STRENGTHENING THE PRESERVICE NURSING AND MIDWIFERY EDUCATION IN INDIA

LEARNING RESOURCE PACKAGE FOR ANM FACULTY TRAINING

Facilitators Guide

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FACILITATORS' GUIDE

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PREFACE

Recent policies and programs of the GoI focused on MNCH services including the Janani Suraksha Yojana (JSY scheme), Integrated Management of Newborn and Childhood illnesses (IMNCI) and operationalization of 24/7 PHCs and First Referral Units. These efforts have put an increased emphasis on the role of the basic health worker in the provision of comprehensive reproductive health (RH) and MNCH services in the country, especially in rural areas. To respond to this need for development of a basic service provider who can provide quality RH and MNCH services at the grass root level, a comprehensive initiative to strengthen the foundation of pre-service education for ANMs (Auxiliary Nurse Midwife) is being undertaken by the Indian Nursing Council (INC).

This book is part of the training package for the, **'Strengthening the pre-service education of Auxiliary nurse midwives in India**' learning resource package for ANM faculty training that was developed to prepare ANM faculty to use the new Government of India guidelines for Skilled Birth Attendance, Integrated Management of Neonatal and Childhood illness, Family Planning and Prevention and Management of Reproductive Tract Infections when teaching midwifery to ANM students.

The package includes a 'Facilitator's guide' to use for the 6-week course, a 'Participant Handbook' that includes materials needed for this 6-week course and 'Tools for teaching' for the ANM faculty to use when teaching ANM students. In addition, there are several other resources available to support training, such as reference manuals, Hindi versions of participant notebooks and the presentation graphics.

It has been endorsed by the Indian Nursing Council (INC) for use in pre-service ANM education.

It is hoped that this learning package will help teachers to deliver quality competency-based clinical training that results in sufficiently prepared ANM's able to deliver appropriate maternal and newborn care in communities and healthcare facilities throughout India.

ACKNOWLEDGEMENTS

In the development and finalization of this training package, numerous people were involved in ensuring the content was comprehensive, practical and appropriate for the Indian context.

(To be decided)

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TABLE OF CONTENTS

List of Abbreviations and Acronyms ---------- 1

TRAINING APPROACH OVERVIEW ---------- 9
- Welcome ---------- 9
- Training approach used in this course ---------- 9
- Key features of mastery learning ---------- 10
- Competency-based training ---------- 10
- Role of the trainer in this course ---------- 12
- Role of the participant in the course ---------- 12
- Components of the ANM faculty training package ---------- 13
- Using the ANM faculty training package ---------- 13
- Evaluation and certification of the participants ---------- 15

COURSE DESCRIPTION ---------- 15
- Course design ---------- 15
- Course structure ---------- 16
- Specific characteristics of this course: ---------- 16
- Course syllabus ---------- 17
- Course goals ---------- 17
- Course objectives ---------- 17

COURSE SCHEDULE ---------- 20

COURSE OUTLINE ---------- 37

PRECOURSE KNOWLEDGE ASSESSMENT ---------- 94
- How the results will be used ---------- 94
- Pre-course knowledge questionnaire ---------- 94
- Clinical experience questionnaire and personal learning plan ---------- 99
- Individual and group assessment matrix ---------- 101

EXERCISES AND ANSWER KEYS ---------- 103

SECTION I: EFFECTIVE TEACHING SKILLS AND PROFESSIONAL RESPONSIBILITIES ---------- 104

ACTIVITIES: ---------- 108
- Activity 1.1: Foundations of education activity ---------- 108
- Activity 1.2: Critique of learning activities ---------- 114
- Activity 1.3: Prepare for teaching activity ---------- 122
- Activity 1.4: Effective Facilitation Skills Review ---------- 126
- Activity 1.5: Guide for role plays, case studies and clinical simulations ---------- 137
- Activity 1.6: Principles of assessment game ---------- 157

SECTION II: FAMILY PLANNING ---------- 158

Pre and post-test questionnaire with answer keys ---------- 159

ACTIVITIES conquer ---------- 161
- Activity 2.1: Brainstorming: Importance of spacing and benefits of Family planning for the mother and the child ---------- 161
- Activity 2.2: Condom race and demonstration of condom use on model ---------- 161

EXERCISES ---------- 162

Exercise 2.1: Technical overview of the family planning methods: ---------- 162
Exercise 2.2: MEC Chart: Hormonal Methods with answer keys ---------- 169
Exercise 2.3: MEC for IUCD chart with answer keys ---------- 171
Exercise 2.4: Infection prevention for IUCD insertion / removal (with answer keys) ---------- 173
Exercise 2.5: Demonstration: Loading IUCD in a Sterile Package ---------- 178
ROLEPLAYS ---------- 179
Role play 2: Demonstration and Practice: FP Counseling Using GATHER approach ---------- 181

SECTION III: INTRODUCTION TO STI, HIV AND PPCTC OF HIV ---------- 183
TEACHING MATERIALS AND HANDOUTS ---------- 188
Session 3.1: Overview of HIV ---------- 188
Handout 3.1: HIV Disease Progression ---------- 202
Handout 3.2: WHO Clinical Staging of HIV/AIDS for adults and adolescents with confirmed HIV infection ---------- 203
Handout 3.3: WHO clinical staging system of HIV/AIDS for children with confirmed HIV infection ---------- 205
Session 3.2: Role of Nurse in care of patient with HIV ---------- 207
Session 3.3: Role of the Nurse in addressing psychological issues ---------- 209
Handout 3.4: Nurse's role in referral, linkages and networking ---------- 214
Session 3.4: Sexually transmitted diseases ---------- 216
Handout 3.5: Vaginal Discharge – What You Need to Know ---------- 211
Session 3.5: Syndromic case management ---------- 222
Handout 3.6: How and What of History Taking with Patients with STIs ---------- 226
Session 3.6: Standard precautions and hand hygiene: ---------- 229
Handout 3.7: Hand Hygiene ---------- 231
Session 3.7: Standard precautions: blood borne pathogens ---------- 232
Session 3.8: Post exposure prophylaxis for HIV ---------- 234
Session 3.9: Parent to child transmission of HIV ---------- 238
Handout 3.8: PPTCT True or False Statements and Answers ---------- 239
Session 3.10: PPTCT strategies ---------- 243
Handout 3.9: Small Group Exercise: Patient Education ---------- 244
Session 3.11: Secondary PPTCT strategies ---------- 252
Handout 3.10: Replacement Feeding Checklist ---------- 254
Session 3.12: Elements of Counseling in HIV ---------- 258
Session 3.13: Pre and Post test Counseling, Ongoing counseling ---------- 261
Handout 3.11: Steps in Pre-Test Counseling ---------- 261

EXERCISES
Exercise 3.1: "We know more than we do" ---------- 265
Exercise 3.2: Clinical Staging Cases ---------- 267
Exercise 3.3: Case Studies: Applying syndromic case management ---------- 268
Exercise 3.4: Steps in Hand Washing – Checklist ---------- 270
Exercise 3.5: Situational Guide - Cleaning up a Blood Spill on the Floor ---------- 271
Exercise 3.6: HIV and Pregnancy Case Study ---------- 272

ROLE PLAYS ---------- 273
Role Play 3.1: Typical Patient Questions ---------- 273
Role play 3.2 (a): Counseling Role Plays ---------- 274
(b): Counseling Assessment Checklist ---------- 277
ANNEXURES ---------- 278

Annexure 3.1: STI Syndrome Flowchart – Management of Lower Abdominal Pain in Females ---------- 279
Annexure 3.2: STI Syndromic Flowchart – Management of Inguinal Bubo ------ 280
Annexure 3.3: STI Syndromic Flowchart – Management of Painful Scrotal Swelling---------- 281
Annexure 3.4: STI Syndromic Flowchart – Management of Genital Ulcers------ 282
Annexure 3.5: STI Syndromic Flowchart – Management of Urethral Discharge in Males ---------- 283
Annexure 3.6: STI Syndromic Flowchart – Management of Vaginal Discharge in Females ---------- 284
Annexure 3.7: STI Syndromic Flowchart – Management of Oral & Anal STIs-- 285
Annexure 3.8: Management of Anogenital warts, Molluscum contagiosum and Ectoparasitic infection ---------- 286
Annexure 3.9: Personal Protective Equipment (PPE) ---------- 289
Annexure 3.10: Guidelines for Disinfection and Sterilization ---------- 291
Annexure 3.11: Factors Increasing the Risk of MTC HIV Transmission ---------- 292
Annexure 3.12: Nurse's Role during Pregnancy, Labour, Delivery, and Postnatal period in the care of HIV positive women ---------- 293
Annexure 3.13: Key Elements of Effective Counseling ---------- 296
Annexure 3.14: Avoiding Counseling Mistakes ---------- 297

SECTION IV: INTRODUCTION TO PERFORMANCE STANDARDS FOR ANMTCS AND THEIR IMPLEMENTATION ----------298

EXERCISES ---------- 299
Exercise 4.1: The Land scape ----------300

ANNEXURES ---------- 301
Annexure 1: Guidelines for supervising clinical practice ---------- 302
Annexure 2: Mid and Post course knowledge questionnaire with answer keys ---- 304
Annexure 3: Objective Structured Clinical Examination with answer keys--------- 315
Annexure 4: Participant assignment signup sheet – facilitation skills ---------- 327
Annexure 5: Participant assignment signup sheet – demonstration skills --------- 328
Annexure 6: Competency Tracking Sheet for Participants ---------- 329

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BEOC	Basic Essential Obstetric Care
BEmONC	Basic Emergency Obstetric and Newborn Care
BP/CR	Birth Preparedness and Complications Readiness
CBT	Competency Based Training
CHV	Community Health Volunteer
CHW	Community Health Worker
DMPA	Depo Medroxy Progesterone Acetate
ETS	Effective Teaching Skills
FP	Family Planning
FRU	First Referral Unit
GoI	Government of India
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
ICM	International Confederation of Midwives
IEC	Information, Education and Communication
IMNCI	Integrated Management of Neonatal and Childhood Illness
INC	Indian Nursing Council
IP	Infection Prevention
IUCD	Intra Uterine Contraceptive Device
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LRP	Learning Resource Package
MCHIP	Maternal and Child Health Integrated Program
MCPC	Managing Complications in Pregnancy & Childbirth
MNC	Maternal and Newborn Care
MNCH	Maternal, Newborn and Childhealth
PHC	Primary Health Center
PNC	Postnatal Care
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intra Uterine Contraceptive Device
RCH	Reproductive and Child Health
SBA	Skilled Birth Attendant
SBMR	Standards Based Management and Recognition
SHG	Self Help Group
TBA	Traditional Birth Attendant (Dai)
TT	Tetanus Toxoid

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization

TRAINING APPROACH OVERVIEW

WELCOME

Welcome – trainers and faculty members to the ANM faculty training course. You are indeed privileged to be a part of this exciting course which would refresh your knowledge and skills on a variety of subjects with a special focus on maternal, newborn and child health and family planning. It would be a time of gaining, sharing and updating knowledge in the above mentioned critical areas which need special attention while teaching the ANM students.

This course has been designed with the assumption that you participate in this training course because you:

- Are interested in updating your knowledge and sharpening your skills.
- Desire to be actively involved in course activities.
- Are dedicated to provide high quality education to the ANM students.

The training approach used in this course stresses the importance of the application of relevant educational technologies including the use of humane training

TRAINING APPROACH USED IN THIS COURSE

The mastery learning approach to training assumes that all learners can master (learn) the required knowledge, attitudes, or skills provided sufficient time is allowed and appropriate training methods are used. The goal of mastery learning is that 100 percent of those being trained will "master" the knowledge and skills.

While some learners are able to acquire new knowledge or a new skill immediately, others may require additional time or alternative learning methods before they are able to demonstrate competency. Not only do people vary in their abilities to absorb new material, but individuals learn best in different ways—through written, spoken or visual means. Mastery learning takes these differences into account and uses a variety of teaching and training methods.

The mastery learning approach also enables the learner to have a self-directed learning experience. This is achieved by having the trainer serve as facilitator and by changing the concept of testing and how test results are used. In courses that use traditional testing methods, the trainer administers pre- and post-tests to document an increase in the learners' knowledge, often without regard for how this change affects performance.

By contrast, the philosophy underlying the mastery learning approach is one of a continual assessment of learner learning. With this approach, it is essential that the trainer regularly inform learners of their progress in learning new information and skills, and not allow this to remain the trainer's secret.

With the mastery learning approach, assessment of learning is:

- **Competency-based**, which means assessment is keyed to the course objectives and emphasizes acquiring the essential knowledge, attitudinal concepts and skills needed to provide quality education to the ANM students and not simply acquiring new knowledge.

- **Dynamic**, because it enables trainers to provide learners with continual feedback on how successful they are in meeting the course objectives and, when appropriate, to adapt the course to meet learning needs.
- **Less stressful**, because from the outset learners, both individually and as a group, know what they are expected to learn and where to find the information, and have ample opportunity for discussion with the trainer.

KEY FEATURES OF MASTERY LEARNING

Training for the ANM faculty is designed and conducted according to adult learning principles—learning is participatory, relevant and practical—and:

- Uses behavior modeling
- Is competency-based
- Incorporates humanistic training techniques

Behavior Modeling

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modeling to be successful, the trainer must clearly demonstrate the skills or activities so that learners have a clear picture of the performance expected of them.

Learning to perform a skill takes place in three stages. In the first stage, **skill acquisition**, the learner sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the learner attempts to perform the procedure, usually with supervision. Next, the learner practices until **skill competency** is achieved and the individual feels confident performing the procedure. The final stage, **skill proficiency**, occurs only with repeated practice over time.

Skill Acquisition: Knows the steps and their sequence (if necessary) to perform the required skill or activity but needs assistance

Skill Competency: Knows the steps and their sequence (if necessary) and can perform the required skill or activity

Skill Proficiency: Knows the steps and their sequence (if necessary) and efficiently performs the required skill or activity

COMPETENCY-BASED TRAINING

Competency-based training (CBT) is distinctly different from traditional educational processes. Competency-based training is learning by doing. It focuses on the specific knowledge, attitudes and skills needed to carry out a specific task. How the learner performs (i.e. a combination of knowledge, attitudes and most important, skills) is emphasized rather than just what information the learner has acquired. CBT requires that the trainer facilitates and encourages learning rather than serve in the more traditional role of instructor or lecturer. Competency in the skill or activity is assessed objectively by evaluating overall performance. For CBT to occur, the clinical skill or activity to be taught first is broken down into its essential steps. Each step is then analyzed to determine the most efficient and safe way to perform and learn it. This process is called **standardization**. Once a procedure has been standardized, competency-based skill development and assessment instruments, such as checklists or algorithms, can be designed. These instruments make learning the necessary steps or tasks easier and evaluating the learner's performance more objective.

An essential component of CBT is coaching; Coaching uses positive feedback, active listening, questioning and problem-solving skills to encourage a positive learning climate. To use coaching, the trainer should first explain the skill or activity and then demonstrate it using an anatomic model or other training aid such as a video or a job aid. Once the procedure has been demonstrated and discussed, the trainer/coach then observes and interacts with the learner to provide guidance in learning the skill or activity, monitors progress and helps the learner overcome problems.

The coaching process ensures that the learner receives feedback regarding performance:

- Before practice—The trainer and learner should meet briefly before each practice session, whether in classroom or in the clinic, to review the skill/activity, including the steps/tasks that will be emphasized during the session.
- During practice—The trainer observes, coaches, and provides feedback as the learner performs the steps/tasks outlined in the learning guide.
- After practice—This feedback session should take place immediately after practice. Using the learning guide, the trainer discusses the strengths of the learner's performance and also offers specific suggestions for improvement.

Humanistic Training Techniques

The use of more humane (humanistic) techniques also contributes to better clinical training. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids such as videos. The effective use of models facilitates learning, shortens training time and minimizes risks to clients. For example, by using anatomic models initially, learners more easily reach the performance levels of skill competency and beginning skill proficiency before they begin working in the clinic setting with clients.

Before a learner attempts a clinical procedure with a client, two learning activities should occur:

- The clinical trainer should demonstrate the required skills and client interactions several times using anatomic model and appropriate audiovisual aids (e.g., video or computer graphics).
- While being supervised, the learner should practice the required skills and client interactions using the model and actual instruments in a simulated setting that is as similar as possible to the real situation.

Only when skill competency and some degree of skill proficiency have been demonstrated with models however should learners have their first contacts with clients.

When mastery learning, which is based on adult learning principles and behavior modeling, is integrated with CBT, the result is a powerful and extremely effective method for providing training. And when humanistic training techniques, such as using anatomic models and other learning aids, are incorporated, training time and costs can be reduced significantly.

ROLE OF THE TRAINER IN THIS COURSE

This course is different from others. In this course, you are training ANM faculty, many who have years of experience in maternal and newborn care. Remember the goal of this course. It is to build on the facilitation and clinical skills of the faculty with regard to maternal, newborn, child health and family planning services. During the first week the participants would complete a course on 'Effective Teaching Skills' and from the second week they would co-facilitate a teaching and demonstration session along with the trainer. The trainer will provide feedback on their teaching skills and ensure the technical content is accurate.

In this course your primary roles as a trainer are to:

- **Facilitate**: ANM faculty as they prepare session plans, facilitate sessions and demonstrations and complete clinical practice experiences
- **Coach:** ANM faculty in teaching skills and ensuring their skills are consistent with the GoI SBA guidelines
- **Ensure client safety**: during clinical practice sessions to prevent adverse events
- **Assess:** ANM faculty's skill at the beginning of training, during and towards the end. As most ANM faculty are very experienced, the goal of this course is to standardize their clinical skills in critical areas to ensure they demonstrate and develop the desired skills in ANM students

A few important tips:

Link course content to teaching ANM students: At the end of each session or each day: Ask the faculty: "How will you use what you learned today in teaching ANM students?" Encourage them to discuss practical next steps rather than just ideas. (For example, I will use this checklist to demonstrate these skills", or "I will use these case studies when teaching in the classroom", etc.)

Highlight the importance of teaching students clinical decision-making skills: Throughout the course, discuss and emphasize ways they can help students develop clinical decision-making skills. There is a handout in the Participant's Handbook that outlines key strategies and tips for teaching clinical decision-making.

Highlight the importance of practice: While many faculties focuses on didactic, finding ways to increase student's time to practice and receive feedback is essential. Focus on the importance on increasing student's time to practice in simulation, and better communication with ward staff to ensure clinical practice provides 'hands-on' experience.

Demonstrate the use of formative assessment: Every few days, ask questions to reinforce key information that is covered. Ask questions that assess their ability to analyze, rather than only recall information. As you facilitate, use formative assessment to reinforce key points, assess understanding and help them learn. Prompt them to integrate the same into their participant practice sessions.

ROLE OF THE PARTICIPANT IN THE COURSE

In this course the participants are recipients as well as co-facilitators. During the first week, the participants undergo a course on effective teaching skills which elaborates on

the methods of facilitation and demonstration. There are practice sessions for the participants to develop, refresh and demonstrate their facilitation skills. During the next five weeks, the participants co-facilitate most of the sessions under the guidance of the trainers. Feedback for each session would be given by the group so that the participant can build on the skills. A final evaluation of the facilitation skills would be done at the end of the course.

COMPONENTS OF THE ANM FACULTY TRAINING PACKAGE

This course package contains the following components:

- A facilitator's guide for the trainers containing the instructions, questionnaires and answer keys of the course and the detailed information for conducting the course.
- A participant's handbook for the participants which contains the course schedule, course outline, questionnaires, exercises, checklist and other tools for teaching.
- SBA training package of Government of India.
- IMNCI training for basic health workers package of Government of India.

The reference materials for this course are:

- Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs, LHVs and Staff Nurses (English & Hindi). April 2010, Government of India
- Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs, LHVs and Staff Nurses (English & Hindi). Facilitator's Guide. April 2010, Government of India
- Guidelines for Antenatal Care and Skilled Attendance at Birth by ANMs, LHVs and Staff Nurses (English & Hindi). Participant Handbook. April 2010, Government of India
- Integrated Management of Neonatal and Childhood Illness (IMNCI) for basic health workers.
- Family Planning: A Global Handbook for Providers. 2007, World Health Organization and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.
- Family Planning and Postpartum Family Planning Counseling reference manual, Jhpiego.
- National guideline on prevention, management and control of reproductive tract infections including sexually transmitted infections, MOHFW, GoI, 2007.
- Effective Teaching: A Guide for Educating Healthcare Providers. World Health Organization and Jhpiego, 2002.

USING THE ANM FACULTY TRAINING PACKAGE

The ANM faculty training package is designed in a unique way to help in the maximal utilization of the Government of India materials so that the information spread is uniform and up-to-date.

The participant's handbook is the road map that guides the learner through each phase of the course. It contains all the information on the course outline with details of the reference materials and when to use them. The exercises for the sections on ETS, HIV,

Family planning and performance standards area are in the participants hand book while the sections on SBA package and IMNCI use the GoI materials as a whole set.

The facilitators guide contains the same material as the participant's handbook as well as material for the trainer. This includes the course outline, all knowledge assessments with answer keys and competency-based qualification checklists.

In keeping with the training philosophy on which this course is based, all training activities will be conducted in an interactive, participatory manner. To accomplish this requires that the role of the trainer continually change throughout the course. For example, the trainer is an instructor when presenting a classroom demonstration; a facilitator when conducting small group discussions or using role plays; and shifts to the role of coach when helping learners practice a procedure. Finally, when objectively assessing performance, the trainer serves as an evaluator.

In summary, the CBT approach used in this course incorporates a number of key features. First, it is based on adult learning principles, which means that it is interactive, relevant, and practical.

Moreover, it requires that the trainer facilitate the learning experience rather than serve in the more traditional role of an instructor or lecturer. Second, it involves use of behavior modeling to facilitate learning a standardized way of performing a skill or activity. Third, it is competency based. This means that evaluation is based on how well the learner performs the procedure or activity, not just on how much has been learned. Fourth, where possible, it relies heavily on the use of anatomic models and other training aids (i.e., it is humanistic) to enable learners to practice repeatedly the standardized way of performing the skill or activity before working with clients. Thus, by the time the trainer evaluates each learner's performance using the checklist, every learner should be able to perform every skill or activity competently. This is the ultimate measure of training.

Ground Rules

To help ensure that time spent at the training is both productive and enjoyable, there are some rules and procedures that we ask participants to follow. The following information includes details on general procedures for the course and requirements for completion of the course. These ground rules are not meant to constrain participants but to contribute to a quality learning environment for everyone.
It is important for course participants to establish and commit to their own group norms on the first morning of the course. The facilitator will lead a brainstorming exercise at the beginning of the course to establish group norms. The following are examples of group norms:

- Respect each other's confidentiality
- Respect each other's contributions, questions, and opinions
- Be on time
- Participate fully in discussions and exercises
- Turn off mobile phones
- Punctuality & time management
- Freely Ask questions
- Respect everyone and their opinions
- No interruption when others are speaking
- Patience
- Group participation

- Flexibility

EVALUATION AND CERTIFICATION OF THE PARTICIPANTS

This training course is designed to produce qualified ANM faculty capable of providing quality midwifery education to the ANM students. Qualification is a statement by the trainers that the learner has met the requirements of the course in knowledge, skills, and practice.
Qualification does not imply certification. Personnel can be certified only by an authorized organization or the Indian Nursing Council.

Evaluation of the knowledge component would be done at the end of each section of the course. There would be a final knowledge assessment covering all the areas of study. Clinical skills would be assessed through OSCE at the end of the SBA section and facilitation skills would be assessed by demonstration at the end of the course.

Participants should use Annexure Four in the GoI Participant Handbook to track their completion of tasks both in simulation and with clients. The tracking sheet in annexure no: should be used to document each participant's demonstration of mastery for the required skills

Qualification is based on the learner's achievement in three areas:
- Knowledge: A score of at least 85% on the Knowledge Assessment
- Skills: Satisfactory performance of clinical skills evaluated by OSCE
- Practice: Demonstrated ability to provide quality services in the clinical setting and demonstrated good facilitation skills.

A certificate of qualification would be provided at the end of the course on successful completion. It is recommended that, within one to two months of qualification, the participants be observed and assessed working in their institution by a course trainer using the same checklist.

COURSE DESCRIPTION

COURSE DESIGN

The ANM faculty training course is designed for the ANM faculty who are involved in teaching midwifery in the ANM schools. The course builds on each participant's past knowledge and takes advantage of her/his high motivation to accomplish the learning tasks in the minimum time. Training emphasizes doing, not just knowing, and uses competency-based evaluation of performance.

COURSE STRUCTURE

Week 1	:	Introduction to the course, Effective teaching skills to strengthen the facilitation skills of the ANMTC faculty (using the participants handbook prepared for the training).
Week 2 – 4	:	Skilled Birth Attendance training with the faculty co-facilitating training in the classroom and clinical area (using the GoI SBA package - 2010).
Week 5	:	Training on integrated management of neonatal and childhood illness (IMNCI) with the participants co-facilitating the trainings (using the GoI package on IMNCI for basic health workers) and prevention os STI, HIV and parent to child transmission of HIV.
Week 6	:	Update on the Family planning methods. Orientation to the INC approved educational standards for nursing and midwifery to be implemented at the ANM training centers and course evaluation.

SPECIFIC CHARACTERISTICS OF THIS COURSE:

- During the morning of the first day, participants demonstrate their Midwifery knowledge by completing a written Pre-course Questionnaire and self-assess their learning needs.
- After reviewing key teaching skills in the first week, participants will facilitate presentations and perform demonstrations using the Government of India SBA Guidelines, the IMNCI and family planning materials. This will provide practical experience using the new learning materials and teaching methodologies they will later use during teaching.
- Participants will be using materials as 'learners' that they will later use to teach students. The power point presentations, case studies, clinical simulations, checklists and other tools that are used in this course will later be used to teach students within the current Midwifery course for ANMs.
- Clinical practice is a key component of the course. An alternative schedule will be used to maximize exposure to clients and increase clinical practice opportunities. Progress in learning new skills is documented using the clinical skills learning guides and clinical logbooks.
- Teaching clinical decision-making is learned and evaluated through case studies and simulated exercises and during clinical practice with patients.
- There is an emphasis on the intra partum period and life-threatening complications. There is also emphasis on practice in simulation and with clients.
- Evaluation of the clinical skills will be done in simulation to determine the attainment of competence.
- There is emphasis on Objective Structured Clinical Examination (OSCE) as an evaluation tool to be used during the training.
- The faculty are oriented to the INC approved educational standards and equipped to implement the standards in their training centers.

COURSE SYLLABUS

This six-week course is designed to strengthen the teaching and facilitation skills of the ANM faculty in the areas of maternal, newborn and child health and family planning.

The materials to be used during the course are:

- Effective Teaching (WHO/Jhpiego) 2002
- Skilled birth attendance (SBA) package of GoI – 2010.
- Integrated management of neonatal and childhood illness package for basic health workers.
- National Guidelines on Prevention, Management and Control of Reproductive Tract Infections including Sexually Transmitted Infections, GoI 2006.
- Family planning materials.

The faculty would be prepared to use these materials while teaching ANM students in their training centers and integrate them into the ANM curriculum.

COURSE GOALS

- To strengthen the facilitation skills of the ANM faculty and to provide an update on the effective teaching methods.
- To provide an update and prepare faculty to use new Government of India learning resources on maternal, child health and family planning in existing ANM curriculum as mandated by the Indian Nursing Council
- To influence in a positive way the attitudes of faculty regarding the importance of adequate practice and feedback for students, first in simulation and later with clients.
- To orient the faculty on the educational standards and help them in implementing the standards in their training centers.

COURSE OBJECTIVES

By the end of the training course, the participant will be able to:

Teaching skills

1. Describe the foundations of educating healthcare providers.
2. Develop objectives for learning.
3. Plan for Teaching: Session-level planning.
4. Demonstrate facilitation skills for a range of learning activities.
5. Apply key principles of effective assessment in developing knowledge assessments.
6. Describe key components for managing clinical practice.
7. Demonstrate effective use of Government of India SBA Guidelines and learning materials.
8. Identify strategies for teaching students the use of evidence-based medicine in life-long learning

SKILLED BIRTH ATTENDANCE

1. Describe the care and importance of the health of the woman and newborn during the antenatal period, labor and postnatal period.

2. Explain the essential care of the newborn and its importance for the health of the baby.
3. Describe the clinical features and initial management of common obstetric complications during the antenatal period, labor and postnatal period.
4. Appreciate the importance of the quality of care provided by midwifery services, and the need for a client-centered approach, the use of infection prevention practices, community involvement and provision of a supportive environment for the mother and family.
5. Demonstrate the measurement of blood pressure, pulse and foetal heart rate (FHR), checking for pallor and oedema, and determining the fundal height, foetal lie and presentation accurately.
6. Perform hemoglobin estimation and testing urine for proteins and sugar.
7. Counsel on birth preparedness, complication readiness, diet and rest, infant feeding, sex during pregnancy; domestic violence and contraception.
8. Conduct pelvic assessment to determine pelvic adequacy.
9. Plot the partograph and knowing when to refer the woman.
10. Conduct safe deliveries, with active management of the third stage of labour (AMTSL), using infection prevention practices.
11. Provide essential care and undertaking resuscitation of the newborn.
12. Insert an intravenous line for the management of shock and PPH.
13. Insert a catheter for the management of PPH and convulsions.
14. Give deep intramuscular injection (Magnesium sulphate).
15. Prepare sterilized/high-level disinfected (HLD) gloves and instruments.
16. Demonstrate infection prevention practices.

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

1. Assess young infants for possible bacterial infection and diarrhea
2. Check for a feeding problem
3. Check the young infant's immunization status
4. Provide treatment and refer when required
5. Correct breastfeeding problems
6. Advise the mother on home care for the sick young infant
7. Conduct home visits for all young infants
8. Identify strategies and tools for teaching IMNCI to ANM students

FAMILY PLANNING

1. Describe the importance of healthy timing and spacing of pregnancy.
2. Identify shifts in counseling approach and family planning themes.
3. Explain the different family planning methods.
4. Describe key points to address in counseling and education related to immediate postpartum IUCD insertion.
5. Describe contraceptive use during the postpartum period.
6. Demonstrate interval IUCD insertion on a model.

7. Identify changes to medical eligibility criteria for various family planning methods.
8. Outline updated recommendations on when IUCD may be inserted.

PREVENTION OF STI/RTI, HIV AND MOTHER-TO-CHILD-TRANSMISSION OF HIV

1. Describe the various STIs and their management in the sub center level.
2. Explain the Prevention of Parent To Child Transmission (PPTCT) Program
3. List risk factors and appropriate interventions for:
   a. HIV transmission during pregnancy
   b. HIV transmission during labour and delivery
   c. HIV transmission postpartum and during infancy
4. Describe the nurse's role in PPTCT.

EDUCATIONAL STANDARDS:

1. Describe the SBM-R process of standardization of educational infrastructure and process.
2. Identify strategies to implement the standards in the ANM training centers.
3. Explain the assessment and scoring of standards.

Training/Learning Methods

- Illustrated lectures and discussion
- Individual and group exercises
- Role plays and case studies
- Brain storming sessions
- Videos
- Simulated practice with anatomic models.
- Guided clinical practice.

Duration of the course:

The duration of the course would be 6 weeks with 36 full working days.

Learner Selection Criteria

This course is designed for ANMTC faculty involved in teaching midwifery for ANM students.

Suggested course composition:

15 participants
2 trainers (exclusively for the program)
1 trainer (from the nodal center)

COURSE SCHEDULE

ANM FACULTY TRAINING – TRAINING SCHEDULE

DAY 1 – Morning : 9 am – 1 pm	DAY 1 – Afternoon : 2-5pm
Opening:(15 mins) ▪ Welcome ▪ Introduction of participants ▪ Participants expectation from the training workshop ▪ Ground rules Course overview and materials: (60 mins) ▪ Goal and objectives of the training workshop ▪ Review of the course schedule, content and training approach ▪ Distribution and review of training package (course materials Pre course assessment : (45 mins) ▪ Knowledge assessment ▪ Clinical experience questionnaire Presentation / Discussion : (60 mins) ▪ Maternal health scenario in India. ▪ MMR status in India. Brainstorming: (20 mins) ▪ Importance of strengthening ANMs capacity for improving maternal and child health Illustrated lectures: (40 mins) ▪ Key interventions and govt schemes for improving maternal health ▪ Overview of the MCHIP program and its focus on supporting ANM faculty	Warm – up Illustrated lectures: (60 mins) ▪ Professional ethics and midwifery. ▪ Review of the ICN code of ethics Brainstorming : (30 mins) ▪ Roles and responsibilities of ANMs. Interactive presentation: (15 mins) ▪ ANM Professional responsibility and accountability. Activity : Role play and Discussion : (60 mins) ▪ ANM in the community ▪ Partnership with TBAs Review of the day's activity & Reading assignments. (15 mins)

WEEK 1 : DAY 2-6: EFFECTIVE TEACHING SKILLS

WEEK 1 /DAY 2	WEEK 1 /DAY 3	WEEK 1 /DAY 4	WEEK 1 /DAY 5	WEEK 1 /DAY 6
Morning : 9 am – 1 pm				
Agenda Warm-up **Illustrated Lecture : (40 min)** ▪ Foundations of pre service education: Guiding principles of educating the health care providers. ▪ Core competencies and their role in curriculum development and design ▪ Effective approaches to teaching and learning **Brain storming : (90 mins)** ▪ Analysis of core competency in the ANM program ▪ Compare with ICM core competencies. **Interactive presentation : (35min)** ▪ Developing learning objectives **Small Group Activity: (75mins)** ▪ Critique of learning objectives	Agenda Warm-up **Illustrated Lecture:(45mins)** ▪ Plan for teaching – session planning **Small Group Activity : (60mins)** ▪ Prepare a session plan for the assigned topic **Interactive presentation:(30 mins)** ▪ Prepare for teaching. **Small Group Activity : (90mins)** ▪ Preparation for teaching	Agenda Warm-up **Illustrated Lecture: (45 mins)** ▪ Facilitation skills for a range of learning activities. **Small Group Activity: (30mins)** ▪ Review of effective facilitation skills and demonstration skills checklist **Small group activity / Demonstration : (150 mins)** ▪ Facilitation skills for a range of learning activities	Agenda Warm-up **Illustrated Lecture : (60 mins)** ▪ Helping students develop competency in new knowledge and skills. **Small group activity : (60 mins)** ▪ Develop group learning activities and critique them. **Discussion : (30 mins)** ▪ Use of clinical simulations in teaching clinical decision making skills. **Demonstration : (30 mins)** ▪ Use of clinical simulations in teaching clinical decision making skills. **Discussion : (15 mins)** ▪ Teaching clinical decision making	Agenda Warm-up **Small group activity : (60 mins)** ▪ Clinical practice tools **Interactive presentation: (60 mins)** ▪ Developing knowledge assessments. **Small group activity : (90 mins)** ▪ Develop knowledge assessments **Large group activity: (15 mins)** ▪ Analysis of the small group activity.
LUNCH				

Afternoon : 2-5pm				
Energizer. Practice and Feedback: (150 mins) ▪ Write learning objectives Discussion: (15 mins) ▪ Review of the key points in develop Objectives for Learning Review of day's activities and reading assignment: (15 mins) Interactive presentation : (30 min) ▪ Understanding general hardware/components and operation of Computer/printer and LCD projector Demonstration : (30 mins) ▪ Components of computers/printer and LCD projector ▪ Operationof Computes/printer and LCD projector	Energizer. Brainstorming and Discussion: (30 mins) ▪ Preparation of Audio-visual aids. Small group activity : (60 mins) ▪ Preparation of Audio-visual aids. Assign topics for presentation for the following day : (15 mins) Individual Activity: (60mins) ▪ Preparation of session plans Review of day's activities and reading assignment: (15 mins) Interactive presentation : (30 min) ▪ Understanding Computer Opearting System, Application, Internet web browsing & Internet Search engine Demonstration : (30 mins) ▪ Computer OS/ Application / E-Mail / Internet Browsing ▪ Operation of e-mail & Internet Browsing with exercise.	Energizer. Small Group Activity:(2hrs) ▪ Practice facilitation skills Discussion : (45 mins) ▪ Analysis of the performance during facilitation. Review of day's activities and reading assignment: (15 mins) Interactive presentation : (15 min) ▪ An Introduction to Microsft Office and their componentsWord, Excel, PowerPoint) Demonstration : (30 mins) ▪ Use of Microsft Word Processing and its features ▪ Operation of MS-Word with Examples & Excersise	Energizer. Small group activity: (90 mins) ▪ Demonstrate effective demonstration and coaching skills. Discussion : (15mins) ▪ Observation during demonstration of a clinical skill Brainstorming : (15 mins) ▪ Making clinical practice successful. Interactive presentation: (45mins) ▪ Managing clinical practice Review of day's activities and reading assignment: (15 mins) Interactive presentation : (30 min) ▪ An Introduction to Microsft Excel Spreadsheet Demonstration : (30 mins) ▪ Use of Microsft Excel spreadsheet and its features. ▪ Operation of MS-Excel with Examples & Excersise	Energizer. Discussion: (60 mins) ▪ Prepare and use skills assessment Interactive Presentation: Motivation ▪ Summary of effective teaching skills. Individual activity: (15 mins) ▪ Participants sign up for teaching assignments Reading assignment and instructions regarding the next section : (15 mins) Interactive presentation : (30 min) ▪ An Introduction to Microsft Power Point Presentation & Summry Demonstration : (30 mins) ▪ Use of Microsft Power Point Presentaion and its features / Summary. ▪ Operation of MS-Power Point Presentation with Examplaes & Excersise

WEEK 2 : DAY 1-6 SKILLED BIRTH ATTENDANCE

WEEK 2 /DAY 1	WEEK 2 /DAY 2	WEEK 2 /DAY 3
Morning : 9 am – 1 pm		
Agenda & Warm-up Course Overview :(30 mins) ▪ Goals and objectives ▪ Pre course knowledge assessment. ▪ Experience record of the trainees prior to the SBA training. Illustrated lecture : (30 mins) ▪ Objective Structured Clinical Examination. Objective Structured Clinical Examination : (3 hrs) ▪ Pre course evaluation of clinical skills	Agenda & Warm-up Illustrated lecture / discussion : (30 mins) ▪ Importance of Antenatal Care and preparation for ANC Small Group Activity : (10 mins) ▪ Estimation of the number of pregnancies' and deliveries annually. Demonstration : (15 mins) ▪ Detection of pregnancy. Individual Activity : (15 mins) ▪ Tracking of pregnant women and Maternal and child protection card. Interactive presentation : (45 mins) ▪ ANC – History taking Exercise : (15 mins) ▪ Calculation of EDD Skill Demonstration : (30 mins) ▪ ANC – General examination Simulation exercise: (1 hr 30 mins) ▪ ANC – general examination – skills practice.	Agenda & Warm-up Brainstorming : (15 mins) ▪ Laboratory investigations for the Antenatal mother. Demonstration : (15 mins) ▪ ANC – Laboratory investigations Skills practice session : (45 mins) ▪ ANC – Laboratory investigations Interactive presentation / Discussion: (45 mins) ▪ ANC – interventions Interactive presentation / Discussion : (30 mins) ▪ ANC counseling Discussion : (45 mins) ▪ Symptoms and signs during pregnancy ▪ Referral to PHC or FRU Role play : (45 mins) ▪ ANC counseling and care
LUNCH		

Afternoon : 2-5pm		
Energizer. Illustrated lecture: (40 mins) ▪ Infection prevention Skill Demonstration: (45 mins) ▪ Hand washing, Decontamination and high – level disinfection. ▪ Processing of Instruments. Simulation exercise: (20 mins) ▪ Segregation of hospital waste Small Group Activity: (1 hr) ▪ Skills practice on infection prevention procedures. Review of day's activities and reading assignment. (15 mins)	Energizer. Skill Demonstration: (30 mins) ▪ ANC – abdominal examination. Simulation exercise: (2 hrs 15 mins) ▪ ANC – abdominal examination Review of day's activities and reading assignment (15 mins)	Energizer. Illustrated lecture: (45 mins) ▪ Care during labour – assessment and care in labour . Skill Demonstration: (60 mins) ▪ Assessment of woman in labour ▪ Vaginal examination during labour Skills practice session: (60 mins) ▪ Assessment of woman in labour ▪ Vaginal examination during labour Review of day's activities and reading assignment. (15 mins)
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator		

WEEK 2 /DAY 4	WEEK 2 /DAY 5	WEEK 2 /DAY 6
Morning : 9 am – 1 pm		
Agenda Warm-up Interactive presentation / Discussion: (60 mins) ▪ Care during labor and delivery – true and false labour pains. ▪ Partograph Exercise: (60 mins) ▪ Plotting of the partograph using case studies. Discussion: (15 mins) ▪ Second stage of labour. Skill Demonstration: (45 mins) ▪ Management of first and second stage of labour. Skills practice session: (60 mins) ▪ Management of first and second stage of labour	Agenda Warm-up Interactive presentation: (30 mins) ▪ Monitoring and management of third and fourth stage of labour Skill Demonstration: (20 mins) ▪ Active management of third stage of labour. ▪ Management during the fourth stage of labour . Skills practice session: (40 mins) ▪ Active management of third stage of labour. ▪ Management during the fourth stage of labour. Illustrated lecture: (30 mins) ▪ Care after delivery - post partum care ▪ Care during first, second and third postpartum visits. Skills practice session: (1hour) ▪ Care after delivery - post partum care ▪ Care during first, second and third postpartum visits NSSK Illustrated lecture: (30 mins) Resuscitation of Newborn Skill Demonstration : (30mins) Resuscitation of newborn	Agenda Warm-up Interactive presentation: (15 mins) ▪ Management of complications during pregnancy, labour and postpartum period Exercise: (45 mins) ▪ Vaginal bleeding during pregnancy Skill Demonstration: (15 mins) ▪ Setting up an IV line Discussion: (30 mins) ▪ Immediate PPH Simulation: (45 mins) ▪ Management of shock and PPH. Discussion: (45 mins) ▪ Pregnancy induced hypertension. Discussion: (30 mins) ▪ Convulsions – eclampsia Skill Demonstration: (15 mins) ▪ Giving deep intramuscular injections.
LUNCH		

Afternoon : 2-5pm		
Energizer. Clinical visit: (2 hrs 45 mins) ▪ Visit to the labour room for observation of normal delivery Review of day's activities and reading assignment. (15 mins)	Energizer. Skill Practice : (30 mins) Resuscitation of new born Lecture and discussion : (1hour) Keeping the newborn warm Skill Demonstraion and practice: (30mins) Kangroo care Mummifying the newborn Skill practice: (1Hour) Kangroo care Mummifying the newborn Review of day's activities and reading assignment. (15 mins)	Energizer. Discussion: (1 hr) ▪ Complications during pregnancy, labour and postpartum Skill Demonstration: (15 mins) ▪ Catheterization Illustrated lecture: (45 mins) ▪ Ensuring quality of care Post course knowledge assessment: (30 mins) Preparation for clinical practice : (30 mins) ▪ Clinical rotation and log book discussion.
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator		

WEEK 3 & 4: DAY 1-6 SKILLED BIRTH ATTENDANCE

Day 1 of Week 3: Practice in simulation. Participants would use the GoI Checklist, the log book, and practice all the skills in simulation. Multiple stations would be set for the procedures.

