate the steps to be followed are given in the manual. Both the pre and post test results have to be updated in the skill lab records (Competency tracking sheet) in soft copy and made available to trainers during mentoring visits.

The manual also contains certificate formats for Basic and Add-on Skill training. This has to be printed and issued to all participants on the last day of the training. The trainers have to be issued a CD with copies of all videos and power points as well as the skills checklist.

TRAINING PACKAGE

In a Skills Lab 2 levels of trainings are undertaken;

a Basic skills – 6 days duration

b Add-On skills – 3 days duration

- Basic skill package will provide skills to ANM/LHV/SN/MO/Nursing Supervisors and faculty/ Obstetricians and Pediatricians working at delivery points. The Basic skill package will refresh the skills acquired during various skill based training in RMNCH+A and can also be utilized for strengthening pre service teaching and training.

- Add-On skill package will be imparted to SN and MOs of BeMOC facilities/Obstetricians and Pediatricians. All MO and staff nurses/ANM in BeMOC facility should undergo 10 days BeMOC. Add-on skills package must not be considered as substitute to it.
- It is desirable that only that ANM/LHV/SN is nominated initially who have already undergone SBA training.

The trainings offered at Skills lab is fully residential.

Training Materials

S no	Material	Learner	Facilitator
1	Training manual	Checklists for self-practice (also provided separately for skills practice)	▸ Instruction on how to conduct training ▸ Sample answers to the questionnaire, case studies etc. ▸ Assessment of the learners
3	Power point presentations	Learning theory Key points for reference	▸ Related theory to the skills ▸ Knowledge imparted to learners should conform to the content of the GoI guidelines
4	Training videos	View the procedure Self-learning and practicing material	▸ Explain the steps for each skill/ procedure
5	Mannequins and Equipments	To practice skills	Demonstration / assessment of skills

TRAINING METHODOLOGY

It is a mix of theory and skills sessions which will be imparted using mannequins, training videos, skills checklist, case scenarios, role plays and power point presentations.

The Skills lab mainly deals with imparting / providing hands on practice on the available mannequins. The theory session will be based on the latest SBA, IMNCI and NSSK curriculum. All the theory session related material has been consolidated and standardized and the same should be used for all skill lab training purpose. It is important for the trainer to make these sessions interactive and participatory by initiating a dialogue with the learners where they come out with the way they are practicing in their facilities.

The trainer should not exceed/try to give more information on the concerned topic. The facilitator needs to make the objectives of the training and limitation of the time clear to the learners.

Skills Lab Session

The facilitator should spend time with the learners at the skill stations to guide and support them during practice of skills. This will involve demonstrating the particular skill (using skills checklist) to the learners

and then supervising the learners to perform these skills and assessing their competency with the help of relevant checklists.

- During the session, the learners will be divided into 4 groups. The groups will practice in a sequence as per the session plan.
- The groups are named as I A,I B, II A&II B. Each group is given different colored tags of blue, yellow, green and red for identification. Each group has 4 members.
- Each group is allocated 1 trainer as mentor for all the 6 days. The mentor also wears the group's color tag.
- While making the group, take care that it is a mixed group i.e. doctors/ nurses, senior staff/ junior staff, bright learners/ not-so-bright learners.
- Make 1 trainer in-charge of 1 skills cabin for all the six days
- In the skills lab, the learners are going to practice on the mannequins, as per the instructions provided to them by the trainer. Complete respect to the mannequin should be given as given to the client. This will help the learner to develop respectful attitude and counseling skills.
- Use the mannequins to perform step-wise demonstration of skills as per checklist
- Time management is important throughout the practice session so that the learners are able to practice all the skills scheduled for the day. DEO should help the facilitators to keep the time.
- By the end of each day, trainers should ensure that each learner gets opportunity to practice the skills learnt.
- Trainer should observe the learners and encourage the weaker ones to do skills practice under their observation during the skills practice sessions at the end of the day.
- At the end of 6 days, learners should be given Skills checklist, power point presentations and training videos, so that they can refresh/reorient themselves as and when they feel so.

Tips For The Facilitator On The Do's & Don'ts During The Training

DO's	
Prepare in advance	Position visuals so that everyone can see them.
Maintain good eye contact and be respectful to the learners	Avoid distracting mannerism and distractions in the room
Involve learners and encourage questions	Be aware of the learners' body language.
Speak clearly and loudly. Check to see if your instructions are understood.	Keep the group focused on the task
Write clearly and boldly	Be patient and recapitulate key points at the end of each session.
Demonstrate skills on mannequins and ask learners for a return demonstration.	Make sure the topics are sequenced logically
Use checklists to observe learners as they practice skills and provide constructive feedback.	Keep it simple and provide clear instructions
Manage time properly as per the schedule.	Keep the mobile phone in silent mode.

DONT's	
Talk to the flip chart or black board	Ignore the learners comments and feedback (verbal and non-verbal)
Block visual aids	Read from the text
Stand at one spot.	Shout at the learners
Move around in the room	Leave the session in the middle of the activity
Interrupt a trainer or a learner while they are speaking. Make your point after they have finished	Be in attentive when the learners are practicing

SESSION PLAN

The teaching aids, preparation required for the sessions, objective of the sessions and step by step training methodology, including the critical skills to be imparted are explained in detail under each session plan.

Pre & Post-Test Assessment

A pre and post-test assessment to be carried out by trainers to assess the knowledge and skills gained based on Structured knowledge questionnaire and Objective Structured Practical / Clinical Examination (OSPE/ OSCE) respectively. The entire group will undergo knowledge assessment in the seminar room, followed by which a group of 4 trainees will be undertaking skills assessment through OSCE and this assessment will continue till all 16 trainees are assessed. The duration of each assessment will be of 40 minutes, which means that by the entire process of Knowledge and Skill assessment will take 200 minutes.

The facilitators may ask the Data Entry Operator (DEO) to supervise the administration of structured knowledge questionnaire to one group, as the facilitators are involved in the OSCE stations. Use knowledge questionnaire as provided in the CD. Facilitator should use different set for every training batch. During OSCE, each facilitator will be responsible for 1 OSCE station.

There are total 4 OSCE stations under Basic skills.

Basic Skills Lab

1 Management of second stage of labour

2 AMTSL

3 Newborn resuscitation

4 Management of shock (CAB approach)

Each learner will spend 10 minutes at each OSCE station, then move to the next station; thus covering all the 4 stations in 40 minutes. In post training learner should clear at each of the 4 OSCE stations and should score minimum 70% for knowledge questionnaire.

The pretest and post test scores should be analyzed by the facilitators to understand the areas with minimum and maximum gain and plan focus areas for mentoring during the monitoring visits. The facilitator should carry the competency record of the learners to be visited during the field visit as a reference to address the gap. This will help them to improve the quality of training.

A certificate of participation will be given to each participant. A performance card will be provided indicating the knowledge and OSCE score.

Use of the 'Skills-Checklists'

The checklists contain the steps or tasks performed on the mannequin/equipment. These serve as guides for the activities or tasks to be performed in a recommended sequence of standard practice.

The checklists are designed to be used for both teaching (demonstration on mannequin/equipment) and supervision of skill acquisition by the learner. The skills checklist can also be used as a peer-learning tool, practice tool during supervised skills practice session and assessment of skills. At the end of steps of the skills checklist, key points related to the skill are mentioned. These are to be emphasized by the facilitators during demonstration and discussion.

Each skills checklist has identified critical steps which are marked in bold. It is mandatory that each learner performs all the critical steps. At the end of each skill station the facilitator will sign the learning log book for only that skill where the learner has done all the critical steps.

Record Keeping

a Attendance sheet /register of the learner

b Scoring record of pre and post knowledge test and OSPE/ OSCE.

c Learners' logbook

d Follow up data base for supportive supervision

e Field supervision and monitoring calendar.

f Batch wise information on the learners profile, performance and follow up record of mentoring visits.

PREPARATORY STEPS

The coordinator in consultation with the district/divisional nodal officer will ensure the following:

Before the training;

- Scheduling of the batch in respect to dates and participants
- Check the functionality of Skills lab with regard to seating arrangement, electricity, drinking water, equipment and instrument, replenishment of consumables.
- The training kits and other materials like pretest questionnaire, case scenarios, role plays are ready and available in adequate number.

During the training;

- Ensure that the skills stations are arranged as per session plan before the day's session starts.
- Consumables are available in sufficient quantity.
- Sessions are conducted in a disciplined and coordinated manner following the session plan.
- The training is conducted with punctuality.
- Individual competencies of each learner is measured and recorded.
- Sufficient time for skills practice is given to the learners

PART II

BASIC SKILLS FOR ANM/LHV/SN/MO

TRAINEES INFORMATION CHART

Trainees have to go to the seminar room and then as per the course schedule they have to move to the cabins.

Seminar Room: Plenary sessions

Day	Activity	Teaching learning aids
Day 1	Introduction session using PPT Knowledge based Pretest PPT and training video for the day	Power point presentation **PPT1: Introductory Session** Pretest Knowledge assessment questionnaire **Videos** ▸ Antenatal (SBA) - EDD, weight recording, ▸ Abdominal palpation and FHS ▸ BP ▸ HB ▸ Urine ▸ UPT ▸ RDT ▸ Hand washing, PPE & Chlorine preparation
Day 2	Recap PPT and training video for the day Plenary-IMEP	**Power point presentation** ▸ Processing of equipment ▸ Partograph **Videos** ▸ Processing of equipment ▸ Organizing Labour room ▸ Cervical dilatation and Normal Delivery
Day 3	Recap PPT and training video for the day Plenary-Documentation Plenary- Counseling	**Power point presentation** ▸ AMTSL ▸ PPH ▸ RMNCH Counselling **Videos** ▸ AMTSL ▸ PPH **Role Play** ▸ Counselling (General Counseling and counseling on FP, RI, Adolescent health, Nutrition, Breast feeding, Complication Readiness)

Day 4	Recap PPT and training video for the day Plenary- Role play (General Counseling and counseling on FP, RI, Adolescent health, Nutrition, Breast feeding, Complication Readiness)	**Power point presentation** ▸ Eclampsia ▸ Hypovolemic Shock - CAB ▸ Family Planning methods **Videos** ▸ Eclampsia -SBA ▸ Hypovolemic Shock – CAB ▸ Interval IUCD ▸ Suction machine ▸ Administration of oxygen, ▸ Radiant Warmer ▸ Glucometer
Day 5	Recap PPT and training video for the day Plenary – Counting respiratory rate, use of Metered Dose Inhalers/ Nebulizer and dehydration signs /ORS Preparation and zinc tab Course evaluation	**Power point presentation** ▸ NRP **Videos** ▸ ENBC ▸ NRP ▸ BF +KMC ▸ MDI &Nebuliser **Exercise:** Documentation
Day 6	Recap Post test- knowledge based Valedictory	Post test Knowledge assessment questionnaire Certificates of participation TA/DA forms

DAYWISE CABINWISE STATIONWISE SKILLS PLAN

There will be 4 Skills Cabin and a Labour Room layout in the Skills lab. The Skills Stations are distributed amongst these 5 spaces depending upon the mannequin/equipment required. Care has been taken to organize the skills station in a way that the facilitator does not have to shift the mannequin/equipment from one skills cabin to the other. Day -Wise Skills cabin plan is displayed here:

Skills Basic					
Days	**Skill Cabin I**	**Skill Cabin II**	**Skill Cabin III**	**Skill Cabin IV**	**Labor room**
Day1	**OSCE 2:AMTSL**	**OSCE 4:CAB**	**Nil**	**Nil**	**OSCE 1- 2nd Stage of Labor and** **OSCE 3: NRP**
	Antenatal Care: EDD calculation Weight recording BP recording **Lab tests:** Urine pregnancy test Hb estimation Urine for albumin /sugar RDK for malaria Glucometer	**Universal Precaution:** Hand washing Preparation of chlorine solution Personal protective attire **Abdominal palpation:** Abdominal palpation FHS recording	**Antenatal Care:** EDD calculation Weight recording BP recording **Lab tests:** Urine pregnancy test Hb estimation Urine for albumin /sugar RDK for malaria Glucometer	**Universal Precaution:** Hand washing Preparation of chlorine solution Personal protective attire **Abdominal palpation:** Abdominal palpation FHS recording	**Nil**
Day2	Partograph	Partograph	**Processingof equipment:** Decontamination Cleaning Sterilization Storage	**Processingof equipment:** Decontamination Cleaning Sterilization Storage	**Normal Delivery:** Cervical dilatation & normal delivery **Organizing LR:** 6 trays NBCC Infection prevention practices

Day3	**Management of PPH:** Management and Inserting IV line	**Nil**	**Management of PPH:** Management andInserting IV line	**Nil**	**AMTSL**
Day4	**Eclampsia:** Initial management InjMagsulf	**Management of shock:** CAB Volume Replacement **Interval** **IUCD:** IUCD insertion And removal	**Eclampsia:** Initial management InjMagsulf	**Management of shock:** CAB Volume Replacement **Interval** **IUCD:** IUCD insertion And removal	**Newborn care corner:** Parts and working of Radiant warmer Suction Oxygen administration
Day5	**PNC+Breast Feeding and KMC**	**Documentation**	**ENBC:** Drying the baby Temperature maintenance Wrapping Cord care **MDI with spacer, Nebulizer**	**MDI with spacer, Nebulizer**	**NRP:** Artificial ventilation with bag and mask
Day6	**OSCE 2:AMTSL**	**OSCE 4:CAB**	**Nil**	**Nil**	**OSCE 1- 2nd Stage of Labor and OSCE 3: NRP**

DAYWISE PROGRAMME SCHEDULE

DAY I

Time	Space	Activity
09.00- 9.30		Registration + Tea
09.30- 10.00	Seminar room: Plenary	Introductory lecture about skills lab and objective + introduction of participants
10.00-11.30	Seminar room & Skills cabin	Pre Test and OSCE (40 mts each and then swap)
11.30-12.30	Seminar room	**Videos** ▸ Antenatal - EDD, BP, weight recording ▸ Hand washing, PPE & Chlorine preparation
12.30–01.30		Lunch
01.30-3.00	Skills cabin	**Concurrent session at skills station:** **(Each group practice first skill for 1.5 hrs)** Group IA. Antenatal - EDD, BP, weight recording (cabin 1) Group IB. Antenatal - EDD, BP, weight recording (cabin 3) Group IIA. Hand washing, PPE & Chlorine preparation (cabin 2) Group IIB. Hand washing, PPE & Chlorine preparation (cabin 4)
3.00-03.15		Tea Break
03.15-4.30	Seminar room	**Videos** ▸ HB, Urine, UPT, RDT ▸ Abdominal palpation and FHS
4.30-6.30	Skills cabin	**Concurrent session at skills station:** **(Each group practice first skill for 1.5 hrs)** Group IA. HB, UPT, RDT, Urine (Albumin / Sugar) (cabin 1) Group IB. HB, UPT, RDT, Urine (Albumin / Sugar) (cabin 3) Group IIA. Abdominal palpation and FHS (cabin 2) Group IIB. Abdominal palpation and FHS (cabin 4)

DAY 2

Time	Space	Activity	
9.00-9.30	Seminar room: Plenary	Recap	
9.30- 10.30	Seminar room: Plenary	**Videos** ▸ Processing of equipment ▸ Organizing Labour room	**Power point presentation** ▸ Processing of equipment
10.30- 11.15	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 30 min and then swap with the other group)** Group IA &Group IB: Processing of equipment (Cabin 3&4) Group IIA &Group IIB: Organizing Labour room (Cabin 5)	
11.15-11.30		Tea break	
11.30-12.15	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 30 min and then swap with the other group)** Group IA &Group IB: Organizing Labour room Group IIA &Group IIB: Processing of equipment	
12.15-1.00	Seminar room	**Videos** ▸ Cervical dilatation and Normal Delivery	**Power point presentation** ▸ Cervical dilatation and Normal Delivery ▸ Partograph
1.00-2.00		Lunch	
2.00-3.30	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 45 min and then swap with the other group)** Group IA &Group IB: Cervical dilatation and Normal Delivery (Cabin 5) Group IIA &Group IIB: Partograph (Cabin 1 & 2)	
3.30-3.45		Tea	
3.45-5.00	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 45 min and then swap with the other group)** Group IA &Group IB: Partograph Group IIA &Group IIB: Cervical dilatation and Normal Delivery	
5.00-6.00	Skills cabin	Supervised Skills Practice time	

DAY 3

Time	Space	Activity	
9.00-9.30	Seminar room	Recap	
9.30-10.30	Seminar room	**Videos** ▸ AMTSL ▸ PPH (IV Oxytocin, bimanual compression)	**Power point presentation** ▸ AMTSL ▸ PPH (IV Oxytocin, bimanual compression)
10.30-11.30	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 30 min and then swap with the other group)** Group IA &Group IB: AMTSL (Cabin 1) for OSCE and (Day 3, Cabin 5) for training Group IIA &Group IIB: PPH Management (IV Oxytocin, bimanual compression) (Cabin 1 & 3)	
11.30-11.45		Tea	
11.45-12.45	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 30 min and then swap with the other group)** Group IA &Group IB: PPH (IV Oxytocin, bimanual compression) Group IIA &Group IIB: : AMTSL	
12.30- 1.30	Seminar room	Plenary - RMNCH Counseling	
1.30 – 2.15		Lunch	
2.15-3.15	Seminar room	Plenary – Counseling on case scenarios & role play (focus on FP, RI, Adolescent Health, Nutrition, BF, complication readiness)*	
3.15-3.30		Tea break	
3.45-4.15	Seminar room	Counseling continues…..	
4.15-5.30	Skills cabin	Supervised Skills Practice time	

**case scenario shall be distributed among groups with one group dealing with one theme only*

DAY 4

Time	Space	Activity	
9.00-9.30	Seminar room	Recap	
9.30-11.00	Seminar room	**Videos** ▸ Eclampsia ▸ Management of Hypovolemic Shock (CAB approach)	**Power point presentation** ▸ Eclampsia ▸ Management of Hypovolemic Shock (CAB approach)
11.00-11.15		Tea	
11.15-12.15	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 30 min and then swap with the other group)** Group IA &Group IB: Eclampsia (dose preparation, deep IM, Knee jerk reflex) (Cabin 1 & 3) Group IA &Group IB :CAB (Cabin 2) for OSCE; (Cabin 2 & 4) for training	
12.15-01.15	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 30 min and then swap with the other group)** Group IA &Group IB:CAB Group IA &Group IB :Eclampsia (dose preparation, deep IM, Knee jerk reflex)	
1.15-2.15		Lunch	
2.15-3.45	Seminar room	**Videos** ▸ Interval IUCD ▸ Suction machine, administration of oxygen, Radiant Warmer, Glucometer	**Power point presentation** ▸ Family Planning methods
3.45-4.00		Tea	
04.00-05.00	Skills cabin	**Concurrent session at skills station:** Group IA &Group IB: Interval IUCD (Cabin 2 & 4) Group IIA &Group IIB : Use of suction , administration of oxygen, Radiant Warmer, Glucometer (Cabin 5)	
05.00-06.00	Skills cabin	**Concurrent session at skills station:** Group IA &Group IB: use of suction, administration of oxygen, Radiant Warmer, Glucometer Group IIA &Group IIB : Interval IUCD	
06.00–07.00	Skills cabin	Supervised Skills Practice time	

DAY 5

Time	Space	Activity	
9.00-9.30	Seminar room	Recap	
9.30-11.00	Seminar room	**Videos** ▸ ENBC ▸ NRP ▸ BF +KMC	**Power point presentation** ▸ NRP
11.00-11.15		Tea	
11.15-01.15	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 1 hour and then swap with the other group)** Group IA: ENBC (Cabin 3) Group IB: NRP (Cabin 5) Group IIA: PNC+BF+KMC (Cabin 1) Group IIB: Documentation (Cabin 2)	
01.15-02.00		Lunch	
02.00-04.00	Skills cabin	**Concurrent session at skills station: (Each group practice first skill for 1 hour and then swap with the other group)** Group IA: PNC+BF+KMC Group IB: Documentation Group IIA: ENBC Group IIB: NRP	
04.00-04.15		Tea	
04.15-04.45	Seminar room	**Videos** MDI &Nebuliser	
04.45-05.45	Skills cabin	**Concurrent session at skills station:** Group IA Group IB: MDI &Nebuliser (Cabin 4) Group IIA Group IIB: MDI &Nebuliser (Cabin 4)	
05.45-6.30	Skills cabin	Supervised Skills Practice time	

DAY 6

Time	Space	Activity
9.00-9.30	Seminar room	Course Evaluation/feedback by trainees
9.30-01.00	Seminar room& Skills cabin	Post test –OSCE & KAQ
01.00-1.30	Seminar room	Valedictory
1.30-02.00		Lunch

BASIC SKILLS LAB- SESSION PLAN

DAY 1

Time: 9.00 am to 9.30 am

Space/ Place: Seminar room

Activity: Registration + Tea

Training/Learning Method: Register the participants

Resource materials/ Teaching-learning aids: Registration formats, Training kits with writing pad, pen, pencil, eraser, sharpener, agenda, photocopied set of skills checklist, name tags of 4 colors for each group of 4

Time: 9.30am - 10.00am

Space/ Place: Seminar room

Activity: Introductory lecture about skills lab and objective + introduction of participants

Training/Learning Method:

- Open training with a welcome by DNO and trainers. An inaugural session can be arranged, if necessary. Facilitate the introduction of all participants and trainers.
- Use the presentation to explain about skills lab and objectives.

Resource materials/ Teaching-learning aids:

- Flip Charts or cards, markers and double sided sticky tapes, LCD, laptop/desktop, pointer, whiteboard
- Presentation on Skills Lab

Time: 10.00am-11.30am

Space/ Place: Seminar roomSkills cabin

Activity: Pre Test and OSCE

Training/Learning Method:

- Divide the participants into **four**groups IA, IB, IIA, IIB
- **Group IA & IB:** Administer the pre- test questionnaire and
- **Group IIA & IIB:** Conduct pre OSCE
- Swap the participants to
- **Group IA & IB:** Conduct pre OSCE
- **Group IIA & IIB:** Administer the pre- test questionnaire
- Each learner will do all 4 OSCE for 5 min each and then move to next one.

Resource materials/ Teaching-learning aids:

- Pre-test questionnaire- 16
- OSCE questionnaire- 16 for each OSCE

Time: 11.30am- 12.30 pm

Space/ Place: Seminar room

Activity:Videos

- Antenatal - EDD, BP , weight recording
- Hand washing , PPE &Chlorine preparation

Training/Learning Method:

- Play the video on calculating EDD, BP, weight recording, hand washingandPPE&Chlorine preparation.
- At the end of each training video discuss with the participants the messages of the procedures demonstrated through videos and clarify doubts.

Resource materials/ Teaching-learning aids:

- Training videos(calculating EDD, BP, weight recording, hand washing and PPE &Chlorine preparation)

12.30 pm –1.30 pm	Lunch

Time: 1.30 pm-3.00pm

Space/ Place: Skill cabin

Activity: Concurrent session at skills station:
(Each group practice first skill for 1 hour and then swap with the other group)

- Antenatal - EDD, BP , weight recording
- Hand washing, PPE & Chlorine preparation

Training/Learning Method:

Divide the participants in to four groups in four skills station as given below, demonstrate the following procedure to the participants and allow the participants to do the return demonstration and practice using the checklist of the skills.

Swap the groups in after 45 mins in given order as below:

Time	Group I A & IB	Group II A & II B
First 45 Mins	calculating EDD, BP, weight recording (cabin 1 & 3)	hand washing and PPE &Chlorine preparation (cabin 2 & 4)
Second 45 Mins	hand washing and PPE &Chlorine preparation (cabin 2 & 4)	calculating EDD, BP, weight recording (cabin 1 & 3)

Resource materials/ Teaching-learning aids:

- **calculating EDD:** 4 Wheel, Local calendar 1, laminated case scenarios-4, , table with different calendar dates on EDD ,
- **BP:** Mercury 2 sets BP apparatus and stethoscope
- **weight recording:** adult weighing scale-1
- **Hand Washing:** UV machine , Red Paint, Bucket with tap and Basin to collect water / wash basin and Bins, 20 pair surgical gloves.
- **Chlorine preparation:** 1 litreplasctic mug, utility gloves,
- **PPE:** plastic apron 5, mask and cap 20 shoe cover 20, goggles 5, plastic tub,woodden/plastic stirrer , air-tight container to store bleaching powder

3.00-3.15	Tea Break

Time: 3.15 pm-4.30pm

Space/ Place: Seminar Room

Activity: Videos

- HB, Urine, UPT, RDT
- Abdominal palpation and FHS

Training/Learning Method:

Play the video on HB test, Urine test, UPT, RDT, Abdominal palpation and FHS.

At the end of each training video discuss with the participants the messages of the procedures demonstrated through videos and clarify doubts.

Time: 4.30pm-6.30pm

Space/ Place: Skills Cabin

Activity: Concurrent session at skills station:

- HB, Urine, UPT, RDT
- Abdominal palpation and FHS

Training/Learning Method:

Divide the participants in to four groups in four skills station as given below, demonstrate the following procedure to the participants and allow the participants to do the return demonstration and practice using the checklist of the skills.