CLINICAL PRACTICE

The participants will be posted in the following areas for supervised clinical practice in rotation (on off hours to increase client exposure):

- Maternity ward.
- Labour room
- Antenatal OPD
- Postnatal OPD
- Newborn unit

The timings can be made flexible to provide 7 hrs of clinical practice. The participants can be on call during the nights (if necessary).

Note :

1. The participants should complete the clinical log book (for the relevant skills, focusing on intrapartum and postpartum skills) (GoI)
2. A review of individual progress with the trainer should be done during the afternoon session of week 3/ day 6. The clinical rotation and plan should be planned for week 4 as per the requirements of the participants.
3. An OSCE for the evaluation of the clinical skills will be done during the afternoon session of week 4/ day 6.

WEEK 5 : DAY 1- 4 OVERVIEW OF THE INTEGRATED MANAGEMENT OF NEONATAL AND CHILDHOOD ILLNESS PACKAGE

WEEK 5 /DAY 1	WEEK 5 /DAY 2	WEEK 5 /DAY 3	WEEK 5 /DAY 4
Morning 9 am-1pm			
Agenda Warm-up Course Overview :(30 mins) ▪ Goals and objectives of IMNCI ▪ Pretest knowledge assessment. ▪ Introduction of the course materials. Pre course knowledge assessment: (30 mins) Illustrated lecture and group discussion: (30mins) ▪ How to assess & classify the sick young infant(up to 2 months of age) ▪ Introduction and use of the chart booklet ▪ Introduction and use of the Recording form Group discussion, case study and demonstration: (90 mins) ▪ Assessment & Classification of the sick young infant for bacterial infections ▪ Case study-Practice	Agenda Warm-up, recap day - 1 Illustrative lecture & discussion: (45 min) ▪ Common breast feeding problems and solutions Interactive discussion & demonstration: (2 hrs 45 mins) Teaching the mother how -to give co trimoxazole at home -Keep the sick young infant warm -bathe the infant. - treat local infection at home -treat diarrhea at home -correct positioning and attachment for breast feeding - express breast milk - feeding with a cup & spoon	Agenda Warm-up, recap day - 2 Interactive lecture,group discussion & video demonstration (2 hr) ▪ Assessment of the child 2 months to 5 years for fever ▪ Classification chart for classifying fever ▪ Video demonstration on assessment of the child for fever and stiff neck. ▪ Video case study 'Pu' ▪ Photographic Exercise To recognize symptoms associated with fever Brainstorm & Discussion: (45 mins) Principles of effective communication Interactive lecture and discussion: (1 hr 15 min) ▪ Management of the sick child. Classify & check for ▪ -Malnutrition ▪ -Anaemia & its prevention in children. Iron and Folic acid supplementation ▪ -Immunization schedule ▪ -Vit A supplementation	Agenda Warm-up , recap day - 3 Field visit nearest Anganwadi centre/Health sub centre.(6 Hrs)s

▪ Video exercise **Group discussion, case study & video demonstration: (60 mins)** Assessment & classification of diarrhea in the young infant ▪ Video Exercise ▪ Case study-Practice exercise			
LUNCH			

Afternoon : 2-5pm			
Energizer. Illustrative lecture and group discussion (60 mins) ▪ Steps for classifying feeding problems ▪ Use of the classification chart Interactive discussion, video demonstration & photographic exercise: (60 min) ▪ Video demonstration of breast feeding assessment ▪ Video Demonstration on correct positioning for breast feeding ▪ Group Discussion of example photographs to recognize signs of good attachment. Interactive lecture, Role play and demonstration: (60 mins) ▪ Introduce: 'identify treatment' on the assessment and classification chart and how to use this classification for identifying treatment. ▪ Role Play: Explaining to the mother that her young infant needs urgent referral ▪ Demonstration on how to use the back of the infant recording form Review of the day's activities and reading assignment: (30mins)	Energizer. Interactive lecture, group discussion & Video demonstration: (60 mins) ▪ Assessment and classification for cough and difficult breathing in a child 2 months to 5 years ▪ Video demonstration on assessment of the child for general danger signs and cough and difficult breathing ▪ Exercise on video case study-'Ben' Interactive discussion, video demonstration & photographic exercise: (2 hr) ▪ Classification chart for diarrhea/dehydration in a child 2 months to 5 years ▪ Video demonstration on assessment of the child for diarrhea and recognizing sunken eyes and slow skin pinch ▪ Video case study 'Josh' ▪ Photographic exercise to recognize signs of dehydration. Review of the day's activities and reading assignment : (15 mins)	Energizer. Interactive lecture & group discussion : (1hr) ▪ Home based remedies for pneumonia, diarrhea. dehydration, preparation of ORS, high fever, cough Interactive discussion: (30 mins) ▪ Follow up care Interactive lecture and discussion (1hr 30 Mins) Complementary feeding in infants & children Review of the day's activities and reading assignment: (15 mins)	Energizer. Post course knowledge assessment (30 mins) Review of the day's activities, Clarification & wrap up.(30 mins)
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator			

WEEK 5: DAY 5 & 6: FAMILY PLANNING AND CONTRACEPTIVE UPDATES

WEEK 5 /DAY 5	WEEK 5 /DAY6
Morning 9 am-1pm	
Agenda Warm up Course overview : (15 mins) ▪ Goals and objectives. ▪ Pre knowledge assessment. Illustrated lecture : (45mins) ▪ India National Family Planning program. ▪ Overview of Family Planning service provision : GoI policy Brainstorming, presentation and Discussion : (45 mins) ▪ Benefits of family planning and spacing of pregnancies Discussion and exercise: (60 mins) ▪ Technical overview of modern Family Planning methods Exercise : (60 min) ▪ Who can use hormonal methods?	Agenda Warm up , recap of day 1 Exercise: (15 min) ▪ Who can use an IUCD? Demonstration : (15 mins) ▪ Loading of IUCD in the sterile package. Skills practice session : (30 mins) ▪ Loading of IUCD in the sterile package Discussion and Presentation :(45 mins) ▪ Infection Prevention Steps in IUCD Insertion Demonstration (30 mins) ▪ IUCD insertion & Removal on Zoe model Skills practice session : (90 mins) ▪ IUCD Insertion and Removal on Zoe model
LUNCH	
Afternoon : 2-5pm	
Energizer. Interactive presentation & discussion: (90mins) ▪ Post partum family planning and LAM Game: (15 mins) ▪ Condom Race & demonstration Illustrated lecture and discussion : (60 mins) ▪ Discuss modern approaches to IUCD Review of the day's activities and reading assignment: (15 min)	Energizer. Interactive presentation : (45 mins) ▪ Elements of counseling and communication skills Discussion &interactive presentation (60 mins) ▪ Elements of FP counseling & post-partum FP counseling Participant's practice : (60 mins) ▪ Role play Post knowledge assessment: (15 mins). Review of the day's activities and reading assignment.
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator	

WEEK 6: DAY 1 & 2: INTRODUCTION TO STI, HIV AND PPTCT OF HIV

WEEK 6 / DAY 1	WEEK 6 /DAY 2
Morning : 9 am – 1 pm	
Agenda Warm-up Course overview : (30 mins) ▪ Goals and objectives. ▪ Pre knowledge assessment. Group activity : (15 mins) ▪ Facts about HIV. Illustrated lecture / Discussion : (1 hr 15 mins) ▪ Magnitude of HIV ▪ What are HIV & AIDS? ▪ HIV transmission. ▪ HIV testing and diagnosis. ▪ HIV disease progression and clinical staging. Group activity : (30 mins) ▪ Case scenarios ▪ Role play Brainstorming: (15 mins) ▪ Role of the ANM in care of patient with HIV Presentation / Discussion : (45 mins) ▪ Role of ANM in addressing psychological issues. ▪ Role in patient education and referral. Illustrated lecture : (30 mins) ▪ Introduction to STIs. ▪ Link between STI & HIV. ▪ Common STIs.	Agenda Warm-up Interactive presentation : (30 mins) ▪ Parent to child transmission of HIV. Small group activity: (30 mins) ▪ PTCTC strategies. Illustrated lecture / discussion : (45 mins) ▪ Primary prevention. ▪ Secondary PPTCT strategies: during pregnancy, labour and delivery. Illustrated lecture /discussion : (45 mins) ▪ Secondary PPTCT strategies: during postnatal period and infancy. Group activity : (60 mins) ▪ ANMs role in PTCTC. Discussion : (20 mins) Key points on PPTCT
LUNCH	

Afternoon : 2-5pm	
Energizer. Illustrated lecture: (60 mins) ▪ Syndromic case management Group activity: (30 mins) ▪ Syndromic case management Illustrated lecture: (40 mins) ▪ Standard precautions and hand hygiene. ▪ Standard precautions : blood borne pathogens. Group activity: (10 mins) ▪ Standard precautions : blood borne pathogens. Illustrated lecture / Discussion: (25 mins) ▪ Post exposure prophylaxis for HIV. Review of the day's activities and reading assignment: (15 mins)	Energizer. Interactive presentation: (15 mins) ▪ Elements of counseling in HIV. Discussion: (60 mins) ▪ Pre and post test counseling. ▪ Ongoing counseling. Role play and discussion: (60 mins) ▪ Counseling. Brainstorming: (15 mins) ▪ Challenges in caring for mothers with HIV. Post assessment of knowledge: (15 mins) Review of the day's activities and reading assignment: (15 mins)
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator	

WEEK 6: DAY 3 & 4: INTRODUCTION TO PERFORMANCE STANDARDS AND THEIR IMPLEMENTATION

WEEK 6/DAY 3	WEEK 6/DAY 4
Morning 9 am-1pm	
Agenda Warm-up Illustrated lecture: (45 mins) ▪ Introduction to SBMR ▪ Steps in the SBMR process. ▪ Overview of the use of standards in Nodal Centers and ANMTCs Large group activity: (15 mins) ▪ Identifications of elements in the change process Illustrated lecture: (30 mins) ▪ Change management Small group activity: (60 mins) ▪ Develop vision for each ANMTC Presentation: (45 mins) ▪ Setting the standards ▪ Qualities of performance standards. Small group activity: (45 mins) ▪ Tool review	Agenda Warm-up Illustrated lecture: (20 mins) ▪ Feedback ▪ Preparation of operational plan. Small group activity: (60 mins) ▪ Conducting feedback meetings. Illustrated lecture: (45 mins) ▪ Roles of key implementing teams. Illustrated lecture: (45 mins) ▪ Different methods for conducting a detailed cause analysis. Group activity: (45 mins) ▪ Application of the methods of cause analysis. Illustrated lecture: (45 mins) ▪ Selection of interventions. Small group activity: (25 mins) ▪ Exercise on selection of interventions.
LUNCH	

Afternoon : 2-5pm	
Energizer. **Illustrated lecture: (20 mins)** ▪ Implementing the standards. ▪ Baseline assessment. **Small group activity: (60 mins)** ▪ Implementing standards. **Discussion: (20 mins)** ▪ Feedback of the small group activity ▪ Challenges in implementing the standards. **Illustrated lecture: (20 mins)** ▪ Implementing the standards – scoring of performance standards. **Small group activity: (40 mins)** ▪ Scoring of performance standards. **Review of the day's activities and reading assignment. (10 mins)**	**Energizer.** **Illustrated lecture: (30 mins)** ▪ Team building ▪ Operational strategy and planning. **Small group activity: (45 mins)** ▪ Expanding the SBMR teams. **Presentation and discussion: (60 mins)** ▪ Measuring progress ▪ Networking and benchmarking **Presentation and discussion: (30 mins)** ▪ Recognize and Reward Achievements **Review of the day's activities and Topic allotment for teaching skills evaluation. (15 mins)**
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator	

WEEK 6: DAY 5 & 6 : ANM CURRICULUM REVIEW AND EVALUATION OF THE TRAINING SKILLS

WEEK 6/DAY 5	WEEK 6/DAY 6
Morning 9 am-1pm	
Agenda Warm-up Illustrated lecture: (30 mins) Resource mobilization. Win-win strategy. Presentation and discussion: (30 mins) Promotion and Agreement Orienting Administration and Co-workers Group activity and discussion: (30 mins) Plan for baseline assessment and next steps Computer Lab Activity: (90 mins) Identify strategies for teaching students the use of evidence-based medicine in life-long learning Group activity: (60 mins) Review of ANM curriculum and incorporation of the teaching aids into it.	Agenda Warm-up Evaluation of the teaching skills of the participants (2 hrs) Post course knowledge assessment: (30 mins) Review individual progress with the trainer: (1 hr 30 mins)
LUNCH	
Afternoon : 2-5pm	
Energizer. Evaluation of the teaching skills of the participants (3 hrs) Review of the day's activities	Action planning: (1 hr) Closing and distribution of certificates: (1 hr).
Computer Practice: Participants to practice MS word, Powerpoint, Exel and internet surfing on structured exercises under guidance of facilitator	

COURSE OUTLINE

The course outline presented here is a model plan of the training to be delivered. It presents enabling objectives needed to accomplish the participant learning objectives described in the course syllabus. For each enabling objective, there are suggestions regarding appropriate learning activities and needed resources and materials. The trainer may develop other practice activities and prepare case studies, role plays or other learning situations that are specific to the country or group of participants.

The course outline is divided into four columns:

- **Time:** This section of the outline indicates the approximate amount of time to be devoted to each learning activity.
- **Objectives/Activities:** This column lists the enabling objectives and learning activities. Because the objectives outline the sequence of training, the objectives are presented here in order. The combination of the objectives and activities (introductory activities, small-group exercises, clinical practice, breaks, etc.) outlines the **flow** of training.
- **Training/Learning Methods:** This column describes the various methods, activities, and strategies to be used to deliver the content and skills related to each enabling objective.
- **Resources/Materials:** The fourth column in the course outline lists the resources and materials needed to support the learning activities.

Note that the course outline is based on the course schedule. As such, changes or modifications to the course schedule should be reflected in this course outline.

ANM FACULTY TRAINING - INTRODUCTION			
TIME	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 1: Week 1 : Day 1, Morning			
15 mins	**Activity:** Welcome participants. Introduction of the participants. Participant's expectation from the training. Formulation of ground rules	Open course with a welcome by organizers and lead trainers, Facilitate the introductions of all participants and trainers. Have participants divide into pairs, interview and then introduce each other by name, position and any unique characteristics. Explore participants' expectations for the course. Ask participants to share their expectations of the course and write their responses on a flipchart. Attach the flipchart page to the wall for reference throughout the course. In the next session on review of the course objectives, address which expectations can be met and which cannot be met. Discuss and agree on the ground rules for the course. Identify a manager and coordinator for the week.	Flip charts or cards , markers and double sided sticky tapes Prepared flip chart with roles and responsibilities of manager and coordinator
60 mins	**Activity:** Goal and objectives of the training workshop. Review of course schedule, content and training approach. Distribution and review of training package.	Present the goal of the course and the participant learning objectives. Review the plan and inform the participants that they will be expected to o sign up and take turns facilitating different learning activities. Explain that the purposeof this is for them to be able to usethe teaching methods and materials in e teaching ANM students during the Midwifery course. Review the course schedule, including starting and ending times and times for breaks and lunch. Distribute and review the materials to be used in the course and ensure that participants understand the use of the different materials.	Flipchart with Course Objectives Copies of course schedule, one for each participant from Facilitator's Guide (FG). Full set of the training package:fore distributioned tor the participants
45 mins	**Activity:** Assess participant's pre course knowledge.	Distribute the Pre course Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished.	Copies of Precourse Knowledge Assessment Sheets one for each participant

	Complete the clinical experience questionnaire	Allow 30 mins for the Pre course Knowledge Assessment. Allow 10 mins for the clinical experience questionnaire. Immediately review the correct responses—do not spend a long amount of time on any questions, but assure the participants that the material will be covered during the course. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers. Use the papers to prepare the Group and Individual Knowledge Matrix and then return the papers.	Copy of the clinical experience questionnaire Copy of Group and Individual Knowledge Matrix
60 mins	**Presentation / Discussion:** Maternal health scenario in India. MMR status in India.	Show the videotape to illustrate the maternal health in India. Discuss the concepts of safe motherhood, and the factors affecting maternal mortality in India. Ask questions of the participants and engage them in the presentation of the information.	Video on Maternal health in India.
20 mins	**Brainstorming:** Importance of strengthening ANMs capacity for improving maternal and child health	Ask the participants to share their views on 'why it is important to strengthen the capacity of the ANMs for improving maternal and child health?' Write their responses on a flip chart without discussion or qualification. Refer to this list and then accept the relevant points and discuss on them.	Flip chart and markers
40 mins	**Illustrated Lecture:** Key interventions and govt. schemes for improving maternal health Overview of the MCHIP program and its focus on supporting ANM faculty	Use the presentation to elaborate on the key interventions and current government schemes particularly for MNCH/FP. Emphasize on the GoI SBA initiative. Use presentation to provide an overview of the MCHIP, its objective and its focus on supporting the ANM faculty through training.	Presentation on GoI SBA initiative. Presentation on MCHIP – program overview.

ANM FACULTY TRAINING			
TIME	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 2: Week 1: Day 1, Afternoon			
60 mins	**Illustrated lecture:** ▪ Professional ethics and midwifery ▪ Review of the ICM code of ethics	Use the presentation on professional ethics and discuss on abiding to the ethics while practicing midwifery. Present the ICM code of ethics and discuss it in relation to the scenario in India	Presentations on Professional ethics and ICM code of ethics.
30 mins	**Brainstorming:** Roles and responsibilities of ANMs.	Brainstorm on "roles and responsibilities of the ANMs". Write their responses on a flip chart without discussion or qualification. Refer to this list and then accept the relevant points and discuss on them.	Flip chart and markers
15 mins	**Interactive presentation:** ANM Professional responsibility and accountability.	Use the presentation on ANM professional responsibility and accountability and discuss with examples from the participants	Presentation on ANM professional responsibility and accountability
60 mins	**Activity: Role play and Discussion** ▪ ANM in the community ▪ Partnership with TBAs	Identify 6 volunteers and group them in pairs. Give each group a role play and give them 10 mins to prepare.. Ask the groups to enact their role plays one after the other and discuss on the various roles of the ANM in the community.	Role play scenario from the participants handbook.
15 mins	**Activity:** ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day.facilitate the manager/coordinator for conducting or having conduct the recap, agenda and a warm up activity for the next day.. Give participants the reading assignment for the next day	ETS reference manual – Pg. 1-1 to 2-11 (module 1 and 2)

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
TIME	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 3: Week 1: Day 2, Morning			
15 mins	Recap Agenda and Warm-up	Recap of the previous days activities to be done by the participants Have the participants share and review the agenda and conduct the warm up.	Flip chart with agenda of the day
30 mins	Illustrated lecture : ▪ Foundations of pre service education: Guiding principles of educating the health care providers. ▪ Core competencies and their role in curriculum development and design ▪ Effective approaches to teaching and learning	Use the presentation in ETS Module 1 and discuss with examples from the participants.	Effective Teaching Module 1, Foundations of Pre-service Education power point presentation.
60 mins	Brain storming : ▪ Analysis of core competency in the ANM program ▪ Compare with ICM core competencies.	▪ Prepare 5–10 flip charts with labeled competency areas around the room ▪ Lead the large group in a brainstorming activity aimed at identifying the core competencies that ANM students as they graduate need to achieve in order to be safe, beginning-level providers. You can also use identified core competencies that relate to the technical content if they exist.	Foundations of Education Activity, Flip charts with labeled core competency areas Post its

		▪ If existing core competencies are available, i.e., ICM core competencies for midwifery, attempt to reconcile it with the results of the brainstorming session. ▪ Label the flip charts with the consensus list of target competencies. ▪ Give each learner 10 small Post-it notes, instructing them to place them on the competencies that they believe require the greatest attention in the curriculum. (Note that they can distribute their notes equally between competencies or place all ten on one competency.) Allow about 20 minutes for this. Discuss the distribution of the notes while counting and removing the flip chart paper; write the number of votes for each competency on the flip chart with a marker. ▪ Which competencies deserve the most attention? ▪ Why? Because of their complexity, difficulty to learn, distribution of knowledge, skills and attitudes. ▪ Ask learners to move to the flip charts and using markers, write as many courses in their curriculum that they believe address each competency. (Note that some courses may address many competencies.) ▪ Discuss the findings. ▪ Which courses address which competencies? ▪ How effective is the current distribution of courses? What suggestions does the group have for improvement?	
30 mins	**Interactive presentation :** ▪ Developing learning objectives	Review Module 2 PowerPoint presentation. Identify the knowledge, skills and attitudes to be learned in your course and write course objectives and supporting objectives.	Effective Teaching Module 2, Powerpointpresentation on'Learning Objectives"
45 mins	**Small Group Activity:** ▪ Critique of learning objectives	▪ Divide participants into small groups ▪ Provide each group with sample objectives and ask them to critique and improve the objectives ▪ Each group has 30 minutes to work Each group has 5-minutes to report out and read the objective as it was, and their improvements	**ANM Curriculum** **Blank flip chart, markers**
60 Mins	**Writing learning Objevtives**	▪ Divide participants into small groups ▪ Assign each group a course from another area of the curricula and ask	**ANM Curriculum** **Blank Flip charts , Markers**

		partcipantsto write the course objectives and supporting objectives ▪ Give each group 30 min minutes to work ▪ Each group has 10 minutes to report and read the objective as it was, and their improvements (if possible, copy their objectives so each group can see a hard copy during their review)	

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
TIME	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 4: Week 1 : Day 2, Afternoon			
45 mins	Energizer Discussion: ▪ Review of the key points in develop Objectives for Learning	Summary/Reinforce key points: ▪ Note how objectives will determine activities-point out objectives that will only get to 'recall', versus those that will help learners 'apply' or 'analyze' information ▪ Note how objectives will determine if assessment is done via direct observation, via questions, or in simulation vs. with a client Based on the objectives, point out how many skills will need to be observed and assessed using direct observation	
60mins	Basic Computer Skills Training	Participants will visit Computer Lab of the institution and will get familiar with the General Hardware /components and operations of the Computer/Printer and LCD Projector	Computer System Overview Ppt. Computer Manual Equipped Computer Lab
60 mins	Demonstration and Practice of Basic computer hardwars and components	▪ Demonstrate the various hardware components of the computer, printer and LCD projectorAllow partcipants to practice operating the computer, printer and LCD projector	
15 mins	Activity: ▪ Review of the day's activities. Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	ETS reference manual – Pg. 3-1 to 5-17 (module 3, 4 and 5)

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
TIME	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 5: Week 1 : Day 3, Morning			
15 mins	Recap Agenda and Warm-up	Recap of the previous days activities to be done by the participants Review of the agenda with participants, as outlinedon the flipchart. Have the participant(s) who volunteered for the opening activity or warm up conduct it.	Agenda week 1 day 3 on a flip chart prepared by the participants
45 mins	Illustrated Lecture: ▪ Plan for teaching – session planning	Use the presentation on session planning and discuss on making plans for teaching	Effective Teaching Module 3, Plan for Teaching Presentation Graphics
60 mins	Small Group Activity: ▪ Prepare a session plan for the assigned topic	Give each participant a sample session plan, or refer them to the one in their participant handbook. Each participant has 30 minutes to prepare a session plan for one of the participant assignments in this course. The purpose of this activity is to practice preparing session plans and receive feedback. Ask participants to share their session plans and discuss how they can be improved, alternatively, collect and provide general feedback on common things done well and things that need improvement the following day.	ANM Faculty Training Participant's Handbook: Sample Session Plan
30 mins	Interactive presentation: ▪ Prepare for teaching.	Use the presentation on preparation for teaching and discuss	Prepare for Teaching PPT
90 mins	Small Group Activity : ▪ Preparation for teaching	Activity: Refer to the Module Four 'Prepare for Teaching' Activity in the facilitators guide	ANMTC Facilitators guide: Module 4 activity

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 6: Week 1 : Day 3, Afternoon			
15 mins	**Brainstorming and Discussion:** ▪ Preparation of Audio-visual aids.	Brainstorm on what are the key tips for developing effective visual aids and list on a flip chart. Ensure the key tips for developing visual aids are all addressed.	Flip charts and markers
45 mins	**Small group activity :** ▪ Preparation of Audio-visual aids	Divide participants into small groups-ask each group to select an objective from the midwifery course, and design an audiovisual aid (flipchart, ppt slide) they may use when teaching their students. Ask them to refer to the manual for tips. Give them30 minutes to work, then discuss in a plenary.	
15 mins	**Assign topics for presentation for the following day**	Review the Instructions for Facilitation. Note that tomorrow they will be practicing and getting feedback in small groups. However, starting the following day, they will be taking turns facilitating different sessions individually and receiving feedback on their performance. Remind of the importance of preparing questions to ask to help ensure learners master the information. Each should prepare a session plan to hand in for feedback.	Assigning Presentations and Demonstrations Instructions for Facilitation Session plan sample
30 mins	**Individual Activity:** ▪ Preparation of session plans	Participants are assigned or select a presentation or demonstration (at random) fornext days small group work. Each participant should prepare a session plan for their activity, and can use the Guidelines and other reference materials as needed. The trainers should circulate and provide feedback into session plans. Key Point: Participants should be sure to plan for questions they can ask to check understanding.	Instructions for Facilitation Session plan sample Participant assignment sign-up Sheet, Facilitator's Guide Reference materials
60 Mins	**Understanding Computers** Operational System, Application/email/Internet browsing and Internet search Engine	Use the presentation to make participant understand the various Operational Systems, Applications mail/Internet browsing and Internet search Engine Later demonstrate and practice of ''how to use internet and how to open an email account.''	Computer Operation Overview – Operating System Ppt. Internet connectivity
15 mins	**Activity:** ▪ Review of the day's activities.	Involve participants in review and discussion of the topics and activities covered during the day. The manager asks a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the	ETS reference manual – Pg. 6-1 to 7-26.(module 6 and 7)

	▪ Reading Assignment	opening session and ask one or more of the other participants to plan an opening activity or warm-up for the next day .Inform the participants the topic and pages for reading and the resource material	

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 7: Week 1: Day 4, Morning			
15 mins	**Agenda** **Agenda and Warm-up**	Recap of the previous day to be done by the participants Review of the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warm up conduct it.	Agenda week 1 day 4 prepared by the Participant
45 mins	**Illustrated Lecture:** ▪ Facilitation skills for a range of learning activities.	Use the presentation on facilitation skills and discuss the skills used for a range of learning activities.	Effective Teaching, Module 6, Prepare and Deliver Interactive Presentations
30 mins	**Small Group Activity:** ▪ Review of effective facilitation skills and demonstration skills checklist	**Discussion:** Review the Effective Facilitation Skills and Demonstration Skills Checklists. Remind them that this checklist will guide them as they practice demonstrating facilitation, whether they are facilitating a presentation, group activity or doing a demonstration. The same skills apply.	Facilitation Skills Checklist, Demonstration skills Checklist
150 min	**Small group activity / Demonstration:** ▪ Facilitation skills for a range of learning activities	Divide the participants into two or three small groups, depending on the number of participants.. Each group should nott be larger than about 8 individuals. Each group should have a facilitator. Each participant will have 10 minutes to present information and include the use of questions, discussion, case study or brainstorming, as well as use audiovisual aids appropriately Peer to peer and trainer feedback after each presentation Each learner will demonstrate their effective facilitation skills for their small group—with one facilitator assigned to each group. Use the checklists to and instructions for feedback to guide feedback provision. Remind the learners you will discuss this activity in plenary the following morning.	Two training rooms, two projection units, two power supply, etc. Facilitation Skills Checklist Instructions for Presentations, Demonstrations and Feedback

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 8: Week 1: Day 4, Afternoon			
60 mins	Small Group Activity: ▪ Practice facilitation skills	Continue the practice of facilitation skills.	
45 mins	Discussion : ▪ Analysis of the performance during facilitation.	Debrief about effective facilitation skills demonstrated. Identify common areas of strength and common areas that require improvement. In the plenary, ask each group to share common areas that were well-done and common areas that need improvement. Refer back to the key presentation skills needed.	
60 Mins	Introduction :Microsoft Office –Word, Excel and PowerPoint Processing and features of the Microsoft Word.	Use of presentation for the introduction of the Microsoft office and their components Word, Excel and Power point. Demonstrate and practice of processing and feature of Microsoft word Exercise and examples.	Computer operation overview-Microsoft Word Handout of exercise
15 mins	Activity: ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	ETS reference manual – Pg. 8-1 to 9-22 (module 8 and 9)

Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 9: Week 1: Day 5, Morning			
15 mins	Recap Agenda and Warm-up	Recap of the previous day to be done by the participants Review of the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warm up conduct it.	Agenda week 1 day 5 prepared by the Participant
60 mins	Illustrated Lecture: ▪ Helping students develop competency in new knowledge and skills.	Review the presentation graphics from Effective Teaching, Module 8. Highlight the importance of their roles in helping students learn to make clinical decisions-not just recall information.	Effective Teaching Manual, Module 8 Facilitate the Development of Healthcare Delivery Skills, ppt presentation
60 mins	Small group activity : ▪ Develop group learning activities and critique them.	Divide the group into threes. Assign each group a case study, role play or clinical simulation. The learners can use exercises 7-1, 7-2 and 7-3 to help guide their development. They will develop one to meet one of their existing learning objectives. Each group has 30 minutes to work. In plenary, randomly select one case study, one role play and one clinical simulation and present it to the large group. No need to demonstrate, just read it. (Collect the others and provide written feedback for them the next day—you won't have time to review each one in plenary). As a group, will provide feedback on each one based on these criteria: Does it meet the learning objective? Are the instructions clear enough? How might it be improved? Remind the group they will be facilitating these throughout the course and will receive feedback on their performance at that time.	Exercise 7-1, 7-2, and 7-3 in ANM Faculty Participant Handbook
30 mins	Discussion: ▪ Use of clinical simulations in teaching clinical decision making skills.	Discussion: Use the Teaching Clinical Decision Making skills handout in the ANM Faculty Training Participant Handbook. Small group activity: Ask four individuals to volunteer to demonstrate how they might 'teach' each step of clinical decision making using the job aid included in the handout. Each demonstration should be under 5 minutes.	ANM Faculty Training Participant Handbook: Teaching Clinical Decision Making Skills Handout
30 mins	Demonstration: ▪ Use of clinical simulations in	Trainer demonstration: Use a clinical simulation (vaginal bleeding in early pregnancy) to help develop clinical decision making skills	ANM Faculty Training Participant handbook: Clinical simulations Case Study 4, Trainer's Guide for

	teaching clinical decision making skills.		Conducting Training of ANMs/LHVs/staff nurses as SBA's June 2010 GOI, p. 71
45 mins	**Discussion:** ▪ Teaching clinical decision making	Review the table in the 'Teaching Clinical Decision Making" in the Participant handbook. Reviewing the objectives in the ANM curriculum midwifery course, which objectives require the use of clinical decisions? What strategies can they apply to teach clinical decision making to their students?	Teaching Clinical Decision Making handout in ANM faculty training participant handbook

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 10: Week 1 : Day 5, Afternoon			
60 mins	**Small group activity:** ▪ Demonstrate effective demonstration and coaching skills.	Remind learners the purpose of this activity is to demonstrate their demonstration and coaching skills, not their technical skills. They will be acting as teachers demonstrating for their students, using the SBA materials. Demonstration and Coaching Skills: ▪ Break into groups of 5–7 participants each. ▪ Each participant will perform about 5 minutes of a 'demonstration' of a clinical skill to demonstrate their demonstration or coaching skills. ▪ Peer-to-peer and trainer feedback after each performance. Assign these skills: newborn resuscitation, AMTSL, sterile gloving, clinical simulation of managing preeclampsia	Instructions for Presentation and Demonstration Handout in Learner's Guide Demonstration and Coaching Skills Checklists Clinical skill checklists from SBA: Related anatomic models and IP equipment
15 mins	**Discussion :** ▪ Observation during demonstration of a clinical skill	Bring the large group together again. A representative from each group should spend a few minutes sharing some of the common things done well and common suggestions for improvement. The trainer should facilitate the discussion. Ask the group how they can incorporate demonstration and coaching in their teaching.	
15 mins	**Brainstorming :** ▪ Making clinical practice successful.	Brainstorm tips for making clinical practice successful.	Flip chart and markers
45 mins	**Interactive presentation:** ▪ Managing clinical practice	Trainer Presentation: Manage Clinical Practice Discussion: Review the Module 9 job aid in the Effective Teaching Manual and discuss what type of communication tools they use with clinical preceptors. What could they use?	Effective Teaching: Managing Clinical Practice, presentation graphics Effective Teaching Reference Manual
30 Mins	**Introduction to Microsoft Spread Sheet.**	**Use of presentation for the introduction of the Microsoft Excel Spread sheet.** **Demonstrate and practice of processing and feature of Microsoft Excel exercise and examples.**	Computer operation overview-Microsoft Excel Handout of exercise
15 mins	**Activity:** ▪ Review of the day's	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda	ETS reference manual – Pg. 10-1 to 12-16 (module 10, 11 and 12)

	activities. ▪ Reading Assignment	for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	
ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 11: Week 1 : Day 6, Morning			
15 mins	Recap Agenda and Warm-up	Recap of the previous day to be done by the participants Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the opening activity or warm up conduct it.	Agenda week 1 day 6 prepared by the Participant
60 mins	Small group activity : ▪ Clinical practice tools	Divide the group by cadre or school. Each group should review key tools currently in use for communication in clinical practice (logbooks, preceptor information forms or guides, etc.) and the samples included in Effective Teaching, Module 9. Each group also reviews the GoI Facilitator's Guide and Participant Handbook and discuss if any of those tools can be used in AMNTC teaching. Each should identify changes they want to make to existing tools or draft new tools (for example: develop a student feedback form or a preceptor orientation form for use in clinical). Each group has 45 minutes to work, then 5 minutes to report out.	ANM Faculty Training Participant Handbook Effective Teaching Manual, Module 9
60 mins	Interactive presentation: ▪ Developing knowledge assessments.	Use the power point on developing knowledge assessments and brief the key points. Use the Principles of Assessment Game to reinforce key points.	Effective Teaching: Prepare and Use Knowledge Assessments, presentation graphics Trainer Presentation: Create Knowledge Assessments Effective Teaching Reference Manual ANM Faculty Training: Facilitator's Guide, Principles of Assessment Game

90 mins	**Small group activity :** ▪ Develop knowledge assessments	▪ Each participant should select one presentation or topic from the curriculum. ▪ Each participant will write three to five multiple-choice questions, with 3-item choices for answering. Ask the participants to try to write questions that assess analysis or application, not only recall. (The evidence supports 3-item questions as more than 3 usually include poorly crafted distracters. We are promoting the use of 3-item, but if that is too controversial, leave it at 4). ▪ Questions should be written or typed. Each person has 45 minutes to work	Trainer's Guide for Conducting Training of ANMs/LHVs/staff nurses as SBA's June 2010 GOI : Annexure G: Pre/Post Test Questionnaire, P. 22-27 , Annexure E: Identification and Management of Complications (Knowledge-based) p. 20
15 mins	**Large group activity:** ▪ Analysis of the small group activity.	Collect all the questions, in plenary, randomly select and review and critique (anonymously) about 10–15 questions. For each question-ask if it is assessing recall or application or analysis. If only assessing recall-how could it be revised to assess analysis or application?	