Swap the groups in after 60mins in given order as below:

Time	Group I A & IB	Group II A & II B
First 60 Mins	HB test, Urine test, UPT, RDT (cabin 1 & 3)	Abdominal palpation and FHS (cabin 2 & 4)
Second 60Mins	Abdominal palpation and FHS (cabin 2 & 4)	HB test, Urine test, UPT, RDT (cabin 1 & 3)

Resource materials/ Teaching-learning aids:

- **Abdominal palpation:** measuring tape, stethoscope/ foetoscope, foot rest, watch with seconds hand, 2 pregnant mannequin/model
- **Hb estimation:** Hub cutter,N/10 HCl,distill water, Sahli'shaemoglobinometer, Kidney Tray,Bowl , puncture proof container for sharps, Hbcolour scale, lancet,
- **RDT kit:** lancet, RDT kit, glass slides
- **Urine Test:** Artificial urine or tea with sugar and egg white,
- **Sample container, uristiks:** UPT: Urine sample, UPT kit, sample container

DAY 2

Time: 9.00 am-9.30am

Space/ Place: Seminar room

Activity: Recap

Training/Learning Method:

- Recap the previous day to be done by one participants
- Review of the agenda with participants, as outlined in the flip chart. Have the participant(s) who volunteered for the opening activity or warm up to conduct it.

Resource materials/ Teaching-learning aids:

- Flipchart, marker pen

Time: 9.30am-10.30 am

Space/ Place: Seminar room

Activity:Videos

- Processing of equipment
- Organizing Labour room

Power point presentation

- Processing of equipment

Training/Learning Method:

- Use the presentation to discuss the importance and steps of processing the equipment's.
- Play the video and discuss on the organization of Labour Room

Resource materials/ Teaching-learning aids:

- Power point and videos
- GOI SBA poster of processing of instruments, training video ,PPT

Time: 10.30am- 12.15am

(11.00 am-11.15 am -Tea Break)

Space/ Place: Skills cabin

Activity:

Concurrent session at skills station:
(Each group practice first skill for 30 min and then swap with the other group)

Group IA & Group IB : Processing of equipment

Group IIA & Group IIB: Organizing Labour room

Training/Learning Method:

Divide the participants in to two groups in two skills station as given below, demonstrate the following procedure to the participants and allow the participants to practice and do the return demonstration using the checklist of the skills

Time	Group I A &IB	Group IIA & II B
First 45 mins	Processing of equipment	Organization of Labour Room (6 trays, NBCC)
Second 45 mins	Organization of Labour Room (6 trays, NBCC)	Processing of equipment

Group IIA & IIB should dismantle the Labour room for the next group to practice.

Resource materials/ Teaching-learning aids:

Equipment

Labour table with footrest and foam mattress, kelly's pad,2 sheets and blanket and pillow with cover, linen, LR protocol/posters, delivery trolly, IV stand, curtains, functional focus lamp, bins for waste seggregation at source, BP apparatus, foetoscope/stethoscope, thermometer, LR register, case sheet, handing-over /taking -over register, referral in/out register, referral slip, partograph, plastic tub for chlorine solution, stool for birth companion, delivery gown, 6 trays (delivery, episiotomy, MVA, baby, routine drug, emergency drugs) with their contents as per EmOC guidelines ,IV sets, attached toilet, cleaning area, RL/NS, surgical drums, cheattle forceps in a dry bottle, PPE, pads, functional oxygen cylinder, oxygen hood, suction apparatus, ventouse/outlet forceps, Newborn corner with Radiant warmer and contents for ENBC and NRP ,hub cutter, newborn ID tag, stamp pad for footprint, hand washing area with sink, liquid soap and running water, case sheet, wall

Time: 12.15 pm-1.00 pm

Space/ Place: Seminar room

Activity:

Power point presentation

- Cervical dilatation and Normal Delivery

Video

- Partograph

Training/Learning Method:

- Play the video to explain the Cervical dilatation and Normal Delivery
- Use the presentation and explain how to plot and interpret partograph

Resource materials/ Teaching-learning aids:

- GOI SBA KushalPrasav video- module 2 normal labour , PPT

1.00 pm -2.00 pm	Lunch

Time: 2.00 pm -4.30pm

Space/ Place: Skills cabin

Activity: Concurrent session at skills station:
(Each group practice first skill for 45 min and then swap with the other group)

- Group IA & Group IB : Cervical dilatation and Normal Delivery
- Group IIA & Group IIB : Partograph

Training/Learning Method:

Divide the participants in to two groups in two skills station as given below, demonstrate the following procedure to the participants and allow the participants to practice and do the return demonstration using the checklist of the skills.

Time	Group I A & IB	Group IIA & II B
First 75 mins	Cervical dilatation and normal delivery	Partograph
Second 75 mins	Partograph	Cervical dilatation and normal delivery

Resource materials/ Teaching-learning aids:

Cervical dilatation and normal delivery

- Cervical dilatation model with different attachments, 2 sets of bony pelvis with foetal skull, bowl for swabs, ,dustbin, GaumardCx Dilatation model
- child birth simulator

Consumables

surgical gloves, plastic apron, savlon swabs, 0.5% chlorine solution , PPE, as per listed in the model labour room station, brass V drape

Partograph:

- 20 Copies of A3 size laminated both sided partographs, pencils, eraser, sharpener, marker pens duster ,masking/ double sided tape

Consumables

- Blown up simplified GoIpartograph for teaching, , case studies from GoI SBA guidelines

4.30 pm-4.45pm	Tea

Time: 4.45 pm-6.00pm

Space/ Place: Skills cabin

Activity: Supervised Skills Practice time

Training/Learning Method:

- The participants can be guided to choose their skills station as the need felt by themselves to have more hands on practice.
- The sessions must be supervised, but not necessarily by all the trainers on all the stations. Peer learning could be encouraged for better learning outcome.

Resource materials/ Teaching-learning aids: Presentation, laptop, LCD projector

- Processing of equipment
- Organization of Labour Room
- Cervical dilatation and Normal Delivery,
- Partograph

DAY 3

Time: 9.00am-9.30am

Space/ Place: Seminar room

Activity: Recap

Training/Learning Method:

Recap the previous day to be done by one participants
Review of the agenda with participants, as outlined in the flip chart.
Have the participant(s) who volunteered for the opening activity or warm up to conduct it.

Resource materials/ Teaching-learning aids:

Time: 9.30am -10.30am

Space/ Place: Seminar room

Activity: Power point presentation and Videos

- AMTSL
- PPH (IV Oxytocin, bimanual compression)

Training/Learning Method:

Use the presentation and discuss the step in management of third stage of labor (AMTSL) and initial management and immediate referral of PPH

Resource materials/ Teaching-learning aids:

- Power point and videos
- SBA poster and checklist

Time: 10.30am -12.45am

(11.30am - 11.45am Tea Break)

Space/ Place: Skills cabin

Activity: Concurrent session at skills station:

(Each group practice first skill for 60 min and then swap with the other group)

- AMTSL
- PPH Management (IV Oxytocin, bimanual compression)

Training/Learning Method:

Divide the participants in to two groups in two skills station as given below, demonstrate the following procedure to the participants and allow the participants to practice and do the return demonstration using the checklist of the skills.

Time	Group I A & IB	Group IIA & II B
First 60 mins	Management of postpartum hemorrhage (PPH)	Active management of third stage of labor (AMTSL)
Second 60 mins	Active management of third stage of labor (AMTSL)	Management of postpartum hemorrhage (PPH)

Resource materials/ Teaching-learning aids

AMTSL

Equipment

2 sets of child birth simulator with accessories,

Consumables

- Syringes with needles, cord clamp-2,
- Sanitary pads ,antiseptic solution,
- Inj. Oxytocin 10IU, clean towel -2,
- Clean sheet-2.
- Sterile gauze, pad and cotton.
- Place the color coded bins (Yellow,Red,Black, blue/puncture proof container),
- Mask, cap, apron, goggles, shoe cover, clean/sterile
- gloves' IV set and IV bottles, relevant SBA posters, V drape

PPH Management: Equipment

- 2 simulation mannequin , dustbin, tub for 0.5% Chlorine solution , (LSTM Photo-MRP)
- I/V arm, catheterization model, drip stand, BP apparatus, stethoscope, tourniquet

Consumables

IV set, 6 amp Inj.oxytocin 10IU- , intracath ,adhesive tape ,IV fluids-RL/NS, cotton swabs, gauze pieces, examination/clean gloves, povidone iodine solution/cetrimide, 0.5 % Chlorine solution, PPE

Ringers/saline drip, drip set, BT set.AcD vial needles 16, 18, 20 number, swabs, intracath, scissors, Foleys and plain catheter, cetrimide/povidone lotion, urobag, sticking tape

Time: 12.45 pm - 1.30pm

Space/ Place: Seminar room

Activity: Plenary – RMNCH+A Counselling

Training/Learning Method:

Use the presentation and discuss on RMNCH+A Counselling

Resource materials/ Teaching-learning aids: Presentation on RMNCH+A Counselling

1.30 pm – 2.15 pm	Lunch

Time: 2.15 pm -4.15pm (3.15pm -3.30pm Tea Break)

Space/ Place: Seminar room

Activity: Plenary – Counseling on case scenarios (focus on FP, RI, Adolescent Health, Nutrition, BF, complication readiness)*

Training/Learning Method:

Demonstarte one roleplay to explain the counseling skills and clarify doubts.

And Divide the participants into four groups. Assign each group a case for 2 topics. Distribute the scenarios just before lunch break so that the groups have enough time to prepare and practice. The role play should be done using guidelines provided under their case. Each group will be given 5 to 10 minutes to perform the role play with in their group. The group will be evaluated by the trainer using counseling skills checklist.

Lead the discussion based on the instruction given in the facilitator instruction

Resource materials/ Teaching-learning aids: Case scenarios for role play* on: FP, RI, Adolescent Health, Nutrition, BF, complication readiness

** Case scenario shall be distributed among groups with one group dealing with one theme only*

Time: 4.15 pm-5.30pm

Space/ Place: Seminar room

Activity: SupervisedSkills Practice time

Training/Learning Method:

The participants can be guided to choose their skills station as the need felt by themselves to have more hands on practice.

The sessions must be supervised, but not necessarily by all the trainers on all the stations. Peer learning could be encouraged for better learning outcome.

DAY 4

Time: 9.00am-9.30am

Space/ Place: Seminar room

Activity: Recap

Training/Learning Method:
Recap the previous day to be done by one participants
Review of the agenda with participants, as outlined in the flip chart. Have the participant(s) who volunteered for the opening activity or warm up to conduct it.

Resource materials/ Teaching-learning aids:

Time: 9.30am-11.00am

Space/ Place: Seminar room

Activity: Power point presentation and videos

- Eclampsia
- CAB

Training/Learning Method:
Recap the previous day to be done by one participants
Review of the agenda with participants, as outlined in the flip chart. Have the participant(s) who volunteered for the opening activity or warm up to conduct it.

Resource materials/ Teaching-learning aids:

11.00-11.15am	Tea Break

Time: 11.15am-01.15

Space/ Place: Skills cabin

Activity: Concurrent session at skills station:

- Eclampsia (dose preparation, deep IM, Knee jerk reflex)
- CAB

Training/Learning Method:
Divide the participants in to two groups in two skills station as given below, demonstrate the following procedure to the participants and allow the participants to practice and do the return demonstration using the checklist of the skills.

(Each group practice first skill for 60 min and then swap with the other group)

Time	Group I A & IB	Group IIA & II B
First 60 mins	Management of Eclampsia	Management of Shock (CAB approach)
Second 60 mins	Management of Shock (CAB approach)	Management of Eclampsia

Resource materials/ Teaching-learning aids:
Management of Eclampsia

Equipment
IM Inj. facilitator(2 models)

Consumables

2 Syringes 10 ml, 2 needles 22 gauze, Cotton Swabs,10 ampoules of Inj.Mgso4 50% ,materials for bio medical waste disposal , Inj Calcium gloconate 10 ml ampoule, hammer (keep 25 % and 50%) and Gaumard IM Hip Model

Management of Shock (CAB approach)

Equipment

Table, sheet to cover, 2 mannequin , drip stand and laptop

Consumables

IV sets, NS/RL, intracath, roll towel, adhesive tape, Bag and mask, Oxygen cylinder with tube, suction apparatus , Endotracheal tube of different sizes

01.15pm-2.15pm	Lunch

Time: 2.30 pm-3.45pm

Space/ Place: Seminar room

Activity: Power point presentation and videos

- Interval IUCD
- Suction machine, administration of oxygen, Radiant Warmer, Glucometer

Training/Learning Method

Use the presentation/ video and discuss how to insert the Interval IUCD and how to use the suction machine (electrical, foot operated), administration of oxygen use of radiant warmer and Glucometer.

Resource materials/ Teaching-learning aids: Presentation, laptop, LCD projector, videos

3.45pm-4.00pm	Tea

Time: 4.00 pm-6.00pm

Space/ Place: Skills cabin

Activity: Concurrent session at skills station:

- Interval IUCD
- of suction , administration of oxygen, Radiant Warmer, Glucometer

Training/Learning Method

Divide the participants in to two groups in two skills station as given below, demonstrate the following procedure to the participants and allow the participants to practice and do the return demonstration using the checklist of the skills.

Time	Group I A & IB	Group IIA & II B
First 60 mins	Insertion and removal of Interval IUCD	▸ Use of suction machine ▸ Administration of Oxygen ▸ Use of radiant warmer ▸ Use of Glucometer
Second 60 mins	▸ Use of suction machine ▸ Administration of Oxygen ▸ Use of radiant warmer ▸ Use of Glucometer)	Insertion and removal of Interval IUCD

Resource materials/Teaching-learning aids: Female lower torso mannequin with normal and postpartum uterus and accessories, tray with lid, SIMS/Cuscus speculum, long artery forceps, mayo's scissors, Volselum/Tenaculum, uterine sound, Anterior vaginal wall retractor, bowl for cotton swabs,sponge holder, kidney tray, dust bin, plastic tub for chlorine solution

Time: 6.00 pm-7.00pm

Space/ Place: Skills Cabin

Activity: Supervised Skills Practice time

Training/Learning Method

The participants can be guided to choose their skills station as the need felt by themselves to have more hands on practice. The sessions must be supervised

DAY 5

Time: 9.00am to 9.30 am

Space/ Place: Seminar Room

Activity: Recap

Training/Learning Method:

Recap the previous day to be done by one participants
Review of the agenda with participants, as outlined in the flip chart. Have the participant(s) who volunteered for the opening activity or warm up to conduct it.

Resource materials/ Teaching-learning aids

Time: 9.30 am to 11.00 am

Space/ Place: Seminar Room

Activity: Power point presentation

- NRP

Videos

- ENBC
- NRP
- BF +KMC

Training/Learning Method

Use the presentation and Video to explain the topics

Resource materials/ Teaching-learning aids: Video and PPTs

11.00am-11.15am	Tea

Time: 11.15 am -01.15 pm

Space/ Place: Skills cabin

Activity: Concurrent session at skills station:
(Each group practice first skill for 1 hour and then swap with the other group)

- ENBC
- NRP
- PNC+BF+KMC
- Documentation

Training/Learning Method:

Divide the participants in to four groups as given below, demonstrate the following procedure to the participants and allow the participants to practice and do the return demonstration using the checklist of the skills.

Time	Group I A	Group I B	Group II A	Group II B
First 60 mins	ENBC	NRP	PNC+BF+KMC	Documentation
Second 60 mins	NRP	ENBC	Documentation	PNC+BF+KMC

Resource materials/ Teaching-learning aids:

Mannequin for simulation and management of PPH; Essential Newborn care and Resuscitation Mannequin

Checklists

Delivery table

Baby tray

- Scissors
- Clamps

Newborn corner

- Radiant warmer
- Bag (240 ml)
- Face mask (0 & 1 size)
- Dee Lee mucous extractor

Consumable

- Gloves
- Cord tie/clamps
- Disposable Syringes and Needles

Drug tray

- Neonatal vaccines (OPV, BCG, DPT)
- Vitamin K

Job-aid

- Resuscitation
- Steps of essential newborn care
- How to use Bag & Mask

Cross cuttings

- Thermometer
- Weighing scale (Digital and Mechanical with 50 grams interval)
- Clean cloths
- Blankets

Bed

Job-aid

- Good attachment
- Correct position

Consumables

- Nappy
- Socks
- Caps
- Clothing for mother
- * Feeding Tube and disposable syringes

Job-aid

- KMC position
- Expression of milk
- Methods of alternative feeding

Others

- Spoon/Paladai/Cup

1.15pm-2.00pm	Lunch

Time: 2.00 pm-4.00pm

Space/ Place: Skills cabin

Activity: Concurrent session at skills station:
(Each group practice first skill for 1 hour and then swap with the other group)

- PNC+BF+KMC
- Documentation
  - ENBC
  - NRP

Training/Learning Method:

Swap the groups after 30 mins in skills stations as below:

Time	Group I A	Group I B	Group II A	Group II B
First 60 mins	PNC+BF+KMC	Documentation	ENBC	NRP
Second 60 mins	Documentation	PNC+BF+KMC	NRP	ENBC

Resource materials/ Teaching-learning aids: As mentioned in above session

4.00pm-4.15pm	Tea

Time: 4.15pm-4.45pm

Space/ Place: Seminar Room

Activity: Power point presentation and videos
MDI & Nebulizer

Training/Learning Method:
Use the presentation and Video to explain the topics

Resource materials/ Teaching-learning aids: Video and PPT

Time: 4.45pm-5.45m

Space/ Place: Skills cabin

Activity Concurrent session at skills station continues:

DAY 6

Time: 9.00am-9.30 am

Space/ Place: Seminar room

Activity: Course Evaluation

Training/Learning Method: Have participants fill out and submit the course evaluation form

Resource materials/ Teaching-learning aids: Course evaluation form

11.00pm-11.45pm	Tea

Time: 09.30am-1.00 pm

(11.00-11.15am Tea Break)

Space/ Place: Seminar room & Skills Cabin

Activity : Posttest –OSCE & KAQ

Training/Learning Method:

Administer the post- test questionnaire to all the participants, provide 30 minutes to complete the post test and divide the participants into four groups* and provide 40 minutes for each group to complete the OSCE post-test. The remaining group except the group which is undergoing OSCE can watch the videos/power point presentations.

Resource materials/ Teaching-learning aids

- Post-test questionnaire
- Post OSCE questionnaire

Time: 1.00 pm – 1.30 pm

Space/ Place: Seminar room

Activity : Valedictory

Training/Learning Method:

Closing remarks by DNO and lead trainer. Congratulate the participants for the successful completion of the course. Get participants feedback of the course and the changes that they will implement when they go back to their facility.

A valedictory function can be organised inviting special guests

Resource materials/ Teaching-learning aids
Completed certificates.

1.30 onward	Lunch

Time	Group IA & Group IB	Group IIA &Group IIB
First 30 mins	MDI	Nebuliser
Second 30 mins	Nebuliser	MDI

Training/Learning Method:

Resource materials/ Teaching-learning aids:

Equipment -Nebulizer, Salbutamol MDI with spacer

5.45pm-6.30pm	

Time: 5.45 pm- 6.30pm

Space/ Place: Skills Cabin

Activity Concurrent session at skills station continues: Supervised

Training/Learning Method:

- The participants can be guided to choose their skills station as the need felt by themselves to have more hands on practice.
- The sessions must be supervised by trainers. Peer learning could be encouraged for better learning outcome.

ANNEXURE

BASIS SKILLS LAB

GUIDANCE NOTES FOR ANNEXURE:

The annexure provides content on a daily basis which includes all check lists, case scenarios and role plays for that particular day. Each check list has some points in bold which need to be emphasized while practicing the skills.

DAYWISE LISTING OF SKILL STATIONS

Day - 1

Objective Structured Clinical Examination

OSCE station 1: Management of II stage of labor

OSCE station 2: Active management of third stage of labor

OSCE station 3: Newborn Resuscitation

OSCE station 4: Immediate management of shock - CAB Approach

OSCE Summary Sheet

Skill 1: Antenatal care

- 1a) Calculation of EDD,
- 1b) weight recording
- 1c) BP recording

Skill 2: Abdominal palpation & auscultation of FHS

Skill 3: Lab. Tests:

- 3a) Pregnancy Detection test,
- 3b) Haemoglobin estimation
- 3c) Urine testing
- 3d) RDT for Malaria

Skill 4: Universal Precautions

- 4a) Hand washing
- 4b) Preparation of 0.5% Chlorine solution
- 4c) Personal Protective Equipment

DAY - 2

Skill 5: Cervical dilatation & normal delivery

- 5a) Assessment of cervical dilatation & effacement
- 5b) Normal Delivery

Skill 6: Plotting & Interpreting Partograph – Case scenarios related to Partograph

Skill 7: Processing of instruments

Skill 8: Organizing Labor room

DAY – 3

Skill 9: Active Management of Third Stage of Labour (AMTSL)

Skill 10: Management of PPH

- 10a) Management of PPH
- 10b) Setting up an IV line

DAY – 4

Skill 11: Administration of Inj. MgSo4 for initial management of Eclampsia

Skill 12: Management of shock (CAB)

- 12a) Rapid Initial Assessment
- 12b) Hypovolemic shock – IV fluid replacement therapy

Skill 13: Interval IUCD Insertion & Removal

Skill 14: New born care Corner

- 14a) Bag & Mask
- 14b) Radiant warmer
- 14c) Suction machine
- 14d) Oxygen Administration

DAY – 5

Skill 15: Essential Newborn Care (ENBC)

- 15a) Essential Newborn Care
- 15b) Temperature Recording
- 15c) Weighing the Newborn

Skill 16: Newborn Resuscitation

Skill 17: MDI & Nebulizer

- 17a) Metered Dose Inhaler with Spacer
- 17b) Nebulizer

Skill 18: Post natal care

- 18a) Breast feeding & KMC
- 18b) Providing Kangaroo Mother Care

Plenary session

Counting respiratory rate

Preparation and use of ORS

Administration of Zinc tablet

Role plays

Counselling on Family Planning choices

Counselling on Adolescence

Counselling on Complication Readiness

Counselling on nutritious diet & family support during pregnancy

Counselling on Routine Immunization

Counselling on Breast feeding & Complementary feeding

DAY - I

OBJECTIVE STRUCTURED CLINICAL EXAMINATION (OSCE)

Station 1: Management of II stage of labor

Name of Participant -_____ **Date** _____

Situation: The woman is fully dilated, having good uterine contractions and the head of the baby is crowning. You are assisting the woman during her second stage of the labor.

Please perform how you will assist the woman.

Observation: Observe if the participant is performing the following steps of assisting the second stage of labor in their correct sequence and technique.

S.N0.	Steps	I/0 score	Remarks
1	Put on personal protective barriers. (Wear Goggles, Mask, Cap, Shoe cover, Plastic Apron). Place the plastic sheet under the woman's buttocks		
2	Palpate the supra pubic region to ensure that the woman's bladder is not full		
3	Perform hand hygiene and put on sterile/HLD gloves		
4	Clean the woman's perineum		
5	Talk to the woman and encourage woman for breathing & small pushes with contractions		
6	Control the birth of the head with the fingers of one hand to maintain flexion, allow natural stretching of the perineal tissue, prevent tears and support the perineum with other hand using the clean pad		
7	Wipe the mucus (and membranes, if necessary) from the baby's mouth and nose		
8	Feel around the baby's neck for the cord and respond appropriately if the cord is present		
9	Allow the baby's head to turn spontaneously and with the hands on either side of the baby's head, delivers the anterior shoulder		
10	When the axillary crease is seen, guide the head upward as the posterior shoulder is born over the perineum		
11	Support the rest of the baby's body with one hand as it slides out and place the baby on the mother's abdomen over the clean towels		
12	Note the time of birth and sex of the baby and tell the mother		
13	Thoroughly dry the baby and cover with a clean, dry cloth and assess for breathing If baby does not breathe immediately, begin resuscitative measures		

Score one for each point conducted in the correct sequence and technique or mark "0" if the task is not done as recommended and calculate the Score.

Pass Score = ***Student Score =*** ***Pass*** ***Yes*** ***No***

OSCE Station 2: Active management of third stage of labor (AMTSL)

Name of Participant # _____ **Date** _____

Situation: The second stage of labour is just over. The baby is well, breathing normally and is comfortably with the mother. Now deliver the placenta by performing Active Management of Third Stage of Labor (AMTSL)

S.N0.	Steps	I/0 score	Remarks
1	Wearing PPE and conduct the preliminary step- Rule out the presence of another baby by abdominal examination		
2	Administer Uterotonic Drug—10 IU oxytocin IM OR Misoprostol 3 tablets (600ug) orally		
3	Perform Controlled Cord Traction during a contraction by placing one hand on the lower abdomen to support the uterus and gently pulling the clamped cord by the other hand close to perineum.		
4	Perform uterine massage until uterus is contracted		
5	Examine the lower vagina and perineum		
6	Examine the placenta, membranes and umbilical cord ▸ Maternal surface of placenta ▸ Foetal surface ▸ Membranes ▸ Umbilical cord		
7	Place instruments in 0.5% chlorine solution for 10 minutes for decontamination		
8	Decontaminate or dispose the syringe, needle and oxytocin ampoule in 0.5% chlorine solution		
9	Immerse both gloved hands in 0.5% chlorine solution and remove the gloves inside-out, leave them for decontamination for 10 minutes		
10	Wash both hands thoroughly with soap and water and dry them with a clean, dry cloth/air dry.		
11	Perform post procedural task as: ▸ Advise mother on immediate postpartum care for her and baby ▸ Record delivery notes in case file		

Observation: Observe if the participant is performing the following steps of AMTSL in the right order, using the right technique. Score one for each point conducted in the correct sequence and technique or mark "0" if the task is not done as recommended and calculate the Score.

Pass Score = ***Student Score =*** ***Pass*** ***Yes*** ***No***

OSCE station 3: Newborn Resuscitation

Name of Participant # _____ **Date** _____

Situation: You are caring for a mother who is about to deliver a baby of 35 weeks gestation and the liquor is meconium stained. How will you prepare to receive the baby? When the baby is born he/she is not crying. Demonstrate how you will resuscitate him/her?

Observation: Observe if the participant is performing the following tasks correctly and in the correct sequence. Score one for each point conducted in the correct sequence and technique or mark "0" if the task is not done as recommended and calculate the Score.

S.NO	Task	I/0 Score	Remarks
1	**Get ready with:** ▸ Bag and mask ▸ Suction equipment ▸ Radiant warmer or other heat source (need to be deleted?) ▸ 2 warm towels ▸ Clock with seconds hand ▸ Oxygen source ▸ Gloves ▸ Shoulder roll ▸ Cord tie ▸ Scissors ▸ Cap ▸ PPE (need to be deleted?)		
2	Suck baby's mouth and nose at mother's abdomen only if meconium is present and baby is not crying		
3	Dry the baby, remove the wet towel and wrap the baby in warm dry towel		
4	Assess breathing		
5	If baby is not breathing cut cord immediately.(To utilize golden minute don't wait for cord pulsations to stop which occur in 1-3 minutes)		
6	Place the baby on a warm, firm flat surface		
7	Position the baby in slight neck extension using a shoulder roll Suction mouth and nose Stimulate the baby by flicking the soles and rubbing the back Reposition and reassess breathing		
8	If not breathing, provide bag and mask ventilation for 30 seconds, makes sure that the chest rises with each ventilation		

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

Pass Score = ***Student Score =*** ***Pass*** ***Yes*** ***No***

OSCE station 4: Immediate Management of Shock with CAB Approach

Name of Participant #_____ Date _____

Situation: You are a care provider at CHC, received a woman who delivered at home 5 hours ago and had a heavy bleeding and developed unconscious.

You have done the initial assessment and Her BP 84/56 Pulse 136/minute Respiration: difficulty in breathing. You have called for help, who could assist you for establishing IV line and catheterization.

Now you will demonstrate ABC approach for immediate management of shock.

Observation: Observe if the participant is performing the following tasks correctly and in the correct sequence. Score one for each point conducted in the correct sequence and technique or mark "0" if the task is not done as recommended and calculate the Score.

S.No	STEP/TASK	Score 1/0	Remarks
1	Call for help		
2	Assess circulation (pulse, BP, skin coloured, température, mental state)		
3	Insert an IV line and give fluids at rapid rate		
4	Keep the woman warm		
5	Position the woman on her left side with her legs higher than her chest.		
6	Give oxygen at 6–8 liters/minute		
7	Monitor pulse/BP and puffiness every 15 minutes and look for signs of Improvement		
8	Catheterize and monitor urine out put		
9	Check airway and breathing by looking at chest movement, listening breathing noise and feeling the breath		
10	If breathing absent or difficult –does head tilt & chin lift and jaw thrust		
11	Do gentle suction and place oropharyngeal airway,		

12	If still not breathing- Start chest compressions with 2 breaths after every 30 compressions every minute		
13	Continue for 20 min Ensure airway is clear, all the time		
14	Once stabilized— manage accordingly		

Pass Score = ***Student Score =*** ***Pass*** ***Yes*** ***No***

OSCE Summary Sheet

Station	Activity	Pass score	Participant score	Pass / Needs Improvement
1	Management of II Stage of Labor			
2	AMTSL			
3	New Born Resuscitation			
4	CAB approach			

Total number of stations passed: _____

SKILLS CHECKLIST

SKILL 1:ANTENATAL CARE – DEALS IN:

1A CALCULATION OF EDD
1B WEIGHT RECORDING
1C BP RECORDING

1A CALCULATION OF EDD

Day 1
Skill station I
Cabin number 1&3

Objective

By the end of this exercise the participant will be able to calculate the EDD for antenatal woman as a part of assessment and examination

You will now calculate EDD using following exercises:

Exercise 1:
Seema, who is 30 years old, comes to you and says that she has not got her period for the past three months. She last got her period on the day before Holi, i.e. March 10. Calculate her due date.
Answer: 9 calendar months + 7 days, i.e. December 16

Exercise 2:
Laxmi, who is 18 years old, says she got her last period on January 2. She wants to know when she will deliver. Calculate her due date.
Answer: 9 calendar months + 7 days, i.e. September 9

Exercise 3:
Kusum, who is 22 years old, comes to you and says that her last period was on 29 March. She wants to know her due date. Calculate her due date.
Answer: 9 calendar months + 7 days, i.e. January 5

Exercise 4:
Archana, comes to the ANC clinic on 20 September and says that she completed eight months of her pregnancy 10 days ago, calculate her due date.
Answer: it becomes clear that she will be completing her ninth month on 10 October and her EDD (9 months plus 7 days) is 1

1B WEIGHT RECORDING

Day 1

Skill station I

Cabin number 1&3

Objective

By the end of this exercise the participant will be able to measure the weight of adult women

S.No	Steps	
1	**Keep the weighing scale on a flat and hard surface and check for zero error before taking the weight**	
2	Ask the person to stand straight on the weighing scale, looking ahead and holding the head upright	
3	Read the scale from the top	
4	**Record the weight to the nearest 100 gms**	
5	**Record the findings in MCP card**	

Key Points to remember

- In a pregnant woman, weight must be recorded during each visit. First visit/registration weight should be treated as the baseline weight.
- Normally, total weight gain during pregnancy is between 9–11 kg and after the first trimester, a pregnant woman gains around 2 kg every month.
- Low weight gain usually leads to Intrauterine Growth Restriction (IUGR) and results in the birth of a baby with a low birth weight.
- Excessive weight gain (more than 3 kg in a month) should raise suspicion of pre-eclampsia, twins (multiple pregnancies) or diabetes.
- Reading must be entered in the MCP card.

1C BP RECORDING

Day 1
Skill station I
Cabin number 1 &3

Objective

By the end of this exercise the participant will be able to correctly measure blood pressure of pregnant women

S.No	Steps	
1	Select the type of blood pressure instrument	
2	Check that bulb is properly attached to the tubing and there is no crack/ leakage	
3	Check mercury column knob is in open mode in mercury Sphygmomanometer	
4	Ask the person to sit on a chair or lie down on flat surface	
5	Place the apparatus on a horizontal surface at the person's heart level	
6	The mercury column is at the observer's eye level.	
7	Tie the cuff 1 inch above the elbow placing both the tubes in front.	
8	Raise the pressure of the cuff to 30 mmHg above the level at which pulse is no longer felt	
9	Release pressure slowly and listen with stethoscope keeping it on brachial artery at the elbow	
10	Note the reading where the sound is heard (systolic pressure)	
11	Follow the sound and note reading where the sound disappears (diastolic)	
12	Deflate and remove the cuff; close the mercury column knob	
13	Record the reading on MCP card	
14	In case of electronic Sphygmomanometer tie the cuff same way and keep the arms stable	
15	Press the ON button & both systolic and diastolic pressure will be displaced automatically on the screen	

Key Points to remember

- In a pregnant woman, BP must be recorded during each visit.
- Hypertension is diagnosed when two consecutive readings taken four hours or more apart show the systolic blood pressure to be 140 mmHg or more and/or the diastolic blood pressure to be 90 mmHg or more and its signifies pregnancy-Induced Hypertension(PIH) and/or chronic hypertension.
- If the woman has high blood pressure, check her urine for the presence of albumin. The presence of albumin (+2) together with high blood pressure is sufficient to categorise her as having pre-eclampsia. Refer her to the higher facility, if further facility for treatment is not available.

- If the diastolic blood pressure of the woman is above 110 mmHg, it is a danger sign that points towards imminent eclampsia. The urine albumin should be estimated at the earliest. If it is strongly positive, the woman should be referred to higher facility, if further facility for treatment is not available.
- If the woman has high blood pressure but no urine albumin, she should be referred to the higher facility, if further facility for treatment is not available.
- A woman with PIH, pre-eclampsia or imminent eclampsia requires hospitalisation. Refer to higher facility, if further facility for treatment is not available.
- Reading must be entered in the MCP card

SKILL 2 ABDOMINAL PALPATION & AUSCULTATION OF FHS

Day 1
Skill station 2
Cabin No. 2 & 4

Objective

By the end of this exercise the participant will be able to do abdominal examination/palpation in a pregnant woman

S.No	Steps	
1	Keep the necessary items for abdominal palpation & auscultation of FHS ready (mannequin on table, measuring tape, stethoscope/foetoscope, watch with second hand)	
2	Stand on the right side of the mannequin	
3	Ensure the bladder is empty & semi flexed position is given during examination	
4	Observe the abdomen for any scar , size and shape, contour	
5	Measure the fundal height using ulnar border of left hand. (Measure it in weeks as well as in cms.)	
6	Palpate the abdomen by following grips: Fundal grip (to find out pole of the foetus at the fundus) Lateral grip (to find out the side of foetal back) Pelvic grips(to find out the foetal head engagement)	
7	Places the foetoscope on the side where foetal back was felt.	
8	Counts the FHR for 1 minute using watch with seconds hand	

Key Points to remember

- In a pregnant woman, abdominal examination & auscultation of FHS must be recorded during each visit to monitor progress of pregnancy and foetal viability and growth.
- Maintain privacy and obtain verbal consent before examination
- Expose only the examining area i.e. abdomen
- Bladder should be emptied before examination
- During palpation ensure that woman partially flexes her legs and knees
- Fetal lie and presentation may be ascertained in palpation during the 3rd trimester.
- The normal lie at term in the majority is longitudinal, with a cephalic presentation. Any other lie is abnormal and the woman must be referred to higher facility for delivery care.
- Correlate the fundal height with LMP
- If the Foetal Heart Rate (FHR) is between 120 and 160 beats per minute, it is normal. If it is < 120 beats/minute OR > 160 beats/minute, the woman should be referred to higher facility for emergency delivery care.
- FHS can only be heard through the abdomen with the help of a Stethoscope or foetoscope after 24 weeks of pregnancy.
- All findings must be entered in the MCP card

SKILL 3: LAB.TESTS – DEALS IN:

3A PREGNANCY DETECTION TEST
3B HAEMOGLOBIN ESTIMATION
3C URINE TESTING
3D RDT FOR MALARIA

3A PREGNANCY DETECTION TEST

Day 3

Skill Station Number 3

Cabin Number 1 & 3

Objective

By the end of this exercise the participant will be able to perform urine pregnancy test

SI NO	Steps	
1	Keep the necessary items ready (Pregnancy test kit with no expiry date, disposable dropper, clean container to collect urine)	
2	Take sample of urine	
3	Remove the pregnancy test card & place it on the flat surface	
4	Use the dropper to take urine from the container	
5	Put 2 -3 drops in the well-marked S & waits for 5 min	
6	If one red band appears in the result window R, the pregnancy test is negative	
7	If two parallel red bands appear the pregnancy detection test is positive	

Key Points to remember

- Collect the random sample of the woman and the first random sample is preferred.
- This must be recorded during the first visit.
- The test is important :
  - To facilitate proper planning and allows for adequate care to be provided during pregnancy for both mother and the fetus.
  - Helps in timely detection of complications at an early stage and its appropriate management.
  - If a pregnancy is detected early and the woman is provided care from the initial stage, it facilitates a good interpersonal relationship between you and her.
- Once the pregnancy is detected the pregnant woman should be registered, her first ANC should be conducted within 12 weeks, and the birth plan should be made.
- MCP card, MCTS entry will be done and MCTS number will be given.
- She should be counseled on importance of ANC, institutional delivery and oriented to the entitlements under various GOI schemes like JSY, JSSK.

3B HAEMOGLOBIN ESTIMATION

Day 3

Skill Station Number 3

Cabin Number 1 & 3

Objective

By the end of this exercise the participant will be able to do Haemoglobin estimation by Sahli's Haemoglobinometer

Sl No	Steps	
1	Keep all the necessary items ready (Sahli's Haemoglobinometer, N/10 HCl, gloves, spirit swabs, lancet, distill water and dropper, puncture proof container, 0.5% Chlorine solution)	
2	Wash hands and wears gloves	
3	Clean the Hb tube and pipette	
4	Fill the Hb tube with N/10 HCl upto 2 gm with the dropper	
5	Cleans tip of the person's ring finger with spirit swab	
6	Prick the finger with lancet and discard first drop of blood	
7	Allow a large blood drop to form on the fingertip and sucks it with pipette upto 20 cu.mm marks.	
8	Take care that air entry is prevented while sucking the blood.	
9	Wipe tip of the pipette and transfer the blood to the Hb tube containing N/10 HCl	
10	Rinse the pipette 2-3 times with N/10 HCl	
11	Leave the solution in test tube for 10 min	
12	After 10 minutes, dilutes the acid by adding distilled water drop-by-drop and mix it with stirrer	
13	Match with the color of the comparator	
14	Note down the reading in gms% (lower meniscus)	
15	Dispose off the used lancet in puncture proof container	
16	Drop the used gloves in 0.5% Chlorine solution	

Key Points to remember

- In a pregnant woman, Hb estimation must be done during each visit.
- The initial haemoglobin level will serve as a baseline with which the later results, obtained at the three subsequent antenatal visits, can be compared.
- Interpretation of findings:
  - Hb > 11 gm% (absence of anaemia) –
    - Prophylactic IFA tablet (100 mg elemental iron and 0.5 mg folic acid) once a day for 100 days ,

- Starting after the first trimester, at 14–16 weeks of gestation.
- Regimen is to be repeated for three months post-partum.

➤ Hb 7-11 gm% (moderate anaemia)-

- Therapeutic IFA tablet twice a day.
- Regimen is to be repeated for three months post-partum.

➤ Hb < 7 gm % (severe anaemia) --

- Start the therapeutic dose of IFA
- Refer to higher facility, if further facility for treatment is not available

- Estimate Hb level again after one month. If it has not increased, refer the woman to a higher facility with a good laboratory infrastructure and trained personnel so that the cause of the anaemia can be determined and the requisite treatment started.
- The women must be counseled on the necessity of taking IFA and the dangers associated with anaemia.
- Every time the reading must be entered in the MCP card.

3C URINE TESTING

Day 3

Skill Station Number 3

Cabin Number 1 & 3

Objective

By the end of this exercise the participant will be able to do urine testing for detecting albumin

S.No.	Steps	
1	Keep all the necessary items ready (Urine specimen collection bottles/container and dipsticks, red bin)	
2	Checks the expiry date on the kit & also carefully read the instructions before use	
3	Remove one strip from the bottle and replace the cap	
4	Completely immerse reagent area of the strip in the urine and remove it immediately	
5	While removing the strip from urine run the edge against the rim of the container to wipe off the excess urine	
6	For Glucose: -After 30 seconds compare the blue colored reagent area against the color chart area on the bottle and records the finding	
7	For Urine :- After 60 seconds compare the yellow colored reagent area against the color chart area on the bottle and records the finding	
8	Discard the stick in red bin.	

Key Points to remember

- In a pregnant woman, urine testing for protein and sugar must be done during each visit.
- Testing the urine for the presence of protein (albumin) is a very important test used for the detection of pre-eclampsia, which (along with eclampsia) is one of the five major causes of maternal mortality.
- Testing urine for the presence of sugar is a test used for screening of gestational diabetes.
- The presence of albumin (+2) together with high blood pressure is sufficient to categories her as having pre-eclampsia. Refer her immediately to the higher facility for further treatment.
- If urine is positive for sugar, refer her to the higher facility to get her blood sugar examined and a glucose tolerance test carried out, if required.
- Reading must be entered in the MCP card.
- Store the tightly sealed bottle in cool dark place
- Each strip should be used only once.

3D RDT FOR MALARIA

Day 3

Skill Station Number 3

Cabin Number 1 & 3

Objective:

By the end of this exercise the participant will be able to do RD test for detecting malaria

S.No.	Steps to prepare the thick and thin Smear:	
1	Select the second or third finger of the left hand	
2	Clean with antiseptic or sterile wipes	
3	Dispose off the cotton swab in the yellow bin	
4	Allow the finger to air dry	
5	The site of the puncture is the side of the ball of the finger, not too close to the finger bed	
6	Allow the blood to come up automatically. Do not squeeze the finger	
7	Hold the sides by its edges	
8	Touch the drop of blood with a clean slide	
9	Collect 3 drops to prepare the thick smear	
10	To prepare thin smear, take other fresh slide & touch the drop of blood from the edge of slide	
11	Spread the drop of blood with the corner of the slide to make a circle or a square of around 1 cm	
12	Bring the edge of the slide to the second drop of blood to the surface of the first slide, wait until the blood spreads along the whole edge	

13	Hold it at an angle of 45 degrees & spread with a rapid but not brisk movement	
14	Write the slide number of the thin film & wait until the thick film is dry	
15	Wrap & send the slides to the laboratory for staining & to be examined under the microscope	

S.No.	Steps for Malaria testing using Rapid Diagnostic test kit (RDT)	
1	Store the kits at the recommended temperature	
2	Check that the RDT kit is not damaged	
3	Check the expiry date on the kit	
4	Remove the RDT packaging. and the dropper from the foil pouch and place it on flat, dry surface	
5	Label the RDT with patient's ID, date performed	
6	Allow the reagents to attain room temperature if kept in cold chain	
7	Select the finger for puncture, clean with spirit swab and allow to air dry	
8	Puncture the finger with a sterile lancet	
9	Slowly add 1 drop of blood to the sample well and add 2 drops of the assay diluent	
10	As the test begins to work, a purple colour is seen moving across the result window in the center of the test device	
11	Interpret test* result at 5-20 minutes (Do not interpret after 20 minutes)	

	*Interptation of the result for Monovalent RDT kit:
Negative result	If only 1 line (band) appears -: the test is working and the patient is negative for malaria
Positive result	If 2 lines (bands) appear within15-20 minutes -: the person is suffering from Falciparum malaria
Invalid result	If no line appears within15-20 minutes - :discard the test and repeat the test

	*Interptation of the result for bivalent RDT kit:
Negative result	If only 1 line (band) appears at C (Control) -: the test is working and the patient is negative for malaria
Positive result	If two lines (bands) appear within 15-20 minutes at C' (control) and T1 –: the person is suffering from P. Falciparum malaria
Positive result	If two lines (bands) appear within 15-20 minutes at C' (control) and T2 - : the person is suffering from P. Vivax malaria
Positive result	If three lines (bands) appear within 15-20 minutes at C' (control) , T1, and T2 -: the person is suffering from both P. Falciparum and P. Vivax malaria
Invalid test	If no line appears within 15-20 minutes –: discard the test and repeat the test

Key points to remember:

- Stores the kits at the recommended temperature
- Never read the result beyond 30 minutes.
- In high malaria-endemic areas, pregnant women should be routinely tested for malaria at the first antenatal visit.
- Screen the woman for malaria every month by conducting the rapid diagnostic test even if she does not manifest any symptoms of malaria.
- If a pregnant woman shows symptoms of malaria at any time, she should be tested. If the result is positive, refer her to higher facility for further treatment.
- Chemoprophylaxis should be administered only in selective groups in high P.Falciparum endemic areas.
- No prophylaxis is recommended, but insecticide-treated bed nets or Long-Lasting Insecticidal Nets (LLIN) should be given on a priority basis to pregnant women in malaria-endemic areas.

SKILL 4 UNIVERSAL PRECAUTIONS

4A HAND WASHING
4B PREPARATION OF 0.5% CHLORINE SOLUTION
4C PERSONAL PROTECTIVE EQUIPMENT

4A HAND WASHING

Day-1

Skill station 4

Cabin -2 & 4

Objective

By the end of this exercise the participant will be able to demonstrate correctly the steps

S .No	Steps	
1	Remove rings, bracelets, and watch.	
2	Wet hands in clean running water. Applies soap.	
3	Vigorously rub hands on both sides in following manner Palms, fingers and web spaces Back of hands Fingers and knuckles Thumbs Fingertips and creases Wrist and forearm up to the elbow	
4	Thoroughly rinse hands in clean running water.	
5	Dry hands using clean towel, paper towel, or allows airing dry keeping the hands above waist level.	

Key points to remember:

- Alcohol rub can also be used if the hands are not soiled by blood or any other secretion however alcohol rub is not a substitute for proper hand washing, hence use judiciously in places where there is no water or in areas in between examining the babies.
- Alcohol hand rub to be used on both sides of hands for 30 seconds or till the solution is dry in the same manner as hand washing is performed.

4B PREPARATION OF 0.5% CHLORINE SOLUTION

Day-1

Skill station 4

Cabin -2 & 4

Objective

By the end of this exercise the participant will be able to demonstrate preparation of 0.5% Chlorine solution

SI NO	Steps	
1	Keep the necessary items ready (plastic bucket and mug, wooden stirrer , tea spoon, bleach powder in an airtight container, 1 lit. water, plastic apron ,Utility gloves)	
2	Wear plastic apron and utility glove	
3	Take 1 liter water in a plastic bucket	
4	Put 3 level tea spoon of bleaching powder in the plastic mug and add little water to make thick paste	
5	Add this paste to 1 liter water in the bucket to make 0.5 % chlorine solution	
6	Stir the solution with a wooden stirrer – a milky white solution will appear & keep it covered.	

Key points to remember:

- Store the bleaching powder in air tight container away from sun light
- Always prepare the solution using plastic spoon and mug wearing utility gloves
- Keep the 0.5% chlorine solution in a wide mouth plastic tub/container
- Change the chlorine solution after 24 hours or if it appears turbid due to multiple/frequent use and prepare fresh solution.
- Ensure the instruments are submerged in the 0.5% chlorine solution for 10 mins for decontamination
- Depending on the quantity of the instruments the required quantity of 0.5% chlorine solution can be arrived

4C PERSONAL PROTECTIVE EQUIPMENT

Day-1

Skill station 4

Cabin -2 & 4

Objective

By the end of this exercise the participant will be able to demonstrate use of Personal Protective Equipments

SI NO	Steps	
1	Wear footwear before entering the labor room	
2	Wear PPE in following sequence Waterproof apron Gown Cap Mask Eye cover	
3	Wears sterile gloves as per the following steps **Open the outer package of the gloves** **Open the inner wrapper exposing the cuffed gloves with the palm facing upwards** **Pick up the first glove by the cuff touching only inside portion of the cuff** **Hold the cuff in one hand and slips the other hand into the glove** **Pick up the second glove by sliding the fingers of the gloved hand under the cuff of the second glove** **Put the second glove on the ungloved hand by maintaining a steady pull through the cuff** **Adjust the gloved fingers and cuff until the gloves fits comfortably**	
4	Remove soiled gloves as per the following steps Grasp one of the gloves near the cuff and pull it off. Leaving the first glove on your fingers, grasp the second glove Pull off the two gloves at the same time, being careful to touch only the inside surfaces of the gloves with your bare hands Place them in a container of 0.5% Chlorine solution	

Key points to remember:

- Be careful not to touch any unsterile item with the gloved hands.
- Keep the gloved hands above waist level
- Do not use gloves that are cracked, peeled or have detectable holes and tears.
- Wash hands immediately after removing gloves

DAY 2

SKILL - 5 CERVICAL DILATATION & NORMAL DELIVERY

5A ASSESSMENT OF CERVICAL DILATATION & EFFACEMENT

5B NORMAL DELIVERY

5A ASSESSMENT OF CERVICAL DILATATION & EFFACEMENT

Day – 2

Skill station 5

Cabin no. LR

SI NO	Steps	
1	Wash hands & wear HDL/Sterilized gloves	
2	Take an Povidone-iodine swab in a sponge holder& clean both labia's from above downwards	
3	Discard the swab in yellow bucket	
4	Separate the labia , clean with swab from above downwards	
5	Insert middle & index finger to do the vaginal examination	
6	Assess cervical dilatation (mention in cms.)*as practiced in models & demonstrated by trainer	
7	Similarly, assess cervical effacement (mention in %)*	
8	Fully dilated & effaced cervix is mentioned as opening of 10cms. Where cervix is no longer felt on vaginal examination	
9	Remove the glove inside out & decontaminate in 0.5% chlorine solution	

Key points to remember:

- Ensure complete aseptic precaution throughout the procedure
- If in active stage of labour(when cervical dilatation is 4 cms.), start plotting in the Partogram
- Ensure proper disposal of swabs & used material

5B NORMAL DELIVERY

Day 2

Skill station – LR

Cabin – 5

Objective

By the end of this exercise the participant will be able to conduct normal delivery

S.No	Steps	
1	Put on personal protective attires. (Wear Goggles, Mask, Cap, Shoe cover, Apron). Place the plastic sheet under the woman's buttocks and clean towel on mother's abdomen	
2	**Wash Hands: Put on Sterile gloves**	
3	Clean the woman's perineum, ask her to push with contractions and in between the contractions ask her to take deep breaths.	
4	**Control the birth of the head with the fingers of one hand to maintain flexion, allows natural stretching of the perineal tissue, and prevent perineal tears, by giving proper support to the perineum with other hand using the clean pad.**	
5	Wipe the mucus (and membranes, if necessary) from the baby's mouth and nose.	
6	Feel around the baby's neck for the cord and respond appropriately if the cord is present.	
7	Allow the baby's head to turn spontaneously and, with the hands on either side of the baby's head, deliver the anterior shoulder.	
8	**When the axillary crease is seen, guide the head upward as the posterior shoulder is born over the perineum and lifts the baby's head anteriorly to deliver the posterior shoulder.**	
9	Support the rest of the baby's body with one hand as it slides out **and place the baby on the mother's abdomen** over the clean towels. Note the time of birth and sex of the baby and tell the mother.	
10	**Thoroughly dry the baby and cover with a clean, dry cloth, and assess breathing. If baby does not breathe immediately, clamp & cut the cord & begin resuscitative measures.**	
11	Look for any vaginal or perineal tear, if present assess the degree of tear and manage accordingly*	
12	Palpate the mother's abdomen to rule out the presence of additional baby (ies) and proceed with active management of the third stage and ENBC	

Key Points to remember

- All equipments, medicine, disposable should be kept ready before the Pregnant women is received in delivery room
- Woman shall be shifted to the labour table in active stage of labour. Unnecessary pushing in between the contractions should be avoided.
- Ensure the woman is hydrated.
- Avoid routine augmentation of labour before delivery without indication
- If indicated, augment only if C- section facility is available
- *For 3rd degree perineal tear, refer the woman immediately for higher specialized care with proper sterilized perineal dressing.
- All neonatal equipment for ENBC and resuscitation should be pre-checked and kept in readiness as soon as the pregnant woman is received.
- Radiant Warmer should be plugged in, should be functional and switched on at least half an hour before the time of delivery.
- A pretested and functional newborn resuscitation bag and mask is kept ready on the shelf just below the radiant warmer.
- Temperature between 25-28 0 C must be maintained in LR. Hilly, cold areas will need warmers during winters
- Provide emotional support and reassurance, as feasible. Encourage presence of a birth companion.
- Maintain Aseptic technique throughout the procedure
- Cleaning of the labour table should be done immediately after transfer of mother to the post natal/ observation ward.