ANM FACULTY TRAINING - EFFECTIVE TEACHING SKILLS			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 12: Week 1: Day 6, Afternoon			
45 mins	**Discussion:** ▪ Prepare and use skills assessment	Review the GoI participant handbook-discuss how those checklists can be integrated into teaching the midwifery curriculum. Review the presentation on OSCE. Discuss key points with the group about how to integrate OSCE into teaching ANM students: 1. What type of objective clinical exam is currently in use? 2. What modifications or steps would they need to take to use this OSCE in their teaching?	OSCE presentation

15 mins	**Discussion:** ▪ Summary of effective teaching skills. ▪ Participants sign up for teaching assignments	Discuss all the key points in effective teaching skills. Ask the participants in rotation to summarize the points and note it on a flip chart. Paste the chart in the wall to be placed throughout the course. Review the section of the syllabus that talks about the ANM faculty co-facilitating most of the course. Review the list of sessions, asking each participant to sign up for at least one learning activity and one demonstration or clinical simulation. Refer them to the teaching skills checklists and the materials needed for teaching in the SBA Facilitator's guide. During the course they will have the opportunity to receive feedback on their teaching skills and get standardized in the latest GoI updates. Throughout the course the group will discuss how to integrate materials and approaches into teaching ANM students to improve their exposure to clinical practice and clinical decision-making.	Flip chart and markers. List of sessions to be taught or facilitated by participants MCHIP Facilitator's Guide: Teaching Skills MCHIP Checklists: Facilitation Skills, Demonstration Skills and Coaching Skills
45 mins	**Motivation**	Introduce the topic using the Story of frog (ppt available) Later use an interactive presentation to explain the importance and types of motivation.	Power point presentation : Motivation Story of frog ppt.
60 Mins	**Introduction to Microsoft Power Point.**	**Use of presentation for the introduction of the Microsoft Power Point.** **Demonstrate and practice of processing and feature of Microsoft Power Point using exercise and examples.**	Computer operation overview-Microsoft Power point Handout of exercise
15 mins	**Activity:** ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	GoI SBA guidelines Pg. 94 -103. Prevention of infection.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 13: Week 2 : Day 1, Morning			
15 mins	Recap **Agenda and Warm-up**	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
30 mins	**Activity:** Goal and objectives of the SBA training package. Assess participant's pre course knowledge. Experience record of the trainees prior to the SBA training.	Discuss the goals of the SBA training package and the participant learning objectives. Distribute the Pre course Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished. Allow 10 minutes for the Pre course Knowledge Assessment. Immediately review the correct responses. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers. Ask the participants to fill in the experience record prior to the SBA training in the GoI SBA handbook.	Flipchart with Course Objectives Copies of Pre course Knowledge Assessment Sheets one for each participant. GoI SBA handbook page 100 – Experience record of trainees prior to SBA training.
30 mins	**Illustrated lecture:** Objective Structured Clinical Examination	Use the presentation on 'Objective Structured Clinical Examination' and brief on the advantages of using OSCE as a clinical evaluation tool.	Presentation on OSCE.
2 hrs 45 mins	**Activity:** Pre course evaluation of skills using Objective Structured Clinical Examination.	Set up 6 stations for the SBA OSCE with guidance from the Facilitators' guide. Demonstrate an example of the exercise. Ask each participant to move around the stations and complete their pre course evaluation of skills.	OSCE in facilitators guide. Skills lab set up as per the stations. Answer sheets for each participant.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 14: Week 2: Day 1, Afternoon			
40 mins	**Illustrated lecture:** ▪ Infection prevention	Use presentation session 1b from SBA package – Infection prevention practices.	Presentation session 1b from SBA package
45 mins	**Skill Demonstration:** ▪ Hand washing, Decontamination and high – level disinfection. ▪ Processing of Instruments.	Set up the skills demonstration unit. Demonstrate the skills using the GoI Skills checklist 5.1 and 5.2	GoI SBA Trainers Guide - Pg. 50. Materials and supplies as per the GoI checklist 5.a and 5.b. GoI handbook for ANMs - Pg. 87-91
20 mins	**Simulation exercise** : ▪ Segregation of hospital waste	Mix various types of wastes from hospital (in simulation) such as cotton, needles, syringes, blood-stained gauze and cotton, cigars and fruit peels. Give the trainees three colour-coded bins (blue, red, yellow). Ask the trainees to separate the waste into infected and non-infected waste.	GoI SBA Trainers Guide - Pg. 51. Hospital wastes and colour coded bins
1 hr	**Small Group Activity:** ▪ Skills practice on infection prevention procedures.	Set up 3 stations and ask the trainees to perform and practice skills on infection prevention in simulation	Materials and supplies as per the GoI checklist 5.a and 5.b. GoI handbook for ANMs- Pg. 87-91
15 mins	**Review of day's activities and reading assignment.**	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	GoI SBA guidelines Pg. 7-23. Antenatal care.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 15: Week 2: Day 2, Morning			
15 mins	Agenda and Warm-up	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
30 mins	Illustrated lecture / Discussion: ▪ Importance of Antenatal Care and preparation for ANC	Use presentation 2a from the SBA package and discuss on the importance of ANC, quality parameters during ANC and preparation for Antenatal checkup	Presentation session 2a from SBA package GoI SBA Trainers Guide - Pg. 53
15 mins	Small Group Activity : ▪ Estimation of the number of pregnancies' and deliveries annually.	Divide the participants into two groups and then read the exercise in 2.a.2 to each group. Ask each group to solve the exercise on 'calculation of expected number of pregnant women in a given area'. Discuss the findings of the exercise and the method of estimation.	GoI SBA Trainers Guide - Pg. 53 Flip chart and markers
15 mins	Demonstration: ▪ Detection of pregnancy.	Show the pregnancy detection kit. Demonstrate the detection of pregnancy using the kit and urine samples of pregnant and non-pregnant women. Use checklist 1.4 of SBA handbook	GoI SBA Trainers Guide - Pg. 55. Pregnancy testing kits and urine samples GoI handbook for ANMs- Pg. 24
15 mins	Individual Activity : ▪ Tracking of pregnant women and Maternal and child protection card.	Explain about the Government of India's tracking system and the relevant registers used for it. Ask the participants to fill – up the Maternal and child protection card (annexure 6) using any pregnant woman in their area that they can recall.	GoI SBA Trainers Guide - Pg. 55. GoI handbook for ANMs- Annexure 6 and 7
45 mins	Interactive presentation : ▪ ANC – History taking	Use the presentation 2.b from the SBA package and discuss on History taking for an Antenatal woman. Follow the steps 1-4 from Session II. b in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 56-57. Presentation 2.b Flip chart and markers
15 mins	Exercise : ▪ Calculation of EDD	Read the exercise in box 2.b.1. Ask the participants to calculate the EDD. Congratulate the participants who have got the answer right.	GoI SBA Trainers Guide - Pg. 57.
30 mins	Skill Demonstration : ▪ ANC – General examination	Set up a skills demonstration station for Antenatal general examination. Use the GoI skills checklist 1.2 and demonstrate general examination for the Antenatal mother.	GoI SBA Trainers Guide - Pg. 58. GoI handbook for ANMs- Pg. 18-20 – Checklist 1.2
1 hr	Simulation exercise: ANC – general examination – skills practice.	Set up 3 skills stations. Divide the participants into three groups and allow them to practice ANC general examination using the Use the GoI skills checklist 1.2	GoI handbook for ANMs- Pg. 18-20 – Checklist 1.2

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 16 : Week 2 : Day 2, Afternoon			
30 mins	**Skill Demonstration :** ▪ ANC – abdominal examination.	Set up a skills demonstration station for abdominal examination of antenatal mother. Use the GoI skills checklist 1.3 and demonstrate abdominal examination for the Antenatal mother. Use presentation 2.d to emphasize the importance of the abdominal examination	GoI SBA Trainers Guide - Pg. 59-60. GoI handbook for ANMs - Pg. 21-23 – Checklist 1.3
1 hr	**Simulation exercise :** ▪ ANC – abdominal examination	Set up 3 skills stations. Divide the participants into three groups and allow them to practice Antenatal abdominal examination using the GoI skills checklist 1.3	GoI handbook for ANMs - Pg. 21-23 – Checklist 1.3
15 mins	**Brainstorming:** Laboratory investigations for the Antenatal mother.	Brainstorm on "what are some of the investigations to be done for an antenatal mother". Write their responses on a flip chart without discussion or qualification. Use presentation 3.a from the SBA package to explain the importance of each investigation	Flip chart and markers. Presentation 3.a GoI SBA Trainers Guide - Pg. 62
15 mins	**Demonstration:** ▪ ANC – Laboratory investigations	Set up a skills demonstration station for laboratory investigations. Use the GoI skills checklist 1.4 and demonstrate the procedure of urine testing for sugar and proteins and blood test for hemoglobin for the Antenatal mother.	GoI SBA Trainers Guide - Pg. 62 GoI handbook for ANMs- Pg. 24-27 – Checklist 1.4
45 mins	**Skills practice session:** ▪ ANC – Laboratory investigations	Set up 3 skills stations. Divide the participants into three groups and allow them to practice Antenatal laboratory investigations using the GoI skills checklist 1.4	GoI handbook for ANMs- Pg. 24-27 – Checklist 1.4
15 mins	**Review of day's activities and reading assignment.**	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	GoI SBA guidelines Pg. 23- 46. Antenatal care and first stage of labour.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 17: Week 2: Day 3, Morning			
15 mins	Recap **Agenda and Warm-up**	Recap of week 2 day 2 to be done by the participants Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart to be prepared by the participants
45 mins	**Interactive presentation/ Discussion:** ▪ ANC – interventions	Use the presentation 3.b from the SBA package and discuss on ANC interventions including importance of IFA supplements, TT injections, malaria prophylaxis and their dosage. Follow the steps 1-2from Session III.b in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 63 Presentation 3.b Flip chart and markers
30 mins	**Interactive presentation/ Discussion**: ▪ ANC counseling	Use the presentation 3.c (i) from the SBA package and discuss on ANC counseling including micro birth planning. Follow the steps 1 from Session III.c in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 64 Presentation 3.c (i)
45 mins	**Discussion:** ▪ Symptoms and signs during pregnancy ▪ Referral to PHC or FRU	Ask the usual complaints of the pregnant woman and note down their responses on a flip chart. Discuss probable diagnosis and the actions to be taken on it. Discuss on the conditions that need referral to a PHC or FRU. Use presentation 3 c (ii) and 2b.	GoI SBA Trainers Guide - Pg. 64 Presentation 3.c (ii), 2b. Flip chart and markers SBA guidelines – Module 1-Table 2– Pg. 37-38
45 mins	**Role play:** ▪ ANC counseling and care	Use the instructions from session III.c, step 4 and facilitate role plays on antenatal counseling	GoI SBA Trainers Guide - Pg. 65-67
60 mins	**Illustrated lecture:** Care during labour – assessment and care during . labor and delivery True and false labor pains	Use the presentation 3.d from the SBA package and discuss on care of the woman during labour. Follow the steps 1-2 from Session III.d in the SBA trainers guide. Discuss on true and false pains and the stages of labour. Use the presentation 4 from the SBA package and discuss on care of the woman during labour. Follow the steps 1- 3 from Session IV in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 68, 71,72. Presentation 3.d Flip chart and markers

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 18 : Week 2 : Day 3, Afternoon			
45mins	Energiser Skill Demonstration : ▪ Assessment of woman in labor ▪ Vaginal examination during labor	Set up skills demonstration station for assessment of woman in labour and vaginal examination. Use the GoI skills checklists 2.1 and 2.2 for demonstration.	GoI SBA Trainers Guide - Pg. 68-69. GoI handbook for ANMs- Pg. 33-38 – Checklist 2.1, 2.2
45 mins	Skills practice session : ▪ Assessment of woman in labour ▪ Vaginal examination during labour	Set up 3 skills stations. Divide the participants into three groups and allow them to practice assessment of woman in labor and vaginal examination using the GoI skills checklist 2.1, 2.2.	GoI handbook for ANMs- Pg. 33-38 – Checklist 2.1, 2.2
30 mins	Interactive presentation/ Discussion: ▪ Partograph	Explain to the participants what is a partograph and its utility. Follow the steps 4 from Session IV in the SBA trainers guide. Show with examples on the enlarged partograph.	. Enlarged Partograph
45 mins	Exercise : Plotting of the partograph using case studies.	Give each participant three partographs and ask them to work on the case studies 1-3 from the GoI SBA handbook for ANMs to fill up the partographs individually.	GoI handbook for ANMs- Pg. 41-43 – Case studies 1-3. Partograph sheets.
15 mins	Review of day's activities and reading assignment.	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	GoI SBA guidelines Pg. 47-54 Second, third and fourth stage of labour, newborn care.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 19 : Week 2 : Day 4, Morning			
15 mins	Recap **Agenda and Warm-up**	Recap of the week 2 day 3 to be done by the participants Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart prepared by the participants
15 mins	**Discussion :** ▪ Second stage of labour.	Discuss on monitoring and managing the second stage of labour. Use the presentation 4 from the SBA package and discuss on care of the woman during labour. Follow the step 6 from Session IV in the SBA trainers guide	GoI SBA Trainers Guide - Pg. 80.
45 mins	**Skill Demonstration** : ▪ Management of first and second stage of labour.	Set up skills demonstration station for demonstrating the steps of normal delivery. Use the GoI skills checklists 2.4 for demonstration.	GoI SBA Trainers Guide - Pg. 80. GoI handbook for ANMs- Pg. 44-46 – Checklist 2.4
60 mins	**Skills practice session** : ▪ Management of first and second stage of labour	Set up 3 skills stations. Divide the participants into three groups and allow them to practice steps of normal delivery using the GoI skills checklist 2.4	GoI handbook for ANMs- Pg. 44-46 – Checklist 2.4
I hr 45 mins	▪ **Clinical Visit** Visit to the labor room for observation of a normal delivery.	Divide the participants into 3 groups. Orient them to the Labour room one group at a time. Depending on the availability of the cases, plan for observation of normal delivery. Review the observations made by the participants during the visit and clarify any doubts that they may have.	

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 20 : Week 2 : Day 4, Afternoon			
30 mins	**Interactive presentation**: Monitoring and 3rd and 4th stage of labour	Discuss on the steps in the management of third and fourth stage of labour. Use the presentation 5.a from the SBA package and discuss on AMTSL. Follow the steps 1- 2 from Session V.a in the SBA trainers guide	GoI SBA Trainers Guide - Pg. 83-84. Presentation V.a. Flip chart and markers
30 mins	**Skill Demonstration:** ▪ Active management of third stage of labour(AMTSL) Management during the fourth stage of labour	Set up skills demonstration station for demonstrating the steps of AMTSL. Use the GoI skills checklists 2.5 for demonstration. Set up skills demonstration station for demonstrating the management during the fourth stage of labour. Use the GoI skills checklists 2.6 for demonstration.	GoI SBA Trainers Guide - Pg. 84. GoI handbook for ANMs- Pg. 47-49 – Checklist 2.5 GoI handbook for ANMs- Pg. 50-51 – Checklist 2.6
30 mins	**Skills practice session:** ▪ AMTSLr Management during the fourth stage of labour.	Set up six skills stations – three stations for the AMTSL and three stations for management during the fourth stage of labour. Divide the participants into six groups and allow them to practice in rotation using the GoI skills checklist 2.5 and 2.6	GoI handbook for ANMs- Pg. 47-49 – Checklist 2.5 GoI handbook for ANMs- Pg. 50-51 – Checklist 2.6
30 mins	**Illustrated lecture:** New born care and resuscitation	Use the presentation 5.b from the SBA package and discuss resuscitation of the newborn. Follow the steps 1- 2 from Session V.b in the SBA trainers guide. GoI SBA Trainers Guide - Pg. 85-86. Presentation V.b. Flip chart and marken 5.c from the SBA package and discuss care after delivery. Follow the steps 1- 2 from Session V. c in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 87. Presentation V.c. Flip chart and markers
45 mins	**Skills practice session**: ▪ Care after delivery - postpartum care Care during first, second and third postpartum visits	Set up six skills stations – three stations for the resuscitation of newborn and three stations for Care after delivery - postpartum care. Divide the participants into six groups and allow them to practice in rotation using the GoI skills checklist 2.7, 3.1 and 3.2.	GoI handbook for ANMs- Pg. 52-63 – Checklist 2.7, 3.1 and 3.2
15 mins	**Review of day's activities and reading assignment.**	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	GoI SBA guidelines Pg. 47-69. Second, third and fourth stage of labour, newborn care and postpartum care.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 21: Week 2: Day 5, Morning			
15 mins	Recap Agenda and Warm-up	Recap of week 2 day 4 to be presented by the participants Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart prepared by the participant
30 mins	Illustrated lecture: NSSK-Introduction to NSSK Resuscitation of newborn	Introduce the Navjat Shishu Suraksha Karyakam (NSSK) on the Basic New born Care and Resuscitation program developed by the MoHFWShown the video on the steps of resuscitating of an asphyxiated newborn .	Video
60 mins	Skill Demonstration: Resuscitation of newborn	Set up a station with all essential equipment required for resuscitation of the newborn. Show and discuss each item of resuscitation equipment Bag, mask, suction device, clock, warm and folded cloths etc. Then demonstratethe steps of resuscitation of the newborn. Use the GoI skills checklists 2.7 for demonstration. Refer to the Newborn resuscitation chart and summarize the steps.	Items needed i. Child model/Mannequin (keep dressed) ii. Cotton sheet – 2 iii. Shoulder towel (3/4") iv. Different sizes of face mask v. Resuscitation bag/neonatal ambu bag, reservoir, oxygen tubing vi. Suction devices: catheter (12, 14F) mucous New born resuscitation flow chart GoI SBA Trainers Guide - Pg. 86. GoI handbook for ANMs- Pg. 52-54 – Checklist 2.7
2hrs 15 mins	Skill Practice : Resuscitation of newborn	Set up skills demonstration station for demonstrating the steps of Resusitation of new born using the steps seen in Video and chart for demonstration and ask the participants to perform it one by one and give peer group feedback,	Same as above

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 22: Week 2: Day 5, Afternoon			
60 mins	**Lecture ,demonstration and practice** Keeping the newborn warm	Tell the participants on the importance of keeping a baby warm how to keep the baby warm. Conduct a demonstration on 'Measurement of axillary temperature using a thermometer' conduct a demonstration on 'Temperature regulation and warm chain' using the poster.	Baby towels Digital thermometer, poster
45 mins	**Skill demonstration** Kangaroo Mother Care(KMC)	Show the video on Kangaroo mother care. Set up a station to demonstrate Kangaroo care	Video on kangaroo mother care. Baby model/Child Simulator Towels
60 mins	**Skill Practice** Kangaroo Mother care Mummifying the newborn	Set up at least 4 stations and ask the participants to practice the keeping the baby warm and Kangaroo care. Circulate amongst the stations and clarify any doubts that the participants may have.	As above
15 mins	**Review of day's activities and reading assignment.**	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material.	GoI SBA guidelines Pg. 73-93. Complications during pregnancy, labour and postpartum period and ensuring quality of care.

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 23: Week 2: Day 6, Morning			
15 mins	Agenda and Warm-up	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
15 mins	Interactive presentation: Complications during pregnancy, labour and postpartum period	Use presentation 6.a. and list the complications during pregnancy, labour, delivery and the postpartum period. Follow the steps 1- 4 from Session VI.a in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 90. Presentation 6.a. Flip chart and markers
45 mins	Exercise: Vaginal bleeding during pregnancy	Use presentation 6.a and checklist 4.1 and discuss on vaginal bleeding during pregnancy. Ask the participants to complete case study 4 and 5 in their handbook	GoI SBA Trainers Guide - Pg. 91-92. Presentation 6.a. GoI handbook for ANMs- Pg. 67-71 – Checklist 4.1. Case study 4 & 5.
15 mins	Skill Demonstration: ▪ Setting up an IV line	Set up skills demonstration station for demonstrating IV insertion. Use the GoI skills checklists 4.7 for demonstration.	GoI SBA Trainers Guide - Pg. 93. GoI handbook for ANMs- Pg. 82 – Checklist 4.7
30 mins	Discussion: ▪ Immediate PPH	Use GoI skills checklists 4.2 and discuss on management of shock and postpartum hemorrhage. Follow the steps 8-9 from Session VI.a in the SBA trainers guide.	GoI SBA Trainers Guide - Pg. 95. GoI handbook for ANMs- Pg. 72-73 – Checklist 4.2
30 mins	Simulation: ▪ Initial management of shock and PPH	Demonstrate the management of shock and PPH in simulation. Use GoI skills checklist 4.2 for guidance. Ask the participants to complete case study 6 from the GoI Handbook	GoI SBA Trainers Guide - Pg. 95. GoI handbook for ANMs- Pg. 72-74 – Checklist 4.2, Case study 6
45 mins	Discussion: Pregnancy induced hypertension.	Discuss on PIH using the guidance from the trainers guide and the checklist 4.3. Ask the participants to complete case study 7 from the GoI Handbook	GoI SBA Trainers Guide - Pg. 98. GoI handbook for ANMs- Pg. 75– Checklist 4.3. Case study 7
30 mins	Discussion: ▪ Convulsions – eclampsia	Discuss on Eclampsia using guidance from the trainers guide and the checklist 4.4. Ask the participants to complete case study 8 from the GoI Handbook	GoI SBA Trainers Guide - Pg. 100. GoI handbook for ANMs- Pg. 76-77– Checklist 4.4, Case study 8
15 mins	Skill Demonstration: Giving deep intramuscular injections.	Set up skills demonstration station for demonstrating administration of Deep Intramuscular injections. Use the GoI skills checklists 4.6 for demonstration.	GoI SBA Trainers Guide - Pg. 100. GoI handbook for ANMs- Pg. 81– Checklist 4.6

ANM FACULTY TRAINING – SKILLED BIRTH ATTENDANCE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 24: Week 2: Day 6, Afternoon			
1 hr	**Discussion:** ▪ Other complications during pregnancy, labour and postpartum	Discuss on the other complications such as Anemia, Urinary Tract infection, pre-term labour, premature rupture of membranes, foetal distress, obstructed labour, prolapsed cord retained placenta, vaginal and perineal tears, puerperal sepsis and breast conditions. Use presentation 6.a. of the SBA package.	Presentation 6.a. GoI SBA Trainers Guide - Pg. 102-106. GoI handbook for ANMs- Pg. 79– Checklist 4.5
15 mins	**Skill Demonstration**: ▪ Catheterization	Set up skills demonstration station for demonstrating catheterization. Use the GoI skills checklists 4.8 for demonstration.	GoI handbook for ANMs- Pg. 83-84 – Checklist 4.8.
45 mins	**Illustrated lecture:** ▪ Ensuring quality of care	Use presentation VI. b. and discuss on ensuring quality care in the community. Follow the steps in session VI. b. from the GoI SBA trainers' guide.	GoI SBA Trainers Guide – Pg. 107-108.
30 mins	**Post course knowledge assessment**	Distribute the post course knowledge Assessment sheet to each participant. Ask them to answer each question. Allow 15 mins for them to finish. Collect the completed assessment sheets. Review the correct responses and discuss.	Post course knowledge assessment questionnaires.
15 mins	**Preparation for clinical practice**	Review the day's activities Inform the participants on the clinical practice sessions of the SBA package. The first day will be of practice in simulation. From the second day of week 3 to week 4, the participants should be posted in the maternity unit, labor room and new born unit in rotation. The timings should be preferably in the afternoons and evenings to avoid overcrowding in the wards. Night calls can be taken as per the availability and requirements. The participants are required to complete the clinical log book.	Clinical rotation plan. GoI SBA handbook for ANMs.
15 mins	**Review of days activities**	Review the days activities and clarify any doubts that the participants may have.	

Note: The SBA training from here forth would be carried forward according to the session plans in the SBA trainers guide and handbook. The participants would facilitate most of the sessions as per the topics allotted to them. The schedule would be according to the overall schedule in the participant's handbook.

WEEK 3 & 4: DAY 1-6 SKILLED BIRTH ATTENDANCE

CLINICAL PRACTICE

The participants will be posted in the following areas for supervised clinical practice in rotation:

- Maternity ward
- Labour room
- Antenatal OPD
- Postnatal OPD
- Newborn unit

Note:

1. The participants should complete the clinical log book (GoI)
2. An OSCE for the evaluation of the clinical skills will be done during the afternoon session of week 4/ day 6.
3. The timings can be flexible to allow at least 7 hours of clinical practice.
4. The evaluation on clinical demonstration and coaching skills will be done on Week 4 at the clinical sites
5. A review of the individual progress should be made from the clinical trainer from time to time. The clinical rotation plan may be modified as per the need of the participant

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 25: Week 5: Day 1, Morning			
15 mins	Agenda and warm up	Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the warm up conduct it.	Flip Chart with agenda
15 mins	▪ Introduction to the IMNCI course ▪ Goal and Objectives ▪ Methodology of the course	Briefly introduce the IMNCI course to the participants and emphasize on the importance of managing sick infants and children Review the goals and objectives of the session with the participants Discuss the training methodology. Tell the participants that they will learn through video demonstrations, exercises, photographic exercises, Role plays & case studies	Flip Chart with session objectives IMNCI GOI Trainers guide
30 mins	Assess participants precourse knowledge	Distribute the Precourse Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished. Allow 20 minutes for the Precourse Knowledge Assessment. Assure the participants that the material will be covered during the course. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers. Use the papers to prepare the Group and Individual Knowledge Matrix and then return them.	Copies of Precourse Knowledge Assessment Sheets one for each participant Copy of Group and Individual Knowledge Matrix Refer facilitators guide pg
90 mins	**Activity:** **Illustrative lecture and Group Discussion:** Introduction to the module on 'Assessment and Classification of the sick young infant' **Discussion:** ▪ Discuss good communication skills ▪ Introduction to the Chart booklet ▪ Introduction to the recording forms	Introduce the session from the participants handbook and tell participants that they will learn how to assess and classify the sick young infant (upto 2 months). Discuss the importance of effective communication in dealing with mothers with young infants Paste the enlarged charts on the wall so that participants can see them. Explain the sections, columns and color coding of the chart for classifying the sick young infant. Paste the enlarged recording forms on the wall so that participants can see them. Explain the sections and columns of the chart	Enlarged chart booklets, Enlarged blank recording forms Case management charts for young infants
90 mins	**Group Discussion, case**	Introduce the session on 'assessment and classification of bacterial	Enlarged classification table for

	study and video demonstration: Assess and classify bacterial infection in the young infant **Case study:** Classify a sick young infant for possible bacterial infections **Video Exercise**	infection in the sick young Infant' from the participant's handbook. Tell the participants what questions to ask the mother, what to look, listen and feel for in the infant. Introduce and demonstrate the classification table for bacterial infections and explain the color codes. Give each participant a case study on how to classify a young infant for bacterial infections. When the exercise is complete compare the answers to the answer sheet and provide feedback, if possible, individually. Introduce the video exercise. Emphasize on the key points to observe in the video exercise.	bacterial infections Exercise/case study for individual work Answer sheet Video tapes FG Pg.

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 26: Week 5: Day 1, Afternoon			
90 mins	**Group discussion, video demonstration and case study:** Assess and classify diarrhea/dehydration in the young infant **Video Demonstration & discussion:** Case studies to assess and classify diarrhea	Discuss how a young infant is assessed for diarrhea. What questions are asked and what to look for. Introduce the enlarged classification table for diarrhea and explain criteria to classify dehydration. Emphasize on the key messages. View the video on how to assess a young infant for diarrhea. Follow this with a discussion. Distribute copies of case studies and let the participants classify the cases on the chart. Follow it with the presentation by the participants and discussions/clarifications.	Enlarged blank recording form Enlarged classification table on dehydration. Video tape, TV & LCD Copies of the case study and classification chart
60 mins	**Group discussion and case study:** Management of the sick young infant	Tell the participants how to manage the sick young infant. Let the participants practice management of the sick young infant on case studies.	Classification tables Copies of case studies
30 mins	Review of days activities, reading assignment	Inform participants the topic and pages for reading and the resource material. Ask one of the participants to prepare the agenda for the next day and few volunteers prepare for the recap & warm up.	Flip Chart. Markers

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 27: Week 5: Day 2, Morning			
10 mins	Agenda and warm up	Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the warm up conduct it.	Flip Chart with agenda
60 mins	**Illustrative lecture and Group discussion:** ▪ Classify common feeding problems. ▪ Demonstrate use of the classification chart	Briefly review with the participants the steps for classifying feeding problems. Display the enlarged section of the classification chart and demonstrate its use.	Enlarged classification chart
60 mins	**Interactive discussion, Video Demonstration and photographic exercise:** To demonstrate breast feeding assessment **Group Discussion:** Photographic exercise to recognize good and poor attachment	View the video on breast feeding assessment. Emphasize that the video will show good and poor attachment and effective and ineffective suckling and correct positioning for breast feeding. Lead a short discussion and emphasize the important points and the four signs of good attachment. Show photographs and ask participants to look for the signs of good or poor attachment and discuss	Video tape, TV, LCD Photographs
60 mins	**Interactive lecture, role play and demonstration:** Introduce 'identify treatment' on the assess and clarify chart. **Exercises:** 'Identify Treatment" **Role Play:** Explain to a mother that her young infant needs urgent referral **Demonstration:** Using infant recording form for identifying treatment	Display the classification chart and explain how to read across the chart from each classification to the treatment. Explain severe classifications that need urgent referral to the hospital. Engage the participants in reading the treatment options aloud. Ask participants to open the pg. no: 26-27 of the participant's handbook and tick the appropriate answer. Follow this with a brief discussion. Select two volunteers to play the role of the physician and mother. Give instructions for the role play. Follow this up with a discussion. Demonstrate the use of the back of the sick young infant recording form for recording treatment	Classification chart with treatment options Participant's handbook. Copy of instructions of role play. Copies of the recording form
45 mins	**Discussion:** Discuss common breast feeding problems and solutions Video Presentation on correct	Ask the participants what the common breast feeding problems are and their possible solutions. Support their answers and clarify ant doubts. View a presentation on the correct positioning for breast feeding.	Video tape, TV, LCD.

	positioning for breast feeding		

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 28: Week 5: Day 2, Afternoon			
2 hrs 45 mins	**Role Play:** Teaching the mother how to give co-trimoxazole at home. **Interactive discussion:** Advise mother & family on Home care: - Exclusive breast feeding - Keep the sick young infant warm - bathe the infant - treat local infection at home - treat diarrhea at home - correct positioning and attachment for breast feeding - express breast milk - feeding with a cup & spoon	Demonstrate through a role play on teaching a mother to give oral drugs at home using good communication skills. After the role play, lead a group discussion. Ask the participants to open their handbook pg. and read the steps involved in giving drugs at home. Ask a participant to list the basic teaching steps that they have just read and observed in the role play. Discuss home care for common problems and procedures	Items for Role Play – doll, bottle of tablets, pen, cup and spoon, drug envelope. Script of the role play.
15 mins	**Review of the day's activities and reading assignment**	Inform participants the topic and pages for reading and the resource material. Ask one of the participants to prepare the agenda for the next day and one to prepare for the recap & warm up.	Flip Chart. Markers

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 29: Week 5: Day 3, Morning			
30 mins	Agenda, warm up & recap of day 2	Review the agenda with participants, as outlined on the flipchart. Have the participants who volunteered for the warm up and recap conduct it.	Flip Chart with agenda
I hr 30 mins	**Interactive lecture, group discussion and video demonstration:** Demonstrate the classification table for cough and difficult breathing in a child 2 months to 5 years **Video demonstration:** To assess and classify a child for general danger signs, cough and difficult breathing. **Video Case study**	Introduce the session on assessment and classification of a child 2 months to 5 years. Discuss the minor differences from assessment and classification of a young infant. Discuss the questions to be asked and signs to look for during the assessment of the child for cough and difficult breathing. Also discuss how to assess for danger signs like fever, diarrhea, vomiting, unable to drink or breast feed, lethargy and unconsciousness. Display the classification table for cough and difficult breathing View a video demonstration on how to assess a child for general danger signs. Prepare for the Video Presentation which shows children with cough and difficult breathing. Follow this up with a question and answer session with emphasis on counting the breath in one minute and how to recognize signs of chest In drawing. Have the participants do the video case study "Ben". Lead a brief discussion	Video tapes on assessment for general danger signs and cough and difficult breathing, TV, LCD
2 hrs	**Interactive discussion, video demonstration and photographic exercise:** Demonstrate the classification table for Assessment of the child 2 months to 5 years for diarrhea Video demonstration on assessment of the child for diarrhea/dehydration **Video Case study** **Photograph exercise:** Group work to identify signs of dehydration in photographs	Introduce the session to the participants. Discuss the questions to be asked if the child has diarrhea and what to look for during the assessment. Display the classification table for diarrhea. Emphasize that all cases of diarrhea should be classified for dehydration. View the Video Presentation which shows children with diarrhea. Follow this up with a question and answer session. During the session focus on signs like sunken eyes and skin pinch Have the participants do the video case study "JOSH". Lead a brief discussion Conduct a photographic exercise to identify skin pinch and sunken eyes	Classification table for diarrhea Video tape, TV, LCD Photographs No:

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 30: Week 5: Day 3, Afternoon			
2 hrs	**Interactive lecture, group discussion and video demonstration:** ▪ Demonstrate the classification table for fever ▪ Video demonstration on assessment of the child for fever- Does the child have a stiff neck? **Video Case study**	Introduce the session to the participants. Discuss the questions to be asked if the child has fever and what to look for during the assessment. Emphasize that fever could be a symptom of other diseases like malaria, meningitis or other viral infections Display the classification table for fever and explain the classification. Prepare for the Video Presentation which shows children with fever. Follow this up with a question and answer session. During the session focus on signs for stiff neck. Have the participants do the video case study "Pu". Lead a brief discussion	Classification table Video tape, TV, LCD
45 mins	**Brainstorm and discussion:** Principles of effective communication	Brainstorm the key points for effective communication while talking to mothers and families of infants and children. Write the responses on a flip chart and discuss the importance of effective communication skills.	Flip chart Markers
15 mins	**Review of the day's activities and reading assignment**	Inform participants the topic and pages for reading and the resource material. Ask one of the participants to prepare the agenda for the next day and one to prepare for the recap & warm up.	Flip Chart. Markers

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 31: Week 5: Day 4, Morning			
15 mins	Agenda, warm up & recap of day 3	Review the agenda with participants, as outlined on the flipchart. Have the participants who volunteered for the warm up and recap conduct it.	Flip Chart with agenda
1 hr	**Interactive lecture and discussion:** Grade and classify malnutrition **Group activity:** Photographic exercise to recognize signs of severe wasting, edema and loss of fat. Classify anemia **Group activity:** Photographic exercise To recognize grades of palmar pallor. **Immunization Activity:** To display the Immunization schedule VIT A Supplementation status Iron Folic Acid Supplementation status	Introduce the session. Tell the participants that all sick children should be checked for malnutrition, anemia. Also check the Immunization status of all children. Discuss what to look and feel for malnutrition. Display the growth chart from birth to 5 years of age and explain how to determine the child's weight for age and grading of malnutrition Display the classification table for malnutrition and explain. Display photographs showing examples of severe wasting, edema and loss of fat Conduct a photographic exercise. Discuss what to look for in anemia. Explain Palmar pallor Display the classification table for anemia and explain. Display photographs showing examples different grades of palmar pallor. Tell the participants that the immunization schedule of all children should be checked. Walk them through the schedule Discuss the Vitamin A schedule. Display the assess and classify chart for dose of Vit A Discuss the Iron and Folic acid recommendation.	Growth chart Classification table for malnutrition. Photographs Classification table for Anemia Photographs Enlarged copy of the Immunization schedule
2 hrs 45 mins	Field visit for VHND	Divide the participants into two groups and plan a visit to the nearest two aanganwadi centers for VHND/Immunization session	Inform the authorities and prepare in advance for the field visit

ANM FACULTY TRAINING – IMNCI			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 32: Week 5: Day 4, Afternoon			
1 hr	**Interactive lecture and group discussion:** Home based remedies for Pnumonia, Diarrhea, Fever, Anemia, Cough and cold **Demonstration:** Preparation of ORS **Discussion:** Follow up care	Introduce the session. Tell the participants that if a child has any of the danger signs or a red classification then refer the child immediately after giving appropriate pre referral treatment. Tell the participants that this session will deal with home based remedies for common ailments. Demonstrate how to give medicines at home for pneumonia, fever, diarrhea and anemia Demonstrate the preparation of ORS Discuss the importance of follow up care. Tell the participants when the mother has to bring the back the child for review for different symptoms .Also discuss the warning signs when the mother should take the child immediately to the hospital	Samples of tablets, ORS powder, container, water. Flip chart markers, Participants handbook
1 hr	**Activity:** **Interactive lecture & discussion** Complementary feeding in infants & young children	Introduce the session on complimentary feeding in Infants & young children. Explain the importance of complimentary feeding. Give examples of 1st food to infants and modified family food. Discuss the energy density of infant foods & frequency of feeding. Talk about the importance of growth monitoring. Ask the participants if a woman should continue to breast feed? Follow this with a discussion. Discuss the importance of safety and hygiene while giving complimentary foods.	Flip chart, Markers, Handouts on complimentary feeding(ref national guidelines on Infant & young child feeding)
45 mins	**Post course knowledge assessment**	Distribute the post course knowledge assessment questionnaire and ask the participants to complete it. Discuss the answers with the participants.	Post course knowledge assessment questionnaire.
15 mins	**Review of the day's activities**	Review the day's activities. Revise key messages Clarify any doubts that the participants may have in IMNCI. Thank the participants & wrap up.	

ANM FACULTY TRAINING – FAMILY PLANNING			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 33: Week 5: Day 5, Morning			
10 mins	**Agenda and Warm-up (15 mins)**	Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the warm up conduct it.	Flip Chart with agenda
5 mins	**Activity:** Goals and Objectives	Review the goals and objectives of the session with the participants	Flip Chart with session objectives
15 mins	**Activity:** Assess participants precourse knowledge	Distribute the Precourse Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished. Allow 10 minutes for the Precourse Knowledge Assessment. Immediately review the correct responses—do not spend a long amount of time on any questions, but assure the participants that the material will be covered during the course. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers. Use the papers to prepare the Group and Individual Knowledge Matrix and then return them.	Copies of Precourse Knowledge Assessment Sheets one for each participant Copy of Group and Individual Knowledge Matrix Refer facilitators guide pg.
45 mins	**Illustrated lecture:** India Family Planning Program and GOI policies for FP service provision.		
45 mins	**Brainstorming / Presentation and discussion:** Benefits of family planning & spacing of pregnancies .	Ask participants the importance of spacing pregnancies and benefits of Family planning both to the mother and child. Use the PowerPoint slides to present information on the impact of pregnancy spacing on maternal, newborn and child health. Ask questions to the participants and engage them in the presentation of the information.	Flip chart, markers, PowerPoint slides on: Pregnancy Spacing and Health benefits of family Planning Session 2 slides 1-6, (PPFP Counseling)
60 mins	**Discussion & Exercise:** Brief technical overview of modern family planning methods	Ask the participants how one can be reasonably sure that a woman is not pregnant before starting any Family Planning method. Write the responses on a flip chart. Then Display Slide 3 and 4 of session3 presentation.	Power Point Slide 3,4 of session 3

		Broadly discuss the modern family Planning methods Divide the participants in pairs. Give each pair the blank exercise format listing the technical details of various family planning methods in the first column. For each statement listed in the 1st column ask the participants to place a check mark in the appropriate box, indicating the statement is correct for which method. Ask a few participants to present their responses. Display the format with the correct answers and discuss.	Exercise: Technical overview of FP methods. Copies of the blank exercise formats. Slide on the correct exercise format
60 mins	**Small group activity: Exercise: Who can use hormonal methods?**	Tell the participants that they will now learn which conditions may affect the choice of hormonal methods of FP. Divide learners into small groups of 3–4 and ask each group to work as a team Give each group a copy of the blank chart on 'Who can and who cannot use hormonal methods of FP' and ask them to review carefully and complete by placing a check mark in the Provide or Do Not Provide column. Ask learners to give a reason for each answer and to note the appropriate WHO MEC category in the space provided Bring learners back together after 10 minutes and ask volunteers to share their answers one at a time Project a completed MEC chart on the screen and reveal the answers one at a time. Reinforce and/or clarify issues raised during this discussion	Copies of the blank chart on 'Who can and who cannot use hormonal methods of FP' (either as handout or from the Workshop Notebook for Learners) Completed for Hormonal FP Methods chart as answer key – to be projected and revealed item by item during discussion

ANM FACULTY TRAINING – FAMILY PLANNING			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 34: Week 5: Day 5, Afternoon			
90 mins	Energizer Interactive Presentation/Discussion: Postpartum Family Planning and LAM	Use the PowerPoint slides to review the general concepts of postpartum family planning. Ensure that participants understand the different types of PPFP, and the use of LAM. Review of the PPFP counseling checklist	PowerPoint slides on: PPFP, Session 3, Slide 7 PPFP counseling checklist Participants handbook
15 mins	Game Condom race & Demonstration	Tell the participants that they will now play a game the 'condom race.' Divide the participants into two groups. Tell them that they will each be given VIPP cards with the steps of condom use in a jumbled order. The groups have to place the cards on the table/ floor in the correct order of the condom use. Ask the group that finishes first to read the steps aloud. Then the other group. Follow this with a discussion & demonstration of the correct use of condom.	2 sets of VIPP cards with steps of condom use , Sufficient samples of condoms, penis model
60 mins	Presentation and discussion: Discuss modern approaches to IUCD	View the presentation on IUCD followed by a discussion	Power point presentation IUCD-CTU video-6
15 mins	Activity: ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	

ANM FACULTY TRAINING – FAMILY PLANNING			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 35: Week 5: Day 6, Morning			
15 mins	Agenda warm up & recap	Review the agenda with participants, as outlined on the flipchart. Have the participant(s) who volunteered for the warm up and recap and conduct it.	Flip chart with agenda
15 mins	Small group Activity: Exercise: Who can use an IUCD?	Divide participants into small groups of 3–4. Give each group a copy of a blank chart on 'who can use an IUCD'. Ask them to review carefully and complete by placing a check mark in the Insert or Do Not Insert column. Ask them to give a reason for each answer and to note the appropriate WHO MEC category in the space provided Ask volunteers to share their answers. Project a completed chart on the screen and reveal the answers one at a time. Reinforce and/or clarify issues raised during this discussion.	Copies of blank IUCD charts Completed MEC IUCD charts
15 mins	Demonstration: Loading the IUCD in the Sterile Package	Demonstrate loading of the IUCD in the sterile package.	Adequate numbers of CuT 380A in the sterile package
30 mins	Skill practice: Loading the IUCD in the sterile package	Participants will practice loading of the IUCD in the sterile package.	Adequate numbers of CuT 380A in the sterile package
45 mins	Discussion and Presentation: To know the Infection Prevention Steps in IUCD Insertion	Discuss the importance of Infection Prevention steps in in IUCD services. View the Presentation on Infection Prevention Ask participants to work in groups of 3-4 as a team. Have each team review the checklist for IUCD Counseling and Clinical Skills and identify the infection prevention steps by marking on the relevant tasks/steps in the checklist Discuss with participants the IP steps that they have marked and ensure that all IP steps for IUCD insertions are enumerated.	Power point presentation CTU-5 Checklist for IUCD counseling and clinical skills for each participant
30 mins	Activity: Demonstration IUCD insertion & Removal	Demonstrate the insertion and removal of the IUCD on the Zoe model. Ask one of the participants to read aloud the steps from the checklist.	Zoe model, Speculum, Vulsellum/tenaculum, anterior vaginal wall retractor, sponge holder, cotton balls, bowl, uterine sound, scissors, CU. T, gloves, 0.5% chlorine solution. Checklist
90 mins	Skill practice:	Divide participants in groups. Ask the participants to practice the insertion & removal of IUCD on the Zoe using the checklist. Facilitate each group.	As above

ANM FACULTY TRAINING – FAMILY PLANNING			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 36: Week 5: Day 6, Afternoon			
45 min	**Interactive presentation:** To know the elements of counseling and communication skills	Introduce the session on counseling View the presentation on counseling and communication skills	CTU presentation on session 4 slide 3-7
60 mins	**Discussion and Interactive presentation:** Elements of FP counseling & post- partum FP counseling,	Discuss informed choice, rights of a FP client, qualities & skills of a good FP counselor and communication skills for FP counseling View the presentation on FP counseling for post- partum women	Power point Slides, Session 4, Slides 8-16 Presentation on session 5, flip chart, participants handbook Handouts for checklists on FP and PPFP counseling
60 mins	**Practice Role Play:** FP counseling	Divide participants in small groups of 4. Give 2 case studies to each group and ask them to practice counseling in the small groups using all audio-visual job-aids for counseling. Every participant should get a chance to play the counselor.	Role Play situations, pg. 43-44, PPFP trainers guide PPFP counseling checklist Discussion questions
15 mins	**Activity:** Post course knowledge assessment Review of days activities Reading Assignment	Distribute the post course knowledge Assessment sheet to each participant. Ask them to answer each question. Collect the completed assessment sheets. Review the correct responses and discuss Involve the participants in review and discussion of the topics and activities during the day. Ask a participant to write the agenda for the next day on the flip chart. Ask one volunteer to plan an opening activity or warm up for the next day. Inform the participants the topic and pages for reading and the resource material	Copies of the post course knowledge assessment. One sheet for each participant Flip Chart, Markers

ANM FACULTY TRAINING – INTRODUCTION TO STI, HIV & PPTCT OF HIV			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 37: Week 6: Day 1, Morning			
15 mins	Agenda and Warm-up	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
30 mins	Activity: Review course objectives and schedule Pre knowledge assessment.	Discuss the goals of the STI/ HIV section of the course and the participant learning objectives and the schedule. Distribute the Pre course Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished. Allow 15 minutes for the Pre course Knowledge Assessment. Immediately review the correct responses. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers.	Flipchart with Course Objectives Copies of Pre course Knowledge Assessment Sheets One for each participant.
15 mins	Group activity: Facts about HIV	Divide participants into 5 groups. Hand each group one set of cards (each group should get 1 'Yes' card, 1 'No' card, and 1 'Not sure' card). Project the questions on the screen. Follow the instructions from the facilitators guide.	LCD projector, cards. Facilitators guide Pg.
1 hr	Illustrated lecture/ Discussion: ▪ Magnitude of HIV ▪ What are HIV & AIDS? ▪ HIV transmission. ▪ HIV testing and diagnosis. ▪ HIV disease progression and clinical staging.	Use the presentation on HIV and discuss the concepts of Magnitude of HIV, What are HIV & AIDS? HIV transmission, HIV testing and diagnosis, HIV disease progression and clinical staging. Ask the participants to refer to the handouts in the participants' handbook.	Presentation on HIV. Facilitators Guide Participants handbook
30 mins	Group Activity: ▪ Case scenarios ▪ Role play	Project the case scenarios and the questions on the slides. Allow participants 2 minutes to read each case and answer the questions. Discuss each case as a large group as participants share their answers to the related questions.	Slides with the case scenarios. Facilitators guide Pg.

		Encourage participants to use Handouts 2 and 3 as references. Use the instructions from the facilitators guide for the role plays and discuss the questions related to them	Handouts from participants handbook Pg.
30 mins	**Brainstorming:** Role of the ANM in care of patient with HIV	Brainstorm on the Role of the ANM in care of patient with HIV.	Flip charts and markers
45 mins	**Presentation/Discussion:** ▪ Role of ANM in addressing psychological issues. ▪ Role in patient education and referral.	Use presentation and discuss the role of the ANM in addressing psychological issues and role in patient education and referral. Initiate discussions using questions such as 'Why is referral important?', 'Why must a nurse develop linkages and network?'' With whom can a nurse develop linkages or network?', 'What skills does a nurse need to develop to be able to effectively network?'	Presentation slides. Flip charts and markers. Handout.
30 mins	**Illustrated lecture:** ▪ Introduction to STIs. ▪ Link between STI & HIV. ▪ Common STIs.	Use presentation to introduce on STIs and describe the link between STIs and HIV.	Presentation on STI.