SKILL 6 PLOTTING & INTERPRETING PARTOGRAPH

Day 2

Skill station – 6

Cabin – 1&2

Objective

By the end of this exercise the participant will be able to plot Partograph correctly

SI NO	Steps	
1	**Record identification Data**	
2	Maternal, newborn, amniotic fluid & membranes, cervical dilatation & uterine contractions shall be properly recorded with respect to time.	
3	Plot cervical dilatation when it is 4cm and above on the alert line along with the time	
4	**Plot every half an hourly the following – Uterine contractions, FHR, Condition of the membrane and color of amniotic fluid, maternal pulse**	
5	Plot every four hourly the following – Cervical dilatation, temp, BP	
6	Interpret the findings and make decision for necessary action. If referral is required then refer the client further with a duly filled referral slip.	
7	**Record the time of birth, sex and weight of the baby**	

Key points to remember

- The first plotting on the Partograph is always on the alert line
- The progress of labor is satisfactory, when the cervical plotting falls on or left of alert line.
- The progress of labor is not satisfactory, when the cervical plotting falls right of alert line. In which the women need to be referred for further intervention
- Ideally, the woman should reach the higher referral centre within two hrs.(time taken from alert to action line)
- Actions for ANMs/SNs:
  - Refer when the plotting on the Partograph moves to the right side of the alert line.
  - Refer when the FHR : less than 120 or more than 160/minute
  - Be alert when the amniotic fluid is meconium stained

CASE SCENARIOS ON PARTOGRAPH

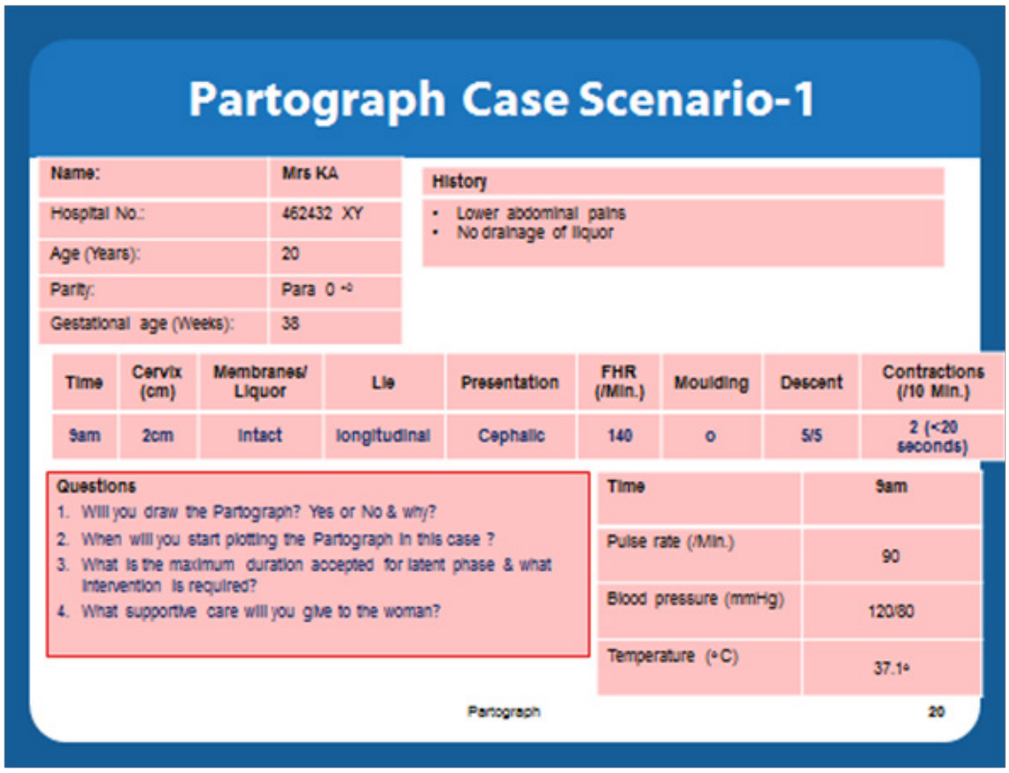
Partograph – Day 2

Skill station number 6

Cabin number 1&2

Case I

Objective – The participants should know when & how to plot the Partograph.



Partograph Case Scenario-1

Name:	Mrs KA
Hospital No.:	462432 XY
Age (Years):	20
Parity:	Para 0 +0
Gestational age (Weeks):	38

History

- Lower abdominal pains
- No drainage of liquor

Time	Cervix (cm)	Membranes/ Liquor	Lie	Presentation	FHR (/Min.)	Moulding	Descent	Contractions (/10 Min.)
9am	2cm	Intact	longitudinal	Cephalic	140	0	5/5	2 (<20 seconds)

Questions

1. Will you draw the Partograph? Yes or No & why?
2. When will you start plotting the Partograph in this case ?
3. What is the maximum duration accepted for latent phase & what intervention is required?
4. What supportive care will you give to the woman?

Time	9am
Pulse rate (/Min.)	90
Blood pressure (mmHg)	120/80
Temperature (°C)	37.1°

Partograph 20

Answer key: –

1 No, we start plotting the Partograph in active phase (cervix 4 cms. Dilated) and presently, she is 2 cm dilated i.e. in latent phase.

2 Once she becomes 4 cm dilated we will draw the Partograph

3 Latent phase is maximum 8 hrs. and beyond this we need to assess the women and intervene for increasing contractions

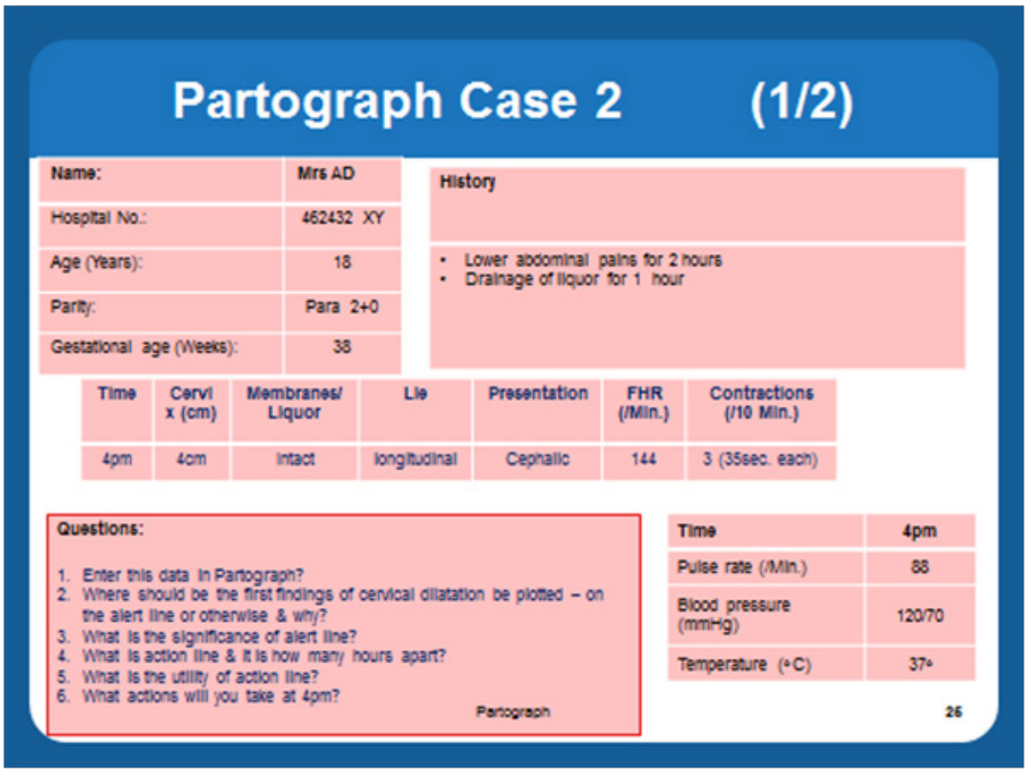
4 Supportive Care during latent phase:

- Encourage & reassure the woman
- Maintain & respect privacy of woman
- Keep woman informed about progress of labour

- Encourage the woman to keep herself clean & mobile during the first stage of labour
- Enema should NOT be routinely given during labour
- Presence of birth companion is beneficial
- Let her choose any position she feels comfortable during labour
- Encourage her to have light, easily digestible, low fat food & drink plenty of fluids

Case 2:

Objective: The participants will be able to plot Partograph & will know about the actions to be taken depending on their level of facility



Answer Key:

1 Check each Partograph for correct documentation

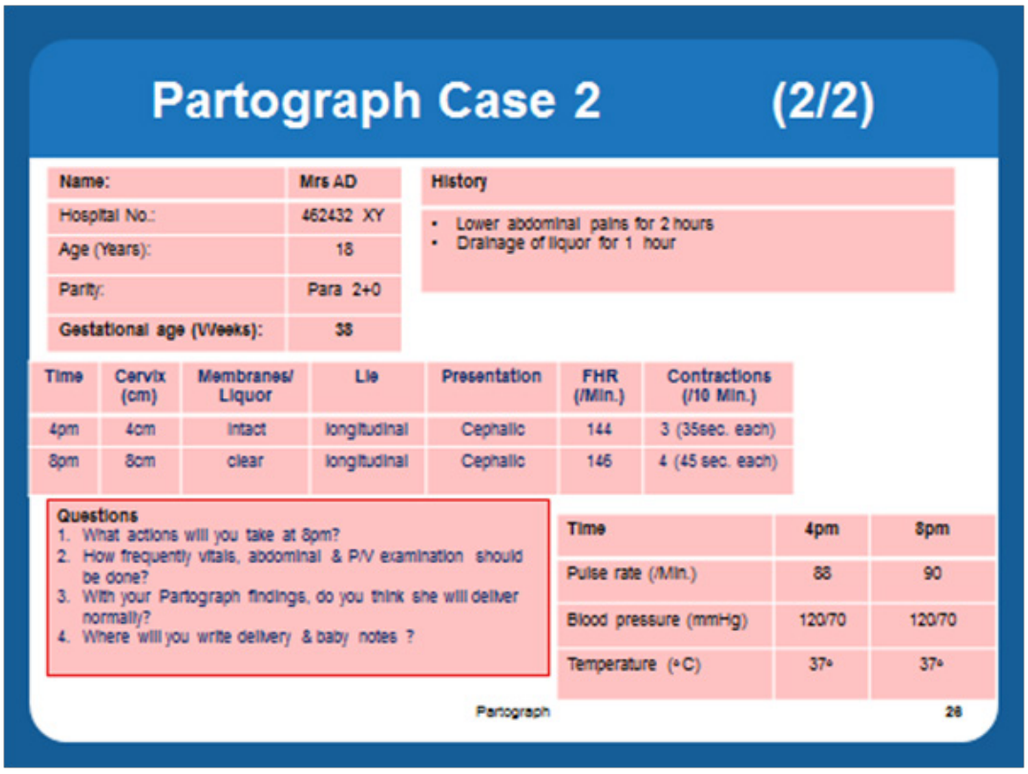
2 First finding of cervical dilatation has to be plotted on alert line then only it can be compared whether the graph shifts to right in abnormal labour cases or remains to left in normal labour cases

3 Alert line is a line on Partograph which starts from 4 cm and progresses to 10 cm with cervical dilatation of 1 cm/hr. which says that there is normal progression of labour. If the graph starts shifting to the right of the alert line this means labour progression is not satisfactory and we need to assess uterine contractions, cervical dilatation and intervene in the form of drugs for increasing contractions or for cervical dilatation

4 Action line is a line parallel to alert line and is 4 hrs. apart

5 If the graph is crossing action line it says that mother and fetus are at risk and immediate intervention is required to save the mother and fetus from complication.

6 The answer to Q.6 above in the slide is not given (What actions you will take at 4pm?)



Partograph Case 2 (2/2)

Name:	Mrs AD
Hospital No.:	462432 XY
Age (Years):	18
Parity:	Para 2+0
Gestational age (Weeks):	38

History

- Lower abdominal pains for 2 hours
- Drainage of liquor for 1 hour

Time	Cervix (cm)	Membranes/ Liquor	Lie	Presentation	FHR (/Min.)	Contractions (/10 Min.)
4pm	4cm	intact	longitudinal	Cephalic	144	3 (35sec. each)
8pm	8cm	clear	longitudinal	Cephalic	146	4 (45 sec. each)

Questions
1. What actions will you take at 8pm?
2. How frequently vitals, abdominal & P/V examination should be done?
3. With your Partograph findings, do you think she will deliver normally?
4. Where will you write delivery & baby notes ?

Time	4pm	8pm
Pulse rate (/Min.)	88	90
Blood pressure (mmHg)	120/70	120/70
Temperature (°C)	37°	37°

Partograph 28

Answer Key:

1 Check Partograph on individual basis and ensure it is filled correctly

2 Observe & record-

- Every half an hour – FHR, uterine contractions, pulse rate
- Every 2 hrs. – BP
- Every 4 hrs. - Cervical dilatation or when needed e.g. – In case, if meconium is recognized

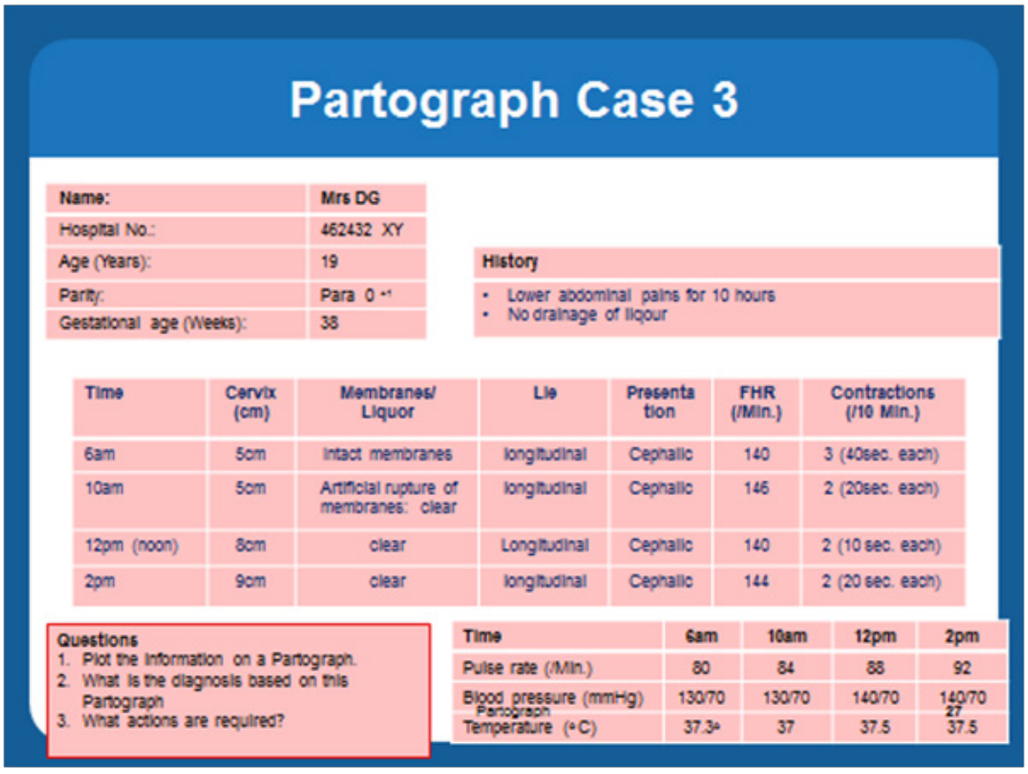
3 Yes, progress of labour adequate, no shift of graph on right side to the alert line

4 Labour and baby notes to be written below action line or on the side Space

Objective: The case scenarios (3, 4 & 5) will help the participants in clinical decision making & timely referral

Case 3: Prolonged Labour

The purpose of this session on how to use the Partograph is to focus on prolonged labour due to inadequate uterine contractions - continued suboptimal progress in labour – distinguishing it from obstructed labour (Case 4).



Partograph Case 3

Name:	Mrs DG
Hospital No.:	462432 XY
Age (Years):	19
Parity:	Para 0 +1
Gestational age (Weeks):	38

History

- Lower abdominal pains for 10 hours
- No drainage of liqour

Time	Cervix (cm)	Membranes/ Liquor	Lie	Presentation	FHR (/Min.)	Contractions (/10 Min.)
6am	5cm	Intact membranes	longitudinal	Cephalic	140	3 (40sec. each)
10am	5cm	Artificial rupture of membranes: clear	longitudinal	Cephalic	146	2 (20sec. each)
12pm (noon)	8cm	clear	Longitudinal	Cephalic	140	2 (10 sec. each)
2pm	9cm	clear	longitudinal	Cephalic	144	2 (20 sec. each)

Questions
1. Plot the information on a Partograph.
2. What is the diagnosis based on this Partograph
3. What actions are required?

Time	6am	10am	12pm	2pm
Pulse rate (/Min.)	80	84	88	92
Blood pressure (mmHg)	130/70	130/70	140/70	140/70
Temperature (°C)	37.3°	37	37.5	37.5

Partograph 27

Answer Key:

1 Ensure correct plotting

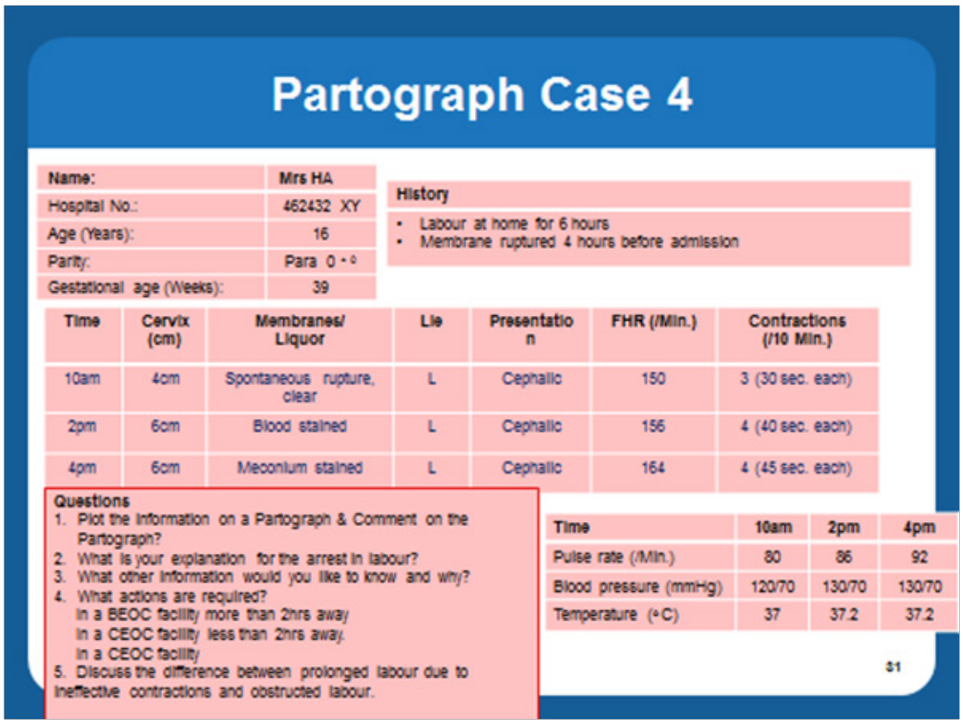
2 Dysfunctional labour – Descent of head not as desired, Patient was admitted in labour but labour not progressing well- cervical dilatation to the right of alert line, No signs of obstruction or fetal distress

3 Augment labour with oxytocin infusion and consider analgesia. Look for what is available locally? What is actually given for pain relief in labour? How to give it and brief comment on when further review should take place after oxytocin is started.

Note: In some settings there will be debate about augmentation

Case 4:

Failure to Progress



Partograph Case 4

Name:	Mrs HA
Hospital No.:	452432 XY
Age (Years):	16
Parity:	Para 0 + 0
Gestational age (Weeks):	39

History

- Labour at home for 6 hours
- Membrane ruptured 4 hours before admission

Time	Cervix (cm)	Membranes/ Liquor	Lie	Presentation	FHR (/Min.)	Contractions (/10 Min.)
10am	4cm	Spontaneous rupture, clear	L	Cephalic	150	3 (30 sec. each)
2pm	6cm	Blood stained	L	Cephalic	156	4 (40 sec. each)
4pm	6cm	Meconium stained	L	Cephalic	164	4 (45 sec. each)

Questions

1. Plot the information on a Partograph & Comment on the Partograph?
2. What is your explanation for the arrest in labour?
3. What other information would you like to know and why?
4. What actions are required?
   In a BEOC facility more than 2hrs away
   In a CEOC facility less than 2hrs away.
   In a CEOC facility
5. Discuss the difference between prolonged labour due to ineffective contractions and obstructed labour.

Time	10am	2pm	4pm
Pulse rate (/Min.)	80	86	92
Blood pressure (mmHg)	120/70	130/70	130/70
Temperature (°C)	37	37.2	37.2

31

Answer Key:

1 This is a case of secondary arrest of cervical dilatation and descent of presenting part with caput and moulding.

2 Suspect obstructed labour.

3 Arrest of labour is unlikely to be due to inefficient contractions ¡, therefore oxytocin should not be considered and actually could be harmful (rupturing uterus).

Assess:

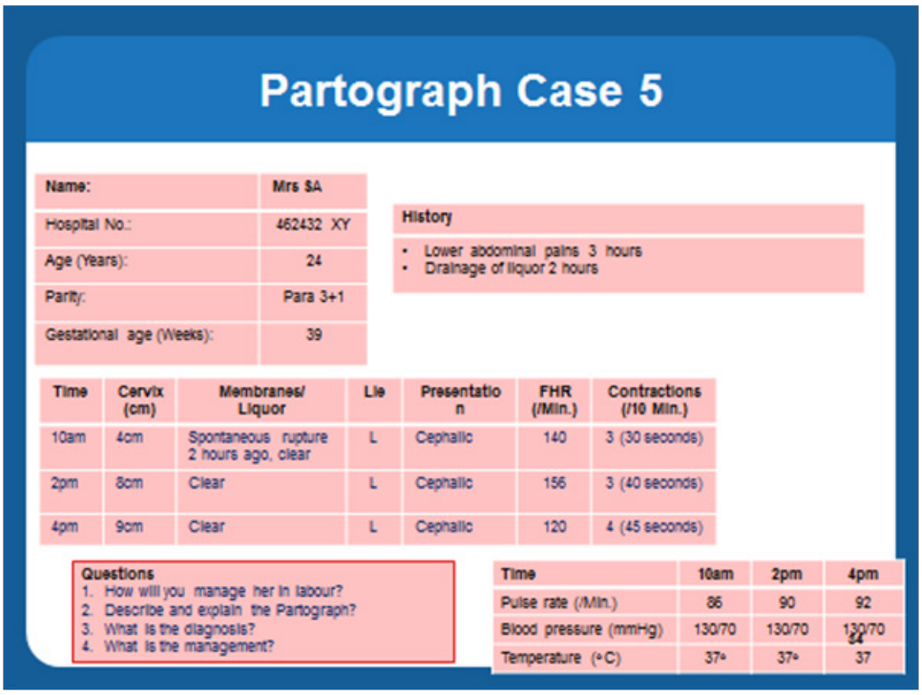
- Size of fetus
- Presence of moulding
- Amount of head palpable abdominally
- Application of presenting part to cervix
- Station

Look for other signs of CPD; cervix poorly applied to presenting part, edematous cervix, ballooning of lower uterine segment, formation of retraction band (Bandl's ring), maternal and fetal distress, ketonuria

4 This means there is an urgent need to perform Caesarean Section. Patient may need transfer to a place where CS and blood transfusion services are available - CEOC facility. In BEmOC facility - transfer urgently with ANM or MO along with her with referral slip, CEmOC facility – 2 hrs. away referral same way & if women is in CEmOC immediate CS should be done.

5 Contractions ineffective, descent of head not as desired but rest parameters normal – reason for prolongation of labour , presence of caput and moulding, meconium and fetal distress – obstructed labour, maternal parameters change – increased pulse rate and ketonuria

Case 5



Partograph Case 5

Name:	Mrs SA
Hospital No.:	462432 XY
Age (Years):	24
Parity:	Para 3+1
Gestational age (Weeks):	39

History

- Lower abdominal pains 3 hours
- Drainage of liquor 2 hours

Time	Cervix (cm)	Membranes/ Liquor	Lie	Presentation	FHR (/Min.)	Contractions (/10 Min.)
10am	4cm	Spontaneous rupture 2 hours ago, clear	L	Cephalic	140	3 (30 seconds)
2pm	8cm	Clear	L	Cephalic	156	3 (40 seconds)
4pm	9cm	Clear	L	Cephalic	120	4 (45 seconds)

Questions
1. How will you manage her in labour?
2. Describe and explain the Partograph?
3. What is the diagnosis?
4. What is the management?

Time	10am	2pm	4pm
Pulse rate (/Min.)	86	90	92
Blood pressure (mmHg)	130/70	130/70	130/70
Temperature (°C)	37°	37°	37

Answer Key:

Ans.1: Management during labour :

- Examine patient to confirm findings
- Start Partograph
- Encourage support from a birth companion
- Respect privacy
- Ensure good communication by staff
- Support breathing and relaxation with contractions
- Encourage mobility
- Encourage hydration and nutrition
- Encourage bladder emptying
- Examine after 4 hour

Ans. 2 – Should be able to explain each section of Partograph

Ans. 3 - Multipara with obstructed labour.

Ans. 4 - Urgent LSCS, is recommended as uterus may rupture. Woman shall be immediately referred to a CEmOC facility where she can undergo surgery.

SKILL 7 PROCESSING OF INSTRUMENTS

Day -2

Skill Station – 7

Cabin Number – 3 & 4

Objective

By the end of this exercise the participant will be able to demonstrate steps for processing of instruments

SI NO	Steps
1	**Decontamination**
	Place the used items/instruments unlocked in 0.5% Chlorine solution in a plastic container
	Let it soak for 10 minutes
	Wear utility gloves, removes instruments from chlorine solution and rinses them in water
2	**Cleaning**
	Clean the instrument with detergent and cold water using soft brush
	Scrub the instruments with special attention at toothed areas & locks in a container filled with water to avoid splashing
	Rinse them thoroughly to remove all detergent and air dries them
3	**Sterilization**
	Fill the bottom of the autoclave with water till the ridge
	Place the items in autoclave drum loosely and puts it on the stove or electrically connected system
	Note the timing when the steam emits from the pressure valve. Keeps the wrapped items for 30 min and unwrapped for 20 min at 15 pounds per square inch at 121 degree centigrade (106 Kilo Pascal).
	Open the pressure valve to release the steam and allows autoclave to cool for 15-30 min before opening.
	Dip instruments like Laparoscope or bag & mask etc. in Glutaraldehyde solution
4	**Storage** – store the instruments at a clean dry place.

Key points to remember

- Place the items loosely in the autoclave to allow steam to circulate.
- Sterilization is a preferred method over HLD
- For chemical sterilization, immerse instruments in 2% Glutaraldehyde for 10 hours
- For HLD by boiling method , count 20 minutes after water starts boiling
- While boiling the instruments make sure that lid is closed, instruments are well soaked in water, no in-between addition or taking out of water and/or instrument
- Avoid splashing while decontaminating or cleaning instruments
- While autoclaving, use a biological indicator to ensure the items are sterilized
- Periodically take samples from the autoclave and send it for lab investigation to rule out bacterial/ viral/ fungal presence

SKILL 8 ORGANIZING LABOR ROOM

Day -2

Skill Station – 8

Cabin Number – LR

Objective

By the end of this exercise the participant will be able to set up/organize labor room in a systematic manner

S. NO	Steps
1	Appropriate environment in the LR is to be maintained with – adequate lighting, cleanliness, appropriate temperature depending on the surroundings, curtains/Screens, windows with intact panes, attached functional toilet with running water. All the important protocols shall remain displayed at appropriate places in the labor room.
2	Equipment needed in the LR is available and functional.
3	**Ensure that all the instrument trays are sterilized & available for each case**
4	The drugs & other trays should always be kept ready
5	All the surfaces are cleaned with bleaching powder solution including the labor tables.
6	**Arranging new born care corner:** Radiant Warmer plugged in, is functional and switched on at least half an hour before the time of delivery. A pretested, disinfected and functional newborn resuscitation bag and mask is kept ready on the shelf just below the RW. A clock with seconds handle shall be placed at prominent place.
7	**Suction apparatus :-** For New born : Dee Lees in the tray For mother : Foot operated/ electric suction is functional along with disposable suction catheter is available
8	Oxygen Cylinder: Check Oxygen is available and flow is checked under water (in a bowl) before inserting the tube The knobs are pre checked New disposable tube is used every time oxygen is administered

9	**IP practices-** Hand washing area has soap and running water, long handle tap which can be operated with elbow Drums to store sterilized items like gloves, instruments, linen, swabs and gauze pieces. Autoclave exclusive for LR is available and is functional, delivery instruments are wrapped in a sheet and autoclaved in enough numbers (1 set for each delivery), autoclaving is done at least twice a day (at the end of morning and evening shift), Soiled items are first put into 0.5% Chlorine solution before processing PPE are used while working in the LR
10	**Waste disposal**- color coded bins are available ,
11	Records- Partograph, case sheets, labor register, refer-in/refer-out registers are available and filled for each case

Key Points to remember:

- Temperature between 25-28 ^{0}C must be maintained in LR. Hilly, cold areas will need warmers during winters
- Equipment must be checked for its functionality during change in shifts of nursing staff
- Privacy (Use plastic curtains between tables) and dignity of the woman to be ensured
- Use sterilized instruments for every delivery
- LR should be draught free.
- 20% buffer stock of Labour room drugs must be available all the time.
- NBCC should not get any direct air from any corner.
- Initiation of breast feeding within one hour.
- Injection Oxytocin should be kept in fridge (not freezer)
- All the staff, doctors, nurses , cleaning staff practices and adheres to infection prevention protocols
- The colour coded bins are emptied at least once a day or as and when they get filled

DAY 3

SKILL 9 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR (AMTSL)

Day -3

Skill Station – 9

Cabin Number – LR

Objective:

To build capacity of the participant to perform active management of third stage of labor

S.no.	Steps	
1	Palpate the mother's abdomen to rule out the presence of additional baby (ies)	
2	**Administer Inj.Oxytocin, 10IU, IM OR Tab. Misoprostol 600 micrograms**	
3	**Deliver the placenta by applying Control cord traction with counter pressure in upward direction to be applied on the uterus at the suprapubic region**	
4	**Massage the uterine fundus in a circular motion and ensures that the uterus is well contracted**	
5	Examine the placenta-maternal and fetal surface for completeness	

Key Points to remember

- Check for uterine contraction and vaginal bleeding every 15 mins for 2 hours
- Never apply CCT without contraction and without applying counter traction (Push) above the symphysis pubis with other hand
- If placenta not delivered after 30 mins, refer to higher facility, if further facility for t\t not available

SKILL 10 - MANAGEMENT OF PPH

10A MANAGEMENT OF PPH
10B SETTING UP AN IV LINE

10A MANAGEMENT OF PPH

Day – 3

Skill Station – 10

Cabin Number – 1 & 3

Objective:

To build capacity of the participant to identify PPH and its probable cause, whether the women is in shock and provide initial management as per need before referring to appropriate facility.

a Placenta delivered: Perform initial management of PPH (Bimanual compression, managing atonic uterus with uterotonic drugs)

b Retained placenta: Manual removal of placenta

S.No.	Steps	
1	Note whether it is immediate or delayed PPH	
2	Check woman's pulse, blood pressure, respiration. Assess whether the woman has heavy bleeding and whether she is in shock	
3	Tries to ascertain the cause : **Check for hardening of uterus, if atonic starts uterine massage**	
4	Shout for help	
5	Start IV Ringer lactate; give Inj. Oxytocin 10 IU infusion IM if not given after delivery & start Inj. Oxytocin 20 IU in Ringer lactate @ 40-60 drops/min. IV drip	
6	Wash hands and wears surgical gloves	
7	**Check for retained placenta/ trauma & continues massage the uterus**	
8	**Perform bimanual compression of uterus**	
9	Frequently Monitors pulse, blood pressure and urine output	
10	**Arrange urgent referral to higher facility, for specialist care with accompanying trained personnel**	
11	If the woman is in shock manages shock	
12	If it is delayed PPH , in addition to above steps, looks for signs of infection and administers the first dose of antibiotic	

Key points to remember

- While starting the IV line, blood sample must be withdrawn for cross matching
- If the patient needs to be referred, detailed referral note must be prepared about vital signs,
- medication given, blood group (if known) etc.

SKILL 10 B SETTING UP AN IV LINE

Day – 3

Skill Station – 10

Cabin Number – 1 & 3

Objective

By the end of this exercise the participant should be able to

- Organize supplies for IV Cannulation
- Perform the procedure of I/V cannulation
- Fix the cannula

SI NO	Steps	
1	**Identify and collect the necessary equipment for IV cannula insertion (Sterile cotton swabs, IV cannula- Size 22F, 24 F, Povidone Iodine, Alcohol/spirit swabs, Adhesive tape, 2 ml normal saline flush in a 2/5 ml syringe , splint, gloves, tourniquet)**	
2	Identify the site of insertion (Using IV arm of mannequin)	
3	Wash hands and wear gloves	
4	Ask assistant to apply tourniquet, if required, proximal to the identified vein	
5	**Clean site with alcohol and wait for 30 seconds and then apply Povidone iodine soln. Remove the Povidone iodine using alcohol and allow to air dry for 30 seconds.**	
6	Hold the IV cannula & Prick the skin at 15 degree angle. Once a gush of blood is seen, progress the IV cannula slowly while withdrawing the stylet.	
7	Keep the stylet in a sterile container	
8	**After insertion, flush with 2ml NS**	
9	Close the hub end with the stopper	
10	**Fix the IV Cannula with adhesive tape**	
11	Splint the part if required.	

Key points to remember

- Adopt aseptic precautions and injection safety methods.
- Prepare skin using spirit-Betadine-spirit. Use appropriate size cannula.
- Dispose sharps and plastic waste as per IMEP guidelines
- Do not apply the adhesive encircling the entire arm.

DAY 4

SKILL 11 ADMINISTRATION OF INJ. MGSO4 FOR INITIAL MANAGEMENT OF ECLAMPSIA

Day 4

Skill station – 11

Cabin Number – 1 & 3

Objective:

To build capacity of the participant to perform initial management of eclampsia by administrating Mg So4

Steps

S. No.	Steps	
1	Wash hands thoroughly with soap and water and dry before and after the procedure	
2	Keep ready 10 ampoules of 50% Mg SO4 (I ampoule=2ml=1g)	
3	Prepares 2 syringes(10ml syringe and 22 gauze needle) with 5 g **(10 ml)** of 50% magnesium sulfate solution in each	
4	Carefully cleans the injection site with an alcohol wipe.	
5	Give 5 g **(10 ml)** by DEEP IM injection in one buttock **(upper outer quadrant)**	
6	Cut the needle with hub cutter and Disposes of used syringe in a proper disposal box	
7	Carefully clean the injection site in the other buttock with an alcohol wipe.	
8	Give 5 g (10 ml)by DEEP IM injection in other buttock(upper outer quadrant)	
9	**Cut the needle with hub cutter and Dispose of used syringe in a proper disposal box**	
10	Record drug administration and finding on the woman's record.	

Key Points to remember

- If the woman is conscious, Tell her that she may experience a feeling of warmth when magnesium sulphate is given
- Cases of Eclampsia shall be referred to higher facility, if further facility for treatment is not available. Ensure that the patient is shifted with basic life support required to manage Eclampsia including initial dose of Inj.MgSo4

SKILL 12 MANAGEMENT OF SHOCK (CAB)

12A RAPID INITIAL ASSESSMENT

12B HYPOVOLEMIC SHOCK – IV FLUID REPLACEMENT THERAPY

12A RAPID INITIAL ASSESSMENT

Day – 4

Skill Station – 12

Cabin Number – 2 & 4

Objectives

To orient the trainees to acquire the different skills for the management of shock using CAB approach & learn about volume replacement.

Steps	Rapid Initial Assessment	
1	**Call for help**	
2	**Do rapid initial assessment of the woman in shock & assesses circulation (pulse, BP, skin colour, température, mental state)**	
3	**Assess Airways patency by looking, listening & feeling the air through nostrils** **If Airway not patent, perform 'Head tilt-Chin lift'**	
4	**Observe breathing**	
5	**Provide immediate management of shock** ▸ Turn patient to side to minimise risk of aspiration ▸ Keep woman warm ▸ Elevate her legs to increase venous return ▸ Loosen tight clothing ▸ Start IV infusion for replacement of ongoing fluid/ blood loss ▸ Monitor vital signs (pulse, blood pressure, breathing) and skin temperature every 15 minutes ▸ Give oxygen @ 6-8 l/min by mask/ cannula ▸ Collect blood for testing & cross matching	
6	**If woman is not breathing –** ▸ Give 30 chest compression followed by 2 breaths @ 100 compression/ min ▸ Press sternum vertically to depress it by 4-5 cm ▸ Breaths should be delivered by bag & mask, ▸ Each breath should be provided for one second & it should raise the chest (Avoid hyperinflation)	

7	**If woman is breathing-** ▸ Rapidly evaluate her vital signs (pulse, blood pressure, breathing) ▸ Prop on left side ▸ Give oxygen at 6–8 liters/minute ▸ Ensure airway is clear, all the time ▸ Once stabilized— manage accordingly	
8	**Steps for catheterization -** ▸ After routine hand wash put on sterile gloves ▸ Clean the vulva with wet cotton swabs soaked in cetrimide solution ▸ Open the sterile pack of size16, 18 Foleys catheter ▸ Separate the labia majora & insert the tip of Foleys catheter in the urinary meatus ▸ Push the catheter & connect the other end of the catheter to the urobag ▸ Check the flow of urine ▸ Inflate the bulb of catheter with 10ml normal saline. ▸ Maintain and monitor the input -output chart	

12B HYPOVOLEMIC SHOCK – IV FLUID REPLACEMENT THERAPY

Day – 4

Skill Station – 12

Cabin Number – 2 & 4

S.No.	Steps	
1	First line of treatment for hypovolemia	
2	Provides time for control of bleeding & obtain blood for transfusion	
3	Intravenous replacement therapy	
4	Crystalloid fluids – Normal Saline, Ringer lactate, Dextrose or Dextrose in normal saline	
5	Volume required is three times the volume lost which includes physiological losses through skin, lungs, faeces & urine	
6	Limited role of colloids for resuscitation	
7	In case of heavy bleeding, blood transfusion will be required	

Key points to remember:

- Emphasize fall in BP is a **LATE** sign.
- IV fluids should normally be given when losses amount to 700mls **i.e. 15 % of circulating blood volume** at which subtle or no signs of hypovolemia will be apparent. In the presence of hypovolemia and the absence of pre-eclampsia or heart failure (anaemia).
- Sizes of cannulae; 20G (pink) can run 1lt in 15 min, 18G (green) can run 1lt in 10 min, 16G (grey) can run 1lt in 5 min.

- If available, **blood should be given when maternal losses exceed 1.5** l i.e. 30% of circulating blood volume.
- Crystalloids should be given initially and infused rapidly [Estimated replacement is usually 3x the blood loss as crystalloid, but need to be guided by clinical condition- pulse, BP, RR. If the patient is shocked then fluid can be run as fast as the drip will give, remembering to check lung bases to rule out pulmonary oedema].
- Colloids are usually given if more severe hypovolemia develops

Steps for removal of catheter—

- Put on sterile pair of gloves
- Take 10 ml syringe & attach the barrel of the syringe to short end of catheter
- Deflate the bulb by withdrawing normal saline with the help of syringe
- Pull out the catheter & dispose catheter & urobag as per the guidelines

SKILL 13 INTERVAL IUCD INSERTION & REMOVAL

Day – 4

Skill Station – 13

Cabin Number - 2 & 4

Objective

By the end of this exercise the participant will be able to demonstrate insertion and removal of interval IUCD

Sl No	Steps	
1	Check the IUCD tray and the necessary equipment	
2	Confirm the eligibility of the client for IUCD and select an appropriate case from the case histories provided. Note the date of last menstrual period.	
3	**Wash hands thoroughly with soap and water and put on sterile gloves in both hands.**	
4	**Perform bimanual examination and note the size & position of the uterus**	
5	Perform speculum examination and see the cervix and vagina for any signs of infection	
6	Clean the cervix and vagina with an antiseptic solution	
7	**Hold the anterior lip of the cervix with a volsellum forceps and gently pulls it**	
8	Introduce the uterine sound gently into the uterine cavity and advance it till uterine fundus, remove the sound and note the length of uterine cavity	
9	**Open the pre-sterilized package containing IUCD, place the plunger rod in the insertion tube and load the IUCD in the insertion tube. Set the length-gauge at the uterine length.** **Align the length-gauge and folded arms of the T to horizontal position. (Loading & plunger rod step is not required in Cu IUCD 375 insertion)**	
10	**Carefully insert the loaded IUCD into the cervical canal and gently push it into the uterine cavity in appropriate direction with a 'No touch' technique. Gently advance it till the blue length-gauge comes in contact with the cervix, keeping the blue length-gauge in the horizontal position.**	
11	While holding the plunger rod stationary, withdraw the insertion tube with one hand, until it touch the circular thumb grip of the plunger rod (Using withdrawal technique but in Cu-375, insertion is by Push technique). Hold the insertion tube stationary and remove the plunger rod. Carefully push the insertion tube toward the fundus.	
12	Withdraw the insertion tube from the cervical canal, see the strings	
13	Cut the strings at 3 to 4 cm from the cervical opening using sharp scissors	
14	Gently remove the vulsellum and the speculum	
15	Put all the used instruments and used gloves in 0.5% chlorine solution for 10 minutes for decontamination before further processing	

Key Points to remember:

- Ask the woman to report if
- She is unable to feel the threads in the vagina
- She misses her menstrual period
- The device is expelled out
- There is heavy vaginal bleeding
- Significant pain in lower abdomen
- Fever and purulent vaginal discharge

Steps for removal IUCD

Sl No	Steps	
1	Check the IUCD tray containing a long straight artery forceps	
2	Wash hands thoroughly with soap and water and put on sterile gloves on both hands.	
3	Insert a HLD /sterile speculum and see the IUCD strings at the cervical opening	
4	**Clean the cervix with an antiseptic solution**	
5	Hold the anterior lip of the cervix with a volsellum	
6	**Grasp the strings of the IUCD with a high-level disinfected / sterile straight artery forceps**	
7	**Gently pulls the string by applying steady but gentle traction with the artery forceps.**	
8	Show the IUCD to the woman and places it in 0.5% chlorine solution for 10 minutes for decontamination	
9	Gently remove the vulsellum and the speculum	
10	Put all the used instruments and used gloves in 0.5% chlorine solution for 10 minutes for decontamination before further processing	

SKILL 14 NEW BORN CARE CORNER

14A BAG & MASK
14B RADIANT WARMER
14C SUCTION MACHINE
14D OXYGEN ADMINISTRATION

14A BAG & MASK

Day 4

Skill Station 14

Cabin – LR

Objective:

Upon completion of this section the participant should be able to

- Describe the parts of a bag & types of masks
- Use the bag
- Describe cleaning of a bag & mask

Indication

- To provide positive pressure ventilation

Contraindication

- Congenital diaphragmatic hernia
- Meconium aspiration syndrome (relative contraindication)

S.No.	Steps	
1	Assemble bag	
2	**Check bag (For this, occlude the patient outlet tightly with your palm and then squeeze the bag & look for the release of the pop-off valve, the pop-off valve goes up along with a hissing sound- this indicates that the bag is functioning normally)**	
3	Connect to oxygen source, if required	
4	Attach the reservoir, if required	
5	**Fix appropriate size mask (00 for extremely preterm, 0 for preterm and 1 for term, the rim of the mask should cover the tip of chin, the mouth and the base of the nose, but not the eyes)**	
6	Apply mask. Ensure adequate seal	

7	Squeeze the resuscitation bag enough for chest rise with each ventilation at the rate of 40-60 breathes per minute.	
8	If the chest is not rising ▸ Repositions the mask and checks that the seal is airtight ▸ Repositions the baby's head and tries again ▸ If there are a lot of secretions, sucks the airway. ▸ Opens mouth and tries again. ▸ Squeezes the bag a little harder	
9	After 30 seconds of effective bag and mask ventilation, assesses the baby's breathing and counts heart rate /cord pulsation for 6 seconds.	
10	Starts Oxygen if available	

Key messages to remember:

- Always keep a clean ,disinfected and functional bag and mask of appropriate size ready while organizing for delivery
- Keep two sets ready if expecting twins
- Reservoir and oxygen source may be used only if required
- Its use is contraindicated in Congenital diaphragmatic hernia and Meconium aspiration syndrome (relative contraindication)
- Always look for adequate seal and chest rise

14B RADIANT WARMER

Day 4

Skill Station 14

Cabin – LR

Objective

By the end of this exercise the participants should be able to

- Identify parts of the radiant warmer,
- Operate the Radiant warmer

S.No.	Steps	
1	Connect to mains and switch on warmer at least 30 minutes prior to the expected time of delivery/arrival of the LBW or Sick Baby.	
2	***Identify servo and manual mode and select the manual mode.***	
3	Keep the heater output to maximum for 20-30 minutes for pre-warming the bassinet and linen.	
4	Switch to servo mode and set the desired skin temperature to 36.5 0 C.	

5	**Place the baby (Baby Doll) in the bassinet. Identify the correct site *(right hypochondrium in supine position/ flank in prone position).***	
6	***Identify and connect skin probe after cleaning with isopropyl alcohol.***	
7	Ensures that the baby's head is covered with a cap and feet with socks. Keeps the baby clothed or covered.	
8	**Checks the sensor probe regularly so as to ensure that it is in place.**	

Key points to remember

1 Use only mild soap and water wipes. Don't use spirit or other chemical to clean the plastic/acrylic parts

2 Use manual mode setting :

- a To pre-warm clothes (2 towels) for receiving the baby
- b To manage a hypothermic baby - Do not forget to monitor axillary temperature frequently every 30 mins.

3 Use Servo mode setting:

- a After initial stabilization of a sick/hypothermic baby
- b For babies admitted in SNCU/NBSU; Check periodically that the probe is in position.

3 Check that the correct surface of the probe is facing the skin and the probe is attached at the correct site.

14C SUCTION MACHINE

Day 4

Skill Station 14

Cabin – LR

Objective

By the end of this exercise participants should be able to

a Identify the parts of the machine

b Operate the suction machine

c Enumerate steps of Disinfection

Checklist: Use of Suction machine (Electrical)

S. No.	Steps	
1	Connect to the main	
2	Switch on the unit	
3	Identify the pressure gauge	
4	**Occlude the distal end to check the pressure reading**	
5	**Adjust the pressure knob to keep suction pressure between 80- 100 mm Hg**	
6	Wash Hands & wear gloves	
7	Take disposable suction catheter and connect to suction tubing	
8	Perform suction gently, first mouth and then nose, not lasting more than 3-5 seconds	
9	Switch off the suction machine	

Check List: Use of Suction machine (Foot/ Hand operated)

S. No.	Steps	
1	Place the foot suction on floor in front of resuscitation trolley, with bellows on right side (if you use your right foot) and fluid collection jar on left side	
2	Place right foot on bellows and press down ensuring that it slides down in contact with the central vertical metal plate	
3	Block the suction tubing, press the bellows and check for suction pressure	
4	**Wash hands, wear gloves & connect suction catheter to patient end of suction tubing of the machine and perform gentle suction, first mouth and then nose**	
5	Place the foot suction on floor in front of resuscitation trolley, with bellows on right side (if you use your right foot) and fluid collection jar on left side	

N. B.: For safety of newborns, maximum suction pressure is limited to 100 mm of Hg, irrespective of foot pressure.

In case suction inlet gets blocked by thick mucus plug, switch suction tubing to alternate suction inlet provided on rubber stopper.