ANM FACULTY TRAINING – INTRODUCTION TO STI, HIV & PPTCT OF HIV			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 38: Week 6: Day 1, Afternoon			
60 mins	**Illustrated lecture:** ▪ Syndromic case management	Use presentation to provide information on syndromic case management.	Facilitators handbook pg.
30 mins	**Group Activity:** ▪ Syndromic case management	Divide participants into two groups and assign each one of the two cases given below. Ask them to go through the flow charts in the annexure. They can take turns in reading the flowcharts and discuss them. Then they have 10 minutes to read the case, discuss the question, and note down their answers. Inform groups to choose one person to read out the case to the class and another one to present their findings. Ask participants to listen closely when the other group presents their case and share any additional points they may have with the large group. Ensure that answers are correct by referring to the appropriate flowchart in the Additional Resource Materials provided at the end of this unit.	Participants' handbook pg. Facilitators guide pg.
40 mins	**Illustrated lecture:** ▪ Standard precautions and hand hygiene ▪ Standard precautions: blood borne pathogens	Use the presentation and discuss on the standard precautions. Divide the participants into pairs and ask them to practice hand washing with the help of the checklist. Use presentation to explain the standard precautions for blood borne pathogens.	Facilitators guide pg. Participants guide pg.
10 mins	**Group activity:** ▪ Standard precautions: blood borne pathogens	Refer participants in Exercise 2 in their Participant Manual. Ask them to review the steps for cleaning up a blood spill on the floor. Spread the red substance on the floor. Ask for one volunteer to demonstrate the proper way to clean up a blood spill on the floor. Set all other items on a table for the volunteer to access/use. After the volunteer completes the task, ask participants, "What cleaning items used by staff are likely to contaminate other items in the environment?" Answer: Items frequently causing contamination include utility gloves, buckets, buckets, mops, and rags.	
25 mins	**Illustrated lecture/ Discussion:** Post exposure prophylaxis for HIV	Use presentation and initiate discussion with the case scenarios. Elaborate on the immediate actions to be taken on occupational exposure and post exposure prophylaxis	Presentation.
15 mins	**Activity:** ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 39: Week 6: Day 2, Morning			
15 mins	**Agenda and Warm-up**	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Recap previous day's learning.	Agenda of the day on a flipchart

		Review agenda of the day.	
30 mins	**Interactive presentation:** Parent to child transmission of HIV	Use the presentation on PPTCT and explain on parent to child transmission of HIV. Discuss on the statements regarding HIV transmission during pregnancy.	Presentation Participants' handbook Pg. Facilitators' guide Pg.
30 mins	**Small group activity:** PPTCT strategies	Divide participants into 5 groups; assign each group one case. Give groups 5 minutes to discuss and write down main points they would consider in preventing PTCT of HIV for their particular case. Ask groups to select one representative that will come forward and present their main points to the large group (3-5 minutes). Other groups will be asked to provide feedback to the responses.	Case scenarios in the participants handbook pg.
45 mins	**Illustrated lecture / discussion:** ▪ Primary prevention ▪ Secondary PPTCT strategies: during pregnancy, labour and delivery	Use presentations and the small group discussion findings to discuss on the primary prevention secondary prevention and ART during pregnancy.	Presentation Case scenarios
45 mins	**Illustrated lecture /discussion:** Secondary PPTCT strategies: during postnatal period and infancy.	Use presentation and elaborate on secondary PPTCT strategies during the postnatal period and infancy. Discuss regarding feeding of the baby of a HIV infected mother. Discuss on replacement feeding checklist	Presentation Handout from participants handbook
60 mins	**Group activity:** ANMs role in PPTCT.	Refer to the case scenario in the participants' handbook. Allow participants15 minutes to read the case study on their own and prepare their answers. ▪ Review the answers to questions as a large group	Case scenario from participants handbook
15 mins	**Discussion:** Key points on PPTCT	Initiate discussion by asking questions such as "What are the main points you have learned from the session?", "what are your key responsibilities with regards to patient care?" Summarize the points on a flip chart	Power point slides with questions Flip chart and markers.

ANM FACULTY TRAINING – INTRODUCTION TO STI, HIV & PPTCT OF HIV			
Time	OBJECTIVES/ACTIVITY	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 40: Week 6: Day 2, Afternoon			
15 mins	**Interactive presentation:** Elements of counseling in HIV	Use presentation on elements of counseling and discuss on the various elements with examples	Presentation
60 mins	**Discussion:** ▪ Pre and posttest counseling ▪ Ongoing counseling	Use the handout and presentations to discuss on the steps in counseling, pre and posttest counseling and ongoing counseling. Show the trigger scenario video and initiate discussions	Handout on steps in pretest counseling in participants' handbook. Trigger scenario: HIV posttest counseling.
60 mins	**Role play and discussion:** Counseling	Divide participants into five small groups of 4 or 5. Assign each group a case. Ask groups to choose one person to play the role of the patient and another, the counselor. Remaining group members will be observers. ▪ Allow groups 10 minutes to plan and practice the role play using the guidelines provided under their case. ▪ Each group will be given 3 to 5 minutes to perform the role-play for the larger group Lead the discussion based on the instructions given in the facilitators guide	Role play instructions in the facilitators guide.
15 mins	**Brainstorming:** Challenges in caring for mothers with HIV	Brainstorm on the challenges met while caring for mothers with HIV. Write the responses on a flip chart and then discuss on them	Flip chart and markers.
15 mins	Posttest knowledge assessment	Distribute the Post course Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished. Allow 10 minutes for the Post course Knowledge Assessment. Immediately review the correct responses. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers.	Post course knowledge questionnaire sheets for all the participants.
15 mins	**Activity:** ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Inform the participants the topic and pages for reading and the resource material	SBMR field guide Pg. 1-39

ANM FACULTY TRAINING – INTRODUCTION TO PERFORMANCE STANDARDS AND THEIR IMPLEMENTATION			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 41: Week 6: Day 3, Morning			
15 mins	Agenda and Warm-up	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
45 mins	Illustrated lecture: ▪ Introduction to SBMR ▪ Steps in the SBMR process.	Present "Standards-Based Management and Recognition of Health Service Delivery." Respond to participants' question on the SBM-R presentation.	Facilitator's Handbook, Presentation Graphics, "Standards-Based Management and Recognition of Health Service Delivery" Copies of the presentation for the participants
15 mins	Large group activity: Identifications of elements in the change process	Present the "Landscape" slide. Ask the large group what they think the landscape says about change. Follow instructions for the exercise from the facilitators guide.	Facilitator's Handbook, "Landscape" Exercise, Presentation Graphics, Landscape slide
15 mins	Illustrated lecture: Change management	Give "Change Management" presentation. Discuss different participants' experiences with change.	Facilitator's Handbook, Presentation Graphics, "Change Management"
60 mins	Small group activity: Develop vision for each facility	Divide into small groups by facility. Ask each group to draw the vision of what they want the facility to be. Ask them to use only drawings, no words. Give the groups 30 minutes to prepare a flipchart with their vision. Each group will have 3–5 minutes to present to the larger group. The facilitator will summarize the presentations by the groups. Tell the groups that their vision can change throughout the process. Keep the flipchart pages from each group for use/review later	Flipchart and markers for each group
45 mins	Presentation: ▪ Setting the standards ▪ Qualities of performance standards.	Present "Setting Standards." Respond to participants' questions on the presentation.	Facilitator's Handbook, Presentation Graphics, "Setting Standards" Copies of the presentation for the participants
45 mins	Small group activity: ▪ Tool review	Group work: Divide the participants into small groups and provide each group with copies of different areas/sections of the assessment tool. Each group has 45 mins to review their area or areas of the tool. Each group will comment on format, different areas and standards, and verification criteria and familiarize with the standards.	Copies of selected areas of the assessment tool for each group Facilitator's Handbook, "Assessment Tool Review" Exercise Copies of the instructions for the participants

ANM FACULTY TRAINING – INTRODUCTION TO PERFORMANCE STANDARDS AND THEIR IMPLEMENTATION			
Time	OBJECTIVES/ACTIVITY	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 42: Week 6: Day 3, Afternoon			
20 mins	**Illustrated lecture:** ▪ Implementing the standards. ▪ Baseline assessment.	Present "Implementing Standards: Measurement of Actual Performance". Discuss on conducting the baseline assessment. Respond to participants' questions on the presentation.	Facilitator's Handbook, Presentation Graphics, "Implementing Standards: Measurement of Actual Performance" Copies of the presentation for the participants
60 mins	**Small group activity:** Implementing standards.	Set up at least two different stations (one station per facilitator or some participants can help at the stations) for participants to practice observing in a simulated setting. Divide into small groups. Each station will have a master observer (usually, the facilitator or another person who knows the process) and one performer who can be volunteers from the group. Each group will have about 20–30 minutes to observe a "provider" performing tasks from the performance standards. Each person should mark "Y" or "N" or N/O for each verification criterion. Discuss the results and variations in results after each simulation, comparing them with the responses of the master observer. Repeat the exercise with the same group at the same station twice, and then rotate participants through the stations. Try to have different methods of data collection (direct observation, guided interview and/or clinical records review).	Copies of selected sections/areas of the assessment tool with the standard or group of standards to be observed for each participants Materials to set up the stations
20 mins	**Discussion:** ▪ Feedback of the small group activity ▪ Challenges in implementing the standards.	Discuss the exercise in the large group. What was difficult? What did they like? What did they learn about observing performance? Review and consolidate the results obtained.	
20 mins	**Illustrated lecture:** Implementing the standards – scoring of performance standards.	Present "Scoring and Summary of Results" Respond to participants' questions on the presentation.	Facilitator's Handbook, Presentation Graphics, "Scoring and Summary of Results"
45 mins	**Small group activity :** Scoring of performance standards.	Divide participants into small groups by facility. Distribute copies of the assessment tool and summary form to each group. Instruct them to score and complete the summary sheet for their sample performance standards. All groups have the same sample, so they should find the same results. They have 40 minutes to do this.	One copy of the assessment tool filled out with Y, N, N/O (all areas or selected areas) and the summary form for each group
15 mins	**Activity:** ▪ Review of the day's activities. ▪ Reading Assignment	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day.Inform the participants the topic and pages for reading and the resource material	SBMR field guide pg. 40- 58

ANM FACULTY TRAINING – INTRODUCTION TO PERFORMANCE STANDARDS AND THEIR IMPLEMENTATION			
Time	**TOPIC /ACTIVITIES**	**TRAINING/LEARNING METHODS**	**RESOURCE MATERIALS**
Session 43: Week 6: Day 4, Morning			
15 mins	**Agenda and Warm-up**	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
15 mins	**Illustrated lecture:** ▪ Feedback ▪ Preparation of operational plan.	Present "Feedback and Operational Action Plan." Respond to participants' questions on the presentation.	Facilitator's Handbook, Presentation Graphics, "Feedback and Operational Action Plan" Copies of the presentation for the participants
45 mins	**Small group activity:** Conducting feedback meetings.	Divide participants into three small groups. Give each group a copy of a summary form with baseline results (results can be the same or different). Ask each group to prepare a role play on how to give feedback about the results to the facility staff. The groups will have 20 minutes to prepare the role play and 7 minutes to present. Facilitate the discussion in the larger group after all groups have presented.	Copies of the summary form for each group with baseline results
30 mins	**Illustrated lecture:** Roles of key implementing teams.	Present "Key Implementing Teams." Brainstorm with participants about who should be part of each key implementing team in their SBM-R process.	Facilitator's Handbook, Presentation Graphics, "Key Implementing Teams" Copies of the presentation for the participants
45 mins	**Illustrated lecture:** Different methods for conducting a detailed cause analysis.	Present "Cause Analysis: Module Two." Ask the group to identify which cause analysis methods discussed will be most useful for them. Ask questions to ensure a good understanding of the different methodologies. Have a flipchart prepared in advance with concrete examples of the following techniques: ▪ Nominal group ▪ Force field analysis ▪ Fishbone diagram ▪ Flowchart ▪ Run chart ▪ Pareto chart	Facilitator's Handbook, Presentation Graphics, "Cause Analysis: Module Two" Copies of the presentation for participants Flipcharts prepared with examples of selected cause analysis techniques
45 mins	**Group activity:** Application of the methods of cause analysis.	Participants will work in their facility groups. Distribute directions for "Performance Gaps and Cause Analysis" Exercise. Circulate and provide coaching/ assistance.	Facilitator's Handbook, "Performance Gaps and Cause Analysis" Exercise Copies of the instructions to each participant or group

			Flipchart and markers for each group
20 mins	**Illustrated lecture:** Selection of interventions.	Present "Selection of Interventions." Respond to participants' questions. Refer the participants to the SBM-R field guide for more information on types of interventions (table with examples of intervention by cause).	Facilitator's Handbook, Presentation Graphics, "Selection of Interventions" Copies of the presentation for participants
25 mins	**Small group activity:** Exercise on selection of interventions.	Participants will continue to work in their facility groups. Distribute directions for "Select Interventions" Exercise. Circulate and provide coaching and assistance.	Facilitator's Handbook, "Select Interventions" Exercise Copies of the instructions to each participant or group Flipchart and markers for each group

ANM FACULTY TRAINING – INTRODUCTION TO PERFORMANCE STANDARDS AND THEIR IMPLEMENTATION			
Time	OBJECTIVES/ACTIVITY	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 44: Week 6: Day 4, Afternoon			
30 mins	**Illustrated lecture:** ▪ Team building ▪ Operational strategy and planning.	Present "Team Building and Operational Strategy and Planning." Respond to participants' questions. Tell the participants that they will receive a booklet with more detailed information on teamwork. During or after the presentation, give the booklet to the participants or teams.	Facilitator's Handbook, Presentation Graphics, "Team Building and Operational Strategy and Planning" Copies of presentation for participants
45 mins	**Small group activity:** Expanding the SBMR teams.	Divide groups by facility again. Do the "Expanding the SBM-R Teams" Exercise.	Facilitator's Handbook, "Expanding the SBM-R Teams" Exercise Copies of the instructions to each participant or group
60 mins	**Presentation and discussion:** ▪ Measuring progress ▪ Networking and benchmarking	Present "Measuring Progress: Networking and Benchmarking." Respond to participants' questions.	Facilitator's Handbook, Presentation Graphics, "Measuring Progress: Networking and Benchmarking" Copies of the presentation for participants
30 mins	**Presentation and discussion:** Recognize and Reward Achievements	Present "Recognizing Achievements" and discuss. Respond to participants' questions.	Facilitator's Handbook, Presentation Graphics, "Recognizing Achievements" Copies of the presentation for participants
15 mins	**Activity:** ▪ Review of the day's activities ▪ Topic allotment for teaching skills evaluation	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day. Allot topics for the teaching skills evaluation session for the participants and enter in the sign-up sheet. The allotment of the topic can be done in lottery method.	SBMR field guide pg. 58- 69

ANM FACULTY TRAINING – INTRODUCTION TO PERFORMANCE STANDARDS AND THEIR IMPLEMENTATION			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 45: Week 6: Day 5, Morning			
15 mins	Agenda and Warm-up	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
30 mins	Illustrated lecture : ▪ Resource mobilization. ▪ Win-win strategy.	Present "Resource Mobilization: A 'Win-Win' Strategy" and discuss. Provide an opportunity for the group to share ways they have done this successfully, or ideas for how they might successfully do it in the future. Share stories of how it has been done successfully in other places.	
30 mins	Presentation and discussion: ▪ Promotion and Agreement ▪ Orienting Administration and Co- workers	Divide the participants into three small groups. Ask each group to prepare a role play on how to give feedback on assessment results to the facility. The groups will have 20 minutes to prepare the role play and 7 minutes to present. Facilitate the discussion in the larger group after all groups have presented.	Facilitator's Handbook: "Promotion and Agreement" Exercise
30 mins	Group activity and discussion: ▪ Plan for baseline assessment and next steps	In a large group discuss on the baseline assessment, the preparation and the persons to be involved. Agree on the dates of assessment if possible and the external support if necessary.	Flipchart and markers
75 mins	Computer Lab Activity: ▪ Identify strategies for teaching students the use of evidence-based medicine in life-long learning	Discuss the importance of life-long learning. Arrange for a time that you can use the computer lab for at least two hours. Provide an orientation for the faculty on using the internet to find and access information. Demonstrate some links to open-access educational materials (several are listed to the right). Ask faculty to select a topic of interest related to any of the subjects addressed during the course and identify 3-5 points or discoveries they identified and the references for each. They will share these with the group the following day.	http://www.mchip.net/resources http://www.widernet.org/egranary/ http://www.hrhresourcecenter.org/tutorial_main http://www.thelancet.com/journals/lancet/issue/current
60 mins	Group activity: Review of ANM curriculum and incorporation of the teaching aids into it.	Divide the participants in groups of 3. Provide the INC ANM curriculum and the tools for teaching. Ask the participants to fit in the materials in the participants' handbook and the tools for teaching into the ANM curriculum.	INC ANM curriculum. Participants handbook Tools for teaching.

ANM FACULTY TRAINING – EVALUATION OF TEACHING SKILLS			
Time	OBJECTIVES/ACTIVITY	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 46 : Week 6: Day 5, Afternoon			
3 hrs	**Evaluation of the teaching skills of the participants**	Allot a time of 30 minutes for the participants to present their topic one after the other. If the group is large, divide into two groups and evaluation can take place in two halls with two facilitators. Evaluation of the skills should be done by the facilitator using the relevant checklist.	Copies of teaching skills evaluation checklists
15 mins	**Activity:** ▪ Review of the day's activities.	Involve participants in review and discussion of the topics and activities covered during the day. Ask a participant to volunteer to write the agenda for the next day on a flipchart, in preparation for the opening session. Ask one or more of the other participants to plan an opening activity or warm-up for the next day	

ANM FACULTY TRAINING – EVALUATION OF TEACHING SKILLS AND CLOSURE			
Time	TOPIC /ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 47: Week 6: Day 6, Morning			
15 mins	**Agenda and Warm-up**	Have a warm-up activity to ensure that the participants are ready to learn and you have created a positive learning environment. Review agenda of the day.	Agenda of the day on a flipchart
2 hrs	**Evaluation of the teaching skills of the participants**	Allot a time of 30 minutes for the participants to present their topic one after the other. If the group is large, divide into two groups and evaluation can take place in two halls with two facilitators. Evaluation of the skills should be done by the facilitator using the relevant checklist.	Copies of teaching skills evaluation checklists
30 mins	**Post course knowledge assessment**	Distribute the Post course Knowledge Assessment sheet to each participant. Ask them to answer each question. Ask the participants to give the assessment sheet over when finished. Allow 20 minutes for the Post course Knowledge Assessment. Immediately review the correct responses. Have participants grade the papers while the trainer reviews the correct answers with them and collect the papers after reviewing all the answers.	Post course knowledge questionnaire sheets for all the participants
1 hr 15 mins	**Review individual progress with the trainer**	Trainers meet with participants individually to discuss their individual progress.	Clinical log book

ANM FACULTY TRAINING – EVALUATION OF TEACHING SKILLS			
Time	OBJECTIVES/ACTIVITY	TRAINING/LEARNING METHODS	RESOURCE MATERIALS
Session 48 : Week 6: Day 6, Afternoon			
1 hr	Action planning	Each group as per the facility should prepare an action plan based on the course. Refer to the action plan/ next steps format in the participants' handbook.	Participants handbook
15 mins	Activity: Course Evaluation	Have participants fill out and submit the course evaluation form.	Copies of Course evaluation forms (one per participant from FG)
1 hr	Closing and distribution of certificates	Closing remarks by training organizers. Distribute certificates to participants.	Completed certificates

PRECOURSE KNOWLEDGE ASSESSMENT:

HOW THE RESULTS WILL BE USED

The main objective of the Pre-course Knowledge Assessment Questionnaire is to assist both the trainer and the participant as they begin their work together in the course by assessing what the participants, individually and as a group, know about the course topics. This allows the trainer to identify topics which may need additional emphasis during the course. Providing the results of the pre-course assessment to the participants enables them to focus on their individual learning needs. In addition, the questions alert participants to the content that will be presented in the course.

The questions are presented in the true-false format. A special form, (in trainer's handbook) the Individual and Group Assessment Matrix, is provided to record the scores of all course participants. Using this form, the trainer and participants can quickly chart the number of correct answers for each of the questions. By examining the data in the matrix, the group members can easily determine their collective strengths and weaknesses and jointly plan with the trainer how to best use the course time to achieve the desired learning objectives.

For the trainer, the questionnaire results will identify particular topics that may need additional emphasis during the learning sessions. Conversely, for those categories where 85% or more of participants answer the questions correctly, the trainer may elect to use some of the allotted time for other purposes.

PRE-COURSE KNOWLEDGE QUESTIONNAIRE

Instructions: In the space provided, print a capital "T" if the statement is true or a capital "F" if the statement is false.

Effective teaching Skills	
1. Competency based training is based on learning by doing rather than learning by acquiring new information.	____
2. Moving about the room while facilitation is not good as it distracts the students.	____
3. A clinical simulation helps in developing a good attitude than gaining good clinical skills.	____
4. The first step in the clinical decision making process is to diagnose	____
Management of Shock: Rapid Initial Assessment	
5. Rapid initial assessment should be carried out on all women of childbearing age who present with a problem.	____
6. A woman who suffers shock as a result of an obstetric emergency may have a fast, weak pulse	____
7. An atonic uterus is a common cause of immediate postpartum hemorrhage.	____
Bleeding during Pregnancy and Labor	
8. The presenting symptoms for threatened abortion include light vaginal bleeding, closed cervix and uterus that corresponds to dates	____
9. Assessment of a woman who presents with vaginal bleeding after 22 weeks of pregnancy should be limited to only abdominal examination and NO vaginal	____

examination.	
10. Abruptio placentae is the detachment of a normally located placenta from the uterus before the fetus is delivered	____
Bleeding after Childbirth	
11. Postpartum hemorrhage is defined as sudden bleeding after childbirth.	____
12. Continuous slow bleeding or sudden bleeding after childbirth requires early and aggressive intervention.	____
13. Absent fetal movements and fetal heart sounds, together with intra-abdominal and/or vaginal bleeding and severe abdominal pain, suggest ruptured uterus.	____
Management of Third Stage of Labor	
14. Active management of the third stage of labor should be practiced only on women who have a history of postpartum hemorrhage.	____
15. If a retained placenta is undelivered after 30 minutes of oxytocin administration and controlled cord traction and the uterus is contracted, controlled cord traction and fundal pressure should be attempted.	____
16. Administering Tab. Misoprostol 600 mcg orally is Active Management of third stage of labor	____
Complications during pregnancy	
17. Hypertension in pregnancy can be associated with protein in the urine.	____
18. The presenting signs and symptoms of eclampsia include convulsions, diastolic blood pressure of 90 mm Hg or more after 20 weeks gestation and proteinuria of 2+ or more.	____
19. A pregnant woman who is convulsing should be protected from injury by moving objects away from her.	____
20. The management of mild pre-eclampsia should include sedatives and tranquilizers.	____
21. The drug of choice for preventing and treating convulsions in severe pre-eclampsia and eclampsia is diazepam.	____
Partograph	
22. Cervical dilatation plotted to the right of the alert line on the partograph indicates unsatisfactory progress of labor.	____
23. Relief measures for abdominal (or groin) pain during labor include having the women change position frequently.	____
24. Vaginal examination should be conducted during labor at the initial assessment and then every 4 hours, unless otherwise indicated	____
25. A head that is felt in the flank on abdominal examination indicates a shoulder presentation or transverse lie.	____
26. When the fetal head is well flexed with occiput anterior or occiput transverse (in early labor), normal childbirth should be anticipated.	____
27. Examination of the vagina and perineum after delivery should be conducted only if the woman has excessive bleeding	____

Normal Labor and Childbirth	
28. If the active phase of labor is prolonged, delivery should be a cesarean section.	____
29. Breast pain and tenderness 3 to 5 days after childbirth is usually due to breast engorgement.	____
Newborn Care	
30. When using a bag and mask to resuscitate a newborn, the newborn's neck must be slightly extended to open the airway.	____
31. A baby should be exclusively breastfed for 3 months and then should begin receiving complimentary foods in addition to breast milk	____
32. The newborn loses heat if the skin of the baby comes in contact with cold surfaces or is exposed to cold air	____
Infection Prevention	
33. Infection can be transmitted from clients to health care workers through splashes in the health care worker's eye of contaminated blood or body fluids	____
34. Hands do not need to be washed before putting on examination gloves	____
STI, HIV and PPTCT of HIV	
35. STIs including HIV are more easily transmitted from men to women than from women to men.	____
36. Pregnancy makes HIV disease worse	____
37. If a woman is HIV positive, all her babies would be HIV positive as they share the same blood	____
Family planning	
38. For health reasons the woman should wait for at least 1 year after delivering a baby before becoming pregnant again.	____
39. Oral contraceptives offer some protection from ovarian and endometrial cancer	____
40. Copper bearing IUCDs prevent pregnancy by preventing the sperm and ovum from meeting	____

Pre-course knowledge assessment – Answer keys

Effective teaching Skills	
1. Competency based training is based on learning by doing rather than learning by acquiring new information.	**TRUE**
2. Moving about the room while facilitation is not good as it distracts the students.	**FALSE**
3. A clinical simulation helps in developing a good attitude than gaining good clinical skills.	**FALSE**
4. The first step in the clinical decision making process is to diagnose	**FALSE**
Management of Shock: Rapid Initial Assessment	
5. Rapid initial assessment should be carried out on all women of childbearing age who present with a problem.	**TRUE**
6. A woman who suffers shock as a result of an obstetric emergency may have a fast, weak pulse	**TRUE**
7. An atonic uterus is a common cause of immediate postpartum hemorrhage.	**TRUE**
Bleeding during Pregnancy and Labor	
8. The presenting symptoms for threatened abortion include light vaginal bleeding, closed cervix and uterus that corresponds to dates	**TRUE**
9. Assessment of a woman who presents with vaginal bleeding after 22 weeks of pregnancy should be limited to only abdominal examination and NO vaginal examination.	**TRUE**
10. Abruptio placentae is the detachment of a normally located placenta from the uterus before the fetus is delivered	**TRUE**
Bleeding after Childbirth	
11. Postpartum hemorrhage is defined as sudden bleeding after childbirth.	**FALSE**
12. Continuous slow bleeding or sudden bleeding after childbirth requires early and aggressive intervention.	**TRUE**
13. Absent fetal movements and fetal heart sounds, together with intra-abdominal and/or vaginal bleeding and severe abdominal pain, suggest ruptured uterus.	**TRUE**
Management of Third Stage of Labor	
14. Active management of the third stage of labor should be practiced only on women who have a history of postpartum hemorrhage.	**FALSE**
15. If a retained placenta is undelivered after 30 minutes of oxytocin administration and controlled cord traction and the uterus is contracted, controlled cord traction and fundal pressure should be attempted.	**FALSE**
16. Administering Tab. Misoprostol 600 mcg orally is Active Management of third stage of labor	**FALSE**
Headaches, Blurred Vision, Convulsions, Loss of Consciousness or Elevated Blood Pressure	
17. Hypertension in pregnancy can be associated with protein in the urine.	**TRUE**
18. The presenting signs and symptoms of eclampsia include convulsions, diastolic blood pressure of 90 mm Hg or more after 20 weeks gestation and proteinuria of 2+ or more.	**TRUE**
19. A pregnant woman who is convulsing should be protected from injury by moving objects away from her.	**TRUE**
20. The management of mild pre-eclampsia should include sedatives and tranquilizers.	**FALSE**
21. The drug of choice for preventing and treating convulsions in severe pre-eclampsia and eclampsia is diazepam.	**FALSE**
Partograph	
22. Cervical dilatation plotted to the right of the alert line on the partograph indicates unsatisfactory progress of labor.	**TRUE**

Normal Labor and Childbirth	
23. Relief measures for abdominal (or groin) pain during labor include having the women change position frequently.	**TRUE**
24. Vaginal examination should be conducted during labor at the initial assessment and then every 4 hours, unless otherwise indicated	**TRUE**
25. A head that is felt in the flank on abdominal examination indicates a shoulder presentation or transverse lie.	**TRUE**
26. When the fetal head is well flexed with occiput anterior or occiput transverse (in early labor), normal childbirth should be anticipated.	**TRUE**
27. Examination of the vagina and perineum after delivery should be conducted only if the woman has excessive bleeding	**FALSE**
28. If the active phase of labor is prolonged, delivery should be a cesarean section.	**TRUE**
29. Breast pain and tenderness 3 to 5 days after childbirth is usually due to breast engorgement.	**TRUE**
Newborn Care	
30. When using a bag and mask to resuscitate a newborn, the newborn's neck must be slightly extended to open the airway.	**TRUE**
31. A baby should be exclusively breastfed for 3 months and then should begin receiving complimentary foods in addition to breast milk	**FALSE**
32. The newborn loses heat if the skin of the baby comes in contact with cold surfaces or is exposed to cold air	**TRUE**
Infection Prevention	
33. Infection can be transmitted from clients to health care workers through splashes in the health care worker's eye of contaminated blood or body fluids	**TRUE**
34. Hands do not need to be washed before putting on examination gloves	**FALSE**
STI, HIV and PPTCT of HIV	
35. STIs including HIV are more easily transmitted from men to women than from women to men.	**TRUE**
36. Pregnancy makes HIV disease worse	**FALSE**
37. If a woman is HIV positive, all her babies would be HIV positive as they share the same blood	**FALSE**
Family planning	
38. For health reasons the woman should wait for at least 1 year after delivering a baby before becoming pregnant again.	**FALSE**
39. Oral contraceptives offer some protection from ovarian and endometrial cancer	**TRUE**
40. Copper bearing IUCDs prevent pregnancy by preventing the sperm and ovum from meeting	**TRUE**

CLINICAL EXPERIENCE QUESTIONNAIRE AND PERSONAL LEARNING PLAN

Date:

Instructions: Review the list of skills, below, and please answer the questions honestly. This will help you and the course facilitators in addressing your learning needs**.**

CLINICAL EXPERIENCE QUESTIONNAIRE		
	DO YOU FEEL CONFIDENT AND COMPETENT IN THIS SKILL?	**WHEN DID YOU LAST PRACTICE THIS SKILL WITH A CLIENT ?**
ANTENATAL CARE		
Antenatal care, identifying risk factors		
LABOR AND CHILDBIRTH CARE		
Initial assessment in labor		
Use of the partograph		
Ongoing assessment and care throughout labor		
Clean and safe childbirth, including active management of the third stage of labor and examination of placenta and birth canal		
Management of prolapsed cord		
Management of shoulder dystocia		
Episiotomy and repair		
POSTPARTUM AND NEWBORN CARE		
Postpartum history taking and examination		
Postpartum care, including breastfeeding support		
Management of vaginal bleeding after childbirth		
Bimanual compression of the uterus		
Fever after childbirth		
Inspection and repair of perineal and vaginal tears		
Family planning counseling and assessment		
NEWBORN CARE		
Immediate newborn care, including warmth, cord care, and breastfeeding		
Newborn resuscitation		
Newborn examination		
OTHER		
Inserting IUCDs		
Using IMCI chart booklet to diagnose and treat newborns		N/A
Implementing PPTCT program		N/A
Teaching clinical-decision making skills		
Demonstrating hand or procedural skills		

Name:_____ **Date:**_____

Review the list of skills and determine the five priority areas in which you wish to improve your knowledge and/or skills.

The **five priority** areas for my learning plan are:

1. _____
2. _____
3. _____
4. _____
5. _____

For each of the five priority areas listed above, I wish to focus on the following component(s) of care (check all that apply):

1._____

❒ Patient assessment/diagnosis ❒ Clinical procedures
❒ Patient management ❒ Infection prevention

2._____

❒ Patient assessment/diagnosis ❒ Clinical procedures
❒ Patient management ❒ Infection prevention

3._____

❒ Patient assessment/diagnosis ❒ Clinical procedures
❒ Patient management ❒ Infection prévention

4._____

❒ Patient assessment/diagnosis ❒ Clinical procédures
❒ Patient management ❒ Infection prévention

5._____

❒ Patient assessment/diagnosis ❒ Clinical procedures
❒ Patient management ❒ Infection prevention

ANM FACULTY TRAINING

INDIVIDUAL AND GROUP ASSESSMENT MATRIX

DATE: _____ **TRAINER(S):**_____

Question number	**CORRECT ANSWERS** (Participants)																				Categories
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	
1																					**Effective teaching Skills**
2																					
3																					
4																					
5																					**Management of Shock: Rapid Initial Assessment**
6																					
7																					
8																					**Bleeding during Pregnancy and Labor**
9																					
10																					
11																					**Bleeding after Childbirth**
12																					
13																					
14																					**Management of Third Stage of Labor**
15																					
16																					
17																					**Headaches, Blurred Vision, Convulsions, Loss of**
18																					

19																					**Consciousness or Elevated Blood Pressure**
20																					
21																					
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36																					
37																					
38																					**Family planning**
39																					
40																					

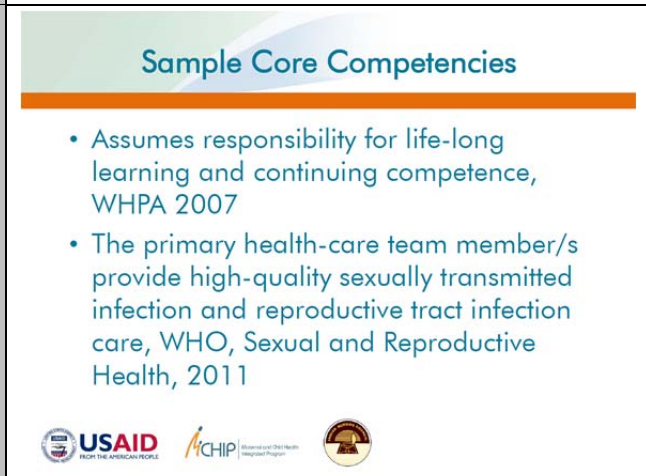
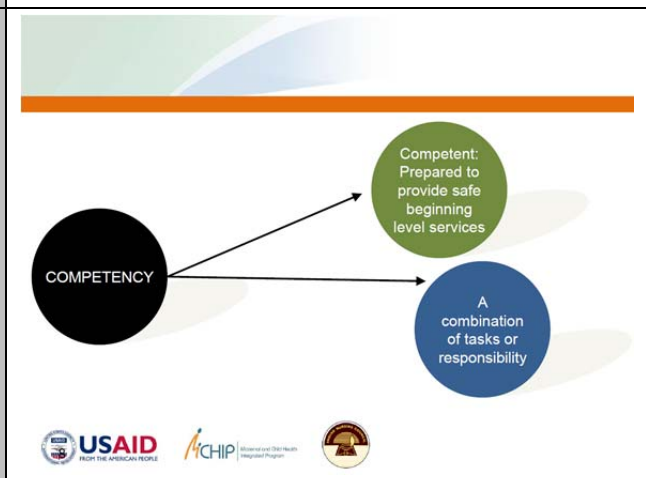
EXERCISES AND ANSWER KEYS

SECTION I

EFFECTIVE TEACHING SKILLS AND PROFESSIONAL RESPONSIBILITIES

Slide 1	Foundations of Educating Healthcare Providers	
Slide 2	Objectives • Describe the guiding principles of educating healthcare providers • Define core competencies and their role in curriculum development and design	
Slide 3	Educational Guiding Principles Students Education improves clinical service Curriculum Health services communities Clinical service improves education	The education of healthcare providers must: ▪ Address the priority health needs and problems within a society, ▪ Identify national policies, guidelines, and standards that are relevant to those needs and problems, and ▪ Define the expected role of healthcare providers. There should be consistency between the curriculum goals, the health services and communities and students. Education and clinical services should support and inform each other.

Slide 4	**Provider Roles** • Caregivers • Decision-makers • Communicators • Community leaders • Managers USAID FROM THE AMERICAN PEOPLE 4CHIP	Health care providers serve in many roles Health professional career: ▪ Begins with undergraduate education ▪ Continues throughout professional practice ▪ Includes inservice training and/or continuing education ▪ Providers should be life-long learners
Slide 5	**Academic Program** • Courses designed to support overall program goals and desired core competencies • Core competencies reflect national health priorities, professional job responsibilities, community needs USAID FROM THE AMERICAN PEOPLE 4CHIP	Refer to figure 1-2 on page 1-6 A series of courses that have both theoretical and practical components and are designed to prepare students as a specific category of healthcare provider. Core competencies are: Aspects of a subject or discipline that are common to all students, essential to practice, and essential to master in order to graduate from an academic program and enter into practice. Each core competency for an academic program may include cognitive (knowledge), psychomotor (skills) and affective (values and behaviors) domains.

Slide 6		Example One: Note that there is knowledge, skill and behavioral components. This is an International example. Note that competencies are very high-level and general…not detailed or specific.
Slide 7		As '' from WHPA publication in 2007 on health consultant competencies or 'the primary health-care team member/s provide high-quality sexually transmitted infection and reproductive tract infection care' from WHO SRH competencies from 2011 or 'Apply the principles of the cellular and molecular basis of immune and nonimmune host defence mechanisms in health and disease to determine the etiology of disease, identify preventive measures, and predict response to therapies' from AAMC in 2009.
Slide 8		

ACTIVITIES:

Activity 1.1 : Foundations of education activity

- Prepare 5–10 flip charts around the room, each labeled competency (# can be anticipated based on complexity of program cadre)
- Lead the large group in a brainstorming activity aimed at identifying the core competencies that graduates of their programs need to achieve in order to be safe, beginning-level providers. You can also use identified core competencies that relate to the technical content if they exist.
- If existing core competencies are available, i.e., ICM core competencies for midwifery, attempt to reconcile it with the results of the brainstorming session.
- Label the flip charts with the consensus list of target competencies.
- Give each learner 10 small Post-it notes, instructing them to place them on the competencies that they believe require the greatest attention in the curriculum. (Note that they can distribute their notes equally between competencies or place all ten on one competency).

Allow about 20 minutes for this.
Discuss the distribution of the notes while counting and removing the flip chart paper; write the number of votes for each competency on the flip chart with a marker.

- Which competencies deserve the most attention?
- Why? Because of their complexity, difficulty to learn, distribution of knowledge, skills and attitudes.
- Ask learners to move to the flip charts and using markers, write as many courses in their curriculum that they believe address each competency. (Note that some courses may address many competencies).
- Discuss the findings.
- Which courses address which competencies?
- How effective is the current distribution of courses?
- What suggestions does the group have for improvement?

Slide 1	Develop Objectives for Learning	
Slide 2	**Introduction** • What are learning objectives? • Have you ever written objectives? • Easy to write? • Look at Figure 2-1	Review Figure 2-1 in the Effective Teaching manual: How Objectives Guide Teaching
Slide 3	**Objectives** • Identify the knowledge, skills, and attitudes to be learned in your course • Write course objectives • Write supporting objectives	

Slide 4		
		Who is familiar w/ learning domains? Knowledge = what we know & is also known as the cognitive learning domain Skills = what we do or perform & is also known as the psychomotor learning domain Attitudes = how we feel about what we know and do & is also known as the affective learning domain Every competency consists of either skills (psychomotor, communication, clinical decision making), knowledge (ability to analyze and make decisions), and attitudes (personal feelings). Note: attitudes are important to address, especially related to professional behavior and social accountability. They are often addressed by speaking to the desired **behaviors**, often observed during clinical skill performance.

Slide 5	**Example** • Refer to sample 2-1 and 2-2 • How is the course objective different from the supporting objectives? • What is the purpose of the supporting objectives?	Sample 2-1 is on page 2-9 of the Effective Teaching manual Sample 2-2 is on page 2-10 of the Effective Teaching manual Course objective (s) —also known as a main objective, primary objective, or course aim—describe in clear, measurable terms what students should know and be able to do after completing the entire course. A course may have one or several course objectives. Course objectives should directly support one or more of the core competencies for the overall academic program. Supporting objectives (also known as a secondary, specific, instructional, or enabling objective) support the main objective by describing the specific knowledge, skills, and attitudes that students must master to achieve the main objective.
Slide 6	**Sample Course Objective** • After completing this course, the student will assess, classify, and treat a sick child in an effective and integrated manner. • *Refer to action verbs in table 2-1*	Table 2-1 is on page 2-7 of the Effective Teaching manual Course objectives relate directly to the core competencies required for an academic program. A course objective is fairly broad and may encompass knowledge, skill, and attitude components. Identify the: **When** to demonstrate the knowledge or perform the skill (After completing this course). **Who** will demonstrate competency (the student). **What** will be demonstrated (action verbs—assist, administer, insert). May also include **how well** or to what standard it must be demonstrated

Slide 7	**Supporting Objective Examples** • Label a diagram with the organs of the male and female reproductive systems • List the signs of correct positioning and attachment for breastfeeding • Describe how to counsel an adolescent about STIs • Demonstrate how to put a condom on a penis model • Identify the signs and symptoms for each severe classification in the Integrated Management of Childhood Illness (IMCI) clinical guidelines	Note each one includes: the **what** as an action verb, and the object of that action: ▪ **Label** a diagram with the organs of the male and female reproductive systems ▪ **List** the signs of correct positioning and attachment for breastfeeding ▪ **Describe** how to **counsel** an adolescent about STIs ▪ **Demonstrate** how to **put** a condom on a penis model ▪ **Identify** the signs and symptoms for each severe classification in the Integrated Management of Childhood Illness (IMCI) clinical guidelines
Slide 8	**Organize Supporting Objectives** • Simple to complex • Performance order • Related objectives • Look at Samples 2-1 and 2-2	Simple to complex – begin with simple objectives and move on to more complex Performance order – place the learning objectives in the order in which the skills would be performed on the job Related objectives – combine related objectives so that the information given builds on the previous sessions Sample 2-1 is on page 2-9 of the Effective Teaching manual Sample 2-2 is on page 2-10 of the Effective Teaching manual

Slide 9		
	Summary • What are the 3 learning domains? • What are the 2 levels of objectives we are using? • What are the 4 parts of a course objective? • What are the 2 parts of a supporting objective? • How can you order your supporting objectives? • Ready for an activity? →	3 learning domains: knowledge, attitude, skills 2 levels of objectives: main (course) objective & supporting (secondary) objective 4 parts of a course objective: when to demonstrate the knowledge or perform the skill, who will demonstrate competency, what will be demonstrated, and evaluation criterion (how well the performance must be demonstrated) 2 parts of a supporting objective: specific action to be taken & object of the action How to order supporting objectives: remember that the order of the objectives will be similar to the order that you use to teach the content during your course. Simple to complex, performance order, and related objectives should all be considered.