Key points to remember -

1 The foot suction must be cleaned immediately after use. Empty the fluid jar immediately when filled more than half and wash with soap and water.

2 The fluid collection jar and silicon tubing should be autoclaved.

3 Rubber lid of fluid collection jar cannot be autoclaved. Wash thoroughly with soap water, rinse, Re-assemble when dry

4 In case fluid jar is full & cannot be emptied immediately; open the alternate suction inlet to prevent overflow of fluid into bellow

5 Do gentle Suction & not vigorous

6 Use only disposable suction catheters

7 Check adequacy of suction pressure

8 Change bottle solution (5% hypochlorite solution) every day in the Electric Suction Machine

14D OXYGEN ADMINISTRATION

Day 4

Skill Station 14

Cabin – LR

Objective

By the end of this exercise the participant should be able to

- Check and assemble parts of an Oxygen cylinder/ oxygen concentrator
- Check for adequate flow of oxygen
- Demonstrate how to give oxygen on a mannequin

S. No.	Steps	
1	Ensure all the parts are available	
2	Ensure oxygen cylinder is secured on flat surface on a trolley.	
3	Attach the regulator	
4	Attach flow meter to the regulator to set the flow rate. Ensure the flow meter is vertical	
5	Attach humidification bottle to the flow meter. Fill clean water up to the mark level on the bottle	
6	Attach oxygen tube to the humidifier	

7	Using a spanner/Key opens the cylinder. Set the desired flow rate on the flow meter. Ensure that there is no leak	
8	Connect oxygen tube to the nasal prongs/ oxygen hood/ face mask/ or catheter / to deliver oxygen to the patient	
9	**Place the nasal prongs just inside the nostril and clear the nose if blocked**	
10	Secure the nasal pongs by taping along the cheek	
11	**Adjust the oxygen flow rate- 0.5 to 1 lit per minute for children less than 2 months and 1 – 2 lit per minutes for children 2 months upto 5 yrs.**	
12	If using nasal catheter, select 8 Fr. catheter for infants. **Measure distance from the side of nostril to the inner margin of the eyebrow. Mark the distance on the catheter**	
13	**Insert the catheter in one nostril up to the mark level. Tape the catheter on child's cheek. Adjust the oxygen flow rate - 0.5 lit per minute for children less than 2 months and 1 lit per minute for children 2 months to 5 years.**	

Checklist: Oxygen Concentrator

Objective: By the end of this exercise the participant should be able to check and assemble parts of an Oxygen concentrator; Check for adequate flow of oxygen

S.No.	Steps:	
1	Plug in the power cable. A green light indicating "power on" comes on.	
2	Switch on the concentrator. Once the concentrator is switched on, a red/ yellow light will come up	
3	Check the distilled water level in the humidifying jar and ensure that it is filled up to the marking	
4	**Adjust the oxygen flow as per need. The red/yellow light will be on till the desired concentration of oxygen is achieved**	
5	Place the nasal prongs inside the baby's nostrils and fixes it with a tape, ensuring that it fits snugly	

Key points to remember

Maintenance

1 Coarse Filter- ensure it is dust free and is washed daily

2 Zeolite granules- change every 20,000 hrs. or as per manufacturer's recommendation

3 Bacterial filter-- change every 1 year or as per manufacturer's recommendation

Oxygen Hood/Nasal prong

- It is used for delivering oxygen to baby
- Has two port holes, O2 inlet and baby port
- Delivers FiO2-90% with ports closed, 60% with one port opened and 30% with both ports opened.
- Clean the hood using soap and water. Never use spirit for cleaning. Nasal prong is disposable.
- Minimum oxygen flow required for Oxygen hood is 3 ltr./min and for prongs is 0.5 to 1 litre/min

DAY 5

SKILL 15 ESSENTIAL NEWBORN CARE (ENBC)

15A ESSENTIAL NEWBORN CARE
15B TEMPERATURE RECORDING
15C WEIGHING THE NEWBORN

15A ESSENTIAL NEWBORN CARE

Day 5

Skill Station 15

Cabin Number 3

Objective

By the end of this exercise the participant will be able to demonstrate steps of Essential Newborn Care

Steps for Essential Newborn Care

SI NO	STEPS	
1	Call out the time of birth and ensure that it is recorded	
2	**Receive the baby in a pre-warmed, clean towel and place on the mothers abdomen**	
3	Immediately wipe the secretions and dry the baby with same warm clean towel	
4	**Remove the wet towel and cover the baby with another warm dry towel**	
5	Assess the baby's breathing	
6	**Clamp and cut the umbilical cord between 1 to 3 mins of birth after the cord pulsation ceases. Check for any oozing of blood**	
7	Place an identity wrist band on the baby	
8	**Allow the baby to remain in between the mothers breast for skin to skin care**	
9	Cover the baby's head with a cap and cover the mother and baby with a warm cloth/ sheet	
10	Initiate breast feeding	
11	Weigh the baby and record the weight	
12	Check for any congenital malformations	

Key Points to remember:

The labour room must be warm (maintain room temp. between 26 – 28 O C) to avoid hypothermia
Assess the baby's breathing, if baby is not breathing/ has difficulty in breathing initiate resuscitation

15B TEMPERATURE RECORDING

Day 5

Skill Station 15

Cabin Number 3

Objective

By the end of this exercise the participant will be able to record temperature of a baby correctly

A Sing Mercury Thermometer

SI NO	Steps	
1	Take thermometer out of box, hold at broad end	
2	**Clean the bulb with cotton spirit swab and allow it to dry**	
3	**Check the position of column of mercury, if above the junction of the bulb with the stem then flicks the wrist gently till the mercury in the column is back in the chamber**	
4	**Place the bulb of the thermometer in the baby's axilla and ensure that the axilla is dry**	
5	Check that the baby's arm is by the side of the chest with the elbow flexed	
6	Keep the thermometer in place for at least 3 minutes	
7	Remove the thermometer and read the temperature	
8	Record the finding, inform mother	
9	Clean the shining tip with cotton spirit swab, place it in the box	

B Using Digital Thermometer

SI NO	Steps	
1	Take thermometer out of its storage case, hold at broad end, and clean the bulb with cotton swab soaked in spirit	
2	Press the on/off switch once to turn on the thermometer	
3	**Hold the thermometer and place the bulb under the baby's arm at the apex of the axilla (ensure that it is dry).**	
4	**Check that the baby's arm is by the side of the chest with the elbow flexed**	
5	**When the long beep is heard, remove the thermometer and record the displayed temperature**	
6	Inform mother	
7	**Turn the thermometer off by pushing the on/off button once**	

Note: Do not wash the tip of digital thermometer
Read manufactures instruction as some digital thermometers have both centigrade and Fahrenheit options

C Using Rectal Thermometer

A rectal temperature is taken by placing a thermometer in baby's bottom. This method provides the most accurate reading.

Getting the Thermometer Ready	
▸ Be sure to use a thermometer that is for rectal use. ▸ Wipe the thermometer with warm, soapy water, then wipe with clear water. Wipe dry or let the thermometer air-dry. ▸ Put a bit of petroleum jelly or water-based lubricant on the tip	
Positioning Your Baby	
▸ Use the position that works best for you. ▸ Put baby on his or her back on a firm surface. Hold baby's ankles and lift both legs, as if changing a diaper. ▸ Or place baby face down across your lap. Use one hand to part baby's buttocks.	
Taking the Temperature	
▸ Gently slip the tip of the thermometer into the rectum, no further than 1/4 to 1/2 inch. ▸ Hold the thermometer in place until it beeps that it is ready. Slide the thermometer out. Read the temperature on the digital display. ▸ Before putting the thermometer away, clean it with soap and warm water.	

Key Points to remember :

- Thermometer should be kept dry in the box
- Clinical thermometer – mercury chamber (bulb) is long and thin
- Rectal thermometer - short and thick and rounded bulb.
- Disinfect thermometer with alcohol after use. The best method is to wipe the bulb with a cotton spirit swab
- Do not wash the tip of digital thermometer
- Read manufactures instruction as some digital thermometers have both centigrade and Fahrenheit options

15C WEIGHING THE NEWBORN

Day 5

Skill Station 15

Cabin Number 3

Objective

By the end of this exercise the participant will be able to weigh newborn using Infant weighing scale and Sling scale

Using Infant Weighing Scale

	Steps	
1	**Place the weighing scale on a flat and stable surface**	
2	Ensure that the pan is centrally placed	
3	Place towel/ autoclaved paper on the pan	
4	**Adjust the setting to "0"**	
5	**Before undressing the newborn ensure that the room temperature is maintained**	
6	Undress and place the baby on the weighing pan	
7	Record the reading in the register	
8	Inform the mother about baby's weight	
9	**Remove the baby from the weighing scale and dress the baby back quickly**	
10	Give the baby to the mother/place back in the baby bassinet	
11	Remove the used towel/ autoclaved paper	
12	Clean the pan if it is soiled	

Using color coded Sling Scale

	Steps	
1	Hook the sling on scale	
2	**Hold the scale by top bar, keeping the adjustment knob at eye level**	
3	**Turn the screw until "0" is visible**	
4	Remove sling from the hook and place it on a clean cloth	
5	Place baby in the sling with minimum clothes on, and put the sling back on the hook	
6	**Hold top bar carefully, lift the scale and sling along with baby, until the knob is at eye level**	
7	Read the weight	
8	Gently unhooks the sling with baby	
9	Remove the baby from the sling and hand over the baby to mother	
10	Record the weight and inform the mother	

Key points to remember-

1 Ensure the weighing machine is placed on a flat surface and the pan is placed centrally.

2 Adjust the scale to zero each time before measuring weight of the baby.

3 Take care to prevent hypothermia by quickly undressing and dressing the baby during weighing.

4 Record accurate weight.

SKILL 16 NEWBORN RESUSCITATION

Day 5

Skill Station 16

Cabin Number LR

Objective

By the end of this exercise the participant will be able to resuscitate a newborn baby

	S. NO	Steps	
0-30 Seconds	1	Ensure all the equipment/material is kept in readiness prior to delivery	
	2	**Receive the baby in pre-warmed, dry, clean linen and place on the mother's abdomen**	
	3	Dry the baby & discard wet towel	
	4	Assess breathing	
	5	If breathing, provide routine care on mothers abdomen as learnt at ENBC station	
	6	If not breathing: Clamp and cut the cord immediately	
	7	Shift the baby under Radiant Warmer (which is switched on at least 30 mins before the delivery)	
	8	**Position the baby's head in sniffing position (to keep the airway open) with a shoulder roll (rolled towel/sheet)**	
	9	**Perform gentle suction of the airway: Gently suction the mouth followed by nose using De Lee's suction trap**	
	10	Evaluate, if baby is breathing well. If not, provide tactile stimulation (Gently rub the back of the baby or flick the sole of the feet)	
	11	**If baby is still not breathing, start bag and mask ventilation using self-inflating bag**	

31- 60 seconds	**Use of self-inflating bag and mask**		
	1	Ensure correct position of the baby by using the shoulder roll to keep the neck slightly extended	
	2	Identify the correct size of the mask and attach it to the bag	
	3	**Place the mask over newborn's mouth and nose correctly covering the tip of the chin , mouth and bridge of the nose to make an airtight seal**	
	4	Squeeze the resuscitation bag at the rate of 40-60 breaths per minute Squeeze…….Two…….Three…….Squeeze ……..Two…….Three Look for chest rise with each ventilation	
	5	**If the chest is not rising** ▸ **Repositions the mask and checks that the seal is airtight** ▸ **Repositions the baby's head and tries again** ▸ **If there are a lot of secretions, sucks the airway.** ▸ **Opens mouth and tries again.** ▸ **Squeezes the bag a little harder** ▸ **Plans to use alternative airway (Endotracheal tube)**	
	6	After 30 seconds of effective bag and mask ventilation, assesses the baby's breathing and counts heart rate /cord pulsation for 6 seconds.	
	7	▸ **If baby is not breathing and heart rate > 100/minute, continues bag and mask ventilation and reassess every 30 seconds. If baby starts breathing, stops ventilation and continues to stimulate and monitor.** ▸ **If baby is not breathing and heart rate < 100/minute, continues bag and mask ventilation and refers to higher center** ▸ **Starts Oxygen if available**	

Key points

- Routine suction is not recommended if the newborn is crying even if the liquor is meconium stained.
- Oropharyngeal suction should be brief and gentle, and should be performed only if the baby is not crying or the liquor is meconium stained.
- If baby is not breathing, call for help
- Ensure that the bag and mask is functional and ready for use.
- The masks are available in "0" and "1" size for preterm and term baby
- Normal newborn respiratory rate is 40-60 breaths/min

SKILL 17 METERED DOSE INHALER & NEBULIZER

17A METERED DOSE INHALER WITH SPACER
17B NEBULIZER

17A METERED DOSE INHALER (MDI) WITH SPACER

Day – 5

Skill Station – 17

Cabin Number- 3& 4

Objective:

By the end of this exercise the participant will be able to use correctly MDI, MDI with spacer &Nebulizer

Check List: Multi dose inhaler (MDI)

S.No.	Steps	
1	**Remove the cap from the inhaler and shake the inhaler well**	
2	Ask the patient to take a few deep breaths and then breathe out gently	
3	Ask the patient to immediately place the mouth piece inside the mouth with lips forming a seal	
4	**Instruct the patient to press the inhaler and at the same time begin a slow, deep breath and continue to breathe slowly and deeply over 3 - 5 seconds. Hold the breath for 10 seconds and then resume normal breathing**	
5	Advise to repeat the above steps when more than one puff is prescribed	
6	**Advise to wait 1 minute between actuations (puff); this may improve penetration of the second actuation into lung airways**	
7	Ask the patient to recap the MDI	

Check List: Multi dose inhaler with spacer

Note: Inhalation by MDI spacer needs four puffs at 2-3 minutes interval to get an equivalent dose for a single salbutamol nebulization.

S.No.	Steps	
1	Remove the cap from the inhaler and shake the inhaler well	
2	Attach the mask to the mouthpiece of the spacer	
3	Insert the inhaler mouthpiece into the slot of the spacer (the inhaler should fit snugly and without difficulty)	
4	**Place the mask over the child's nose and mouth so that it make a seal with the face**	

5	Press down on the inhaler canister to spray one puff of medicine into the spacer	
6	**Hold the mask in place and allow the child to breathe in and out slowly for five breaths**	
7	If child needs another dose, waits for 2-3 minutes, shake the inhaler and repeats steps 4 to 7	

17B NEBULIZER

Day – 5

Skill Station – 17

Cabin Number- 3& 4

Objective:

To demonstrate the correct use of a Nebulizer on a mannequin/volunteer.

S.No.	Steps	
1	Wash hands thoroughly before using a nebulizer	
2	Makes sure the equipment is clean	
3	**Measure the correct dose of medication to be administered and pour into the nebulizer chamber (cup) and add saline solution to make the volume to 3 ml.**	
4	**If the medicine is in single-use vials, twist the top off the plastic vial and squeeze the contents into the nebulizer cup**	
5	Connect the mouthpiece, or mask to the T-shaped elbow (face mask for smaller children and mouthpiece for older children)	
6	Connect the nebulizer tubing to the port on the compressor. Turn the compressor on and check the nebulizer for misting	
7	Hold the nebulizer in upright position to avoid spillage, while using mask ensure that it is fitting well. In older children ask the patient to keep the mouthpiece inside the mouth and close lips around it	
8	**Ask the patient to take slow deep breaths and if possible hold the breath for up to 10 seconds before exhaling. Occasionally, tap the side of the nebulizer to help the solution drop to where it can be misted**	

SKILL 18 POST NATAL CARE, BREAST FEEDING & KMC

18A POST NATAL CARE
18B BREAST FEEDING
18C PROVIDING KANGAROO MOTHER CARE (KMC)

18A POST NATAL CARE

Day – 5

Skill Station – 18

Cabin Number- 1

Objective

By the end of this exercise the participant will be able to demonstrate Post natal care including counseling on various components related to post natal period. Emphasis will be given on contraception & abnormal puerperium.

Examination of mother

S. NO	Steps	
1	Make the woman comfortable & check the details/documents of the delivery	
2	Explain her why the examination is important & how it will be conducted	
3	Ask for any symptom like fever, pain abdomen, excessive bleeding, foul smelling discharge etc.	
4	Does the general examination & make a special note on pulse & temperature	
5	**Does the breast examination:** ▸ Look for the nipples- retraction/cracks/tenderness/blood discharge ▸ Look for engorgement/red tender areas suggesting mastitis /lump suggesting abscess (with pain) or malignancy ▸ Always examine the axilla for axillary breast tissue or lymph node ▸ Examine the breast for sufficient milk secretion	
6	Examine abdomen for contracted uterus for involution	
7	Wash hands & does local examination after wearing sterilized/ HDL gloves	
8	**Examine episiotomy/perineal wound, if any**	

9	**Perineal Care :** ▸ Look for excessive bleeding, unhealthy discharge(Lochia) ▸ Perineal wash after urination/defecation (at least 2 washes to be ensured by the service provider to the women with tear/episiotomy ▸ If foul smelling discharge/wound disruption, start antibiotic & refer for further treatment to higher facility ▸ Use cotton swabs with antiseptic solution to clean perineal area, above downwards ▸ Discard the swab in yellow colour coded bin ▸ Repeat the same procedure on other side with other cotton swab & discard in the same way	

Examination of newborn

S. NO	Steps	
1	Match the tag of the baby with the mother; ensure the sex of the baby	
2	**Keep the baby's clothes* to minimal & check for breathing, temperature, color, skin, general alertness, movements and muscle tone**	
3	Weigh the newborn	
4	Examine head , face, mouth & eyes & look for jaundice, if any	
5	Examine the umbilicus for cord drying and signs of any infection	
6	**Examine genitalia, anus and spine**	
7	Make a note of any congenital anomaly like cleft lip, cleft palate etc.	
8	Look for the danger signs in the baby	

**Ensure that the room is warm & comfortable during examination*

Post natal advices

S. NO	Steps	
1	Advice on Personal hygiene & perineal wash	
2	Advice on diet & rest	
3	Advice on IFA	
4	Advice about exclusive breast feeding for 6 months & ensure the proper attachment as per the guidelines	
5	Advise about rooming in	
6	Explain the danger signs & about Puerperal sepsis	
7	Gives contraception advice through Cafeteria approach	
8	Emphasize the importance of PPIUCD	
9	Advise special care, in LBW babies	

Examination for abnormal Puerperium

S. NO	Steps	
1	**If examination shows** - high temperature, abdominal tenderness & foul smelling discharge	
2	Suspect Puerperal sepsis, gives first dose of antibiotics as recommended & refers to the higher facility	
3	**If examination shows** – Cracked nipples – Advice to apply hind milk*	
4	**If examination shows** – Redness/ lumps- Suspects mastitis/breast abscess- Give first dose of antibiotic & refer to higher centre	
5	**If examination shows** – excessive bleeding treats as per management of PPH protocol	
6	**If examination shows** – sub- involution of uterus – refer to higher facility	
7	**If examination shows** – any wound disruption/discharge from the wound site – refer to higher facility	

**After completion of baby's breast feed, usually a small amount of milk drops trickles down*

Key Points to remember

- During PNC period both mother & baby should be treated as a single unit & should be examined for any abnormal findings
- Care to be given to both mother & baby
- Through Perineal care prevents Puerperal Sepsis
- Mother should be explained about the normal signs of baby's growth & development
- Danger signs of both mother & baby to be explained
- Proper Postnatal advices to be given to reduce the Post-partum morbidities
- Issues related to breast feeding & breast care are important as they may prevent breast abscess formation
- Puerperal sepsis – one of the major causes of maternal morbidity & mortality which can be prevented provided danger signs are recognized on time.

18B BREAST FEEDING

Day – 5

Skill Station – 18

Cabin Number- 1

Objective

By the end of this exercise the participant should be able to

- Help mother breast feed in correct position.

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

18C PROVIDING KANGAROO MOTHER CARE

Day – 5

Skill Station – 18

Cabin Number- 1

Objective

By the end of this exercise the participant should be able to demonstrate Kangaroo Mother Care

Steps for providing Kangaroo Mother Care

Sl No	Steps	
1	Counsel the mother, provides privacy to the mother. Request the mother to sit or recline comfortably	
2	Undress the baby gently, except for cap, nappy and socks	
3	**Place the baby prone on mother's chest in an upright position with the head slightly extended, between her breasts in skin to skin contact in a frog like position; turn baby's head to one side to keep airway clear. Support the baby's bottom with a sling/binder.**	
4	**Cover the baby with mother's 'pallu' or gown; wrap the baby-mother duo with an added blanket or shawl depending upon the room temperature**	
5	Advise mother to breastfeed the baby frequently	
6	**Ensure warm room with room temperature maintained between 26 – 280 C.**	
7	Advise the mother to provide KMC for at least 1 hour per session. The length of skin-to-skin contact should be as long as possible	

Key Points to remember

1 Eligibility criteria for KMC
   - All LBW babies.
   - Sick hemodynamically stable babies needing special care(even those on IV Fluid or on Oxygen)

2 The two components of KMC are:
   - Skin-to-skin contact
   - Exclusive breastfeeding

3 The two prerequisites of KMC are:
   - Support to the mother in hospital and at home
   - Post-discharge follow up

4 Benefits of KMC

- Reduces risk of hypothermia
- Promotes lactation and weight gain
- Reducing infections and hospital stay
- Better bonding between Mother and newborn

PLENARY SESSION*

Counting respiratory rate

Objective:

To build capacity of the participants to count the respiratory rate and interpret the same for subsequent action

Articles required

LCD TV, DVD player, CD/DVD, Electric point

Methodology

Large group activity

- The facilitator will play IMNCI Video on counting the breathing rate in young infant and children
- The facilitator will explain interpretation of respiratory rates and actions to be taken for each
- The participants will practice video exercise on counting respiratory rate as instructed.

Preparation and Use of ORS

Objective:

To build capacity of the participants to

- Identify signs & symptoms of dehydration and
- Correctly prepare and calculate amount of ORS to be given to the child

Methodology

Large group activity

The facilitator will

- Discuss signs and symptoms of dehydration using a Video
- Demonstrate how to prepare ORS
- Discuss the quantity of ORS to the child according to age and degree of dehydration

Check list:

S. No	Steps	
1	**Wash hands with soap & water**	
2	Empty the content of 1 lit ORS packet into a clean container. Ensures no powder is left in the packet	
3	**Measure one lit of clean drinking water using a measuring jar or one lit plastic bottle**	
4	**Pour the measured one lit water in to the container with continuous stirring so that whole powder is dissolved**	
5	**Keep the container covered. The prepared ORS solution can be used up to 24 Hours**	
6	Ask the mother to give ORS by cup & spoon in the presence of service provider.	

Amount of ORS to be given during first 4 hours to a child with some dehydration

Age	Up to 4 months	4 months up to 12 months	12 months up to 2 years	2 years upto 5 years
Weight	Less than 6 kg	6- < 10 kg	10-<12 kg	12-19 kg
In ml	200-400	400-700	700-900	900- 1400

Amount of ORS to be given to a child with NO dehydration after each loose stool

Up to 2 years	50 to 100 ml
2 years or more	100 to 200 ml

Administration Of Zinc Tablet

Objective:

To build the capacity of the participants to calculate the dose and administer Zinc tablets

Methodology

Large group activity

The facilitator will

- Discuss importance of giving Zinc tablet and compliance for completing the dose during a diarrheal episode.
- Explain the dose based on age of the child.
- Demonstrate how to administer Zinc tablet.

Check list:

S No.	Steps	Remarks
1	**Wash hands with soap and water**	
2	**Take a clean spoon and places half tablet of Zinc for child 2 months up to 6 months and 1 tablet for a child from 6 months up to 5 years**	
3	Pour expressed breast milk or clean water in the spoon.	
4	Allow the tablet to disperse (30 seconds to 1 minute).Check that the tablet is completely dissolved.	
5	**Ask the mother to administer the prepared medicine to the baby in the presence of service provider. If some portion of the medicine is left in the spoon puts little breast milk or water and give to the child.**	

**PPTs and Videos covered under daywise schedule*

ROLE PLAYS

Guidance note for role plays:

Each role play is divided into four sections.