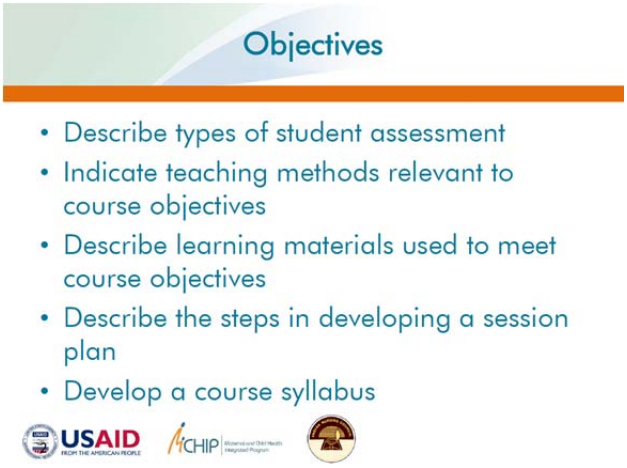
Activity 1.2 : Critique of learning activities

- Divide the trainees into small groups.
- Provide them with sample objectives.
- Ask them to critique on the objectives and improve on them.
- Each group has 30 minutes to work on.
- A representative from each group can present the findings of the group in the large group.

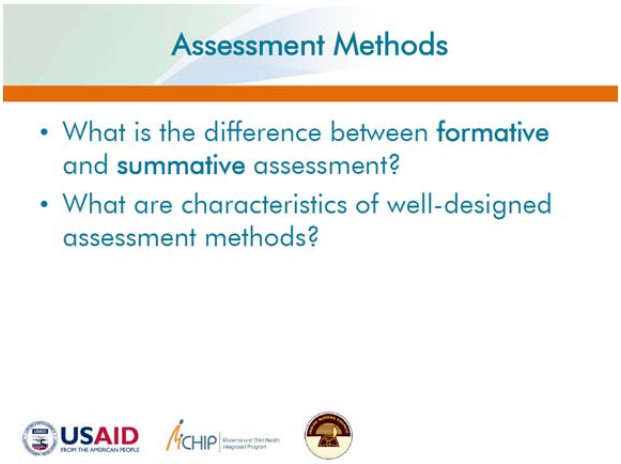
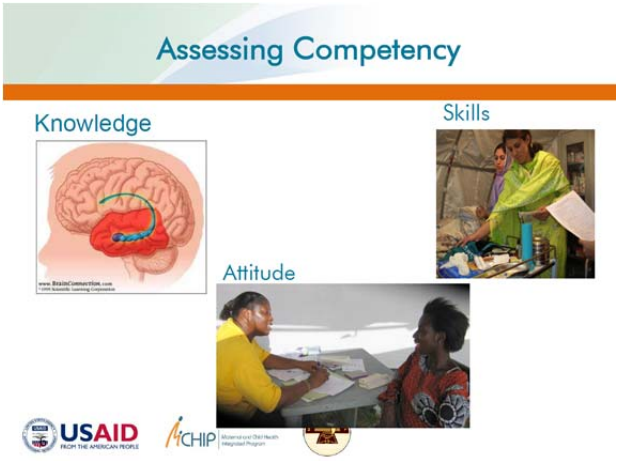
Sample course objectives

On completion of the course the student will be able to:

1. Describe the male and female reproductive organs.
2. Explain the process of conception and foetal development.
3. Describe the female pelvis and the muscles involved in delivery of the fetus.
4. Conduct normal delivery and provide care to the newborn.
5. Provide need based counseling to the mother and to her family during antenatal, intra natal and post natal period at home and hospital.
6. Provide need based counseling to the mother and to her family during the antenatal, intranatal and postnatal period.
7. Resuscitate the high risk newborn baby.
8. Identify highrisk pregnancies and refer them immediately for safe motherhood.
9. Identify deviation from normal labour in time and take necessary action.
10. Provide adequate care identifying normal puerperium.
11. Administer the drugs as per the protocol.
12. Educate community for improving quality of life of the family.
13. Provide care and guidance to women with reproductive health problems.
14. Participate in reproductive health and family welfare programs

Slide 1		Effective teaching requires careful planning. As a teacher, you may be responsible for planning or adapting entire courses, or parts of courses. Plan carefully for teaching by developing a course syllabus, planning for student assessment, selecting teaching methods, identifying learning materials, and developing a course schedule.
Slide 2		

Slide 3	**Plan for Student Assessment** • *Insert a photo of a multiple-choice question exam and another of a student being examined doing an OSCE*	Ask the participants what the main purpose of student assessment is. Guide them to the answer that it is to 'improve students learning'. Ask the participants WHY we assess students – write the responses on a flip chart. Review responses, ensuring key elements are described: ▪ Help teachers decide if students should progress to the next stage of study ▪ Motivate students by providing feedback on their progress ▪ Determine if the course is meeting its objectives ▪ Ensure that important subjects are given priority within the course ▪ Offer evidence to national regulating authorities that standards are being met
Slide 4	**What Does Effective Assessment Require?** 	Have participants turn to page 3-5 of the resource manual and invite individuals to read the 8 bullets. Highlight the three elements of competency (knowledge, attitude, skills). Ask if effective assessments must measure all three (the response is no, many assessments, such as MCQ only test knowledge, but this method of assessment is still effective; it is important to ensure other assessment measures are included for a defined competency) *(image from American Lung Association, Christmas Seals)*

Slide 5		State that the objectives should guide the selection of appropriate assessment methods. **Formative assessment:** helps students to improve performance by providing feedback **Summative assessment:** determines if a student should move to the next stage of studies Discuss the importance of validity, reliability, feasibility, objectivity, and criterion-referencing with regards to assessment procedures. Refer to pp. 3-8 to 3-10 in the resource manual if necessary.
Slide 6		#1: Discuss means to assess knowledge. Refer to Table 3-2 on page 3-15 in the resource manual (Drills, quizzes, and practice tests; Written exercises; Case studies, clinical scenarios, and patient management problems; Project reports; Essay examinations; Objective written examinations; Structured practical examinations; Oral examinations; Clinical rounds.) #2: Discuss means to assess skills. Refer to Table 3-3 on page 3-16 in the resource manual. #3: Discuss which of these assessment methods described under knowledge and skills may also be used to assess attitudes

Slide 7	**Teaching Methods** • Brainstorming • Case Study • Clinical Simulation • Demonstration • Discussion • Facilitated Practice • Game • Guest Speaker • Individual or Group Tutorial • Interactive Presentation • Panel Discussion • Role Play • Study Trip	Ask the participants what type of teaching methods they currently use. Have a participant write down the responses on a flip chart. Do not reveal the slide responses until discussed. When reviewing the methods, consider the following questions: ▪ Are the resources that this method requires available? ▪ Are special facilities required? ▪ What is the projected size of the class? ▪ Is a special room arrangement needed for this method?
Slide 8	**Importance of Practice** • Students need opportunities to practice or apply new knowledge, skills, and attitudes. • Practice activities have two essential features: practice and feedback. • Practice and feedback will also help students to develop appropriate attitudes.	Throughout the course, schedule practice activities including reading, homework, or other assignments to help students apply new knowledge, skills, and attitudes. Practice opportunities can occur individually or in groups.
Slide 9	**Selecting Learning Materials** • Appropriate to the learning objective(s) • Up-to-date, unbiased, factual, consistent, and technically correct • Feasible (i.e. will visual aids work with the equipment that is already available?) • Relevant and culturally appropriate • At the appropriate reading level • Affordable	Learning is more effective when a variety of appropriate materials are used. Ensure the materials are:

Slide 10

Types of Materials

- Handouts (worksheets, notes)
- Printed materials (textbooks, manuals, job aids, workbooks, exercises, checklists, schedule books)
- Visual aids (videotapes, audiotapes, flipcharts)
- Computer-based materials (CD-ROMs)

Some materials are more effective for teaching and learning concepts and principles, while others are more effective for demonstrating and practicing skills. It is important to have a variety of learning materials to meet the learning needs of different students.

Slide 11

Develop a Course Schedule

- The **course schedule** is a session-by-session summary of learning activities and topics for the course.

The course schedule is a session-by-session summary of learning activities and topics for the course. It should include the dates of the course sessions, as well as due dates for assignments, details on planned activities, and times scheduled for practice, activities, and tests.

Refer to Sample 3-1 on pages 3-27 to 3-30 and sample 3-2 on pages 3-31 to 3-34 in the reference manual

Slide 12

Session Plan

Date: June 23, 2009	Venue: Lecture Hall 1	Duration: 210 min	Session no.:1
Topic: Plan for teaching			

Session Objectives

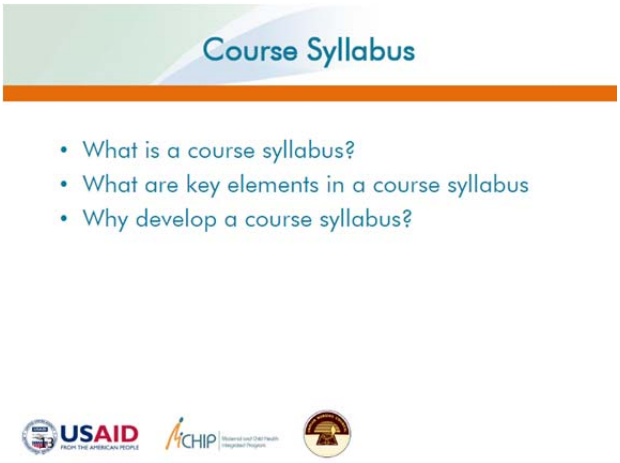
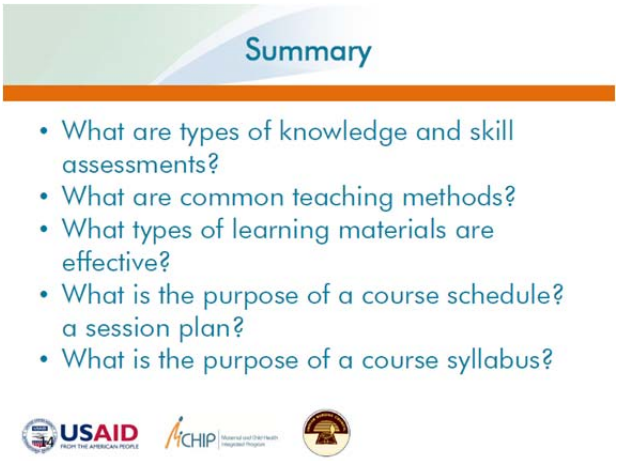
By the end of this session, students will be able to:

- Develop a course syllabus
- Plan for student assessment
- Select teaching methods
- Select and adapt learning materials
- Develop a course schedule
- Prepare a session plan

Methods and Activities	Materials/Resources
• Brainstorm/Intro (10 min) • Interactive presentation (60 min) • Group work adapting course syllabus and write session plans (110 min) and present 5 min each group (25) • Summary (5 min) Review/Evaluation notes:	• PowerPoint slides • ETS LRP • Laptop and LCD • Flipchart paper • Markers

Mention review and evaluation. Go through this sample lesson plan and describe how lesson plans can assist with teaching:

- Provides structure of a session
- Helps to keep track of the session
- Saves time when to present it again

Slide 13		The syllabus is a CONTRACT between you and the students Have participants turn to the Effective Teaching resource manual and look at Sample 3-1 on pp. 3-27 to 3-30 and Sample 3-2 on pp. 3-31 to 3-34
Slide 14		Knowledge assessment methods include quizzes, written exercises, project reports. Skill assessment methods include direct observation, logbooks, structured practical examinations Common teaching methods include brainstorming, case studies, facilitated practice, games, guest speakers, etc. Effective learning materials include handouts, visual aids, computer-based materials, textbooks, etc. The course schedule allows students to see the sequence of course and clinical activities. A session plan provides detailed information for the portion of a course. A course syllabus is the design document for a course, providing all of the basic information about a course.

Slide 15	**45 Minutes to Develop a Syllabus** • Divide into (4) small groups • Each group will take the objectives they wrote for their course in Module 2 and create a course syllabus. Refer to Exercise 3-1 for guidance. • Each group will give examples of learning materials and methods of teaching & assessment that they would use for 2 of the learning objectives, using Table 3-5 in the resource manual as a template	Let the group know that they will have 45 minutes to work together and 10 minutes to present their syllabus to the group. After presenting their syllabus, they will be provided feedback by the larger group, taking the following questions into consideration: Are the teaching & assessment methods and learning materials appropriate for the learning objective?

Activity 1.3 : Prepare for teaching activity

Instructions

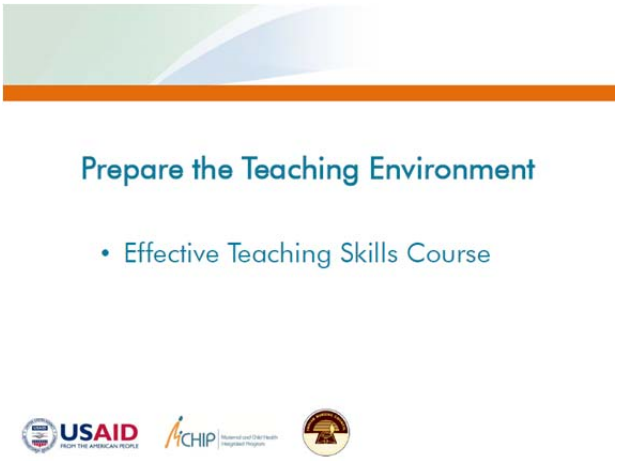
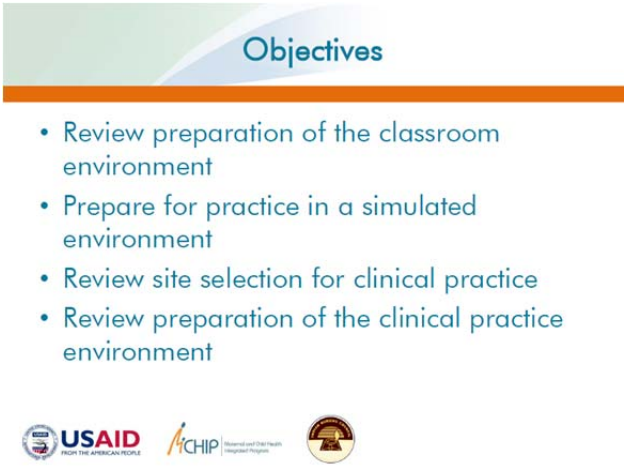
- Divide the group into groups of four. Assign each group one of these topics to discuss and present upon. They have 45 minutes to work, and each group will have about 10 minutes to present. If using educational performance standards-they can use the related standards to self-assess their performance.

- Group 1: Describe how you will integrate skills labs and practice into developing competency in family planning related skills

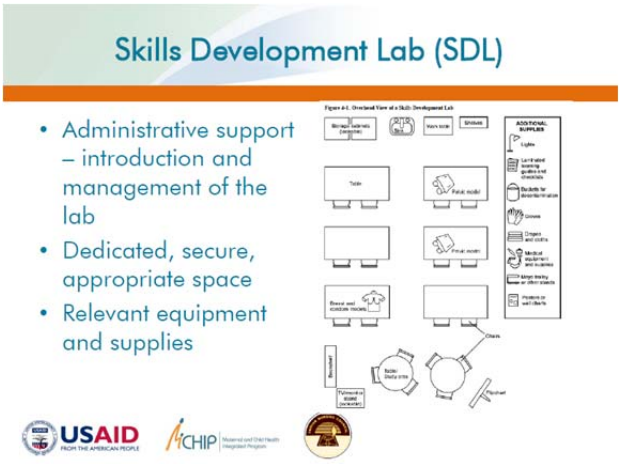
- Group 2: Review how you are currently using skills labs and identify how you will use them in the future

- Group 3: Identify ways to assess and document student's completion and mastery of skills in simulation

- Group 4: Identify ways you can increase students access to clients for clinical practice

Slide 1		In addition to planning for your course, you will need to prepare the classroom and clinical teaching environment. You must be well prepared for the theoretical and practical aspects of teaching to ensure that students have adequate opportunities to learn theory and apply knowledge, skills, and attitudes in the classroom, practice skills in a simulated environment, and work with appropriate patients in clinical practice sessions.
Slide 2		
Slide 3		Ask the participants to describe the **worst** teaching environment they have ever experienced & why. Ask the participants to describe the **best** and why.

Slide 4		
		The classroom should provide a good environment for learning. Indicate to participants that for 20–25 trainees there should be 60–80 m^2 of floor area, appropriately shaped (square). Ideally, there should be space for students to work in small groups (if applicable) Ask participants what materials should be available in the teaching/learning space to ensure learning: ▪ There should be some form of writing board, flipchart stand, and ideally a screen for a projector ▪ If there is a projector, there should be means for darkening the room without stopping ventilation ▪ Ideally the furniture should include moveable desks and chairs so that the participants can: Face each other during discussion or Face the screen/writing board when material is presented there

Slide 5		1) Ask the participants for examples of simulated practice activities. Examples: Practice counseling during role plays; Learn to perform a pelvic examination using an anatomic model; Practice counting breathing rate using videos of children with acute respiratory infections; Practice assessing maternal nutrition using simulated patients 2) Ask participants where simulation can take place. Examples: in the classroom (supplies ready, room set up); in a skills development lab or clinical skills center; and at the clinical practice site (take supplies and equipment, practice with feedback, good when caseload is low). 3) Ask participants the types of equipment used for simulated practice. Examples: Anatomic models; Learning materials (manuals, books, checklists, charts, exercises, etc.); Physical supplies (chairs, tables, AV equipment, flipchart with markers, etc.); and/or Medical supplies (gloves, instruments, drapes, IP supplies, etc.)
Slide 6		

Activity 1.4: Effective facilitation skills review

Instructions

Use a game or pose these questions to the large group. Reinforce key information after each question.

Game: Divide participants into three teams. Ask each team to decide on a team name. Give them 10 minutes to review Module 6 to prepare for the exercise.
Explain the rules for the exercise. You will ask 10 questions. Whoever thinks they can answer the question, claps (alternatively they can line up and 'grab' a marker or object). The first person to clap (or catch the marker or object) gets the first chance to answer the question. Five points are awarded to the team for the correct answer. If the team is not able to answer or if their answer is wrong, the question will pass to the next team. If this team answers correctly, they receive 3 points. If this team is not able to answer correctly, the question will pass to the third team. If this team answers correctly, they receive 1 point. Limit the activity to about 15-30 minutes.

1. Remember the basic facilitation process used for any activity from the Effective Facilitation Skills Module? Describe it:
   Answer should be similar to these steps: Introduce the activity, facilitate using questions, feedback, and audiovisual aids and summarize. All of this is based on a foundation of planning and organization.

2. What do you think is the most important part of INTRODUCING an activity?
   Answer:
   - Review the learning objectives-make sure the learner knows the expected outcome of the activity

3. These are basic tips that apply when using audiovisual aids, what are three of them?
   Answer can include any of these:
   - Make sure aids are visible
   - Make sure aids are easy to read and not crowded
   - Underline or emphasize important info
   - Prepare complicated materials before hand
   - Always face the learners
   - Always check equipment ahead of time before hand

4. There are many effective facilitation skills you can use when lecturing students or facilitating small group practice-list 5 of them.
   Answer can include any of these:
   - Project your voice
   - Maintain energy and enthusiasm
   - Communicate effectively
   - Use learners names
   - Provide feedback
   - Model behavior

- Respect time limits
- Ensure clear transitions

5. What is the most important thing to remember when providing feedback during learning? **Answer** should include something about feedback being specific. Whether it's positive feedback or suggestions for improvement-feedback is only as useful as it is specific.

6. There are many uses of questions or questioning during learning activities. As a teacher, what do you think are 3 important uses of questions when facilitating learning activities? **Answer** can include any of these. While all may be listed, the first three are the more critical uses of questions.
   - Assess learner understanding.
   - Help learners analyze information or apply to situations
   - Evaluate the effectiveness of the learning activity.
   - Engage your learners
   - Increase learner participation.
   - Respond to learners needs at a variety of stages (help master basic knowledge, then move to more complex understanding and comprehension)

7. Here are two sample presentations. Which of them do you think is more effective and why?

   Teacher A is presenting on anatomy and physiology. She uses diagrams in a text book as audiovisual aids. She doesn't use transparencies or a presented presentation. She asks checking questions to help learners apply the information during a discussion of voluntary surgical contraception.

   Teacher B is presenting on family planning counseling. She uses well created transparencies to outline the key steps involved in counseling. She involves students by asking them to read different parts of the presentation.

   Answer: Teacher A's presentation is more effective. While she doesn't use transparencies, she uses a more appropriate visual aid for detailed diagrams-a textbook. She also uses questions effectively-to help students learn.

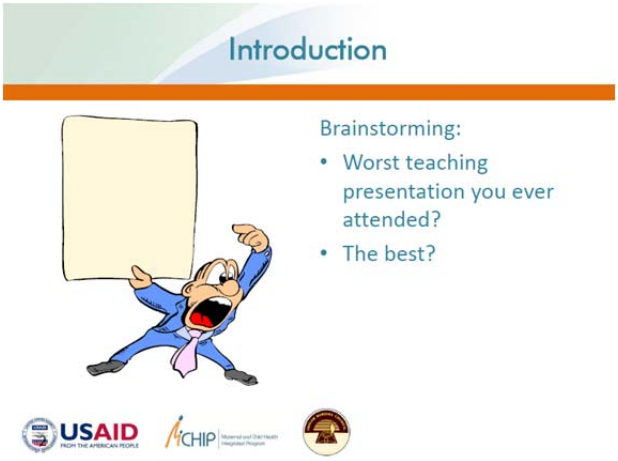
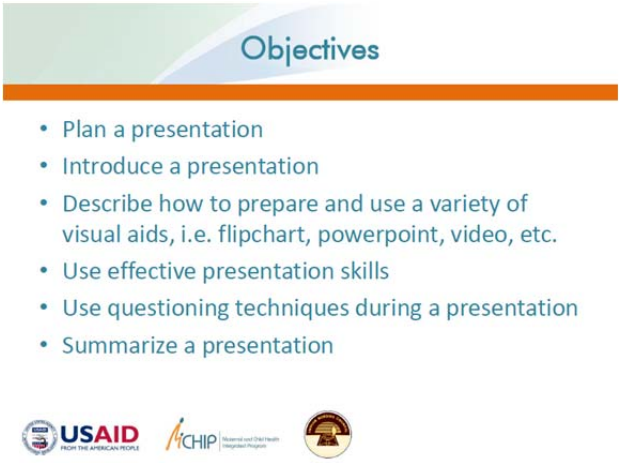
   Teacher B is using a presentation to teach about a skill-using demonstration would be a more effective learning activity for this objective. Also, asking students to read transparencies is not an effective way to transfer information or check understanding.

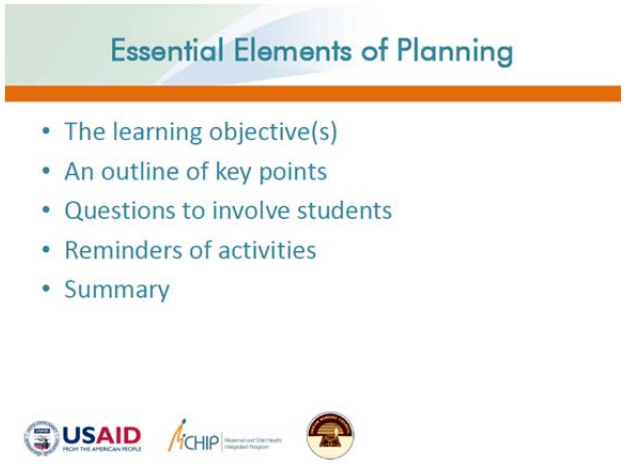
8. What is one way a discussion is different from a brainstorming session?

   Answer: Discussion is an opportunity for a group to discuss an issue, whereas brainstorming focuses on generating ideas but not discussing them at that time.

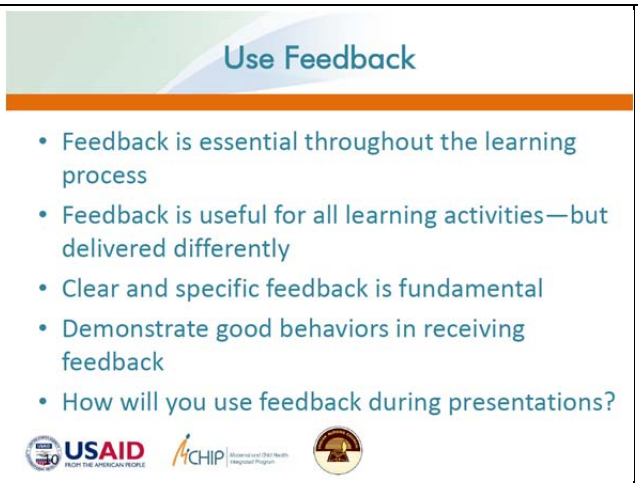
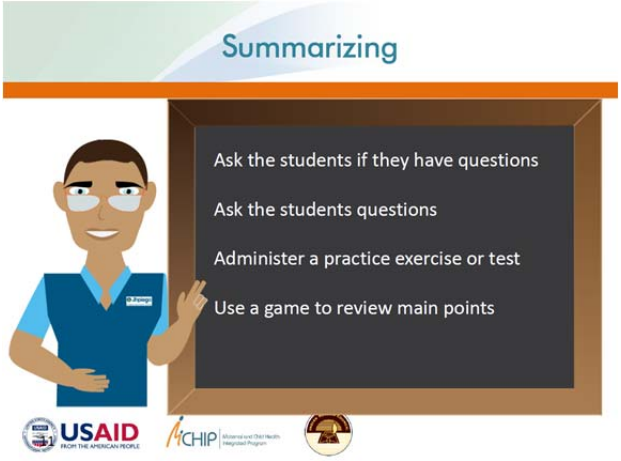
9. You have just done a demonstration of a psychomotor skill. List two important points about effective summaries to remember when summarizing this learning activity.

   Answer can include: Effective summaries should: reinforce understanding and review main points. The summary should also relate the content to other activities or topics and provide a clear transition.

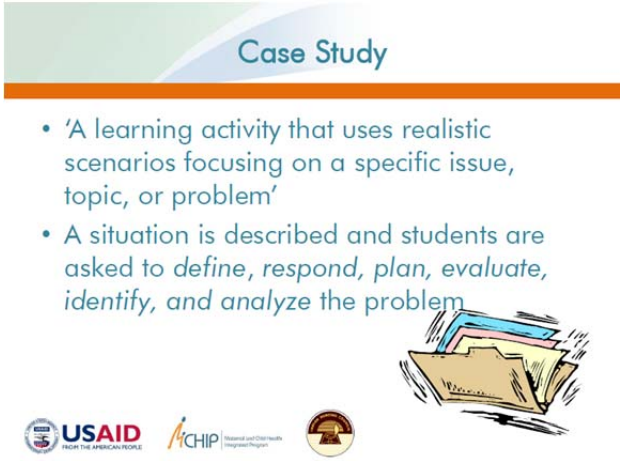
Slide 1		Delivering information through an effective interactive presentation can be one of a teacher's most exciting and rewarding experiences. Please note that modules five and six in the Effective Teaching manual are covered in this presentation.
Slide 2		Review with the participants the best presentation they gave or attended and contrast with the worst presentation. Discuss why they considered presentations good or bad.
Slide 3		This module focuses on introducing, planning, delivering, and summarizing interactive presentations.

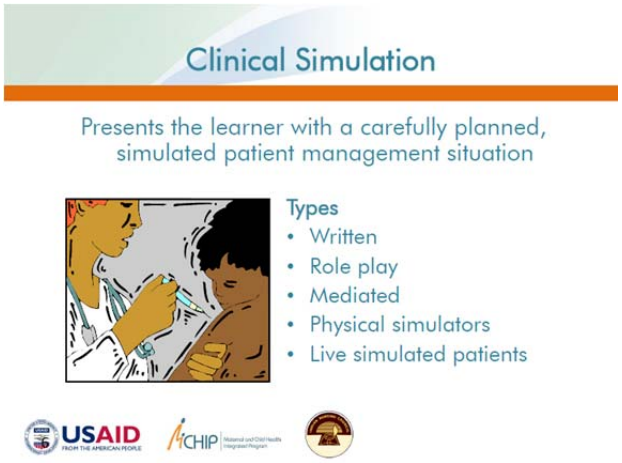
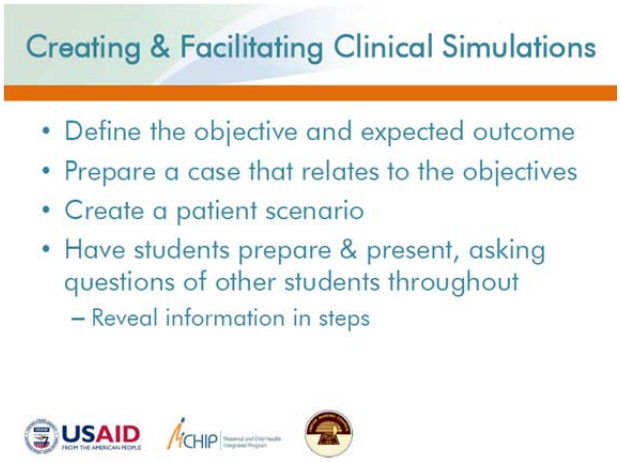
Slide 4		Discuss the use of the 5 items for developing a presentation plan: ▪ The learning objective = what students should know and be able to do after the presentation ▪ An outline of key points ▪ Key questions to engage students ▪ Reminders of activities during the presentation, i.e. use of visual aids or group learning activities ▪ Summary with questions, comments or activities
Slide 5		In addition to applying the basic facilitation skills, there is a basic process for all the learning activities you will conduct. It is is based on a foundation of good planning and organization. ▪ Introduction of the activity in a way that generates interest. Review the objective(s) of that learning activity. ▪ Conduct, or facilitate the learning activity using questioning, audiovisuals aids, feedback, etc. ▪ Summarize effectively and creatively.
Slide 6		▪ First step in the process of is providing a good introduction. The first few minutes are critical in stimulating student interest and providing clear information ▪ Every learning activity has an objective(s) and expected learning outcomes. The introduction is to ensure learners know the learning objectives. ▪ **ALL** learning activities should be introduced

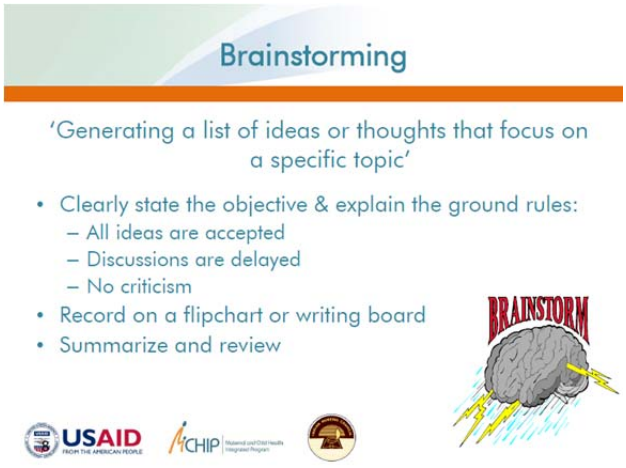
Slide 7	**Effective Facilitation** • Follow an outline • Communicate clearly • Display enthusiasm about everything! • Interact with students – Use appropriate audiovisual aids – Use feedback (positive) throughout – **Use questions**	Before showing the slide, ask the group what techniques can be used to make presentations more effective. Review the bullet point example. After introducing an activity, you will facilitate it using questioning techniques, audiovisual aids and feedback to help develop competencies in learners.
Slide 8	**Effective Use of Audiovisuals** • What are common tips for effective audiovisual use-no matter which format you use? • What are the uses of the audiovisuals? – Writing board – Flipchart – Overhead transparency – Slide – Video – Computer	Lead the group in a discussion about what makes a presentation effective, with regards to the audiovisuals used and brainstorm the use of the various audiovisuals – 10 mins ▪ Visible ▪ Easy to read ▪ Use highlighting or underlining ▪ Prepare ahead of time ▪ Keep graphics simple ▪ Don't turn your back ▪ Check equipment No matter which visual aids are used, remember to: ▪ Keep it simple ▪ Keep it relevant ▪ Keep it focused
Slide 9	**Using Questions Effectively** • Prepare questions in advance • Repeat correct answers • Address questions from the learners: • Use a variety of questioning techniques • If you don't know the answer, admit it! Find the answer for the next session Question 1	Emphasize with the learners that whenever possible, they should ask questions of the students during a presentation. Good questioning techniques include: ▪ Prepare your questions in advance. ▪ Repeat correct answers so everyone can hear ▪ Address and answer questions from the learners. Consider using a 'Parking Lot' flipchart ▪ Use a variety of questioning techniques

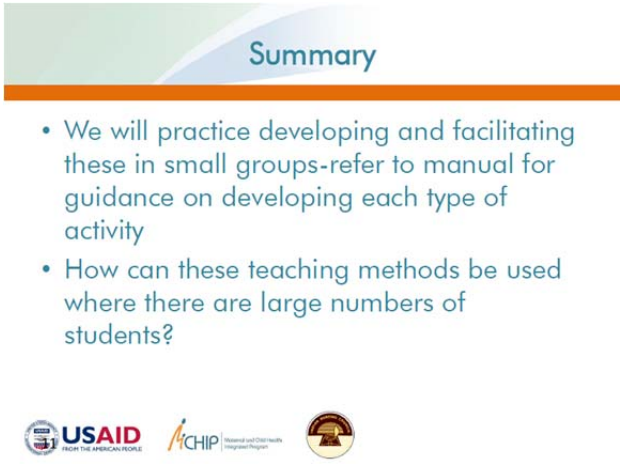
Slide 10		Providing clear and specific feedback is fundamental for learning and performance. Feedback is only as useful as it is clear and specific. Emphasize to participants that feedback is an essential part of any learning activity, not just skills coaching. Feedback: ▪ May be written or oral ▪ Is not provided in front of clients. ▪ Is short during discussions and presentations ▪ Is one-to-one and detailed during skills practice ▪ Should be modeled for learners
Slide 11		A good summary: ▪ Is brief and reinforces the main points ▪ Reminds learners of the relevance of the topic ▪ Relates the content to other activities and provides a clear transition If course topics are complex, use periodic summaries throughout the presentation to ensure students understand before moving ahead to new material.
Slide 12		Remember to 1) define learning objectives; 2) plan your presentation; 3) introduce each presentation; 4) use effective presentation skills; 5) use questioning techniques; and 6) summarize your presentation Review the facilitation skills checklist with participants as a review of the key points of the presentation. Ask the group how they can you use this to plan presentations, demonstrations, group activities?

Slide 1		Group learning activities can be used during classroom and practical sessions to help students build knowledge, skills, and appropriate attitudes.
Slide 2		In this module you will teach about five useful group learning activities: role plays, case studies, clinical simulations, brainstorming sessions, and discussions.
Slide 3		INTRODUCE: Describe the activity before dividing the students into small groups and explain how the group should record its decisions. Provide instructions on how each group will report back to the larger group. The activity is clearly described, stating **what** the students will do and the **time** they have to do it. Ask each group to select someone to act as the recorder.

Slide 4		Refer to Sample 7-1 on page 7-8 in the Effective Teaching reference manual. The three types of role plays are: ▪ **Informal**—acting it out with little or preparation time ▪ **Formal**—planned in advance with instructions ▪ **Demonstration**—of communication or other skills **Key points:** Provide clear instructions, explain what the other students should observe and what kind of feedback they should give, provide the students with questions or activities that will help them to focus on the main concepts being presented, keep the role play focused on the expected outcome, and summarize and link back to objectives.
Slide 5		A case study is a learning a learning activity. Students typically read, study, and react to the case study individually or in small groups. Refer to Sample 7-2 on Page 7-12 in the Effective Teaching reference manual. Students may be asked to do any of the following: Define the problem in the case study and develop suggestions for solutions; Respond to a clinical situation by suggesting appropriate interventions and discussing them; Evaluate clinical decisions and the process used to make the decision; Identify the possible impact of choices or decisions made; Analyze the causes of a problem; Identify attitudes that may influence the healthcare providers' behaviors described. When facilitating a case study, provide clear directions on how to complete the case study, how to present the answers, and the time limit or due date.

Slide 6		Clinical simulations are an excellent method for developing cognitive or clinical decision making skills and helping student practice responding to emergency situations. Clinical simulations can take a variety of forms, listed as 'types' on the slide. Refer to Sample 7-4 on page 7-23 in the Effective Teaching reference manual.
Slide 7		Define the objective and expected outcome: Will it be used to help students practice responding to emergency situations? To walk them through a clinical problem that will also require a demonstration of skills? Prepare a case that relates to the objectives: You may ask students to share cases from their own clinical experiences. Create a list of questions to ask students about how they would chose to manage the case. Create a patient scenario that includes the problem, the related lab and diagnostic results, and possible outcomes for different interventions. Document this information so that you do not have to re-crease scenarios. Have students prepare & present, asking questions of other students throughout. This type of clinical simulation is more effective with senior-level students who have more experience with managing patients.

Slide 8		If not reviewed in group discussions after the previous activity, discuss why brainstorming is useful: stimulates interest in a topic, allows students to share their ideas without criticism, allows for creative thinking, generates ideas, allows for expressing opinions, and encourage broad or creative thinking. The key to successful brainstorming is to separate the generation of ideas, or possible solutions to a problem, from the evaluation of these ideas or solutions.
Slide 9		Discussions create interest and stimulate thinking about a topic and encourage active participation. Other teaching methods which group discussions are useful for include: concluding a presentation; summarizing the main points of a videotape; checking students' understanding of a clinical demonstration; examining alternative solutions to a case study; exploring attitudes exhibited during a role play; and analyzing the results of a brainstorming session. Group discussions focus on the learning objectives. General discussions addresses students' questions about a learning topic. For example, a student asks about a situation she observed in the clinic. You decide that this is an important question and therefore devote 5 minutes to a general discussion. Panel discussion in which a moderator conducts a question and answer session among panel members and students.

Slide 10		The role of the discussion facilitator is to keep the discussion focused, ensure that all the students have an equal opportunity to participate, and to intervene when the discussion moves away from the objectives. Conclude the discussion with a summary of the main ideas and how they relate to the objectives presented during the introduction.
Slide 11		Whenever possible, prepare group learning activities to be included in classroom and practical sessions

Activity 1.5: Guide for role plays, case studies and clinical simulations

Use questions or discussion to review these key points about each of these learning activities:
Case Study

8. A case could be written type or narrated as a story, use a real client or a simulated one
9. Students should be provided with time to think critically on the information provided and analyze the situation before they are asked to respond to questions
10. Case description and posed questions should be clear

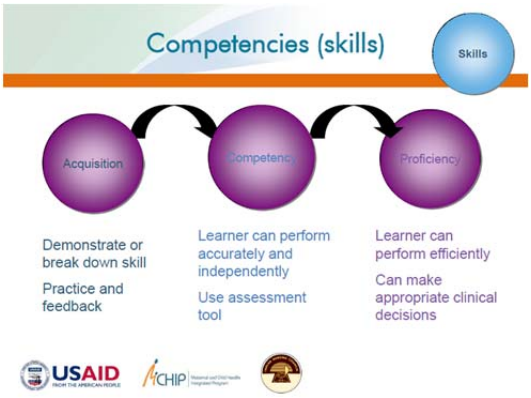
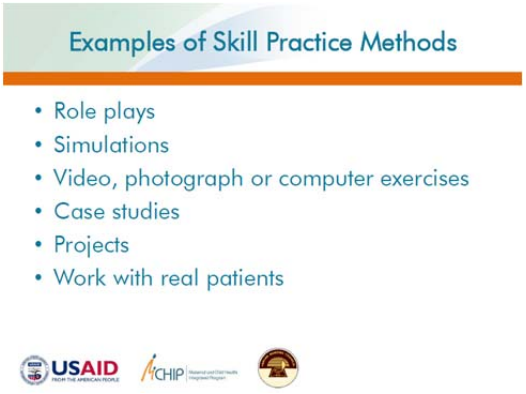
Role Play

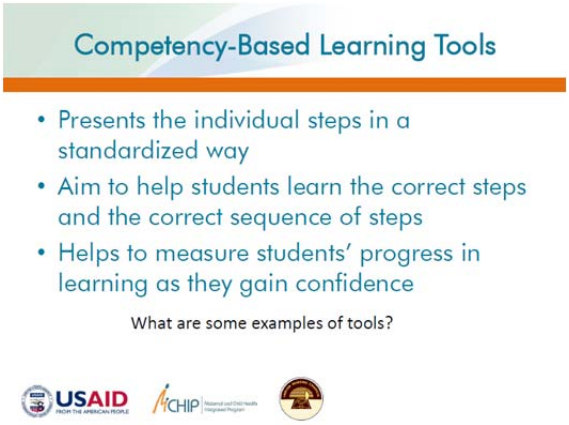
- It should be systematic and structured in a way and limited to 15 minutes
- Must link to an objective-not just be a drama
- Often used in demonstration and practice of counseling (and even clinical decision making skills)

Clinical Simulation

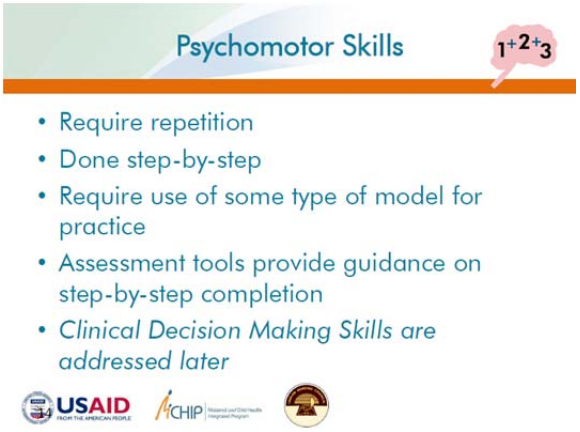
- Assists the learner in critical thinking and clinical decision making
- Use in combination with a structured assessment tool (checklist or other protocol)
- Has structured answers and questions for the facilitator

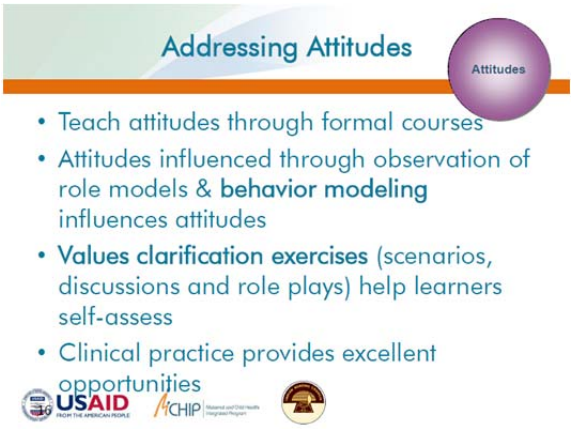
Slide 1		
Slide 2		Review the objectives with the participants. Ask the group why we demonstrate competencies? Where are core competencies or skills demonstrated? How and when are students given opportunities to practice these skills?
Slide 3		Review the competency domains When planning for teaching, one must think carefully about the skills students should master by the end of the course. Inform the participants that clinical decision making, a primary core competency, will be covered in the next presentation

Slide 4		The steps of skills development. There are three phases in the transfer and development of all types of skills. *Acquisition*: students are aware of the skill and know how it should be performed, but do not always perform it correctly *Competency*: students perform the skills correctly, but may not always progress from step to step efficiently *Proficiency*: last stage of skills development = consistently performing skills correctly and efficiently
Slide 5		Have participants turn to figure 8-2 on page 8-4 of the Effective Teaching manual.
Slide 6		

Slide 7		There are common steps when teaching all types of skills: ▪ Develop and review the assessment tools you plan to use ▪ Review and practice yourself to ensure proficiency ▪ Highlight the steps in the assessment tool ▪ Demonstrate correct behaviors ▪ Provide coaching and supportive feedback during practice
Slide 8		Tools include: Learning guides, Decision trees, Flowcharts, Algorithms, Posters, Charts Have participants refer to Figures 8-4 and 8-5 on pages 8-8 and 8-9, respectively, of the Effective Teaching manual.
Slide 9		A group of healthcare providers who are proficient in performing the skill are identified ▪ Observe several of the healthcare providers as they perform the skill. Record each step that each healthcare provider performs. ▪ Develop an initial list of steps. ▪ Discuss the skill with the same group of healthcare providers. ▪ Test the initial list of steps. ▪ Test the final standard way of performing the skill.