1. Check list to evaluate the counselling skills of the trainees/role players (A reference check list is given just below; the same check list is to be used for each role play)
2. Directions for the role play
3. Questions & Answers to lead the discussion with the group of participants after observing the role play by selected participants
4. Related knowledge Component

CHECK LIST TO EVALUATE THE COUNSELLING SKILLS OF THE TRAINEES/ROLE PLAYERS

Counseling skills and techniques	Done
Establishes therapeutic relationship ▸ Creates comfortable external environment ▸ Uses culturally appropriate greeting gestures that convey respect and caring ▸ Offers seat (if available) ▸ Uses appropriate body language and tone of voice ▸ Makes eye contact ▸ Establishes a conversation with a difficult / confronting client	
Active listening ▸ Looks at client when speaking ▸ Attentive body language and facial expression ▸ Continuous eye contact ▸ Occasional gestures, such as nods to acknowledge client	
Effective questioning ▸ Uses open ended questions to elicit information ▸ Asks relevant questions ▸ Reflects statements back to client for conformation	

ROLE PLAY 1: COUNSELLING ON FAMILY PLANNING CHOICES

Directions for the Role play

The teacher will select two learners to perform the roles specified. For example: an health care provider, and a woman seeking information about family planning methods. The two learners participating in the role play should take a few minutes to read the background information provided below and to prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play.

The purpose of the role play is to provide an opportunity for learners to appreciate the importance of good communication when providing counseling to a woman who is seeking a family planning method about available health care services for safe motherhood.

Participant/student roles

Provider: The provider is an experienced health care provider at the health center who has good communication skills.

Client: Anjana is a 21 year old mother; she has 2 children, an 11 month old and a 2 year old. She is still breastfeeding. She would like to delay having another child for 2 or 3 years.

Situation

Anjana has come to the health center to get information about family planning methods. Some of her friends have had "the Copper-T." Her husband has agreed to her trying a family planning method, but he does not want to use condoms. She is nervous about the safety of family planning; she has heard that it can make it impossible to have more children.

Focus of the role play

The focus of the role play is the interaction between the health care provider and Anjana. The health care provider should assess Anjana's knowledge about the available family planning methods (IUD, Depo-Provera, condoms, and the pill). She should provide Anjana with information about each of the available methods and assess the appropriateness of each of the methods for Anjana. The health care provider should provide Anjana with emotional support and reassurance. Anjana should continue to express her fears and concerns until the health care provider has provided her with enough information and reassurance to decide what method she would like to try.

Questions

1 How did the health care provider approach Anjana?

2 Did the health care provider give Anjana all of the information that she needed to make the best decision for herself?

3 What did the health care provider do to demonstrate emotional support and reassurance during her interaction with Anjana? Were the health care provider's explanations and reassurance effective?

4 What could the health care provider do to improve her interaction with a client?

Answer key

The following answers should be used by the trainer/teacher to guide the class discussion after the role play. Although these are "likely" answers, other answers provided by the participant/students during the discussion may be equally acceptable.

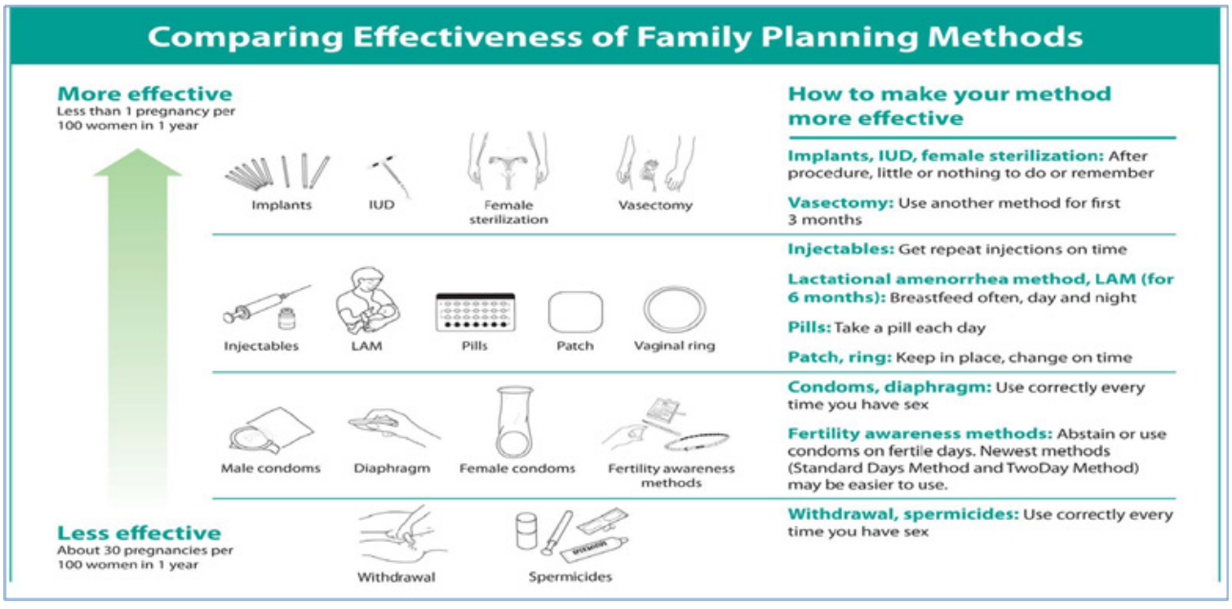
1 The health care provider should introduce him/herself and address Anjana by name. She should speak in a calm and reassuring manner, using terminology that Anjana will easily understand.

2 Sufficient information should be provided about each of the family planning methods available (IUD, Depo—Provera, condoms, and the pill); the risks and benefits of each of these methods should be explained.

3 The health care provider should listen and express understanding and acceptance of Anjana's feelings about family planning. She should address each of Anjana's questions with respect, ensuring that Anjana fully understands the family planning methods available to her.

4 Nonverbal behaviors, such touching or squeezing Anjana's hand or a look of concern, may be enormously helpful in providing emotional support and reassurance for Anjana. Using visual aids, such as posters, flipcharts, drawings, samples of methods and anatomic models as well improves the interaction with Anjana.

Knowledge Component



- Oral contraceptive pills that women must take daily to prevent pregnancy. Combined oral contraceptives (COCS) contain low doses of the hormones progestin and estrogen while progestin-only pills (pops), also called Minipills which contain low doses of the progestin hormone only, allowing breastfeeding women to use them. COCS, work by preventing ovulation—the release of eggs from the ovaries. Pops work mainly by thickening cervical mucus, which blocks sperm from meeting an egg, and they also prevent ovulation. Emergency contraceptive pills (ECPS), or "morning after" pills, can be taken up to five days after unprotected sex to prevent pregnancy. ECPS contain either progestin only or progestin and estrogen and prevent ovulation. ECPS, do not work if a woman is already pregnant, and they do not disrupt an existing pregnancy.
- Injectable contraceptives are given by injection into the muscle, slowly releasing a hormone into the woman's bloodstream. Progestin-only injectables include DMPA, administered every 13 weeks, and net-en, administered every 8 weeks. Combined injectable contraceptives (CICS) contain both progestin and estrogen and are administered monthly. Both types of injectables prevent ovulation.
- Hormonal implants are small, flexible rods inserted just under the skin of the upper arm by a clinician. Immediately reversible and very effective for three to seven years depending on the particular type, implants release progestin only, making them safe for breastfeeding women. Implants prevent ovulation and thicken cervical mucus, blocking sperm from meeting an egg.
- Intrauterine devices (IUDS) are small, flexible plastic frames inserted into a woman's uterus by a clinician. The copper-bearing IUD has copper sleeves or wire around the plastic frame while the levonorgestrel-releasing IUD (LNG-IUD) steadily releases small amounts of the hormone levonorgestrel daily to suppress the growth of the lining of the uterus (endometrium). The copper-bearing iud is very effective for at least 12 years, and the lng-iud for up to five years. Both are immediately reversible when removed from the uterus.
- Sterilization provides very effective, permanent protection against pregnancy. Female sterilization, done by a clinician, involves surgical blocking or cutting of a woman's fallopian tubes so that eggs released from the ovaries cannot move down the tubes to meet sperm. Male sterilization, also done by a clinician, involves the cutting or blocking of the man's vas deferens, or the tubes that carry sperm to the penis.
- Barrier methods of male condoms and female condoms provide dual protection against both pregnancy and sexually transmitted infections (STI's), including HIV. Male condoms are sheaths or coverings that fit over a man's erect penis, forming a barrier that keeps sperm out of the vagina. Female condoms are sheaths or linings with flexible rings at both ends that fit loosely inside a woman's vagina, forming a barrier that keeps sperm out of the vagina to prevent pregnancy.
- Fertility awareness methods, also referred to as natural family planning, rely on a woman's ability to tell when she is fertile. Calendar-based methods, such as the standard days method®, involve keeping track of the days of the menstrual cycle to identify the fertile period. Symptoms-based methods, such as the two day method, require observation of the signs of fertility, which include cervical secretions and basal body
- The lactational amenorrhea method (LAM) is a temporary family planning method for postpartum women that require women to meet three conditions for effective protection against pregnancy:

1 The mother's monthly bleeding has not returned

2 The baby is fully or nearly fully breastfed and is fed often, day and night

3 The baby is less than six months old.

ROLE PLAY 2: COUNSELLING ON ADOLESCENCE HEALTH

Role play directions

The teacher will select two or three learners to perform the roles specified. For example: an health care provider (ANM/SN/MO) a woman seeking information about the services available at the health center, and the woman's mother. The two/three learners participating in the role play should take a few minutes to read the background information provided below and to prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play.

The purpose of the role play is to provide an opportunity for learners to appreciate the importance of good communication when providing information to mother about available health care services for adolescence.

Participant roles

Staff nurse in PHC: the provider is an experienced health care provider (ANM/SN/MO) at the health center who has good communication skills.

Nisha: Nisha is a 19-year-old girl; she has complaints of irregular menstrual periods.

Nisha's mother - Kusum: Kusum is 52 years old. She is mother of two children. Her elder son is akash is 23 years old. He is taking drugs at the age of 19 years. He is not concentrating to his studies. Nisha is her younger daughter, she is 19 years old. Her menstrual periods are not regular, she used to have periods after two to three months gap.

Situation

Recently Kusum came to know that her neighbor's daughter is three months pregnant , and she is unmarried. So she is very much worried about her daughter as her menstrual periods are irregular. Kusum came with her daughter Nisha to PHC to show her, as she has irregular periods. She also worried about her son as he taking drugs.

Focus of the role play

The focus of the role play is the interaction between the health care provider, Kusum and Nisha.

The health care provider should:

- Be friendly and reassuring,
- Assess Kusum knowledge about the adolescence care, role of the health care provider and the services available for adolescence health care at the health center, briefly explain what services are available for adolescent at the health center.
- Encourage the Kusum to ask questions and address the questions that are asked

- Kusum and Nisha should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider and services available for adolescent at the health center.

Discussion questions

The teacher should use the following questions to facilitate discussion after the role play:

1 How did the health care provider approach Kusum and her daughter Nisha?

2 Did the health care provider use the language that Kusum and her daughter Nisha could easily understand?

3 Did the health care provider give enough information to Kusum and her daughter Nisha about her/ his role? About the health center services specially for adolescent care?

4 Did health care provider used any educational tools& AV aids to clarify or reinforce the health message, were they effective?

5 Did the health care provider encourage Kusum and her daughter Nisha to ask questions? Did she/ he adequately address their questions and concerns?

6 What communication skills did the health care provider use to make her interaction with the two women more effective?

7 What could the health care provider do to improve the interaction with Kusum and her daughter Nisha?

Answer key

The following answers should be used by the teacher to guide the class discussion after the role play. Although these are "likely" answers, other answers provided by the learners during the discussion may be equally acceptable.

1 The health care provider should introduce herself and address Kusum and her daughter Nisha or (culturally accepted manner). She should speak in a calm and reassuring manner, using words that the women will easily understand.

2 The health care provider should address Kusum and her daughter Nisha's knowledge about the adolescent health. She should respectfully correct any misconceptions.

3 Sufficient information should be provided about the adolescent health care. The health care provider should also provide information to Kusum and her daughter Nisha regarding adolescent health. Health care provider should informed to Kusum that Nisha is looking pale, anemic and malnourished. Because of anemia, she may have irregular periods. She also explained to Kusum about growth and development, nutritional needs of adolescent and how Kusum can prevent anemia in Nisha. Health care provider also educated the Nisha regarding sexual health, contraceptive methods, STD & HIV and adolescent abortion. She told to Kusum that she should also show her son for the treatment of drugs addiction. Treatment of drugs addiction can be possible.

4 Health care provider can use the charts and posters related to adolescence health.

5 The health care provider should listen to the questions and concerns that Kusum and Nisha express.

The health care provider should address each of their questions with respect, ensuring that the woman fully understand the information.

6 Kusum and Nisha should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider and the care available at the health center on adolescence health.

7 The health care provider should listen to the questions and concerns that Kusum and Nisha express. She should address each of their questions with respect, ensuring that the women fully understand the care that is available. Nonverbal behaviors, such as touching Kusum hand or a look of concern, may be enormously helpful in providing emotional support and reassurance for Kusum.

Knowledge component

- A large number of adolescents in India are out of school, malnourished, get married early, working in vulnerable situations, and are sexually active.
- The problems of adolescents are multi- dimensional in nature and require holistic approach.

The following changes are taking place during adolescent period:

a Biological changes – onset of puberty

b Cognitive changes – emergence of more advanced cognitive abilities

c Emotional changes – self-image, intimacy, relation with adults and peers group

d Social changes – transition into new roles in the society

Impact on adolescence health:	Adolescent health problems	Reasons for adolescent reluctant to seek help	Services/provider
▸ Lack of formal or informal education ▸ School dropout and childhood labour ▸ Malnutrition and anemia ▸ Early marriage, teenage pregnancies ▸ Habits and behaviours picked up during adolescence period have lifelong impact ▸ Lot of unmet needs regarding nutrition , reproductive health and mental health ▸ They require safe and supportive environment ▸ Desire for experimentation ▸ Sexual maturity and onset of sexual activity ▸ Transition from dependence to relative independence ▸ Ignorance about sex and sexuality ▸ Lack of understanding ▸ Sub optimal support at family level ▸ Social FRUstration ▸ Inadequate school syllabus about adolescent health ▸ Misdirected peer pressure in absence of adequate knowledge ▸ Lack of recreational, creative, and working opportunity	▸ Anorexia nervosa ▸ Obesity & overweight ▸ Adolescent pregnancy ▸ Micronutrient deficiency ▸ Emotional problems ▸ Behavioural problems ▸ Substance abuse & injuries ▸ Sexually transmitted infection ▸ Thinking and studying problems ▸ Identity problems ▸ Health problems can be prevented by providing ▸ Health education ▸ Skill based health education ▸ Life skill education ▸ Family life education ▸ Counselling for emotional stress ▸ Nutritional counselling ▸ Early diagnosis & management of medical and behavioral problem	▸ Fear ▸ Uncomfortable with opposite health worker ▸ Poor quality perception ▸ Lack of privacy ▸ Confidentiality ▸ Cumbersome procedure ▸ Long waiting time ▸ Parental consent ▸ Operational barrier ▸ Lack of information ▸ Health education ▸ Skill based health education ▸ Life skill education ▸ Family life education ▸ Counselling for emotional stress ▸ Nutritional counselling ▸ Early diagnosis & management of medical and behavioral problem ▸ Feeling of discomfort	▸ Criteria for adolescent friendly health worker should be ▸ Welcoming and friendly nature ▸ Knowledgeable ▸ Presentable ▸ Have good communication skill ▸ Maintain confidentiality ▸ Punctuality ▸ Flexibility ▸ Understanding ▸ Good listener ▸ Non-judgemental ▸ Adolescent friendly health center services ▸ Reproductive health services ▸ Sexual & reproductive health education ▸ Contraception ▸ Pregnancy testing and option ▸ MTP ▸ STD/HIv screening counselling and treatment ▸ Prenatal & postpartum care ▸ Well baby care ▸ Nutritional services ▸ Growth & development monitoring ▸ Anticipatory guidance about substance abuse and other risk taking behavior ▸ Counseling for life skill development ▸ Screening for various disorders

ROLE PLAY3: COMPLICATION READINESS

Role play directions

The teacher will select two or three learners to perform the roles specified. For example: A health care provider (ANM/SN/MO) woman seeking information about the services available at the health center, and the woman's mother. The two/three learners participating in the role play should take a few minutes to read the background information provided below and to prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play.

The purpose of the role play is to provide an opportunity for learners to appreciate the importance of good communication when providing information to women about available health care services for antenatal woman, postnatal women and able to handle the complications related to maternal & child health.

Participant roles

Skilled birth attendant: The provider is an experienced health care provider (ANM/SN/MO) at the health center who has good communication skills.

Disha: Disha is a 28-year-old woman; she is 4 months pregnant with her second child.

Disha's husband: Disha's husband Mahesh is 30 years old; he is doing a private job. He is earning 7000/ month, Mahesh salary is not sufficient for his family. They are living in a village.

Situation

Disha came to the health center with her husband. She is living with her mother in law and father in law. Mahesh is the only earning member in the family. This is Disha's second pregnancy. In her first pregnancy she had some complications; her baby was died in 8rth month of pregnancy. Disha and her husband worried about this pregnancy. They do not know about the reason of that death of the fetus. In this pregnancy she is having edema, headache, and blurring of vision, same these condition were happened in her earlier pregnancy also. But this time they came to PHC. They met with an experienced ANM, who was present in the health centre. They have expressed their problem with the ANM.

Focus of the role play

The focus of the role play is the interaction between the health care provider, Disha, and her husband.

The health care provider should:

- ANM was friendly and reassuring,
- Assessed Disha's knowledge about the complications in pregnancy , role of the health care provider

focusing mainly on complications of pregnancy and its management.

- ANM examined the Disha and she checked vital signs specially BP, weight of Disha, physical examination as well as antenatal examination.anm found that Disha' BP was 160/110 mm of hg, her wt was 90 kg, and she was having generalized edema and growth of the baby was not relating with months of pregnancy(fetal growth was less than the month of pregnancy).
- ANM informed to the Disha and her husband that Disha is having pregnancy induced hypertension.
- Disha and her husband were looking worried, and they were not aware about this problem.
- ANM asked Disha that you were having same problems in previous pregnancy like edema, headache and sudden increase in the weight.
- Disha said, yes she was having same problems and after 8th month she was not feeling fetal movement. After one week of this she had labour pains and she delivered a dead baby.
- ANM told Disha that baby was died might be because of PIH.
- ANM explained to Disha that now your BP. is high but manageable, now you have take to care of this pregnancy otherwise you can have same complication like earlier.
- ANM shown Disha to the physician, doctor prescribed antihypertensive medication, salt restricted diet and bed rest, regular checking of BP.
- ANM explained to Disha and her husband that these complications can be prevented if antenatal mother comes regularly for antenatal checkups and willing for institutional delivery by trained birth attendant and if facilities are not sufficient in health centre, then trained birth attendant can timely refer the mother to higher facility area.
- After this discussion ANM said to Disha that now she has to came for antenatal checkups regularly ,she has to take medication on time, salt restricted diet and bed rest and she should regularly come for checking of her B.P
- ANM encouraged Disha to ask questions and she addressed the questions that were asked
- Disha and husband have asked questions and expressed concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider in improving the knowledge regarding complications in pregnancy and its management.

Discussion questions

The teacher should use the following questions to facilitate discussion after the role play:

1 Disha asked ANM that whether baby will be normal after delivery as I am having high B.P

2 Disha asked why should i check my b.p. regularly?

3 Disha's husband asked why we should opt for institutional delivery?

4 Disha asked ANM what are the alarming sign of high b.p. in pregnancy?

5 How ANM realized that Disha and her husband have understood about the comlpliactions in pregnancy?

Answer Key

The following answers should be used by the teacher to guide the class discussion after the role play. Although these are "likely" answers, other answers provided by the learners during the discussion may be equally acceptable.

1 The health care provider answered to the Disha that if you will take hypertensive medications regularly and check your B.P. timely then you will have normal baby after birth.

2 ANM said that if you will not come for regular B.P. checkup than because of high B.P., it will cause distress to the baby .

3 ANM said to Disha's husband that as Disha is having high B.P. she may chance to have any complication at the time of birth of baby.

4 ANM said she will have persistent severe headache, abdominal pain, visual disturbances, and swelling during your third trimester.

5 ANM asked questions related with the complications to Disha and her husband. They were able to give answers and ANM also corrected them if their answers were incomplete.

Knowledge component

Danger Signs	**Signs and symptoms of True labor pain**
▸ Vaginal Bleeding/Leaking Per vaginum ▸ Respiratory Difficulty ▸ Fever/Foul smelling Discharge ▸ Severe Headache/blurred vision ▸ Generalised swellig of the body, puffiness of face ▸ Pain in abdomen ▸ Convulsions/loss of consciousness ▸ Decreased or excessive or absence of fetal movements	▸ Begins irregularly but becomes regular and predictable ▸ Felt first in the lower back and sweeps around to the abdomen in a wave pattern. ▸ Continues no matter what the woman's level of activity ▸ Increases in duration, frequency and intensity with the passage of time ▸ Accompanied by 'show' (blood-stained mucus discharge) ▸ Achieves cervical effacement and cervical dilatation

Complications in pregnancy

During pregnancy	During labour	Postnatal period
1 Bleeding in pregnancy	**Obstructed labour due to**	1 Poastpartum hemorrhage
2 Sever nausea and vomiting in pregnancy	1 Malpresentation (breech birth (i.e. Buttocks or feet first), face, brow, or other)	2 Injury to perineal area
3 Decrease fetal activity	2 Failure of descent of the fetal head through the pelvic brim.	3 Infection, puerperal fever
4 Contractions early in third trimester	3 Poor uterine contraction strength	**Complications related to newborn**
5 Leakage of water per vagina	4 Active phase arrest	1 Fetal distress
6 A persistent severe headache, abdominal pain, visual disturbances, and swelling during your third trimester	5 Cephalo-pelvic disproportion (CPD)	2 Infection due to prolong rupture of membrane
7 Flu like symptoms	6 Shoulder dystocia	3 Preterm baby
		4 Mechanical fetal injuries
		5 Very low birth weight baby

Complication readiness

- Recognizing signs of labor
- Awareness and recognition of danger signs during pregnancy, delivery and postpartum period
- Identification of nearest functional FRU / PHC
- Identification of transportation facilities

ROLE PLAY4: IMPORTANCE OF NUTRITIOUS DIET AND FAMILY SUPPORT DURING PREGNANCY

Role play directions

The teacher will select two or three learners to perform the roles specified. For example: a health care provider (ANM/SN/MO) a woman seeking information about the services available at the health center, and the woman's mother. The two/three learners participating in the role play should take a few minutes to read the background information provided below and to prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play.

The purpose of the role play is to provide an opportunity for learners to appreciate the importance of good communication when providing information to women about available health care services for antenatal woman.

Participant roles

Skilled birth attendant: The provider is an experienced health care provider (anm/sn/mo) at the health center who has good communication skills.

Madhu: Madhu is a 24-year-old woman; she is 4 months pregnant with her second child. Her first child is one year old. Madhu looks pallor and she complains that all the time, she is feels tired and lethargic.

Madhu's mother in law: Madhu's mother in law is 52 years old. Madhu is staying in combined family. Her mother in law is having five children. She is thinking that pregnancy in normal process and it is not required any special care.

Situation

Madhu has come to the health center with her mother in law. She is living with her mother in law. This is her second pregnancy, age of first baby is one year old, she complains that all the time , she feels lethargic and tired. She is not able to do her routine house work because of tiredness. Her mother in law said in first pregnancy she was not feeling tired all the time. Madhu told her first baby is very oftenly get ill and baby growth is also not normal. She is worried as her baby is looking very weak comparatively with other children of same age. Madhu is looking nervous about her current pregnancy because of her health status and tiredness. Madhu and her mother in law are not having enough of knowledge about importance of nutritious diet in pregnancy and care of antenatal mother. Her mother in law told to the health care provider that pregnancy is normal process why madhu is so much worried so much about her health.

Focus of the role play

The focus of the role play is the interaction between the health care provider, madhu and her mother in law.

The health care provider should:

- Be friendly and reassuring,
- Assess madhu's knowledge about the importance of nutritious diet in pregnancy and care of antenatal mother , role of the health care provider focusing mainly on nutritious diet in pregnancy and care of antenatal mother .
- Encourage the women to ask questions and address the questions that are asked
- Madhu and her mother in law should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider in improving the knowledge regarding the importance of nutritious diet in pregnancy and care of antenatal mother.

Discussion questions

The teacher should use the following questions to facilitate discussion after the role play:

1 How did the health care provider approach madhu and her mother in law?

2 Did the health care provider use the language that madhu and her mother in law could easily understand?

3 Did the health care provider give madhu and her mother in law enough information about her/his role?

4 Did health care provider used any educational tools& av aids to clarify or reinforce the health message, were they effective?

5 Did the health care provider encourage madhu and her mother in law to ask questions? Did she/he adequately address their questions and concerns?

6 What communication skills did the health care provider use to make her interaction with the two women more effective?

7 What could the health care provider do to improve the interaction with madhu and her mother in law?

Answer key

The following answers should be used by the teacher to guide the class discussion after the role play. Although these are "likely" answers, other answers provided by the learners during the discussion may be equally acceptable.