Slide 10	**How are the checklists used?** • Students can follow the steps while someone **demonstrates** • Pairs of students can work together to **practice** • Students can **observe** each other and give **feedback** • Before, during, and after clinical practice sessions, use as a **reference** • Students can **assess** themselves or peers	
Slide 11	**A Good Coach…** • Is **proficient** in the area being taught • **Supports** learners • **Facilitates** learning • Is **self-aware** • Provides **specific** feedback 	The most important step in teaching and learning skills is practice, performed by students in the presence of a clinical instructor or coach. The instructor must be proficient, preferably expert, in the skills being taught Good coaches: ▪ Introduce the practice session ▪ Facilitate the practice session ▪ promote open communication ▪ Actively listen ▪ provide feedback in a way that maintains learner self-esteem and encourages confidence ▪ are self-aware ▪ provide specific feedback in a timely manner
Slide 12	**Demonstration: Whole-Part-Whole Approach** • Demonstrate the whole procedure from beginning to end • Isolate or break down the procedure or activity into parts and allow practice of the individual parts of the procedure • Demonstrate the whole procedure again and then allow students to practice it from beginning to end	

Slide 13		Starting with demonstrations that do not involve patients enables you to take time, stop and discuss key points, and repeat difficult steps without endangering the health or comfort of a patient.
Slide 14		Psychomotor, or hand skills, are appropriate for small group practice. Learners can help each other and provide feedback. Key points: ▪ Video or other means to show things over and over is helpful. ▪ Checklists with detailed performance standards are important to outline steps ▪ Assess each learner for mastery of psychomotor skills with models before developing competency in clinic working with clients
Slide 15		Communication skills are not as simple to demonstrate and teach as psychomotor skills, and much of communication is non-verbal. Role plays, especially when well-structured and used with assessment tools that outline key points, are very useful for demonstrating communication skills, including non-verbal communication.

Slide 16		Attitudes may be taught in formal courses on professional ethics and philosophy Provide opportunities learners to reflect on attitudes and compare them to professional ethics expected. Discussions, role plays and thought-provoking scenarios are useful for discussing attitudes. Use clinical practice as an opportunity for learners to compare observed attitudes with desired professional and ethical attitudes. Emphasize the importance of keeping a positive learning climate by asking questions to help learners evaluate their attitudes.
Slide 17		Review the job aid in module 8 with participants - it covers the steps in the skills development process and may be found on pages 8-21 to 8-22

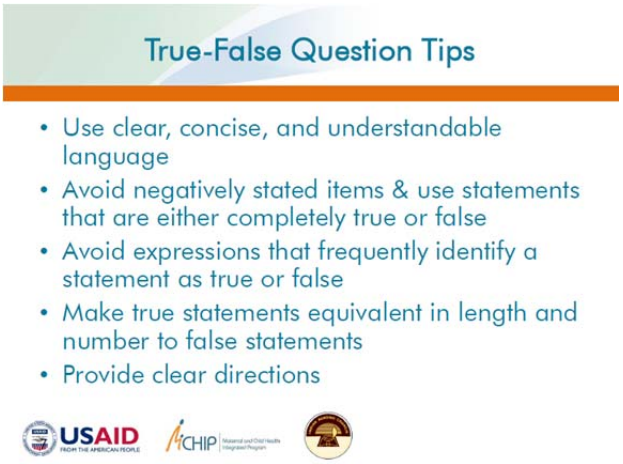
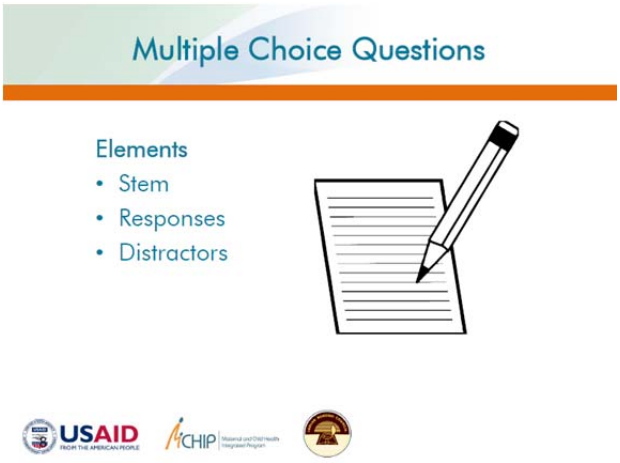
Slide 1	Manage Clinical Practice	
Slide 2	Objectives • Select and prepare clinical instructors and staff • Coordinate clinical practice • Conduct clinical practice sessions • Monitor students' progress	Review the objectives. Ask participants: ▪ What challenges do you face when students are working in the clinical area to practice their skills? ▪ Is the facility appropriate? ▪ Does the staff welcome your students?
Slide 3	Clinical Instructor Attributes Selection Criteria: • Time available • Desire to work with students • Up-to-date clinical expertise / proficiency Skills in: • Desired competencies • Communication • Organization • Teaching – Demonstration – Coaching – Feedback – Performing assessments	The clinical instructor coordinates students activities in the clinical setting. S/he may also be the classroom teacher; most importantly s/he is proficient if not **expert** in the competencies s/he teaches

Slide 4	**Prepare Clinical Instructors** • Discuss objectives and requirements for the clinical rotation • Detail the students' abilities and learning needs • Describe & provide tools to give feedback on student performance • Review expectations: including skills they will be responsible for observing	Ensure clinical instructors: ▪ Have up-to-date skills and clinical knowledge ▪ Have teaching skills (demonstration, coaching, feedback, assessments) ▪ Are fully aware of expectations
Slide 5	**Coordinate Clinical Teaching** • Work closely with all members of the team • Meet with clinical instructors in advance • Share copies of the syllabus, student performance report, and checklists with the clinical instructors • Discuss plans for student assessment	Review with participants that when coordinating clinic teaching, there are several important points to consider: ▪ Discuss student placement, preparation of the staff and student communication with clinical instructors ▪ Share relevant course materials and expected outcomes of the placement ▪ Clinical instructors should be involved in student assessment from the beginning, i.e. design of checklists of competencies to be assessed
Slide 6	**Student Responsibilities** • Review assignments • Take an active role in learning • Observe demonstrations of skills and perform skills • Health assessment, diagnosis, and management / treatment of patients • Coordinate and communicate patient management with the clinical instructor • Document findings and experiences in an organized, thorough manner • Evaluate clinical practice experience	Prior to showing the slide, ask participants what they believe are student responsibilities. Refer to the bulleted highlights.

Slide 7	**Clarify Roles & Responsibilities of Teachers & Clinical Instructors** • Maintain proficiency (expertise) in healthcare delivery • Review learning objectives & select appropriate patients • Review, distribute and utilize teaching materials: learning objectives, checklists, logbooks • Logistical arrangements for student experiences • Orientation of clinical staff & students • Communication • Demonstrate, observe, assess (monitor) performance and provide feedback	Turn to pages 9-5 to 9-7 in the Effective Teaching Resource Manual to review the roles and responsibilities of the educators and students
Slide 8	**Use Objectives to Plan** • Review the learning objectives to assist in planning appropriate clinical practice activities • Determine which objectives can be met in the outpatient department and which in the inpatient ward. • External clinics, communities, and home visits are other sites used in clinical practice activities.	Use objectives to plan clinical practice activities. Refer students to the module on developing objectives for learning if they would like to review.

Slide 1	Prepare and Use Knowledge Assessments	Most tasks or skills have an important knowledge component and educators must ensure to assess students' knowledge in a valid, reliable, and feasible way.
Slide 2	Introduction • Why is knowledge assessed? • What problems did you have with tests as a student? • As a faculty member? 	Facilitate an open discussion with participants around perceptions and current implemented methods of knowledge assessment.
Slide 3	Objectives • Select methods for assessing students' knowledge • Prepare knowledge assessments • Develop questions for objective written examinations • Administer and score knowledge assessments • Use assessment results to improve performance	After completing this module, the participants will be able to prepare and use knowledge assessments.

Slide 4	**Knowledge Assessments** Formative • To help guide students toward meeting the learning objectives Summative • To ensure that students finish the course with the required knowledge How is knowledge assessed?	Review with participants the difference between formative and summative assessments. Review the various ways to assess knowledge, referring to pages 10-3 and 10-4 in the Effective Teaching Reference Manual: ▪ Drills, quizzes, and practice tests ▪ Written exercises ▪ Case studies, clinical scenarios, and patient management problems ▪ Project reports ▪ Essay examinations ▪ Objective written examinations ▪ Structured practical examinations ▪ Oral examinations
Slide 5	**Key Points in Preparing Knowledge Assessments** • Identify the learning objectives • Use simple and clear language & grammar • Provide clear directions for each type of item • Develop answer keys • Arrange test items by subject matter, type of question, or level of difficulty • Review the assembled test 	Refer participants to p. 10-5 in the Effective Teaching Reference Manual and go over how to develop and assemble knowledge assessments. Indicate to the students that they will be using this information in the exercise following the presentation.
Slide 6	**Preparing a Test Bank** • Work in a group to develop questions. • Sort questions based on subject, category, level of knowledge, or type of test item. • Store the questions on a computer or cards. • Ensure that only authorized persons have access to the question bank.	Objective written examinations can cover a large number of learning objectives in one examination. Question banks provide a resource that teachers can use to easily prepare quizzes, exercises and tests. Review the important steps in preparing a question bank covered in the slide.

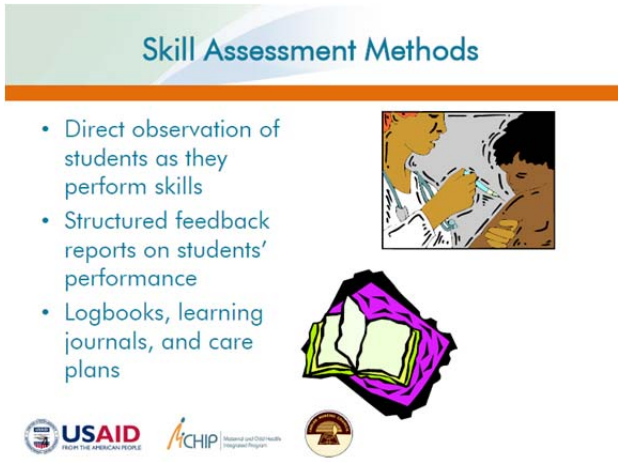
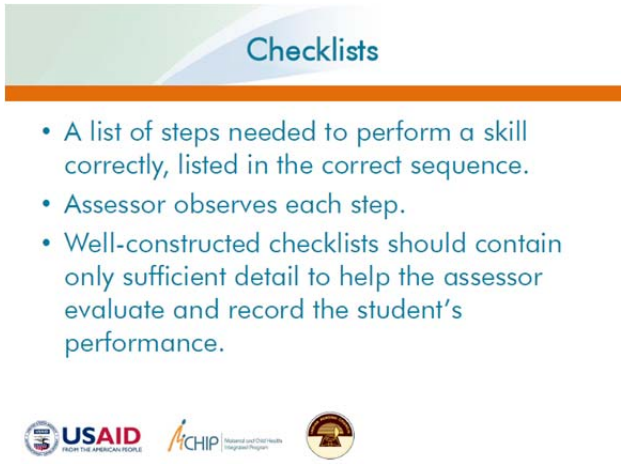
Slide 7		True-false questions are one of the most commonly used question formats for objective written examinations. Review the tips with participants. Refer to page 10-9 in the Effective Teaching reference manual as needed. Ask participants which words often found in false statements: *only, never, all, every, always, none, and no*. Ask participants which words often found in true statements: *usually, generally, sometimes, customarily, often, may, could, and frequently*. Emphasize that True-false items should focus on one idea and should challenge, but not trick, the students.
Slide 8		Multiple choice questions are the most commonly used question formats for objective written examinations. They are preferable to true-false questions because they make guessing the correct answer more difficult. Review the elements with participants. Refer to page 10-10 in the Effective Teaching reference manual as needed. Stem: poses a question or problem situation that is followed by alternative answers Responses: one is correct while the others are incorrect Distractors: the incorrect responses

Slide 9	**Multiple-Choice Question Tips** • Write simple stems that state the problem and avoid using negative terms • Provide a coherent list of possible answers • Write reasonable distractors • Distractors should be of similar length to avoid giving clues to the correct response • Avoid use of "All" and "None of the above" in responses • Give clear directions	Refer to page 10-10 in the Effective Teaching reference manual as needed.
Slide 10	**Sample Scenario MCQ** Mrs. B. is 20 years old and had an IUD inserted a month ago. She came to the health center 2 days ago with vaginal discharge and abdominal and pelvic pain. She reports that she does not have any fevers or chills. What is your plan? A. Gather history, send vaginal cultures, remove the IUD. B. Gather history, send vaginal cultures, follow up in 3 days. C. Gather history, treat with antibiotics for presumptive PID. D. Gather history, send vaginal cultures, treat with antibiotics for PID, and remove the IUD if the woman wishes.	Another form of the MCQ is the scenario item. It presents a situation an asks the student a series of questions related to the situation. Review the sample scenario items with participants.
Slide 11	**Matching Questions** • Consists of two lists 1. Premise 2. Response • Imperfect matching items are more objective • Tips: • Focus on one subject • Keep statements brief • Arrange in logical order	Matching questions are commonly used question formats for objective written examinations. It consists of two lists of words and phrases to be matched. Review the tips with participants. Refer to pages 10-12 and 10-13 in the Effective Teaching reference manual as needed.

Slide 12	**Short-Answer Question Tips** • Make the questions clear and easy to understand • Prepare a structure marking sheet • Include questions that have possible multiple responses 	Short-answer questions require the student to provide one or several responses to a question or situation. Review tips for writing short-answer questions with participants. Refer to the Effective Teaching Reference Manual p. 10-14 as necessary.
Slide 13	**Test Administration** • Time allowed • How to select and record answers • Scoring system to be used • Physical environment • Remain in the room • Lighting and ventilation 	When giving directions for an examination, focus on HOW students should complete. Review with participants the key components of test administration as listed in the slide.
Slide 14	**Scoring the Knowledge Assessment** • Answers can be marked directly onto the test or onto a separate answer sheet • Use an answer key (or a computer with scanner) to score the tests • See the module for more information on scoring knowledge assessments	One of the advantages of a written objective examination is that it is easy for educators to score. Refer to pages 10-15 and 10-16 in the Effective Teaching reference manual for more detail.

Slide 15	**Using Assessment Results** • Formative assessments help students decide what content areas they need to spend more time studying • Summative assessments determine if students are meeting the learning objectives.	Knowledge is assessed to determine whether students are meeting the learning objectives and have acquired the required information base to become competent healthcare providers.
Slide 16	**Helping Students Learn** • Instruct them to review the material related to the questions they missed • Give them an opportunity to ask questions about any test item • When many students had trouble with the same question – The teaching methods or materials did not adequately address that learning objective OR – The question needs to be rewritten	Review how educators can use assessment results to improve performance. Refer to pages 10-16 and 10-17 in the Effective Teaching reference manual.
Slide 17	**Summary** • What questions do you have about developing, administering and scoring knowledge assessments? • How can we assist faculty members in developing, administering and scoring knowledge assessments to support implementation of curricula?	Remind participants to use results from knowledge assessments to help students identify areas in which they need to improve.

Slide 1	Prepare and Use Skills Assessments	
Slide 2	Three Steps in Skill Development 1. Introduce and demonstrate a skill. 2. Observe students as they practice the skill and give feedback to help them improve their performance. 3. Assess students for competency in the skill. 	Review the key components of module 8 *Facilitate the Development of Healthcare Delivery Skills*: introduce, observe, and assess.
Slide 3	Objectives • Select methods for assessing the skills of students • Prepare skills assessments • Develop structured practical examinations • Administer and score skills assessments • Use results to improve performance	As in the assessment of knowledge, clear learning objectives are essential to assess skills. After completing this module, you will be able to prepare and use skills assessments.

Slide 4		Review the skills assessment methods with participants, referring to pages 11-2 to 11-4 in the Effective Teaching reference manual. Key points: ▪ Direct observation is most valid way to assess students' skills. ▪ Structured feedback: assesses sustained performance. Refer to sample 11-2 on page 11-14 and sample 11-3 on page 11-15 of the reference manual. ▪ The logbook contains a list of skills or tasks that students should be able to perform. A learning journal is used to record learning experiences, particularly when the student has minimal supervision. A care plan is used to document the patient's problems, care required, and expected outcomes.
Slide 5		Preparing skills assessments: a checklist requires minimal judgment on part of the assessor.

Slide 6	**Designing a Checklist** • Identify the steps or tasks • Place the steps in the correct sequence. • Identify the standards or minimum level of performance • Include the key elements of a checklist • Field-test the checklist • Validate with subject matter experts	Review the steps in designing a checklist and refer to pages 11-5 and 11-6 in the Effective Teaching resource manual. Ask participants to turn to samples 11-4, 11-5, and 11-6 on pages 11-16 to 11-20 and review the key elements within these examples.
Slide 7	**Structured Practical Examinations** • Students rotate through a series of stations and is observed by an assessor • Students demonstrate a skill, interpret diagnostic materials, or respond to short questions or case studies during a limited time • All students are assessed according to the same standards • MSAT & OSCE	Structured practical examinations can be used to asses a wide range of knowledge, skills, and attitudes. Also known as multiple station assessment test (MSAT) or Objective Structured Clinical Examination (OSCE), structured practical examinations are not an assessment method but an administrative structure in which a variety of assessment methods are incorporated.
Slide 8	**Steps to Prepare for a Structured Practical Examination** • Select the learning objectives to be tested • Decide on an activity that addresses each learning objective • Map out a plan for the stations • Plan the details for each station	Review the steps in planning for a structured practical examination with students. Refer to the text on page 11-9, as well as the multiple station map, sample 11-1 on page 11-8 of the Effective Teaching reference manual. Review what is involved in planning the details for each station: ▪ Write the task/scenario to be completed ▪ Develop instructions ▪ Develop assessment tools ▪ List the resources needed

Slide 9	**Use Results to Improve Performance** • Give students an opportunity to ask questions • Instruct students to practice the steps that they performed incorrectly • The teaching methods did not adequately cover that learning objective, or the task needs to be redefined if many students had trouble with the same tasks 	Not only does skills assessment help determine whether students are competent in the core learning objectives, but they also help to improve student performance. Make every effort to help students achieve competency when assessing them.
Slide 10	**Summary** • Direct observation is the most valid method for assessing skills • This method can be improved by using standardized tools • Structured practical examinations require time for planning and preparing valid stations • Assessing students' skills is one of the keys to improving students' performance	Review what was covered in the module and highlight the fact that choosing a valid, reliable, and feasible method for assessing the competency of students requires careful thought, planning, and time–emphasizing the importance of direct observation.

Activity 1.6: Principles of assessment game

Directions: Divide the group into two, or call out the questions and provide points for each correct answer.

- What is the primary difference between formative and summative assessment?

  Formative assessment is used help learners develop competency. It is used to provide feedback, assess learner progress and help them develop knowledge, skills and attitudes. Formative assessment has been described as ‘assessment FOR learning’.

  Summative assessment is described as ‘assessment OF learning’ and is used to formally assess and document learner progress at specific times. For example, a quiz may be used as a formative assessment when it is used to provide feedback and identify weak areas. The same quiz may be used as a summative assessment when it is used to document if the learners have mastered the content and are ready to progress to new topics.

- List 2 key principles about effective assessment. Answer should include:
  - Assessment methods must match the learning objective.
  - Assessment is structured and objective.

  Here’s an explanation: Among the many, these are important: assessment methods must match the learning objective. For example-To be sure a pilot is safe and that lives will not be lost, you would assess their ability using a standardized checklist and observing their skills both in simulation and in reality. For certain clinical skills, lives are also at stake and similar strict criteria should be used in assessment. Formal assessment is structured and objective. For example-an oral exam between the tutor and student will be more effective if it has structured questions and objective scoring criteria identified. If not, it’s a subjective assessment and lacks validity.

  Your school uses many project reports and essay examinations-how can you make these methods more objective? Add scoring criteria or objective guidance on scoring. For example, you can outline grading criteria for project reports, or list key points to be scored during for an essay.

- Most assessment of skills requires what?

  Direct observation-using a structured assessment tool or other means to objectively assess performance

- What are three ways you can assess attitudes?
  - written assessment of knowledge of professional ethics
  - structured observation of attitudes during service delivery
  - structured feedback forms

SECTION II

FAMILY PLANNING

PRE-COURSE KNOWLEDGE ASSESSMENT QUESTIONNAIRE

Instructions: For every statement below please write "T" if the statement is TRUE and "F" if the statement is FALSE.

Woman should be fully breastfeeding her baby in order to practice LAM.	
To avoid condom slippage after sex, penis should be removed from vagina when it is still hard.	
Man should put on condom before penis comes in any contact with vagina.	
Combined Oral Contraceptive pills prevent pregnancy by preventing release of ovum from the ovary.	
A woman who has active jaundice or in past had jaundice while using COC can use COC pills.	
It is okay for a woman to forget one or two active pills during the cycle. She does not require any actions	
Taking COC pills at the same time every day helps reduce side effects of irregular bleeding	
Motivation is making decision whether to use Family Planning, whereas counseling is making decision on what method to use.	
A good counselor never tells clients about the side effects of contraceptive methods.	
Counseling is providing women/couples with correct information on contraceptive methods and helping them choose a method they want to use.	
Emergency Contraceptive Pills work the best when taken within 7 days of unprotected sex.	
ECP provides protection against pregnancy from the acts of sex within 5 days before taking it but not for the sex act performed on second day of taking ECP.	
IUCD Copper T 380A is effective for 10 years.	
Bleeding disturbances are most common during the initial months of IUCD use.	
IUCD can be inserted anytime during the menstrual cycle provided you are reasonably sure that the woman is not pregnant.	
IUCD should not be provided to a woman who has current Pelvic Inflammatory Disease.	
A woman who says that she wants female sterilization does not need any counseling.	
There is no need to tell the woman that the female sterilization is a permanent method for all practical purposes and it is very difficult to reverse the procedure.	
Following male sterilization the couple has to use condoms or other method of contraception for three months.	
Healthcare worker should wash hands before and after every client contact	

ANSWER KEY: PRE-COURSE KNOWLEDGE ASSESSMENT

Woman should be fully breastfeeding her baby in order to practice LAM.	T
To avoid condom slippage after sex, penis should be removed from vagina when it is still hard.	T
Man should put on condom before penis comes in any contact with vagina.	T
Combined Oral Contraceptive pills prevent pregnancy by preventing release of ovum from the ovary.	T
A woman who has active jaundice or in past had jaundice while using COC can use COC pills.	F
It is okay for a woman to forget one or two active pills during the cycle. She does not require any actions	F
Taking COC pills at the same time every day helps reduce side effects of irregular bleeding	T
Motivation is making decision whether to use Family Planning, whereas counseling is making decision on what method to use.	T
A good counselor never tells clients about the side effects of contraceptive methods.	F
Counseling is providing women/couples with correct information on contraceptive methods and helping them choose a method they want to use.	T
Emergency Contraceptive Pills work the best when taken within 7 days of unprotected sex.	F
ECP provides protection against pregnancy from the acts of sex within 5 days before taking it but not for the sex act performed on second day of taking ECP.	T
IUCD Copper T 380A is effective for 10 years.	T
Bleeding disturbances are most common during the initial months of IUCD use.	T
IUCD can be inserted anytime during the menstrual cycle provided you are reasonably sure that the woman is not pregnant.	T
IUCD should not be provided to a woman who has current Pelvic Inflammatory Disease.	T
A woman who says that she wants female sterilization does not need any counseling.	F
There is no need to tell the woman that the female sterilization is a permanent method for all practical purposes and it is very difficult to reverse the procedure.	F
Following male sterilization the couple has to use condoms or other method of contraception for three months.	T
Healthcare worker should wash hands before and after every client contact	T

ACTIVITIES

Activity 2.1: Brainstorming: Importance of spacing and benefits of Family planning for the mother and the child.

Purpose: Identify the understanding that the participants have on the importance of spacing and benefits of Family planning for the mother and the child using participatory approach.

Total time: 15 minutes

Instructions for the facilitator:

- Announce the topic. "Now we are going to do brainstorming to have a better understanding on the importance of spacing and the benefits of family planning for the mother and the child"
- Review the ground rules. "One participant speaks at a time, all ideas will be listed, please do not comment or criticize either verbally or nonverbally any idea being presented. There is nothing like a wrong idea or a right idea. We will continue for about 7 minutes. Once we have listed the idea we will do the quick review of the list and identify those that are looking very promising."
- List all ideas on the flip chart . Please invite your fellow trainer to help list the ideas.
- Start the brainstorming and manage participation. If one participant is contributing too much move from one to the other asking everyone to contribute.
- Thank the trainer who helped writing. Thank all participants for their contributions.
- Review each idea very briefly and accept them as per their appropriateness.
- Display the flipchart on the wall.

Activity 2.2: Condom race and demonstration of condom use on model

Instructions:

Divide the participants in two groups. Give each group VIPP cards with the steps of condom use in a jumbled order. The groups have to place them on the floor or table in the correct order. The group that finishes first wins. Ask a member from the group to read the steps aloud and the other group follows.

VIPP CARDS (make the cards and jumble them)

Check the condom package.	**Tear open the package carefully**	**place the condom on the erect penis**
Pinch the tip of the condom to expel air.	**Place the condom on the tip of the erect penis with the rolled side out**	**Unroll the condom all the way to the base of the erect penis**
Immediately after ejaculation hold the rim of the condom in place and withdraw penis while still erect	**Check for tear or breakage**	**Tie a knot at the open end of the condom and dispose it**

Demonstration of condom use on model

Purpose: To demonstrate the correct steps of use of male condom using the penis model.

Instructions for the facilitator:

- Introduce the activity. "Now I am going to demonstrate the use of condoms using the penis model." Tell participants that most healthcare providers think that the clients know how to use condoms but that may not be true in every case and they should be prepared to demonstrate the steps of condom use if client requests
- Make sure that you have penis model and several condoms.
- Review the steps of condoms use given on page 203 or 363 of the Family Planning Global Handbook 2008 (English) and page 213 or 377 of the Global Hand book 2007 (Hindi)
- As you review the steps with participants have volunteer participant or the fellow trainer hold the penis model and demonstrate how each step is performed
- Once the demonstration is over, invite the volunteer participant to come and repeat the steps
- Summarize the demonstration by emphasizing main points from the handbook.

EXERCISES

Exercise 2.1: Technical overview of the family planning methods:

Instructions

Divide participants in small groups of 3-4 people and ask each group to act as a team

- Give each group a copy of blank forms (3 charts: Chart 1, 2 and 3 given at the end of this session) as given below and ask them to review the tables on "The important characteristics of the commonly available family planning methods" given in the chapter 2 of the reference manual and based on the information given in the tables, complete the blank forms (3 charts given to the small groups) by putting a check mark in the appropriate box
- Bring participants back together after 30 minutes and ask volunteers to share their answers on following points for each family planning method
    - Mechanism of action
    - Contraceptive effectiveness
    - Benefits
    - Limitations
    - Who should not use the method

Technical Overview of FP Methods (Exercise format for participants)

Instructions: Below is a chart listing technical details of various family planning methods on the left side (first column). For each statement listed in the first column, place a check mark in the appropriate box, indicating the statement is right for which method.

Technical Details	Condoms	Lactational Amenorrhea Method (LAM)	Combined Oral Contraceptive Pills (COCs)	Intrauterine Contraceptive Devices (IUCDs)	Inj. DMPA	Female Tubal Ligation	Vasectomy
Mechanism of Action							
Blocks the tubes carrying sperms (vas deferens) and prevents sperms from entering the semen							
Slow sperm movement in the uterus, so sperms cannot meet the eggs							
Temporary infertility after childbirth that may last as long as 6 months if women fully or nearly fully breastfeed and their menses have not returned							
Barrier method that physically prevent sperms from uniting with the egg as the method does not allow ejaculation and sperms to be deposited in direct contact with the vagina							
The hormones estrogen and progesterone suppress ovulation							
Blocks the fallopian tubes to prevent sperm and egg from uniting							
The hormone progesterone suppresses ovulation							

Technical Details	Condoms	Lactational Amenorrhea Method (LAM)	Combined Oral Contraceptive Pills (COCs)	Intrauterine Contraceptive Devices (IUCDs)	Inj. DMPA	Female Tubal Ligation	Vasectomy
Benefits							
Long term reversible method, no hormonal side effects, immediately reversible with no delay in return to fertility, does not require daily actions, does not interfere with sexual intercourse, no effect on breastfeeding							
Regulates the menstrual cycle, reduces menstrual flow, does not interfere with sexual intercourse, pelvic exam is not required before use							
Does not interfere with intercourse, no systemic side effects, no supplies required, promotes nutritional benefits to infant, helps mother's uterus return to normal size quicker, helps reduce the amount of bleeding by keeping the uterus contracted							
Only method that protects from STIs, including HIV/AIDS, no effect on breastfeeding, no hormonal side effects							
Does not interfere with sexual intercourse, given by inj. once every 12 weeks and no daily action required, pelvic exam is not required before use, for some women, may help prevent iron deficiency anemia							
Simple surgery performed on women, permanent procedure, no effect on breast milk production							
Permanent procedure, easier to perform than tubal ligation							

Technical Details	Condoms	Lactational Amenorrhea Method (LAM)	Combined Oral Contraceptive Pills (COCs)	Intrauterine Contraceptive Devices (IUCDs)	Inj. DMPA	Female Tubal Ligation	Vasectomy
Limitations							
Delayed effectiveness (requires at least 3 months for procedure to be effective), permanent method and reversal surgery is difficult, expensive.							
Minor side effects like longer and heavier bleeding, spotting between periods, more cramps and pain during periods- these disappear spontaneously after initial months, requires a trained provider for initiation of the method							
Uncommon complications of surgery – infection, bleeding; requires a trained provider and health facility providing the service, not reversible							
Must be taken every day, side effects in some women such as nausea, headache, weight gain, risk of developing cardiovascular disease in women over 35 years of age and who smoke							
May produce minor side effects such as light spotting, bleeding, amenorrhea, or weight gain; delayed return to fertility, currently not available in the public health facilities							
Supply must be readily available before intercourse begins, effectiveness depends on following instructions for correct use							
Effective only when all 3 criteria are met, such as baby is less than 6 months old, woman is fully or nearly fully breastfeeding her baby and her menses have not returned							

Technical Overview of FP Methods (with answers)

Instructions: Below is a chart listing technical details of various family planning methods on the left side (first column). For each statement listed in the first column, place a check mark in the appropriate box, indicating the statement is right for which method.

Technical Details	Condoms	Lactational Amenorrhea Method (LAM)	Combined Oral Contraceptive Pills (COCs)	Intrauterine Contraceptive Devices (IUCDs)	Inj. DMPA	Female Tubal Ligation	Vasectomy
Mechanism of Action							
Blocks the tubes carrying sperms (vas deferens) and prevents sperms from entering the semen							✓
Slow sperm movement in the uterus, so sperms cannot meet the eggs				✓			
Temporary infertility after childbirth that may last as long as 6 months if women fully or nearly fully breastfeed and their menses have not returned		✓					
Barrier method that physically prevent sperms from uniting with the egg as the method does not allow ejaculation and sperms to be deposited in direct contact with the vagina	✓						
The hormones estrogen and progesterone suppress ovulation			✓				
Blocks the fallopian tubes to prevent sperm and egg from uniting						✓	
The hormone progesterone suppresses ovulation					✓		

Technical Details	Condoms	Lactational Amenorrhea Method (LAM)	Combined Oral Contraceptive Pills (COCs)	Intrauterine Contraceptive Devices (IUCDs)	Inj. DMPA	Female Tubal Ligation	Vasectomy
Benefits							
Long or short-term reversible method, no hormonal side effects, immediately reversible with no delay in return to fertility, does not require daily actions, does not interfere with sexual intercourse, no effect on breastfeeding				✓			
Regulates the menstrual cycle, reduces menstrual flow, does not interfere with sexual intercourse, pelvic exam is not required before use			✓				
Does not interfere with intercourse, no systemic side effects, no supplies required, promotes nutritional benefits to infant, no cost to mother, helps mother's uterus return to normal size quicker,		✓					
Only method that protects from STIs, including HIV/AIDS, no effect on breastfeeding, no hormonal side effects	✓						
Does not interfere with sexual intercourse, given by inj. once every 12 weeks and no daily action required, pelvic exam is not required before use, for some women, may help prevent iron deficiency anemia					✓		
Simple surgery performed on women, permanent procedure, no effect on breast milk production						✓	
Permanent procedure, easier to perform than tubal ligation							✓

Technical Details	Condoms	Lactational Amenorrhea Method (LAM)	Combined Oral Contraceptive Pills (COCs)	Intrauterine Contraceptive Devices (IUCDs)	Inj. DMPA	Female Tubal Ligation	Vasectomy
Limitations							
Delayed effectiveness (requires at least 3 months for procedure to be effective), permanent method							✓
Minor side effects like longer and heavier bleeding, spotting between periods, more cramps and pain during periods- these disappear spontaneously after initial months, requires a trained provider for initiation of the method				✓			
Uncommon complications of surgery – infection, bleeding; requires a trained provider and health facility providing the service, not reversible						✓	
Must be taken every day, side effects in some women such as nausea, headache, weight gain, risk of developing cardiovascular disease in women over 35 years of age and who smoke			✓				
May produce minor side effects such as light spotting, bleeding, amenorrhea, or weight gain; delayed return to fertility, currently not available in the public health facilities					✓		
Supply must be readily available before intercourse begins, effectiveness depends on following instructions for correct use	✓						
Effective only when all 3 criteria are met, such as baby is less than 6 months old, woman is fully breastfeeding her baby and her menses have not returned		✓					

Exercise 2.2: MEC Chart: Hormonal Methods

Instructions: Below is a chart listing various conditions which may affect choice of hormonal FP methods by clients. For each condition, place a check mark '√' in the appropriate column, indicate the WHO Category (1, 2, 3, 4) and give a reason in the space provided.

Client condition	Combined oral pills		Progestin only pills		DMPA		Reasons/Comments
	Provide	Do not provide	Provide	Do not provide	Provide	Do not provide	
21 years old and newly married.							
Anemic, with haemoglobin 8 gms.							
Immediately postpartum not breastfeeding							
2 month postpartum and using LAM							
8 months postpartum and breastfeeding							
History of blood clots in the legs							
Taking rifampicin for tuberculosis							
Current purulent cervical discharge							
History of high blood pressure, where BP cannot be measured							
Post abortion							
Menses started 6 days ago.							
Using hormonal method and did not have menses this past month							

Exercise 2.2: MEC Chart: Hormonal methods (Answer key)

Instructions: Below is a chart listing various conditions which may affect choice of hormonal FP methods by clients. For each condition, place a check mark '√' in the appropriate column, indicate the WHO Category (1, 2, 3, 4) and give a reason in the space provided.

Client condition	Combined oral pills		Progestin only pills		DMPA		Reason/comment
	Provide	Do not provide	Provide	Do not provide	Provide	Do not provide	
21 years old and newly married.	✓		✓		✓*		Category 1. *If planning a pregnancy in coming 6 months, DMPA might not be best choice
Anemic, with haemoglobin 8 gms	✓		✓		✓		Hormonal methods overall reduce the amount of monthly bleeding
Immediately postpartum not breastfeeding		✓(3)	✓		✓		Wait 3 weeks to start COCs
2 month postpartum and using LAM		✓(3)	✓		✓		Better to provide method when woman requests, rather than wait until after she finishes using LAM
8 months postpartum and breastfeeding	✓		✓		✓		Any hormonal method is safe after 6 months postpartum
History of blood clots in the legs		✓(3)	✓		✓		Estrogen increases risk of blood clots
Taking rifampicin for tuberculosis		✓(3)		✓(3)	✓(2)		The serum levels of DMPA remain adequate even with rifampicin
Current purulent cervical discharge	✓		✓		✓		Category 1 for all Hormonal Methods
History of high blood pressure, where BP cannot be measured		✓(3)	✓(2)		✓(2)		
Post abortion	✓		✓		✓		Category 1 for 1st and 2nd trimester abortions
Menses started 6 days ago.	✓+		✓*		✓		+ If starting COCs after day 5, use a backup method (condoms) for first 7 days of taking pills *If starting POPs after day 5, use a backup method (condoms) for first 2 days of taking pills
Using hormonal method and did not have menses this past month	✓		✓		✓		Give any method if reasonably sure she is not pregnant

Exercise 2.3: MEC FOR IUCD CHART

Objectives

The purpose of this activity is to

- Familiarize the participants with the use of Medical Eligibility Criteria for IUCD to help them make decisions about using IUCD based on certain medical conditions
- Reinforce the identification of conditions that pose health risk to the woman with the use of IUCD for contraception

Instructions: In the following chart, different conditions of a client have been listed which influence her decision to use IUCD. For each condition, make a '✓' in the relevant column and mention the WHO category in the comments column and also write the reason for that category.

SN	Client's Condition	IUCD Inserted	IUCD Not Inserted	Reasons/Comments
1.	Age 18 years and has one child			
2.	Has high blood pressure			
3.	After a first or second trimester abortion			
4.	Soon after a delivery			
5.	Puerperal infection or infection in lower reproductive organs and lower abdomen			
6.	History of ectopic pregnancy			
7.	History of having Gonorrhea			
8.	Having fibroids in the uterus, having fibroids at the outer wall of the uterus			
9.	Anemia with haemoglobin 8 grams			
10.	HIV positive but clinically healthy			
11.	Has AIDS and has not started any ART yet			
12.	Is taking Rifampicin for TB			

13.	Has vaginal bleeding whose cause is not known			
14.	Has had more than 5 pregnancies			
15.	Has cervical cancer			

Exercise 2.3: MEC FOR IUCD CHART (Answer keys)

SN	Client's Condition	IUCD Inserted	IUCD Not Inserted	Reasons/Comments
1.	Age 18 years and has one child	✓		Category 1
2.	Has high blood pressure	✓		Category 1
3.	After a first or second trimester abortion	✓		Category 1
4.	Soon after a delivery	✓		Category 1
5.	Puerperal infection or infection in lower reproductive organs and lower abdomen		✓	Category 4, IUCD is not inserted in a client with puerperal sepsis
6.	History of ectopic pregnancy	✓		Category 1
7.	History of having Gonorrhea	✓		Category 1, Check for risk of STIs and counsel for condom use if required for dual protection
8.	Having fibroids in the uterus, having fibroids at the outer wall of the uterus	✓*	✓^	*Category 1, If fibroid is towards the outer wall of the uterus and not distorting the cavity ^Category 4, If fibroid is distorting the inner layer of the uterus so that the cavity is not normal
9.	Anemia with haemoglobin 8 grams	✓		Category 2
10.	HIV positive but clinically healthy	✓		Category 2
11.	Has AIDS and has not started any ART yet		✓	Category 3, IUCD may increase the risk of severe infection following insertion due to overall immuno-compromised state of the client. She can get IUCD inserted once she has started ART and her CD 4 cell count improves and she becomes symptom free
12.	Is taking Rifampicin for TB	✓		Category 1
13.	Has vaginal bleeding whose cause is not known		✓	Category 4, First diagnose the cause of the bleeding, manage it and if it becomes normal, then may be inserted
14.	Has had more than 5 pregnancies	✓		Category 1
15.	Has cervical cancer		✓	Category 4, Refer for management and help client choose another appropriate contraceptive method

Exercise 2.4: Infection prevention for IUCD insertion / removal (with answer keys)

The purpose of this activity is to:

- To familiarize participants with infection prevention steps during IUCD insertion/removal.