1 The health care provider should introduce herself and address madhu and her mother in law or (culturally accepted manner). She should speak in a calm and reassuring manner, using words that the women will easily understand.

2 The health care provider should address madhu and her mother in law's knowledge about the importance of nutritious diet in pregnancy and care of antenatal mother. Need of family support during pregnancy. She should respectfully correct any misconceptions.

3 Sufficient information should be provided about the importance of nutritious diet in pregnancy and care of antenatal mother & importance of regular antenatal checkups in health center. Need of family support during pregnancy. Health care provider informed the madhu and her mother in law that pregnancy is high risk condition, madhu needs to have special attention during pregnancy and she also required family support during this period. She said madhu is looking very pale because of anemia and less gap in between two pregnancy. She told madhu's mother in law that nutritious diet is very important in pregnancy otherwise madhu and her second baby can have some complications like iugr, low birth weight of newborn and madhu can also have chance of pih and pph due to anemia. Madhu also needs to have good sleep of 8 hrs during night time and rest of 2hrs during afternoon. Family members and her husband should help madhu in her daily work. Health care provider also educated madhu about that she should have at least three years gap in between two pregnancies and opt for small family norms by using any contraceptive methods by her and her husband's choice.

4 Health care provider can use the charts and posters showing care of antenatal mother and importance of nutritious diet in pregnancy and. She also shown charts and posters which are explaining what is nutritious diet and amount of diet in pregnancy & importance of regular antenatal checkups in health center.

5 The health care provider should listen to the questions and concerns that madhu and her mother in law express. The health care provider should address each of their questions with respect, ensuring that the woman fully understand the information.

6 Madhu and her mother in law should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider in improving the knowledge regarding importance of nutritious diet in pregnancy and care of antenatal mother. Support of family members during her pregnancy.

7 The health care provider should listen to the questions and concerns that madhu and her mother in law express. She should address each of their questions with respect, ensuring that the women fully understand the care that is available. Nonverbal behaviors, such as touching madhu's hand or a look of concern, may be enormously helpful in providing emotional support and reassurance for madhu.

Knowledge component

- The woman should be advised to eat more than her normal diet throughout her pregnancy. Remember, a pregnant woman needs about 300 extra kcal per day compared to her usual diet.
- She should be told that she needs these extra calories for:
  - -maintenance of her health as a mother
  - -the needs of the growing foetus
  - -successful lactation
- Special categories of women have been identified who should be given priority for additional nutrition during pregnancy. They include the following:
  - -women with a reduction in the dietary intake below habitual levels during pregnancy
  - -women who have an increased level of physical activity above the usual levels during Pregnancy
  - -women with a combination of both the above-mentioned factors
  - -pregnancy in adolescent girls
  - -pregnancy during lactation
  - -pregnancy within two years of the previous delivery.
- The woman's food intake should be especially rich in proteins, iron, vitamin a and other essential micronutrients.
- Some of the recommended dietary items are cereals, milk and milk products such as curd, green leafy vegetables and other vegetables, pulses, eggs and meat, including fish and poultry (if the woman is a non-vegetarian), nuts (especially groundnuts), jaggery, FRUits, etc. Give examples of the types of food, suggested preparations. Tell her about the locally available foods rich in iron such as groundnuts and jaggery.
- Tell the woman to avoid taking tobacco, tea or coffee, especially within 1 hour of a meal, as they have been shown to interfere with the absorption of iron. Also advise her to take foods rich in proteins and vitamin c (e.g. Lemon, amla, guava, oranges, etc.) As both help in the absorption of iron.
- The diet should be rich in fibre so that she does not have constipation.

- The diet should be advised keeping in mind the socioeconomic conditions, food habits and taste of the individual.
- Food taboos must be looked into while counselling the woman regarding her dietary intake. If there are taboos about nutritionally important foods, the woman should be advised against these taboos.
- In certain communities, food taboos (especially omissions) exist for sex selection of the foetus. These should be strongly discouraged.
- If a woman has pih, she should be encouraged to eat a normal diet with no restrictions on fluid, calorie and/or salt intake; such restrictions do not prevent pih from converting into pre-eclampsia, and may be harmful for the foetus.
- The woman should be advised to refrain from taking alcohol or smoking during pregnancy.
- The woman should be advised not to take any medication unless prescribed by a qualified health practitioner.
- The other members of the family, especially those who take decisions regarding the type of food brought home and/or given to the pregnant woman, such as her husband and mother-in-law, should also be taken into confidence and counselled regarding the recommended diet for the pregnant woman. Encourage them to help ensure that the woman eats enough and avoids hard physical work.

Prevention of Anemia

Avoidance of frequent of child birth:

At least two years an interval between pregnancies is most necessary to replace the lost iron during childbirth process and lactation. This can be achieved by proper family planning guidance.

Supplementary iron therapy:

Iron supplementary should be a routine after the patient becomes free from nausea and vomiting. Daily 60mg iron with 1mg folic acid is a quite effective prophylactic procedure.

Dietary prescription:

- Well balanced diet rich in iron and protein should be advised. The food rich in iron are liver, meat, egg, green vegetables, green pea bean, whole wheat etc.
- Adequate treatment should be instituted to eradicate the illness likely to cause anaemia. These are hookworm infestation, dysentery, and malaria, bleeding piles, urinary tract infection etc.
- Early detection of falling hemoglobin level is to be made. Hemoglobin level should be estimated at the first antenatal visit at the 28th and finally at 36th weeks.

ROLE PLAY 5: COUNSELLING ON ROUTINE IMMUNIZATION

Role play directions

The teacher will select two or three learners to perform the roles specified. For example: an health care provider (ANM/SN/MO) a woman seeking information about the services available at the health center, and the woman's mother. The two/three learners participating in the role play should take a few minutes to read the background information provided below and to prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play.

The purpose of the role play is to provide an opportunity for learners to appreciate the importance of good communication when providing information to women about available health care services for antenatal woman.

Participant roles

Skilled birth attendant: the provider is an experienced health care provider(ANM/SN/MO) at the health center who has good communication skills.

Astina: Rani is a 28-year-old woman; she is 4 months pregnant with her first child.

Astina's mother: Rani's mother in law is 52 years old. She lost her one child at the age of 3 for tetanus. And out of her five living children, one has polio. She is worried about Mrs.Rani and her child.

Situation

Rani has come to the health center with her mother in law. She is living with her mother in law. This is her first pregnancy and she has not yet immunized against TT. She learned about the health center from her ASHA. The women is interested in learning more about the care for women that is available at the health center and the immunization for her and baby.

Rani is nervous about her current pregnancy because her husband's family history.

Focus of the role play

The focus of the role play is the interaction between the health care provider, Rani, and her mother in law.

The health care provider should:

- Be friendly and reassuring,
- Assess Rani's knowledge about the immunization services available, role of the health care provider and the services available for women at the health center, briefly explain what services are available for women and child at the health center focusing mainly immunization services.

- Encourage the women to ask questions and address the questions that are asked
- Rani and her mother in law should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider and the immunization services available at the health center.

Discussion questions

The teacher should use the following questions to facilitate discussion after the role play:

1 How did the health care provider approach Rani and her mother in law?

2 Did the health care provider use the language that Rani and her mother in law could easily understand?

3 Did the health care provider give Rani and her mother in law enough information about her/his role? About the health center services specially immunization?

4 Did health care provider used any educational tools& AV aids to clarify or reinforce the health message, were they effective?

5 Did the health care provider encourage Rani and her mother in law to ask questions? Did she/he adequately address their questions and concerns?

6 What communication skills did the health care provider use to make her interaction with the two women more effective?

7 What could the health care provider do to improve the interaction with Rani and her mother in law?

Answer key

The following answers should be used by the teacher to guide the class discussion after the role play. Although these are "likely" answers, other answers provided by the learners during the discussion may be equally acceptable.

1 The health care provider should introduce herself and address Rani and her mother in law or (culturally accepted manner). She should speak in a calm and reassuring manner, using words that the women will easily understand.

2 The health care provider should address Rani and her mother in law's knowledge about the importance of routine immunization schedule. She should respectfully correct any misconceptions.

3 Sufficient information should be provided about the importnace of routine immunization schedule including immunization during pregnancy and child upto 5 years. The health care provider should also provide information about immunization which all diseases are covered by immunization. She/he should advice Rani that these are preventable.

The health care provider should also immunize Rani for Inj.TT first dose and should give clear instruction to Rani and her mother in law about when to return for second dose of Inj.TT. The health care provider should make sure that Rani and her mother in law is understood about the importance of routine immunization schedule for her baby also.

4 Health care provider can use the RI chart and also give her the MCP card to reinforce the information regarding routine immunization.

5 The health care provider should listen to the questions and concerns that Rani and her mother in law express. The health care provider should address each of their questions with respect, ensuring that the woman fully understand the information.

6 Rani and her mother in law should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider and the care available at the health center on immunization.

7 The health care provider should listen to the questions and concerns that Rani and her mother express. She should address each of their questions with respect, ensuring that the women fully understand the care that is available. Nonverbal behaviors, such as touching Rani's hand or a look of concern, may be enormously helpful in providing emotional support and reassurance for Rani.

Knowledge component

Current UIP schedule

Vaccine	When to give	Dose	Route	Site
For Pregnant Women				
TT-1	Early in pregnancy	0.5 ml	Intra-muscular	Upper Arm
TT-2	4 weeks after TT-1*	0.5 ml	Intra-muscular	Upper Arm
TT- Booster	1 dose if TT dose given in last 3 yrs*	0.5 ml	Intra-muscular	Upper Arm
For Infants				
BCG	At birth or as early as possible till one year of age	0.1ml (0.05ml until 1 month age)	Intra-dermal	Left Upper Arm
Hepatitis B-0	At birth or as early as possible within 24 hours	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV-0	At birth or as early as possible within the first 15 days	2 drops	Oral	Oral
OPV 1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	2 drops	Oral	Oral
DPT1,2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid thigh
Hepatitis B 1, 2 & 3	At 6 weeks, 10 weeks & 14 weeks	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
Measles 1	9 completed months-12 months.	0.5 ml	Sub-cutaneous	Right upper Arm
Vitamin A (1stdose)	At 9 months with measles	1 ml	Oral	Oral
For Children				
DPT booster-1	16-24 months	0.5 ml	Intra-muscular	Antero-lateral side of mid-thigh
OPV Booster	16-24 months	2 drops	Oral	Oral
Measles 2	16-24 months	0.5 ml	Sub-cutaneous	Right upper Arm
Japanese Encephalitis**	16-24 months with DPT/OPV booster	0.5 ml	Sub-cutaneous	Left Upper Arm
Vitamin A (2nd dose)	with DPT/OPV booster	2 ml	Oral	Oral
Vitamin A (3rd to 9th dose)	One dose every 6 months up to the age of 5 years.	2 ml	Oral	Oral
DPT Booster-2	5-6 years	0.5 ml.	Intra-muscular	Upper Arm
TT	10 years & 16 years	0.5 ml	Intra-muscular	Upper Arm

*Give TT-2 or Booster doses preferably before 36 weeks of pregnancy.

** JE Vaccine, in select endemic districts

Note- In selected states, pentavalent vaccine 1, 2 & 3 dose replaces DPT 1, 2 & 3 dose and Hepatitis B 1, 2 & 3 doses.

For additional information contact the nearest Government Health Facility

ROLE PLAY 6: COUNSELLING ON BREAST FEEDING AND COMPLEMENTARY FEEDING

Role play directions

The teacher will select two or three learners to perform the roles specified. For example: an health care provider (ANM/SN/MO) a woman seeking information about the services available at the health center, and the woman's mother. The two/three learners participating in the role play should take a few minutes to read the background information provided below and to prepare for the role play. The observers in the group should also read the background information so that they can participate in the small group discussion following the role play.

The purpose of the role play is to provide an opportunity for learners to appreciate the importance of good communication when providing information to women about available health care services for antenatal woman and postnatal women.

Participant roles

Skilled birth attendant: the provider is an experienced health care provider(ANM/SN/MO) at the health center who has good communication skills.

Rani: Rani is a 28-year-old woman; she is 4 months pregnant with her second child.

Rani's mother: Rani's mother in law is 52 years old. She is following traditional ways for upbringing their children. She also insists her daughter in law to following the same traditional ways for upbringing of her child.

Situation

Rani has come to the health center with her mother in law. She is living with her mother in law. This is her second pregnancy, age of first baby is two years old, she complains that her first baby is very often get ill and babies growth in not normal. She is worried as her baby is looking very weak comparatively with other children of same age. Rani is looking nervous about her current pregnancy because of health status of her first child. She is not having enough of knowledge about breast feeding and complementary feeding.

Focus of the role play

The focus of the role play is the interaction between the health care provider, Rani, and her mother in law.

The health care provider should:

- Be friendly and reassuring,
- Assess Rani's knowledge about the breast feeding and complementary feeding , role of the health

care provider focusing mainly on breast feeding and complementary feeding.

- Encourage the women to ask questions and address the questions that are asked
- Rani and her mother in law should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider in improving the knowledge regarding importance of exclusive breast feeding up to six months and when Rani should start giving complementary feeding because as baby will grow after six months breast feeding is not sufficient for the child's growth .

Discussion questions

The teacher should use the following questions to facilitate discussion after the role play:

1 How did the health care provider approach Rani and her mother in law?

2 Did the health care provider use the language that Rani and her mother in law could easily understand?

3 Did the health care provider give Rani and her mother in law enough information about her/his role?

4 Did health care provider used any educational tools& av aids to clarify or reinforce the health message, were they effective?

5 Did the health care provider encourage Rani and her mother in law to ask questions? Did she/he adequately address their questions and concerns?

6 What communication skills did the health care provider use to make her interaction with the two women more effective?

7 What could the health care provider do to improve the interaction with Rani and her mother in law?

Answer key

The following answers should be used by the teacher to guide the class discussion after the role play. Although these are "likely" answers, other answers provided by the learners during the discussion may be equally acceptable.

1 The health care provider should introduce herself and address Rani and her mother in law or (culturally accepted manner). She should speak in a calm and reassuring manner, using words that the women will easily understand.

2 The health care provider should address Rani and her mother in law's knowledge about the importance of exclusive breast feeding up to six months and when Rani should start giving complementary feeding because as baby will grow after six months breast feeding is not sufficient for the child's growth. She should respectfully correct any misconceptions.

3 Sufficient information should be provided about the importance of exclusive breast feeding up to six months and when Rani should start giving complementary feeding .health care provider should make Rani understand why complementary food should start after six months.

4 Health care provider can use the charts and posters related to breast feeding and complementary feeding.

5 The health care provider should listen to the questions and concerns that Rani and her mother in law express. The health care provider should address each of their questions with respect, ensuring that the woman fully understand the information.

6 Rani and her mother in law should ask questions and express concerns until the health care provider has provided them with enough information so that they understand the role of the health care provider in improving the knowledge regarding importance of exclusive breast feeding up to six months and importance of giving complementary feeding.

7 The health care provider should listen to the questions and concerns that Rani and her mother express. She should address each of their questions with respect, ensuring that the women fully understand the care that is available. Nonverbal behaviors, such as touching Rani's hand or a look of concern, may be enormously helpful in providing emotional support and reassurance for Rani.

Knowledge component

Exclusive breastfeeding: an infant's consumption of human milk with no supplementation of any type (no water, juice, non-human milk, and no foods) except for vitamins, minerals, and medications.

- Initiation of breastfeeding: counsel the mother that breastfeeding should ideally be initiated within half-an-hour of a normal delivery (or within two hours of a caesarean section, or as soon as the mother regains consciousness, in case she undergoes a caesarean section).
- It is common practice in india to delay initiation. Colostrum (the first milk) is thrown away, and prelacteal feeds are given instead. This has obvious disadvantages. First, the pre-lacteal feed may not be hygienic and can cause an intestinal infection in the baby. Second, the baby is deprived of colostrums which is very rich in protective antibodies.
- Most importantly, the sucking and rooting reflex in the child, which are essential for the baby to successfully start breastfeeding, are the strongest immediately after delivery, making the process of initiation much easier for the mother and the baby. These reflexes gradually become weaker over the span of a few hours, thus making breastfeeding difficult later on.
- Exclusive breastfeeding for 6 months: it should be emphasized to the mother that only breast milk and nothing but breast milk should be given to the baby for the first 6 months, not even water. The mother should be assured that breast milk has enough water to quench the baby.s thirst (even in the peak of summer) and satisfy its hunger for the first 6 months.
- Take special care in the case of a female child to ensure that she is adequately breastfed and not discriminated against because of her sex.
- Demand feeding: this refers to the practice of breastfeeding the child whenever he/she demands. It, as can be made out by the child crying. The practice of feeding the child by the clock should be actively discouraged.
- After a few days of birth, most children will develop their own .hunger cycle.and will feed every 2.4 hours. Remember that each child is different as far as the feeding requirementsand timings are concerned.
- The practice of giving night feeds should be actively encouraged. Often, there is a misconception that breastfeeding the baby at night disturbs the mother.s sleep, thus depriving her of adequate rest. Inform the woman and her husband that this is not so. Night feeds help the baby to sleep more soundly.

- Rooming in: this refers to the practice of keeping the mother and baby in the same room and preferably on the same bed. This is usually practised in the Indian setting. This practice should be encouraged as it has certain advantages.
- Makes demand feeding easier to practise, as the mother can hear the child cry.
- Keeps the baby warm, thus preventing hypothermia in the newborn.
- Helps build a bond between the mother and the baby.

Benefits of exclusive breastfeeding

- Positive effects of breastfeeding are most significant during the first six months of life with exclusive breastfeeding
- Exclusive breastfeeding has been shown to:
- Provide better protection against many diseases and infections
- Increase the likelihood of continued breastfeeding for at least the first year of life health benefits
- Health effects
- Babies who are not fed human milk have higher rates of:
- Otitis media
- Allergies
- Respiratory tract infection
- Necrotizing enterocolitis
- Urinary tract infection
- Gastroenteritis
- Health effects
- Babies who are not breastfed have a higher risk of hospitalization in the first year of life due to increased risk of bacterial illness
- Bacterial meningitis
- Bacteremia
- Diarrhea
- Immune system
- Babies who are not breastfed may also develop lower antibody titers in response to immunization
- Intelligence
- Studies have shown slightly higher IQ and developmental scores among children who were breastfed

Introducing solids

Complementary feeding at 6 months

- Complementary feeding at 6 months: the mother should be told that after 6 months of age, breast milk alone does not meet the baby's nutritional requirements. The baby needs supplementary food,
- In addition to breast milk. Advice the mother to begin with semi-solid soft food devoid of spices, supplemented with a small amount of ghee/butter/oil.
- The frequency of feeds and the quantity of each feed should be increased gradually. Over a period of time the baby may be given solid foods.
- A one-year-old child should start eating from the family pot, and should have an intake that is about half the adult diet.
- Feeding bottles should be strictly discouraged.

EVALUATION

Skills Evaluation sheet for trainees

	OSCE Stations				Basic stations					
Name of Trainee	Normal delivery	AMSTL	NRP	Management of shock	Antenatal Care	Partograph	Processing of equipment	Organising LR	Abdominal palpation	

& FEEDBACK

	Eclampsia	Lab tests	Interval IUCD	Universal Precaution	NBCC	PPH	ENBC	MDI and Nebulizer	BF and KMC	Documentation

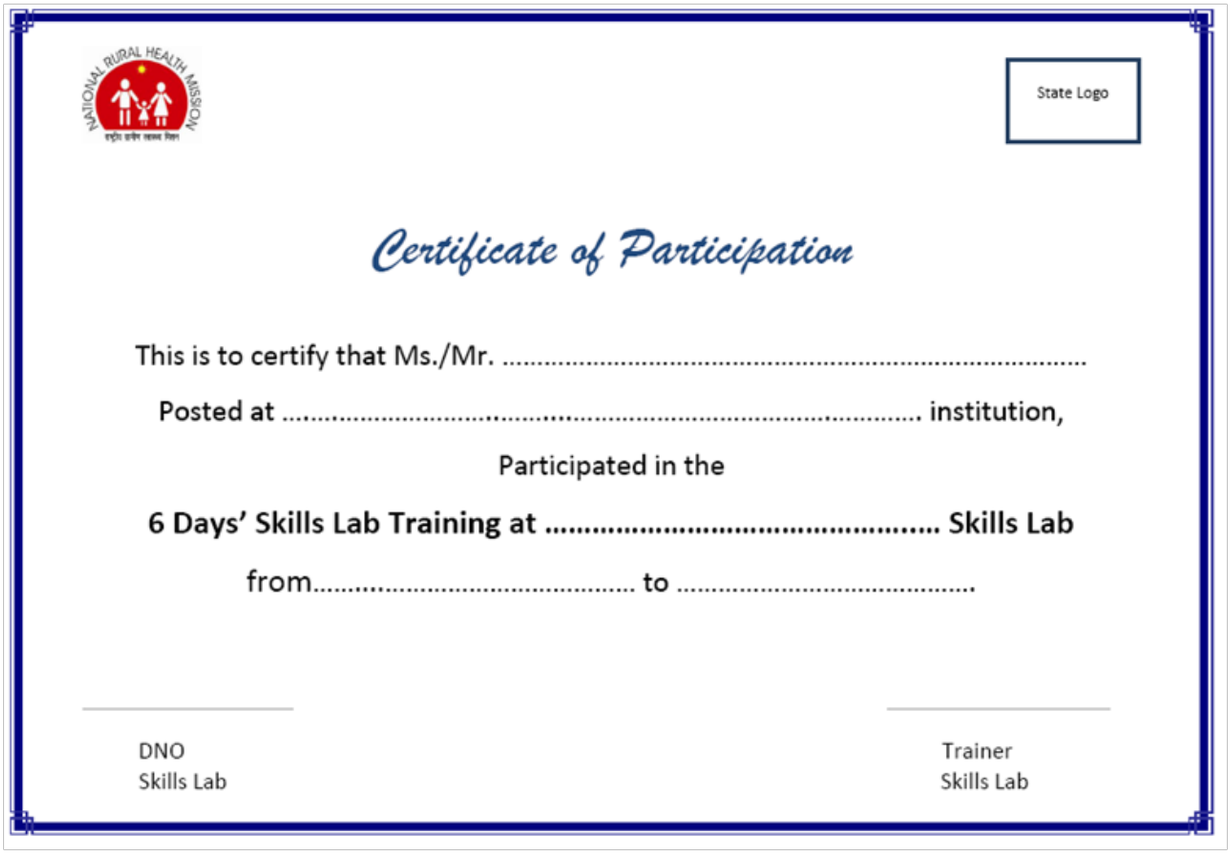
Skill acquisition/competency tracking sheet for participants

Skills lab:..... name of the candidate: ..... date of training:.....

S. No.	Basic skills evaluation	Competency level achieved		Facilitators' signature
		Competent	Needs improvement	
	Osce stations			
1	**Normal delivery**			
2	**AMTSL**			
3	**NRP**			
4	**Management of shock**			
	skill stations			
5	**Antenatal care**			
6	**Partograph**			
7	**Processing of equipment**			
8	**Organizing lr**			
9	**Abdominal palpation**			
10	**Management of PPH**			
11	**Eclampsia**			
12	**Lab tests**			
13	**Interval IUCD**			
14	**Newborn care corner**			
15	**ENBC**			
16	**Universal precaution**			
17	**MDI with spacer, nebulizer**			
18	**PNC**			
19	**Breast feeding and KMC**			

Skills lab facilitator:..... Sign..... Date.....

Certificate format



State Logo

Certificate of Participation

This is to certify that Ms./Mr. .....

Posted at ..... institution,

Participated in the

6 Days' Skills Lab Training at ..... Skills Lab

from..... to .....

DNO
Skills Lab

Trainer
Skills Lab

Course evaluation: skills lab training

Location:…….. Date:……

(to be completed by learners)

Please indicate your opinion of the course components using the following rate scale:

	Course component	1 Strongly isagree	2 disagree	3 No opinion	4 Agree	5 Strongly disagree
1	Individual attention was provided during learning & practice.					
2	The course content was sufficient and helpful for my current practice					
3	The learning activities were helpful and comprehensive					
4	There was sufficient time scheduled for planning the classroom learning activities and skill demonstrations.					
5	There was sufficient time for skill practice.					
6	I am now confident in :					
	➤ Plotting and interpreting partograph to monitor labour					
	➤ Managing normal labour					
	➤ Providing essential newborn care					
	➤ Newborn resuscitation using bag and mask					
	➤ Preparation and method of using injection magnesium sulfate in prevention and management of severe pre-eclampsia/ eclampsia					
	➤ Providing amtsl in prevention of pph					
	➤ Providing initial management of pph and shock by using oxytocin and i/v line and cab approach					
	➤ Standard precautions in infection					
	➤ Prevention and use of personal protective equipments					
	➤ Insertion of iucd					
	➤ Techniques of counseling					

Comments:

1 What topics (if any) could be omitted (and why) to improve the course?
2 What topics (if any) should be added (and why) to improve the course?
3 What parts of the training did you enjoy most?
4 Any other suggestion?

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