Time: 25 minutes total (5 minutes instructions, 15 minutes review of IUCD Checklist, 5 minutes review answers)

Instructions

- Participants will work in groups of 3 – 4 people
- Each group will review the checklist for IUCD Counseling and Clinical Skills in their Handout Exercise 4 and identify the infection prevention steps by marking on the relevant tasks/steps in the checklist.
- The trainer will facilitate a discussion after 20 minutes to review the IP steps which the groups have marked and ensure that all IP steps for IUCD insertions are enumerated.

The answer is marked as a '√' in the checklist below.

CHECKLIST FOR IUCD COUNSELING AND CLINICAL SKILLS

Place a "✓" in case box of step/task is performed satisfactorily, an "✗" if it is not performed satisfactorily, or **N/O** if not observed.
Satisfactory: Performs the step or task according to the standard procedure or guidelines
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines
Not Observed: Step, task or skill not performed by participant during evaluation by trainer

Participant _____ **Course Dates** _____

CHECKLIST FOR IUCD COUNSELING AND CLINICAL SKILLS (REGULAR COPPER T 380A)					
STEP/TASK	**CASES**				
METHOD-SPECIFIC COUNSELING					
1. Once the woman has chosen to use the IUCD, assess her knowledge of the method.					
2. Counsel her regarding the mechanism of action, how long can be used, effectiveness, advantages, limitations, common side effects, need for follow-up					
3. Ensure that she knows that menstrual changes are a common side effect among IUCD users, and that the IUCD does not protect against STIs.					
4. Describe the medical assessment required before IUCD insertion, as well as the procedures for IUCD insertion and removal.	√				
5. Encourage her to ask questions. Provide additional information and reassurance as needed.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
IUCD INSERTION					
Client Assessment					
6. Review the client's medical and reproductive history.	√				

CHECKLIST FOR IUCD COUNSELING AND CLINICAL SKILLS (REGULAR COPPER T 380A)					
STEP/TASK	**CASES**				
7. Ensure that equipment and supplies are available and ready to use.	√				
8. Have the client empty her bladder and wash her perineal area.					
9. Help the client onto the examination table.					
10. Tell the client what is going to be done, and ask her if she has any questions.					
11. Wash hands thoroughly and dry them.	√				
12. Palpate the **abdomen**.					
13. Wash hands thoroughly and dry them again.	√				
14. Put clean or HLD gloves on both hands.	√				
15. Inspect the external genitalia.					
Note: ▪ **If findings are normal**, **perform the bimanual exam first** and the speculum exam second. ▪ **If there are potential problems**, **perform the speculum exam first** and a bimanual exam second.					
15a. Perform a **bimanual exam** (see **Note** above)					
15b. Perform rectovaginal exam only if indicated.					
15c. If rectovaginal exam is performed, change gloves before continuing.	√				
16. Perform a **speculum exam** (see **Note** above). (**Note:** If laboratory testing is indicated and available, take samples now.)					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
Pre-insertion and Insertion Steps (Using aseptic, "no touch" technique throughout)					
17. Provide an overview of the insertion procedure. Remind her to let you know if she feels any pain.					
18. Gently insert the HLD (or sterile) speculum to visualize the cervix (if not already done), and cleanse the cervical os and vaginal wall with antiseptic swabs twice.	√				
19. Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.	√				
20. Insert the HLD (or sterile) sound using the "no touch" technique.	√				
21. Load the IUCD in its sterile package.	√				
22. Set the blue depth-gauge to the measurement of the uterus.					
23. Carefully insert the loaded IUCD, and release it into the uterus using the "withdrawal" technique.					
24. Take out the plunger. Gently push the insertion tube upward again until you feel a **slight** resistance to ensure fundal placement of the IUCD.					
25. Partially withdraw the insertion tube until the IUCD strings can be seen.					
26. Use HLD (or sterile) sharp Mayo scissors to cut the IUCD strings to 3–4 cm length in the vagina.	√				
27. Gently remove the tenaculum and speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.	√				
28. Examine the cervix for bleeding.					

CHECKLIST FOR IUCD COUNSELING AND CLINICAL SKILLS (REGULAR COPPER T 380A)					
STEP/TASK	**CASES**				
29. Ask how the client is feeling and begin performing the post-insertion steps.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
Post Insertion Steps					
30. Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.	√				
31. Properly dispose of waste materials.	√				
32. Process gloves according to recommended IP practices.	√				
33. Wash hands thoroughly and dry them.	√				
34. Provide post-insertion instructions (key messages for IUCD users): ▪ Basic facts about her IUCD (e.g., type, how long effective, when to replace/remove can come anytime she has concern or query or problems or wants to remove the IUCD) ▪ No protection against STIs; need for condoms if at risk ▪ Possible side effects ▪ Warning signs (PAINS) ▪ Checking for possible IUCD expulsion ▪ When to return to clinic					
35. Complete the woman's records					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
IUCD REMOVAL					
Pre-removal Steps					
1. Ask the woman her reason for having the IUCD removed.					
2. Determine whether she will have another IUCD inserted immediately, start a different method, or neither.					
3. Review the client's reproductive goals and need for STI protection, and counsel as appropriate. ✓					
4. Ensure that equipment and supplies are available and ready to use.	√				
5. Have the client empty her bladder and wash her perineal area.					
6. Help the client onto the examination table.					
7. Wash hands thoroughly and dry them.	√				
8. Put new or HLD gloves on both hands.	√				
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
Removing the IUCD					
9. Provide an overview of the removal procedure. Remind her to let you know if she feels any pain.					
10. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic swabs twice.	√				
11. Alert the client immediately before you remove the IUCD.					
12. Grasp the IUCD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.	√				
13. Apply steady but gentle traction, pulling the strings toward you, to remove the IUCD. **Do not use excessive force**.					
14. Show the IUCD to client.					

CHECKLIST FOR IUCD COUNSELING AND CLINICAL SKILLS (REGULAR COPPER T 380A)					
STEP/TASK	**CASES**				
15. Place the IUCD in 0.5% chlorine solution for 10 minutes for decontamination. ✓	√				
16. If the woman is having a new IUCD inserted, insert it now if appropriate. [If she is not having a new IUCD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.]	√				
17. Ask how the client is feeling and begin performing the post-removal steps.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
Post-removal Steps					
18. Before removing the gloves, place all used instruments and the IUCD in 0.5% chlorine solution for 10 minutes for decontamination.	√				
19. Properly dispose of waste materials.	√				
20. Process gloves according to recommended IP practices.	√				
21. Wash hands thoroughly and dry them.	√				
22. If the woman has had a new IUCD inserted, review key messages for IUCD users. [If the woman is starting a different method, provide the information she needs to use it safely and effectively (and a back-up method, if needed).]					
23. Complete the woman's records					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

EXERCISE 2.5: DEMONSTRATION: LOADING IUCD IN A STERILE PACKAGE

Purpose: To demonstrate steps of loading of IUCD in a sterile package and the withdrawal technique for IUCD insertion and improve the skills of the participants.

Instructions for the facilitator

- Introduce the activity. "Now I am going to show you the technique to load the IUCD CuT 380A in a sterile package. This will help ensure that you do not touch IUCD even with gloved hands before you insert it. It will help reduce the chances of infection"
- Ensure presence of the IUCDs in a sterile package as well as hand-held uterus model
- Ask participants to follow the guidelines given for loading the IUCD in sterile package
- Ask the participants to identify the following parts of the IUCD package , Copper T and its insertion Kit – Transparent front and white back flap of the package, arms and stem of the Copper T ,inserter tube, Blue depth gauge ,ID card and plunger white rod of the insertion kit
- Complete the whole procedure ensuring all participants can see it. Divide participants into small groups so that more than one trainer can make the demonstration
- Once the IUCD is loaded in the sterile package using no-touch technique also demonstrate the steps of withdrawal technique using the hand held uterine model
- Invite participants to ask any question that they may have
- Encourage them to practice following the steps in the guidelines for loading IUCD in a sterile package.

Materials:

- IUCDs CuT 380A in sterile package at least one for each participant and one to two for demonstration
- Hand held uterine model

ROLEPLAYS

Role play 2.1: Demonstration and Practice: FP Counseling Using GATHER approach

Purpose: To provide participants with an experience of counseling a client for family planning using GATHER approach.

Instructions for facilitators

- Divide the participants in groups of three (One counselor, One client, and an observer).Provide participants instruction on role play
  - Read the role play (5 mins)
  - Assign roles (One counselor, one client, one observer)
  - The observer uses the checklist for counseling observation guide to provide feedback
  - The counselor performs as per the guidance in role play
  - The client plays the role according to the situation in the role play
  - Get ready to change roles in the group when one provider/counselor has finished. Each provider/counselor will get 5-10 minutes to complete the role play
- The trainers/facilitators will float from group to group to ensure that the participants are not deviating from the theme of the role play. Announce when it is time to change the roles
- During the follow up discussion focus on quality of counselor and counseling skills, invite suggestions for improvement. List them all on the flip chart.
- Summarize the session by drawing the main point

Role play #1

Mrs. Sitadevi is a 21 years old mother of two children. The older one is 2 year old male child and the younger one is 7 months old baby girl. Sitadevi lives in a small village about 3 kms from the PHC. It is a vaccination day today and Sitadevi and her mother-in-law have come for vaccination of both children. Sitadevi's husband, Ramkishan is a painter and stays with her. He makes money just enough to survive. Sitadevi and he talked several times about not having more babies for at least 2-3 years.

She has heard about several methods and is sure of not using condoms. A couple of friends told about oral pills. Her husband has agreed that she can use any method but he does not want to get involved. Mother-in-law says, "Have as many babies as you want before your body starts to fail and you become weak."

Roles:

Client: Even though you have been to this facility many times you are still worried today. You have several questions like, which method is good? What if I cannot get pregnant after stopping the method? What will the pills do in the body? And how effective these methods are?

Mother in Law: You are a little dominating and tell your daughter-in-law that IUCD is better than oral pills as well as keep on giving your opinion on several things.

Provider: You are an experienced FP service provider with 20 years services. You know the community well and people generally respect you. You have just returned from a Contraceptive Technology Update workshop. All information that you provide is very up to date and you follow the GATHER approach to counseling. You effectively manage the Mother-in-law who is a bit dominating.

Q. How will the provider counsel Sitadevi to address her concerns?

Role play # 2

Mina is 21 years old. She is a teacher and is married with no babies. Her husband and she have plans to do higher studies together and will want to have babies only after they finish studies and have a job in the city.

They have been using condoms correctly and regularly but last night ended up having sex without condoms.

Now she is really worried. They do not want a baby now and is scared she may get pregnant. Someone told her that there is ECP but she thought it was only for those who are unmarried and she also thinks that the tablets will affect her future ability to get pregnant.

She is anxiously waiting for Meenakshi the ANM at MCH center so that she can talk to her.

Roles:
Client: Mina is looking very concerned and has several questions related to ECP before making decisions to take it. Most importantly she wants to know if it will be 100 percent effective in preventing pregnancy

Provider: Meenakshi is young ANM with three years of work experience. She had just returned from a Contraceptive Technology Update workshop and received very up to date information on Emergency Contraceptive Pills. Meenakshi is being very patient and answering all ECP related questions that Mina has.

Q. How will Meenakshi counsel Mina about ECPs?

COUNSELING OBSERVATION GUIDE		
Good counseling behavior	**Observed** **"Yes" or "No"**	**Remarks: If "yes" what was good about it and if "no" what suggestions you have for improvement**
Establish a supportive, trusting relationship		
Allow the woman to talk and listen to her		
Engage woman's family members (if present) with the woman's consent		
Ask about any previous experiences with family planning, and if she has a particular method in mind		
Assess partner/family attitude about family planning		
Ask about her reproductive goals, especially need for spacing or limiting		
Ask about her need for protection against STIs		
Ask whether she is interested in a particular family planning method		
Provide general information about benefits of birth spacing		
Provide information about postpartum birth spacing methods		
Help the woman to choose a method and describe the medical assessment		
Provide method specific information about the method chosen		
Ensure that the woman understands what was discussed		
Plan for next steps and arrange for follow up visit		

SECTION III:
INTRODUCTION TO STI, HIV AND PPCTC OF HIV

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Pre and posttest questionnaire.

Location: Workshop Dates: Participant No:

Instructions:

- You have 25 minutes to complete this test
- Please read the questions carefully and write your answer in the box provided i.e.
- Remember, you can only choose ONE answer for each question.
- For True or False questions, tick the appropriate choice against each sub question.
- If you have difficulty understanding the QUESTIONS, write "Did not understand the question" before moving to the next.
- Answers will be discussed at the very end of the training.

1. HIV is transmitted
   (a) By hugging an infected person
   (b) By sharing food, bath towels, toilet, and soaps with an infected person
   (c) Through mosquito and insect bites
   (d) Through unprotected sexual contact and by sharing needles with an infected person

2. Which of the following HIV +ve people has clearly progressed to AIDS
   (a) Mrs. K who has Tuberculosis
   (b) Mr. J whose CD4 count is 170 and has been admitted for Cryptococcal Meningitis
   (c) Mr. S who has an unexplained fever for more than one month
   (d) Mr. B who has had a persistent cough for more than three weeks

3. Which of the following body fluids contains high concentration of HIV?
   (a) Saliva
   (b) Vaginal secretions
   (c) Urine
   (d) Vomit

4. Mr. V comes to your clinic and says he had a sexual encounter 10 days ago. He suspects that his partner may have HIV. There is no counselor available, so you as the nurse need to counsel him about HIV testing. Keeping in mind the effect of the window period, what would you counsel him to do?
   (a) Do nothing now, but return in 6 weeks for an HIV test.
   (b) Take an HIV rapid test now, and if the result is negative, you would inform him of his negative status, and send him home.
   (c) Go straight away to an HIV clinic for treatment.
   (d) Take an HIV rapid test now, and if the result is negative, you would counsel him on safe sex and ask him to return in 6 weeks to repeat testing.

5. People with this condition should be referred for HIV testing. (Tick TRUE or FALSE against each). True False
   (a) Malaria
   (b) Tuberculosis
   (c) Gonorrhoea
   (d) Arthritis

(e) Pregnant women

6. As a health care professional it is unethical to
(a) Disclose the PLHAs status to his/her spouse against their wishes in cases where you have been unable to convince the patient to do so themselves despite intensive counseling
(b) Refer pregnant women for HIV testing
(c) Mark PLHA case sheets with labels such as “HIV patient” or “Biohazard”
(d) Teach the family simple care procedures to help the PLHA at home

7. Condoms are effective in preventing
(a) Sexually transmitted infections i.e. syphilis
(b) Reinfection of HIV in PLHAs (People Living with HIV/AIDS)
(c) Sexual transmission of HIV
(d) All of the above

8. Which of the following procedures would require a nurse to use all protective equipment (gloves, mask, eyewear, shoes, apron and gown)
(a) Dressing a large open wound (not caused by burns)
(b) Conducting a delivery
(c) Doing a Pelvic/Vaginal exam
(d) Assisting in a lumbar puncture

9. If you had accidental needle prick on your finger the first step you should take is
(a) Squeeze the finger to allow the blood to flow, then wash hands
(b) Do an HIV test on the patient on whom the needle was used
(c) Wash the hands thoroughly with soap and running water
(d) Self-medicate for PEP medicines

10. Tick TRUE or FALSE against each of the following statements True False
(a) Biologically, men are at higher risk to get STI’s than women
(b) STI’s can cause infertility
(c) Reducing STI’s among people will also reduce their risk HIV risk
(d) For effective treatment of STI’s the patient AND their partners need to be treated

11. An in-patient with HIV has diarrhoea for more than 1 month, is in severe dehydration, oral candidiasis, loss of weight (>10% body weight loss) and has a CD4 of 152. (Tick TRUE or FALSE).
(a) The person should be started on ART immediately
(b) The person is said to be in clinical stage II according to WHO
(c) No medical treatment can be provided and the patient should be sent home
(d) Treatment for diarrhoea and oral candidiasis should be started

12. Tick TRUE or FALSE against each of the following statements True False
(a) Effective anti-retroviral treatment (ART) blocks the ability of HIV to reproduce or replicate
(b) Effective anti-retroviral treatment (ART) can reduce the risk of sexual transmission of HIV but will not prevent it completely
(c) Once a person is started on ART for HIV infection, it needs to be taken life long

(d) A patient regularly skips doses of ART is more likely to develop resistance than one who takes their ART regularly as prescribe
(e) The most important criteria for starting ART is the person must show readiness and commitment

13. Palliative care includes
(a) Aggressive treatment management
(b) Pain management
(c) Slowing down the process of death

14. Case Study: Anita is a 31 year old single mother of a healthy 7 year old child. Anita has been on treatment of pulmonary TB during the last 4 months, and she is improving. In the past she has had one episode of herpes zoster and oral thrush – she recovered completely from these episodes but had troublesome itching of the skin. Anita has come to the clinic because she thinks she may be pregnant. Her pregnancy test is positive, and after pre-test counseling and a HIV test, the result shows she is HIV+ve. Her CD4 count is 250/mm3, and her hemoglobin is 9.6g.

(A) Tick TRUE or FALSE against each of the following statements
(i) Anita should be counseled to have an abortion _____
(ii) Anita should be advised to have a hospital delivery _____
(iii)Anita should be advised to have a caesarian delivery _____
(iv) Anita should be advised to give both breast milk and powder milk to the baby after delivery _____
(v) Transmission of HIV from Anita to her baby can be prevented 100% if she takes antiretroviral (ARVs) drugs _____
(vi) Transmission of HIV from Anita to her baby is more likely to occur if Anita's viral load is high _____

(B). Which of the following ARVs should be avoided during Anita's pregnancy?
(i) Efavirenz (Sustiva)
(ii) Stavudine (d4T, Zerit)
(iii)Zidovudine (AZT, ZDV)
(iv)Lamivudine (3TC, Epivir)
(v) Nevirapine (Viramune)

(C) .Which of the following ARVs should be avoided in Anita's case due to the potential side effect of anemia?
(i) Efavirenz (Sustiva)
(ii) Stavudine (d4T, Zerit)
(iii)Zidovudine (AZT, ZDV)
(iv)Lamivudine (3TC, Epivir)
(v) Nevirapine (Viramune)

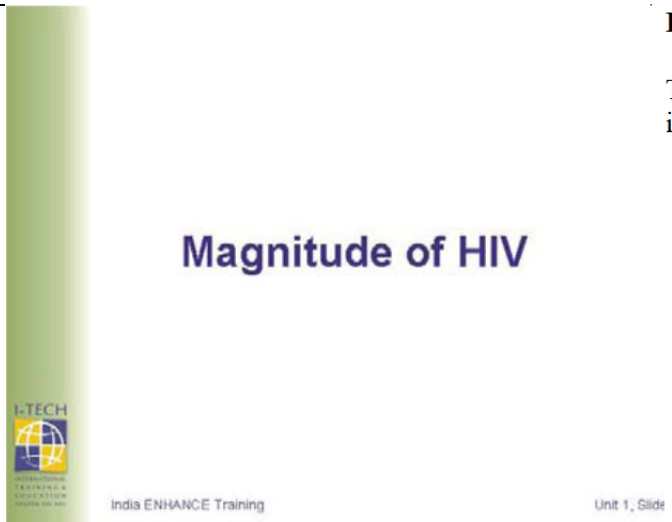
15. Tick TRUE or FALSE against each of the following statements True False
(a) The HIV disease progression is the same in children and adults _____
(b) Generally, HIV exposed children should be given immunizations as usual _____
(c) HIV+ children are likely to get PCP at an earlier stage than adults _____
(d) ART medication should be dosed the same in children as in adults _____

ANSWER KEY

1. d.
2. b.
3. b.
4. d.
5. a. F
   b. T
   c. T
   d. F
   e. T
6. c.
7. d.
8. b.
9. c.
10. a. F
    b. T
    c. T
    d. T
11. a. F
    b. F
    c. F
    d. T
12. a. T
    b. T
    c. T
    d. T
    e. T
13. B
14. (A). i. F
    ii. T
    iii. F
    iv. F
    v. F
    vi. T
    (B). a.
    (C).c.
15. a. F
    b. T
    c. T
    d. F

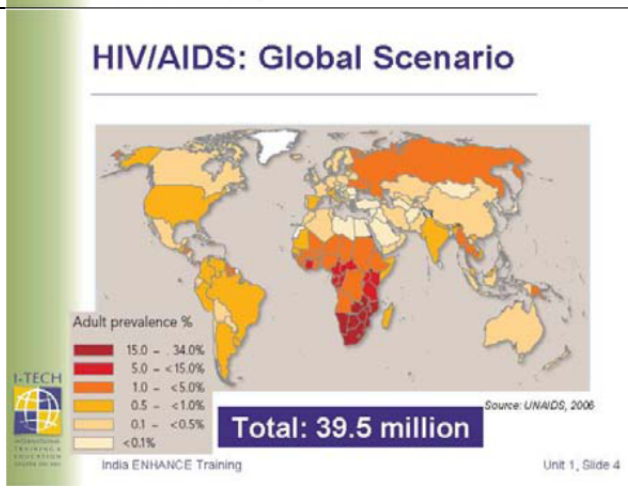
TEACHING MATERIALS

Session: 3.1: Overview of HIV



Facilitator's Notes:

The following slides explain the magnitude of HIV infection globally and nationally.



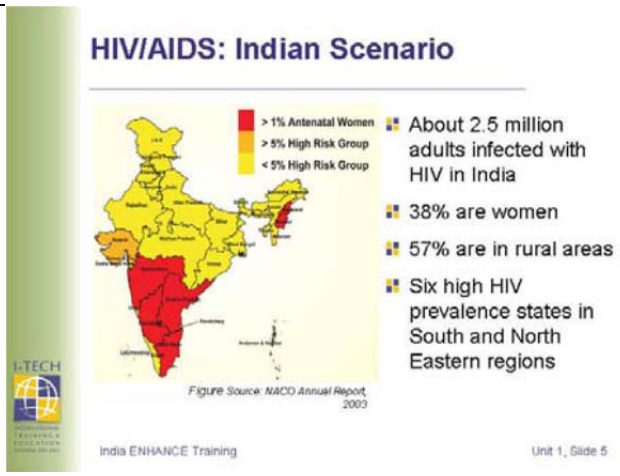
Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2006 Report on global AIDS epidemic. [http://www.unaids.org/en/HIV_data/2006GlobalReport/defaul t.asp](http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp)
Graphic Source: http://www.unaids.org/en/HIV_data/Epidemiology/epi_slides.*asp*

Facilitator's Notes:
Explain that this map shows HIV prevalence in various countries across the globe.

- Prevalence means the percentage of the population that is affected with HIV at a given time.
- Ask participants which areas in the globe are hardest hit by the HIV epidemic?
- Answer: Sub-Saharan Africa.

In 2006 approximately:

- **39.5 million people were living with HIV**
- **worldwide**
- **4.3 million people became newly infected with HIV**
- **2.9 million people died of AIDS-related illnesses**
- **By The year 2010 it is estimated that an additional 45 million people will become HIV infected in 126 low- and middle-income countries if current (2006) infection rates continue.**
- **>40% of these 45 million will be in Asia and the Pacific**
- **• As of the year 2006, Sub- Saharan Africa had the largest number of People Living with HIV/AIDS (PLHAs) but South & South East Asia is in danger of becoming region with the highest number of PLHAs in the world.**



This map shows the six high prevalence states: Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, Manipur, and Nagaland.

Meaning of High, Medium and Low risk states:

- **High Prevalence (red on the map): When > 5% amongst high risk groups and > 1% amongst antenatal cases**
- **Medium Prevalence (orange): When > 5% amongst high risk groups and < 1% amongst antenatal cases**
- **Low Prevalence (yellow): When < 5% amongst high risk groups and < 1% amongst antenatal cases**

There are 111 high prevalence districts in India.

There are regional differences in modes of transmission:

- Heterosexual routes is the most common in Tamil Nadu, Karnataka, Andhra Pradesh, and Maharashtra.
- Through sharing needles of injection drug users in Nagaland and Manipur.

Source: National AIDS Control Organisation. 2006 Sentinel Surveillance.

Facilitator's Notes continued:

Ask participants which groups are considered high risk groups/populations?

Answer:

Commercial Sex Workers (CSWs)
Men who have Sex with Men (MSM)
IDU (Injection Drug Users)
Trafficked women

Graphic Source: National AIDS Control Organisation. Annual Report 2002-2003 2003-2004 (up to July 2004). Page 18 http://www.nacoonline.org/annualreport/annualreport.pdf

Some interesting facts:

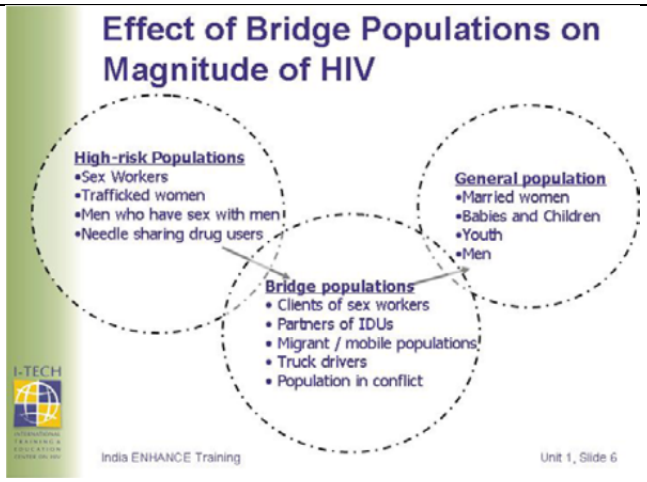
- 2005 estimate is 5.7 million PLWHA (adults and children) in India.
- First HIV case in India was seen in 1986 in Tamil Nadu.
- First full blown case of AIDS was in Mumbai (1987).
- HIV infection has been reported in all States.
- HIV prevalence tends to be higher in the industrialized peninsular states.

Ask participants how many patients are testing Positive for HIV every month at their local site, if known? Has this changed over time?

In 2006, 2-3.1 million adults infected with HIV in India. *Source: http://data.unaids.org/pub/PressRelease/2007/070706_indiapressrelease_en.pdf_26.10.07*

- **38% are women**
- **57% of these are in the rural areas**

Source: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2006 Report on global AIDS epidemic. http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp



Facilitator's Notes:

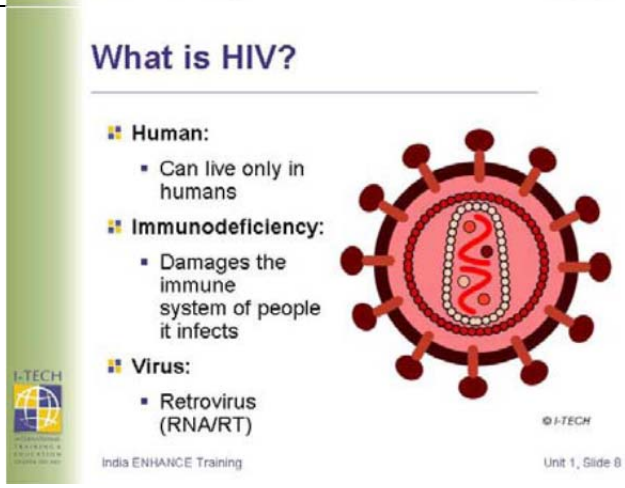
High-risk populations:

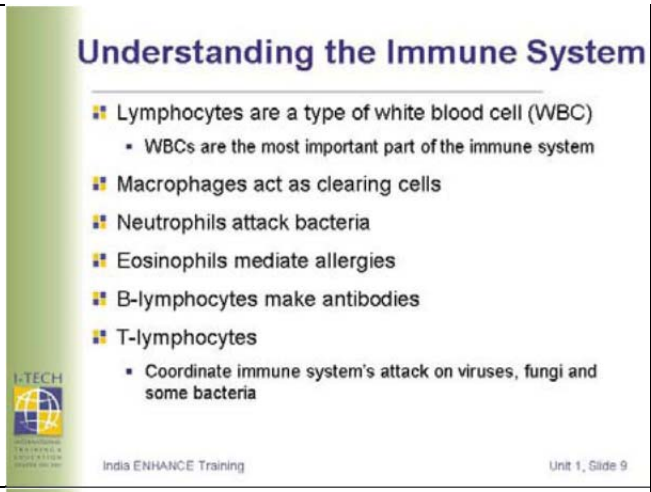
- Initially HIV infection was restricted to high risk populations namely the sex workers, women who were sold for sex work, or men having sex with men (MSM) and injection drug users (IDUs).

Bridge populations:

- These HIV-infected individuals can transmit
- HIV infection through unsafe contact (i.e. sexual, needle sharing, unprotected sex) to individuals who are termed the bridge population.
- People who live in areas of conflict and war are often subject to violence or may be involved in unsafe practices that could result in increased spread of HIV.

General population:

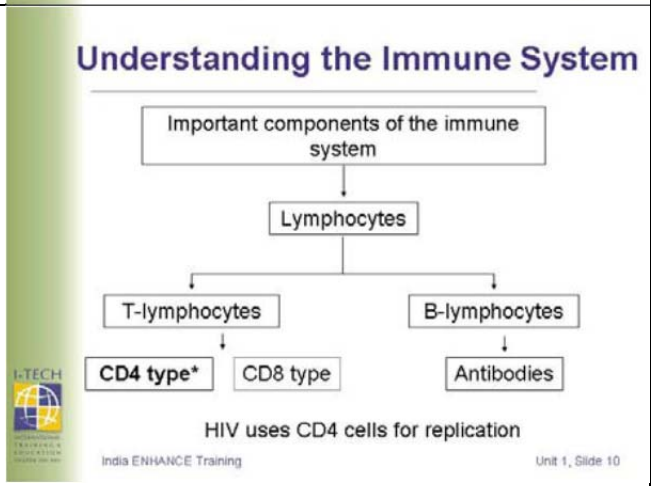
	▪ Once a member of the bridge population (e.g. truck drivers, clients of sex workers, migrants, etc.) is infected, they can infect their spouses and their babies, considered the general population. This is a very common scenario in India. ▪ HIV today is no longer restricted to any particular group of individuals. It has reached the general population who has never had any high risk behaviour - this includes married women, babies and children, youth and men.
	Ask participants, "Are HIV and AIDS the same thing?" If they say no, ask them "How are they different?" **Wait for their answers and then project the next series of slides.**
	**Facilitator's Notes:** **Human** ▪ HIV, like all viruses, must enter other cells if it is to replicate and survive. HIV cannot stay alive outside the human body unless under laboratory conditions. **Immunodeficiency:** ▪ HIV damages an individual's immune system and unlike most viruses, it cannot be destroyed by the body. After becoming infected, a person has HIV for the rest of his or her life. **Virus:** ▪ HIV is a "retrovirus" ▪ The genetic material of retroviruses are carried in the form of RNA rather than DNA. ▪ Retroviruses usually contain an enzyme reverse transcriptase that helps in converting RNA to DNA during the replication process.



Discuss the basic components of the immune system in the human body using the points on the slide.

The body protects itself from infections in two ways:

- Skin and mucous membrane: prevent infection from physically entering the body
- The Immune System: fights infection inside the Body. The immune system protects the body by recognizing and destroying: infectious agents such as bacteria, viruses, and parasites, abnormal cells and foreign objects – anything from small objects like thorns, to transplanted organs

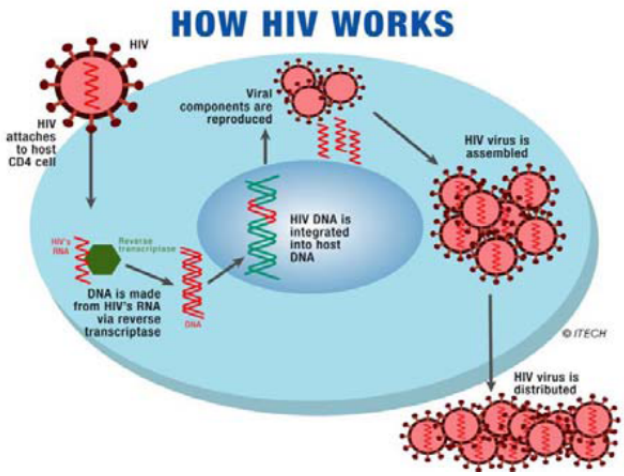


Lymphocytes are present in lymphoid organs which are found throughout the body. They help manufacture white blood cells (WBCs) that protect the body.

- B-lymphocytes are produced in the bone marrow.
- T-lymphocytes are processed and stored in the thymus.
- The most important of T-lymphocytes are CD4 type and CD8 type.

The HIV virus is especially attracted to the CD4 type of lymphocytes. It enters the CD4 lymphocyte and multiplies in them thereby destroying the CD4 cells. Gradual loss of these CD4 cells results in the loss of immunity.

Ask participants to think about how they can give patients simple explanations about the immune system as part of ongoing patient education.

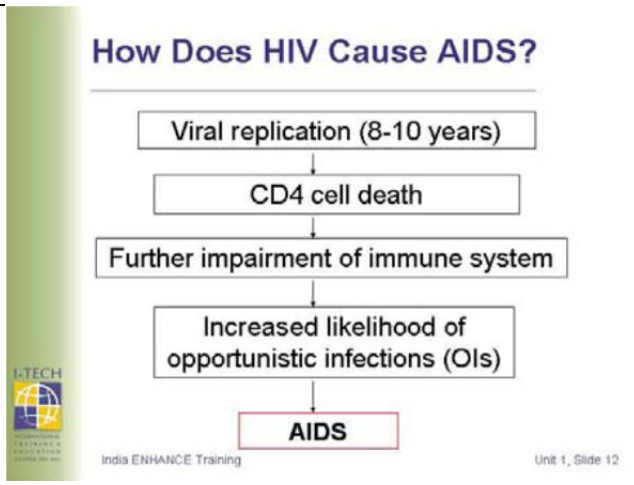


Review slide and explain the six stages of the HIV life cycle.

HIV uses the CD4 cell like a factory to reproduce more of itself:

- HIV attaches to the CD4 cell & releases RNA & enzymes on entry.
- The enzyme 'Reverse Transcriptase' makes a DNA copy of the viral RNA.
- New viral DNA is then integrated using the enzyme 'Integrase' into the CD4 cell nucleus.
- New viral components are then produced, using the cell's machinery.
- These are assembled together using the enzyme 'Protease'.
- The new viruses are released.

The host CD4 cell eventually gets destroyed by this process



The natural progression of infection in a PLHA who is not treated:

- As CD4 cells get destroyed, the immune systemis weakened and the body's capacity to fight infections is reduced.
- Person becomes susceptible to many infections including opportunistic infections (OIs) (caused by organisms that naturally reside in the body (i.e. PCP) or that are in the environment (i.eTB).
- Presence of major OIs indicates AIDS.

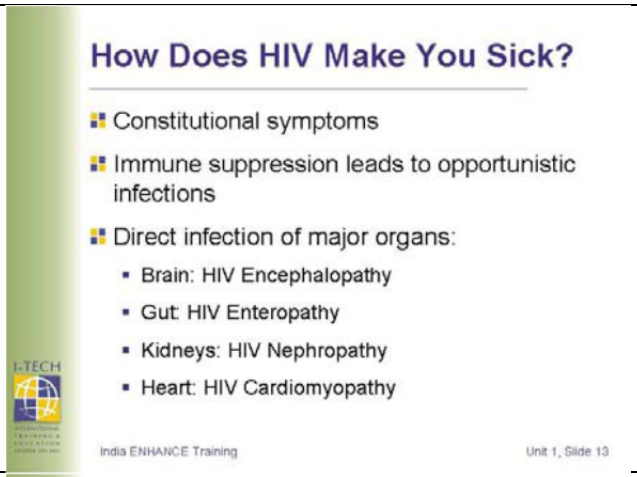
Ask participant's "What is an opportunistic infection (OI)?"

- **Answer:** An infection that occurs with a weakened immune system that a person with a strong immune system may be able to fight off.

Then ask participant's to give you examples of an OI.

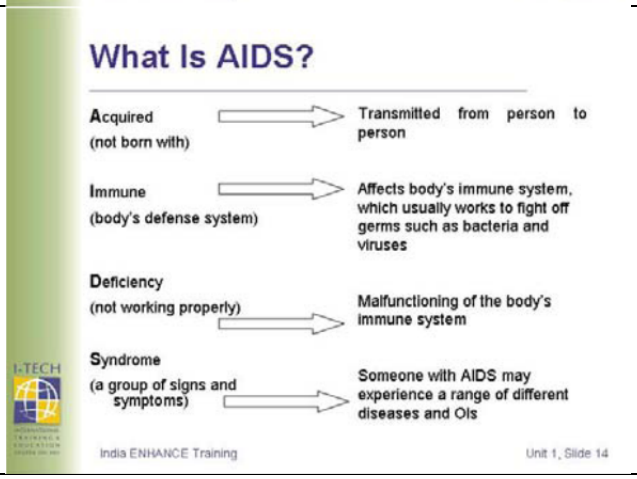
- Examples: PCP, oesophageal candidiasis, etc.

Ask participants if there are any questions or doubts so far, and if so, take a few minutes to clarify and summarize.



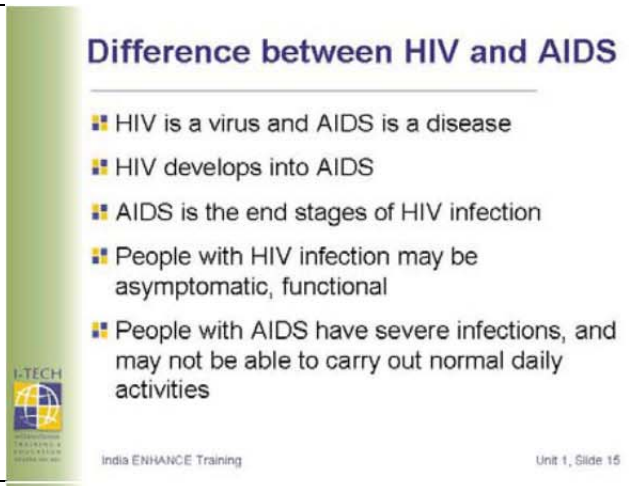
Patients can become sick from constitutional symptoms of HIV such as fever, night sweats, fatigue and rash, without an OI.

Patients with HIV can die from opportunistic infections such as TB, pneumonia, herpes, and meningitis. But HIV can also directly affect organs in the body as mentioned in the slide.

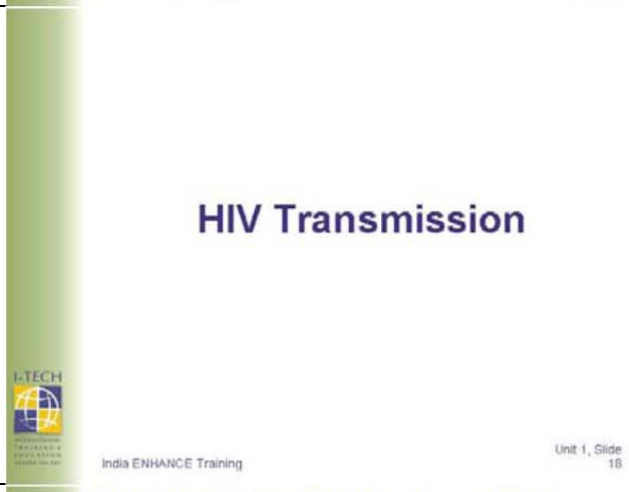


Someone may be infected with HIV for many years before their immune system is damaged sufficiently (CD4<200) to cause opportunistic infections and hence AIDS.

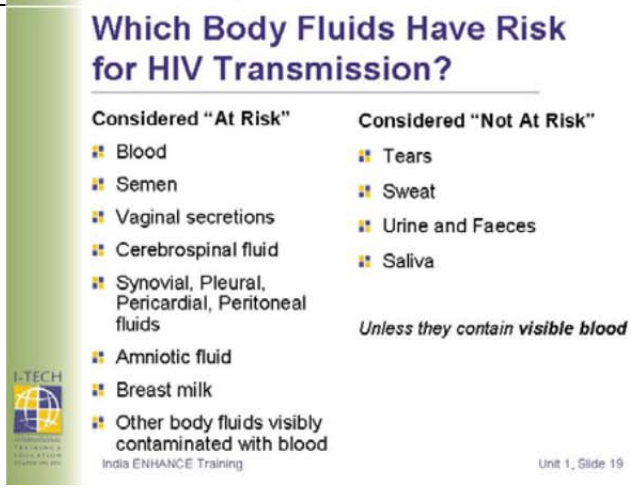
Ask participants, "In summary, can you explain the difference between HIV and AIDS?"
Wait for their responses and then project the next slide.



Review the differences between HIV and AIDS.
Some persons remain HIV-infected and never progress to AIDS, i.e. long term progressors, elite controllers.

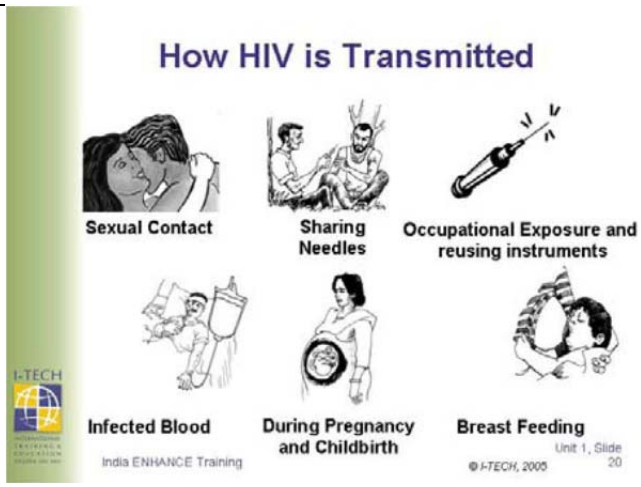


Ask participants "How is HIV transmitted?" Write their responses on flipchart paper/board and then project the next few slides.



This slide is animated.
Ask participants to call out which body fluids have risk of transmitting HIV and which do not.
Wait for their responses and then click the mouse or press the down arrow button for each bullet to appear in the slide.

Clarify that amniotic fluid does not contain HIV unless there is interruption in the integrity of the amniotic sac (i.e. rupture of membranes, invasive procedures such as amniocentesis or trauma).
HIV has been found in saliva and tears in very low quantities from some AIDS patients. HIV has not been recovered from the sweat of HIV-infected persons.
Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV**.**



HIV infected body fluids are transmitted from one person to another through the routes mentioned in the slide.

Define each type of sexual contact/practice and risk of HIV transmission:

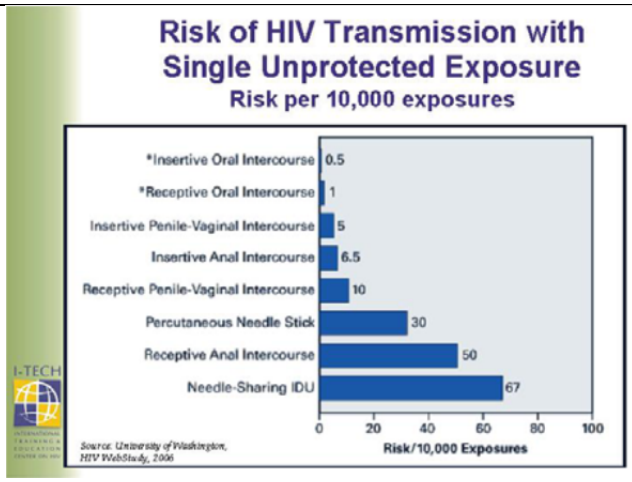
- **Anal sex**: insertion of the penis into the rectum of a man or a woman - high risk for recipient because the lining of the rectum is thin and can tear and semen can pass through the mucous membrane of the rectum.
- **Vaginal sex**: insertion of the penis into the vagina – high risk because semen can pass through the mucous membrane lining of the vagina or the head of the penis, but higher risk for the woman.
- **Oral sex**: stimulation of the genitals with the mouth – although less risky, HIV can be transmitted through contact with vaginal fluid or semen especially if there are open sores in the mouth or genital area.

Sharing infected needles can lead to transmission of HIV. **Needle routes of HIV transmission are**:

- Injection drug use
- Reusing infected instruments (i.e. needles or surgical instruments) in the health care setting
- Getting a deep needle stick from a person infected by HIV during an occupational exposure

Receiving infected blood, blood products, or organs can allow transmission of HIV.

Mothers can transmit the virus to their babies during pregnancy, delivery, or breast feeding**.**



Sources:

1. Rothenberg RB et al. AIDS 1998;12:2095-2105.
2. Am J Epidemiology 1999;150:306-11.
3. NEJM 336(15):1072-8. (rates in Europe & U.S.)
4. Am J Epidemiology 1999;150:306-11
5. CDC, MMWR 47; RR-17, 1998.
6. Bell DM. Am J Med 1997; 102 (suppl 5B): 9—15.
7. Am J Epidemiology 1999;150:306-11 and CDC, MMWR 54; RR-
2, 2005 (http://www.cdc.gov/mmwr/PDF/rr/rr5402.pdf).

Tell participant's that the risk of HIV transmission would be higher with multiple exposures or if the person who is exposed has an STI or has a weak immune system due to TB, malnutrition or other disease. All transmission risks assume an HIV-infected source partner/patient.

Interpretation of data presented in slide:

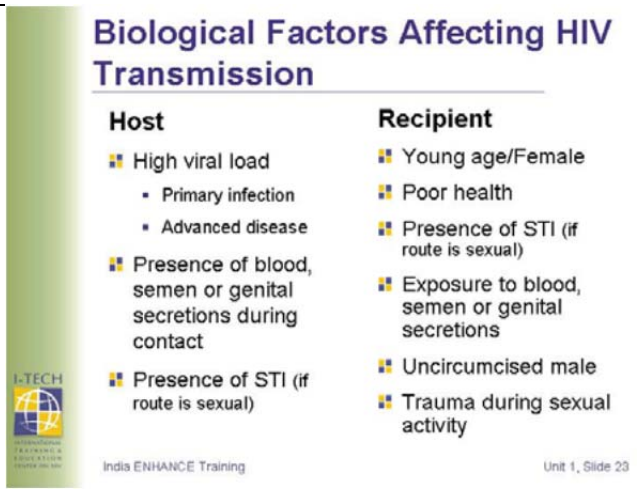
1) Approximately 0.5 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through unprotected insertive oral intercourse.

2) Approximately 1 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through unprotected receptive oral intercourse.

3) Approximately 5 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through unprotected insertive penile-vaginal intercourse. (female to male)

4) Approximately 6.5 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through unprotected

8. CDC, MMWR 47; RR-17, 1998.	insertive anal intercourse. **5)** Approximately 10 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through unprotected receptive penile-vaginal intercourse. (male to female) **6)** Approximately 30 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through occupational percutaneous injury. **7)** Approximately 50 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through unprotected receptive anal intercourse. **8)** Approximately 67 out of 10,000 people will acquire HIV with a single exposure from an HIV infected source through needle sharing.
	Brainstorm with participants why HIV cannot be transmitted as mentioned in the slide. **HIV is NOT transmitted by:** ▪ Kissing and hugging – contact with intact skin is not harmful. ▪ Contact with sweat, tears, urine or faces – as long as none of these contain blood, they pose no risk for transmission of HIV. ▪ Insect bites – HIV cannot be transmitted by insects – it is a human virus. ▪ Swimming, sharing utensils, toilet seats, etc. – HIV cannot exist outside the human body, so there is no risk of transmission through these methods. ▪ Eating food prepared by an infected person – will not lead to transmission of HIV. This is just a common myth and increases stigma towards HIV +ve people. **Ask participants, "What other myths have you heard about routes of transmission?" Clarify any doubts before moving on.** **Ask participants, "Is it important to know how patients got infected with HIV?"** The answer should be **NO** – regardless of how the patient became infected, the nurse still needs to do a good current risk assessment to be able to counsel on safe behaviors in the present and future, and the care and treatment will be the same no matter how the person became infected. Ask participants what biological factors increase the risk of HIV transmission. After eliciting their responses, show the next slide.



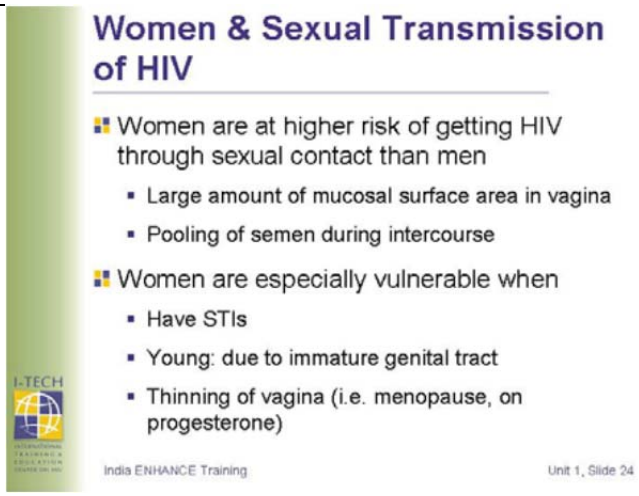
(*CDC. Male circumcision and risk of HIV transmission: implications for US. March 2007. http://www.cdc.gov/hiv/resources/factsheets/circumcision.htm*)

Susceptibility of **recipient** is increased with the following factors (**women and HIV will be discussed in the next slide, so don't spend too much time on it here**):

- **Age**, if female: The younger the girl, the greater the risk of trauma during sexual intercourse.
- **Gender**: Women are more susceptible.
- **Presence of STI**: Inflammation, lesions could increase entry of the virus into the body.
- **Exposure** to infected blood, semen or other genital secretions which contain high volumes of the virus.
- Uncircumcised men having unprotected sexual contact with an infected person.
- Compared to the dry external skin surface of the penis, the inner mucosa of the foreskin has less keratinization (deposition of fibrous protein), a higher density of target cells for HIV infection, and is more susceptible to HIV infection in laboratory studies.
- It has also been argued that the foreskin may have greater susceptibility to traumatic epithelial disruptions (tears) during intercourse, providing a portal of entry for pathogens including HIV.
- In addition, the micro-environment in the preputial sac between the unretracted foreskin and the glans penis may be conducive to viral survival.
- Finally, the higher rates of sexually transmitted genital ulcerative disease, such as syphilis, observed in uncircumcised men may also increase susceptibility to HIV infection.
- Trauma during sexual activity could increase risk of transmission

Ask the participants "Which of these factors in the slide could we change, so that the transmission of HIV is decreased?"

Answer: Everything except age and gender; infectiousness at various stages of disease can be decreased by practicing safer sex, healthy lifestyle, and counseling to empower vulnerable groups (young women or women exposed to domestic violence)



Biologically, women are more prone to HIV than men.

- Women have a larger mucosal surface area which allows pooling of semen therefore increasing risk of exposure to HIV.
- STIs are difficult to detect in women, and may be asymptomatic. Having an STI increases a person's risk of acquiring HIV through sex.
- Vaginal tract is fragile in women who are nearing menopause, on progesterone or very young girls. Rough vaginal sexual intercourse leading to chafing or tears may make them more susceptible to HIV infection.
- HIV-positive women's sexual partner(s) have a greater risk of getting HIV, if sexual contact occurs during menstruation.

With the large group, discuss each bullet with regards to:

- **What it means**
- **How it can impact HIV transmission**

Social Mobility: HIV/AIDS follows routes of commerce. Can be transmitted when urban and rural migrations occur, there is a mobile population in search of jobs (i.e. truck drivers) and when there is inadequate economic growth, unemployment.

Gender: Cultural practices that support multi-partner relationships for men and lack of negotiating power of women enable transmission of HIV. Unequal distribution of power between men and women create barriers for women to negotiate precaution for HIV and other STIs.

Poverty: Results in lack of access to information, care, and treatment thus enabling spread of HIV. Might also force a person into commercial sex work or trafficking as only means of financial support.

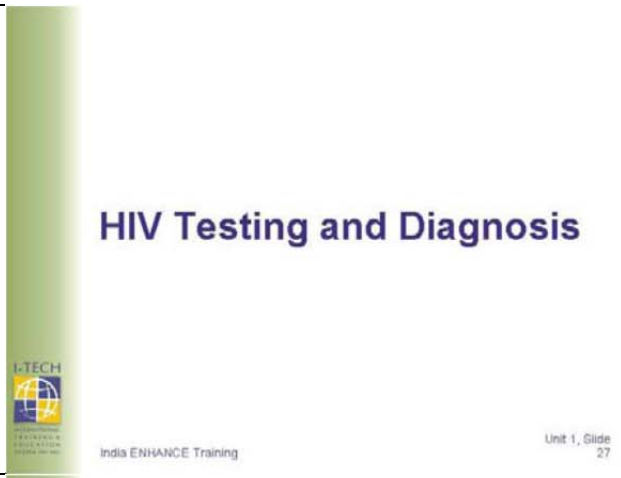
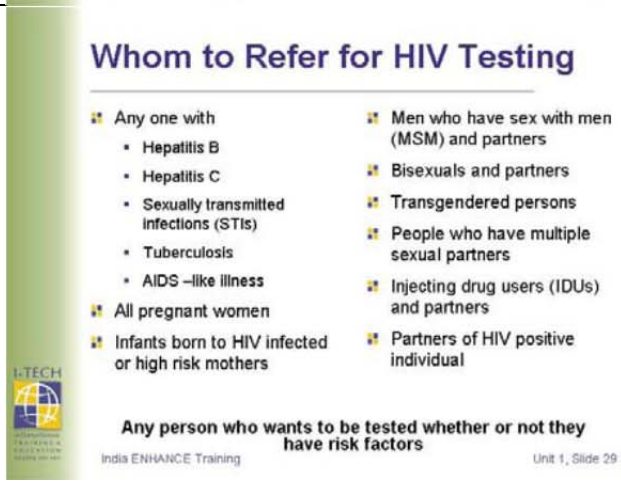
Cultural: Traditions, beliefs, and practices affect understanding of health and disease and acceptance of conventional medical treatment.

Stigma and Denial: Denial and silence about HIV is the norm. Stigma prevents people from getting tested and seeking care which enables the spread of HIV.

Drug Use and Alcohol Consumption: Leads to impaired judgment. Encourages high risk behavior such as sharing needles and unsafe sex which contributes to the rapid spread of HIV not only in high risk groups but also in the general population.

Domestic and Community Violence: People in trauma due to violence have little negotiating power and often are exposed to high risk behaviour. Can be physical or sexual violence in home or community which puts the victim at risk of acquiring HIV.

People in Conflict: People who live in areas of conflict and war are often subject to violence or may get involved in unsafe practices that could

	result in increased spread of HIV.
	Nurses play an important role in HIV testing and diagnosis. They can: ▪ Identify and refer patients who need HIV testing ▪ Educate patients about tests and clarify need for repeat testing if necessary
	Brainstorm with participants the question on the slide and write their responses on a flipchart/ board. Advance to the next slide for answers.
	**Answer: Refer the following individuals to Integrated Counseling and Testing Centers (ITCTs) for testing:** ▪ Anyone with Hepatitis B, Hepatitis C, sexually transmitted infections (STIs), Tuberculosis, ▪ AIDS –like illness or illness consistent with AIDS ▪ All pregnant women ▪ Infants born to HIV infected or high risk mothers ▪ Any person worried about the possibility of being exposed to HIV ▪ Men who have sex with men (MSM) ▪ Men who have sex with men AND women ▪ Transgendered persons ▪ People who have multiple sexual partners – for money, pleasure or drugs ▪ Injecting drug users (IDUs) ▪ Partners of MSMs, men who have sex with men AND women, and any HIV positive individual ▪ **Today any person can present for an HIV testing and the person need not have any risk factor or behaviour in order to be tested.**

Prerequisites of HIV testing - Consent of patient - Confidentiality - Counselling: pre and post-test India ENHANCE Training — Unit 1, Slide 30	**Stress the importance of the 3 'C's : Consent, Confidentiality and Counseling.** **They will be dealt with in detail in the unit on Stigma, Legal and Ethical Issues as well as in the Counseling unit – so just list them here and emphasize their importance.**

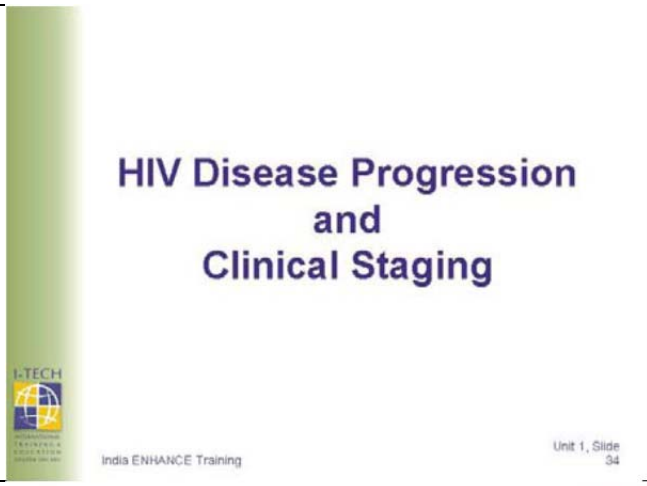
Type of Tests used to Diagnose HIV
- Antibody Based Tests
  - Rapid test (e.g. TriDot; Immunocomb)
  - ELISA test
- Antigen Based Tests
  - P24 Antigen
- PCR Tests
India ENHANCE Training — Unit 1, Slide 31
	Ask participants if they can explain the meaning of antibody and antigen:
	
	▪ An antibody or immunoglobulin is produced and used by the immune system to identify and neutralize foreign objects like bacteria and viruses.
	▪ An antigen is a molecule that stimulates an immune response (in this case – the HIV virus).
	▪ PCR tests look for particles of the virus itself.

HIV Antibody Based Tests - Most commonly used tests for diagnosis (age > 18 months) - Economical - Rapid - Can be performed easily in most laboratories India ENHANCE Training — Unit 1, Slide 32	**Review antibody based tests using the slide and asks participants if they have heard of this test before.**

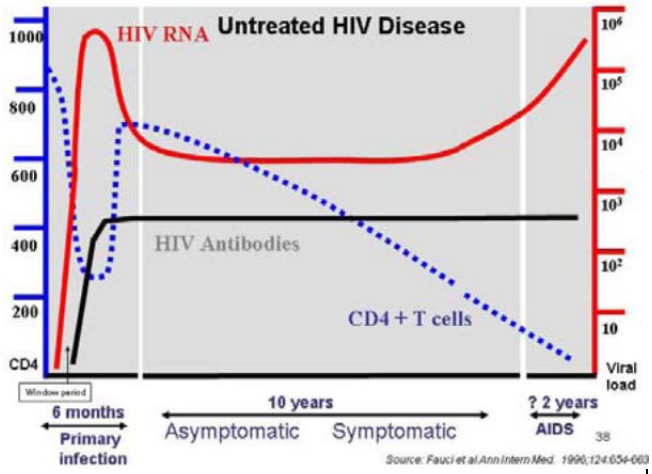
Interpretation of Antibody Test Results: Special Cases
- **HIV positive** individuals recently infected in the window period could get **negative** test results
  - Usually 2-6 weeks
  - Can be 2-12 weeks
  - Rarely up to 6 months after exposure
- **HIV negative** children <18 months born to HIV positive women can get **positive** test results
India ENHANCE Training — Unit 1, Slide 33
	There are two special cases when antibody test results can be misleading. Explain these two scenarios to the participants:
	HIV positive people who test negative:
	▪ The 'window period' is the time when a person has HIV virus in the body and has not yet developed enough antibodies. During this time, commonly used HIV test kits are not able detect the antibodies to the virus.
	▪ Seroconversion is the time when there is evidence in the blood (sero) that there is antibody response to HIV virus. This means that a person will have a positive HIV test.
	▪ Seroconversion usually occurs within 2 to 6 weeks but can be 2 to 12 weeks and rarely up to

	6 months after exposure. ▪ When positive individuals test negative it is probably because their blood has not yet seroconverted. This is why they are asked to come in for repeat tests later, so that their status can be confirmed. **HIV negative children born to HIV-positive mothers**: misleading positive test results may occur up to 18 months of age because mothers pass HIV antibodies to their newborn children during antenatal period.
HIV Antigen Based Tests ▪ Detect HIV sooner than antibody test ▪ Usually used for ▪ Diagnosis: age < 18 months ▪ Monitoring HIV disease progression ▪ Monitoring response to ARV therapy ▪ Expensive ▪ Require expertise to perform and interpret India ENHANCE Training Unit 1, Slide 34	**Review antigen based tests using the slide and asks participants if they have heard of this test before.** **If testing is done at their facility, ask them which kind of test is usually used at their centre.**
NACO Testing Strategies ▪ **Strategy I** - all samples tested with one ELISA/Rapid (E/R) ▪ **Strategy II** - all samples tested with one E/R, reactive samples tested again on different system (different antigen and principle) ▪ **Strategy III** - all samples tested with one E/R, reactive samples from the first test tested with different antigen preparation, reactive samples from the second test again tested with third system (of different antigen and principle) India ENHANCE Training Unit 1, Slide 35	**Although the participants may not be conducting tests, they need to know what NACO's testing strategies are in order to educate patients and advocate for appropriate HIV testing** *Source: NACO, Ministry of Health and Family Welfare, GOI. Training Modules for Specialists on HIV Care and Treatment (including ART), May 2007. Page 30.*
NACO Testing Strategies India ENHANCE Training Unit 1, Slide 36	*Source: NACO, Ministry of Health and Family Welfare, GOI. Training Modules for Specialists on HIV Care and Treatment (including ART), May 2007. Page 33.*

Testing Strategy	Objective of Testing
I	Transfusion/ Donation safety
I & II	Surveillance
II	Diagnosis of symptomatic patients
II & III	Diagnosis of asymptomatic patients



HIV Disease Progression and Clinical Staging (Slides 37-41) - 15 minutes



Facilitator's Notes:

This slide is animated and has several frames.

Explain concept of each phase:

- Frame 1. 3 axes represent Time (at the bottom), CD4 count (on the extreme left) and viral load (10^2 =100, etc.) (on the extreme right)
- Frame 2. acute, primary infection: many critical events followed by seroconversion (anytime between 2 – 12 weeks)
- **Primary infection is when the body is first infected with HIV, and at this time the viral load would be very high and the person is considered extremely infectious.**
- **There is usually a window period – a period of time between infection and seroconversion. This needs to be kept in mind when performing antibody tests for diagnosis.**
- **80% of those infected experience something called Acute Retroviral Syndrome which is a flu like illness occurs within 2 - 4 weeks of exposure. Symptoms include fever, headache, rash, pharyngitis, arthralgia, myalgia, lymphadenopathy and weight loss. Symptoms may be mild to severe and may last 1-2 days to several weeks and in rare cases, several months.**
- Frame 3: asymptomatic and symptomatic infection
- Frame 4: AIDS

Explain the lab tests used to mark the progress of HIV using the next few frames.

- Frame 5: Red line = HIV RNA = quantity of virus in blood, very high during primary infection and AIDS
- Frame 6: Black=HIV antibodies persist after "window period"
- Frame 7: Blue Dotted = CD4 + T cells -- decline with acute primary infection, recovers somewhat, then slow decline with HIV progression
- Frames 8, 9 & 10: Re-emphasize 3 phases of disease progression
- Frame 11: Last frame, entire graph

The title "? 2 years / AIDS" on the lower right side, under the graphic, indicates that in the absence of treatment, time until death varies for a person with AIDS. The example given here is "?", meaning unknown, or "2 years".

Progression to AIDS among individuals is variable.

- Some PLHAs progress rapidly (within 1-2 years) to a low CD4 count, become ill and, without treatment, die.
- Some may become infected and remain healthy with relatively normal CD4 counts for many years (>10)

Refer participants to *Handout 1: HIV Disease Progression* in the Participant Manual for concise information on HIV disease progression. Ask if there are any questions or doubts and clear them before moving on.

Before projecting the next slide, ask participants if they can list some OIs at the various stages of HIV infection shown on the graph.

Graphic Source: Fauci AS, Pantaleo G, Stanley S, Weissman D. Immunopathogenic mechanisms of HIV infection. Ann Intern Med. 1996;124:654-663.

Handout 3.1: HIV Disease Progression

Progression to AIDS among individuals is variable. Some individuals progress rapidly within 1 to 2 years; while others remain healthy for many years.

Stages of HIV Disease Progression

Primary HIV Infection **Or** **Acute Retroviral Syndrome (ARS)** **"Window period"**	When HIV first enters the body, the immune system recognizes the "antigen" and causes flu-like symptoms. During this time, HIV viral load is high and therefore infected person is highly infectious and can easily transmit virus to others during this time. ARS is symptomatic in 53% to 90% of people. Occurs 2 – 4 weeks after exposure and lasts 1 – 2 weeks Common Symptoms: Fever, rash, lymphadenopathy, pharyngitis, erythematous maculopapular with lesions on face/trunk and sometimes palms or soles, myalgia or arthralgia, Lethargy/malaise. Once infected with HIV it takes usually 2-12 weeks for antibodies to develop. This period is called the "window period". During this "window period" the person although infected, tests negative for HIV antibodies.
Asymptomatic Chronic Infection	Early immune depletion - CD4>500. Level of virus is low. HIV replication takes place mostly within lymph nodes. Generally lasts 5 years or more. May be less for patients with malnutrition or co-infection. Generalized persistent lymphadenopathy. Usually no other symptoms.
Symptomatic HIV Infection	Intermediate immune depletion – CD4 between 500 – 200. Infections start and persist as CD4 count decreases. ART and OI prophylaxis considered.
Advanced HIV Infection/AIDS	Advanced immune depletion – CD4<200. Case definition of AIDS is having a CD4 count of <200. OIs develop.
OIs are the leading cause of morbidity and mortality in HIV-infected individuals. The most common OIs are preventable and treatable	

Handout 3.2: WHO Clinical Staging of HIV/AIDS for Adults and Adolescents with Confirmed HIV Infection

WHO has developed a staging system in which four clinical stages of disease are identified based on certain signs and symptoms. These stages give us an idea of the severity of disease and prognosis and facilitate planning for appropriate treatment and care.

Clinical Stage 1 ▪ Asymptomatic ▪ Persistent generalized lymphadenopathy
Clinical Stage 2 ▪ Unexplained moderate weight loss (<10% of presumed or measured body weight)[i] ▪ Recurrent respiratory tract infections (sinusitis, tonsillitis, otitis media and pharyngitis) ▪ Herpes zoster ▪ Angular cheilitis ▪ Recurrent oral ulceration ▪ Papular pruritic eruptions ▪ Seborrhoeic dermatitis ▪ Fungal nail infections
Clinical Stage 3 ▪ Unexplained severe weight loss (>10% of presumed or measured body weight) ▪ Unexplained chronic diarrhoea for longer than one month ▪ Unexplained persistent fever (above 37.5°C intermittent or constant, .for longer than one month) ▪ Persistent oral candidiasis ▪ Oral hairy leukoplakia ▪ Pulmonary tuberculosis ▪ Severe bacterial infections (such as pneumonia, empyema, pyomyositis, .bone or joint infection, meningitis or bacteraemia) ▪ Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis ▪ Unexplained anemia (<8 g/dl), neutropaenia (<0.5 × 109 per litre) .and/or chronic thrombocytopaenia (<50 × 109 per litre)
Clinical Stage 4[iii] ▪ HIV wasting syndrome* ▪ Pneumocystis pneumonia ▪ Recurrent severe bacterial pneumonia ▪ Chronic herpes simplex infection (orolabial, genital or anorectal .of more than one month's duration or visceral at any site) ▪ Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs) ▪ Extrapulmonary tuberculosis ▪ Kaposi's sarcoma ▪ Cytomegalovirus infection (retinitis or infection of other organs) ▪ Central nervous system toxoplasmosis ▪ HIV encephalopathy ▪ Extrapulmonary cryptococcosis including meningitis ▪ Disseminated non-tuberculous mycobacterial infection ▪ Progressive multifocal leukoencephalopathy ▪ Chronic cryptosporidiosis ▪ Chronic isosporiasis ▪ Disseminated mycosis (extrapulmonary histoplasmosis or coccidiomycosis) ▪ Recurrent septicaemia (including non-typhoidal *Salmonella*) ▪ Lymphoma (cerebral or B-cell non-Hodgkin) ▪ Invasive cervical carcinoma ▪ A typical disseminated leishmaniasis ▪ Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy

- Assessment of body weight i n pregnant woman needs to consider the expected weight gain of pregnancy.
- Unexplained refers to where the condition is not explained by other causes.
- Some additional specific conditions can also be included in regional classifications (such as reactivation of American trypanosomiasis [meningoencephalitis and/or myocarditis]) in the WHO Region of the Americas and penicilliosis in Asia).

Source: WHO. WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children. 2006. Page 15, Table 3.
Available at http://www.who.int/hiv/pub/guidelines/hivstaging/en/index.html

*HIV wasting syndrome can be defined as profound involuntary weight loss greater than 10% baseline body weight, plus either diarrhea (at least two loose stools per day for more than 30 days) or chronic weakness and documented fever (for more than 30 days, intermittent or constant) in the absence of concurrent illness or condition other than HIV infection that could explain the findings (such as cancer, tuberculosis, cryptosporidiosis or other specific enteritis).
Source: Stedman's Medical Dictionary 28th Edition, Copyright©2006_Lippincott Williams & Wilkins.

Handout 3.3: WHO Clinical Staging System of HIV/AIDS for Children with Confirmed HIV Infection

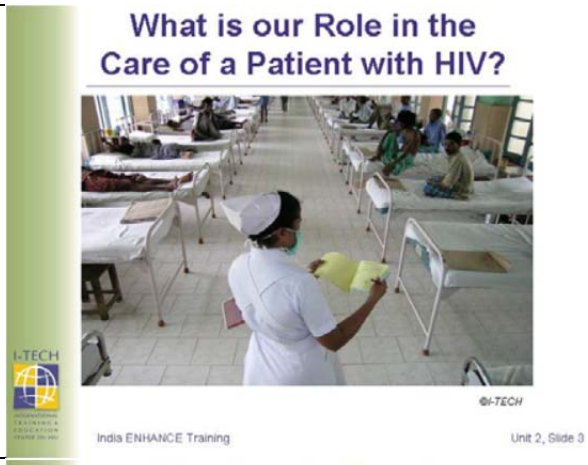
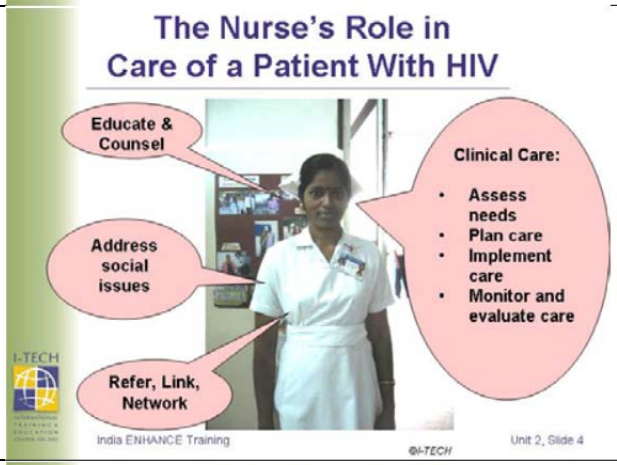
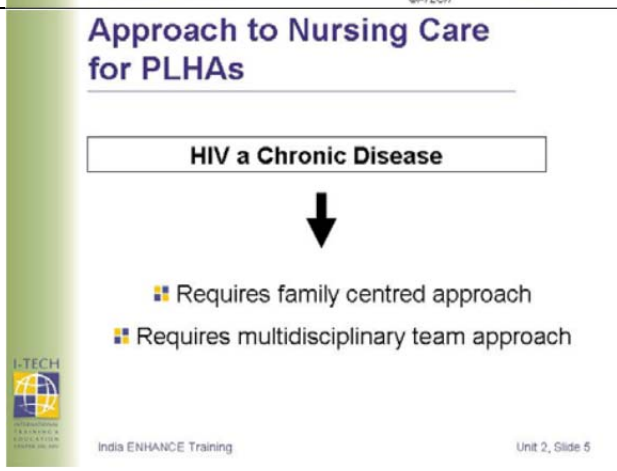
Clinical Stage 1 ▪ Asymptomatic ▪ Persistent generalized lymphadenopathy
Clinical Stage 2 ▪ Unexplained persistent hepatosplenomegaly ▪ Papular pruritic eruptions ▪ Fungal nail infection ▪ Angular cheilitis ▪ Lineal gingival erythema ▪ Extensive wart virus infection ▪ Extensive molluscum contagiosum ▪ Recurrent oral ulcerations ▪ Unexplained persistent parotid enlargement ▪ Herpes zoster ▪ Recurrent or chronic upper respiratory tract infections ▪ (otitis media, otorrhoea, sinusitis or tonsillitis)
Clinical Stage 3 ▪ Unexplained moderate malnutrition or wasting not adequately responding to standard therapy ▪ Unexplained persistent diarrhoea (14 days or more) ▪ Unexplained persistent fever (above 37.5°C intermittent or constant, for longer than one month) ▪ Persistent oral candidiasis (after first 6–8 weeks of life) ▪ Oral hairy leukoplakia ▪ Acute necrotizing ulcerative gingivitis or periodontitis ▪ Lymph node tuberculosis ▪ Pulmonary tuberculosis ▪ Severe recurrent bacterial pneumonia ▪ Symptomatic lymphoid interstitial pneumonitis ▪ Chronic HIV-associated lung disease including brochiectasis ▪ Unexplained anemia (<8 g/dl), neutropaenia (<0.5 × 109 per litre) ▪ And or chronic thrombocytopaenia (<50 × 109 per litre)
Clinical Stage 4 [iii] ▪ HIV wasting syndrome ▪ Pneumocystis pneumonia ▪ Recurrent severe bacterial pneumonia ▪ Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site) ▪ Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs) ▪ Extrapulmonary tuberculosis ▪ Kaposi's sarcoma ▪ Cytomegalovirus infection (retinitis or infection of other organs) ▪ Central nervous system toxoplasmosis ▪ HIV encephalopathy ▪ Extrapulmonary cryptococcosis including meningitis ▪ Disseminated non-tuberculous mycobacterial infection ▪ Progressive multifocal leukoencephalopathy ▪ Chronic cryptosporidiosis ▪ Chronic isosporiasis ▪ Disseminated mycosis (extrapulmonary histoplasmosis or coccidiomycosis) ▪ Recurrent septicaemia (including non-typhoidal *Salmonella*) ▪ Lymphoma (cerebral or B-cell non-Hodgkin)

- Invasive cervical carcinoma
- Atypical disseminated leishmaniasis
- Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy

- Unexplained refers to where the condition is not explained by other causes.
- Some additional specific conditions can also be included in regional classifications (such as reactivation of American trypanosomiasis [meningoencephalitis and/or myocarditis] in the WHO
- Region of the Americas, disseminated penicilliosis in Asia and HIV-associated rectovaginal fistula in
- Africa).

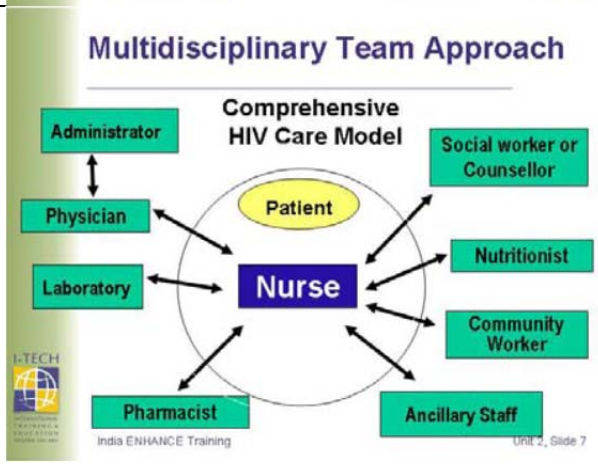
Source: WHO. WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children. 2006. Page 17, Table 4. Available at:
http://www.who.int/hiv/pub/guidelines/hivstaging/en/index.html

Session 3.2: Role of Nurse in care of patient with HIV

	**Ask participants to brainstorm what they think their role is in the care of HIV patients.** **• Ask a volunteer to write the responses on a flip chart / board so that all participants can see.**
	This slide is animated. Keep clicking on the down arrow button till all 4 bubbles appear one by one. These are just a few examples of a nurse's role in care of an HIV patient - participants will have different and/or more responsibilities according to their particular practice sites.
	The process of HIV progression to AIDS is similar to a chronic disease as discussed in the first unit. In order to manage HIV as a chronic disease: ▪ Patient and health providers must work as team. ▪ A consistent relationship between patient and health care team members must be maintained ▪ Continuity of care through all stages of disease and life span of the patient must be provided **The concept of providing team based care may be new for nurses.** **Ask participants if they currently have a team model at the site where they practice. If not, ask them to think about how this might work with HIV patients in their setting as they learn more about this approach in the next few slides.**

The family plays an important role in an individual's life in terms of providing care, support, etc. It is important that health care providers recognize this and draw on the family in order to provide the best environment for the PLHA. If the family learns the best way to be involved with care, the patient will:

- be more confident and increase ability to manage his/her health needs. Learn ways to live well with HIV and delay HIV disease progression
- be more likely to adhere to treatment and access care
- have increased capacity for home-based care



Explain the nature of multidisciplinary team approach to HIV care using the information below.

Highlight how the nurse plays a central role in communicating with all the members of the health care team as shown in the diagram.

Features of multidisciplinary team approach to care:

- Puts clinical issues into the context of medical and psychosocial needs, acknowledging the multiple needs of PLHA.
- It links family and community to medical care thus ensuring that care is coordinated and decisions are made collaboratively.
- It recognizes that all members of the health care team make important contributions which may not be possible when working alone.
- The patient should be informed that members of this team respect the patient's privacy and confidentiality. For example, when staff and
- Patients live in the same community, patients may fear that others will find out about his/her HIV status.

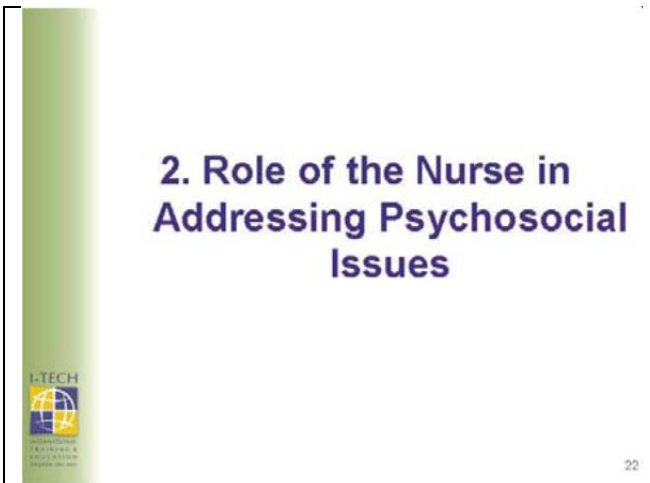
Before moving onto the next slide ask participants– "We have seen that the nurse plays a role in the multidisciplinary team, but why do you think the nurse is often the central member on a team caring for HIV patients?" Wait for their responses and then project the next slide.

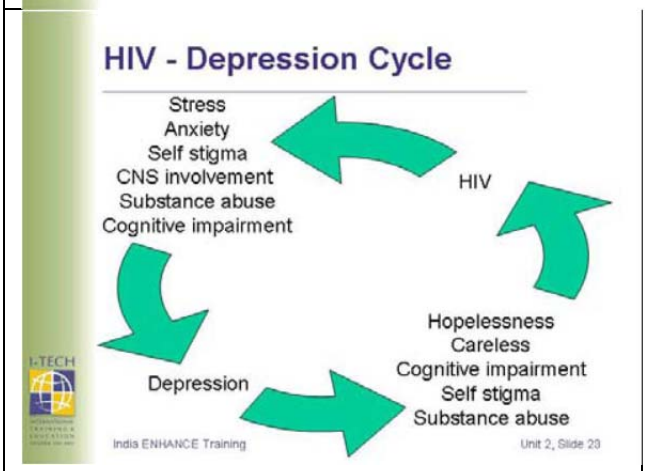
The nurse is in the ideal situation for this role as she/he is often the primary contact for the patient and the main connection between the patient/ family and other members of the health care team.

Presently, in most settings, the social worker takes on this crucial role, but the nurse could take on this role because the nurse is:

- The person in the hospital who is in contact with the patient for the longest period
- Often the "coordinator" of the care plan for the patient from start to finish
- Frequently the team member who implements the care plan or "makes it all happen"

Session 3.3: Role of the Nurse in addressing psychological issues



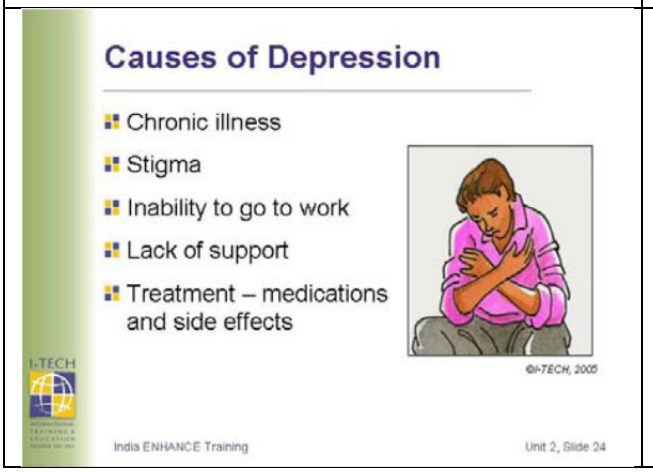


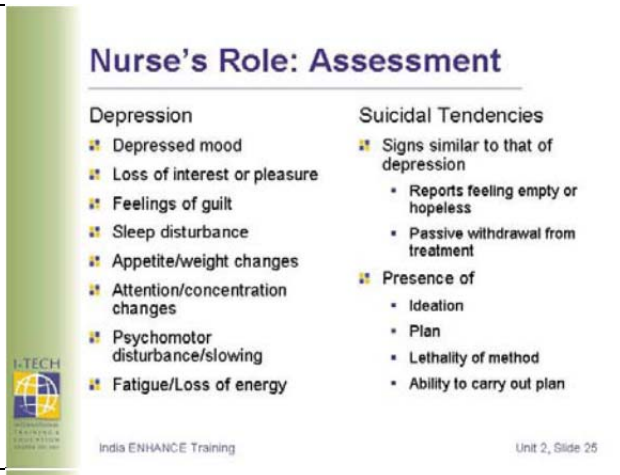
Depression is a significant problem in HIV because:

- It can increase the risk for HIV transmission persons with depression are likely to care less about their own safety, are hopeless, and are more impulsive.
- It can result in poor compliance and adherence to effective treatment in patients.

Moreover, HIV infection worsens depressive symptoms by creating an atmosphere of helplessness and stress. An advanced infection of HIV creates direct injuries to the subcortical regions of the brain. Depression may be viewed as a self perpetuating cycle with increasing morbidity in a single patient or it may be viewed on a societal level, increasing the epidemic spread of HIV. Studies show that depression has a negative effect on patients' adherence, quality of life, and treatment outcome. Despite this important evidence, depressive conditions remain under-recognized, under diagnosed and under-treated.

Reinforce to participants that it is important to recognize the signs of depression in a patient/ PLHA and take appropriate measures to reduce it.





Depressive symptoms are the most common psychiatric complication of chronic medical illness.

A person must have at least five of the symptoms listed in the slide under depression, one of which must be a depressed mood or loss of interest or pleasure

• Bereavement is not considered a mood disorder or psychiatric condition. Normal grief usually lasts no more than 6 months and is considered a self limiting condition.

Ask participants, "What is the practice for intervention, if any, at your facility when a patient expresses suicidal thoughts?"

- Hospitalization with 24 hour watch?
- At minimum, contract with patient not to harm self?
- Get family involved in staying with patient and accompanying them to clinic?
- Other?

Ask participants if suicide is common among their HIV patients. Then ask them to think about any experiences they've had. Ask one or two volunteers to describe their experience(s).

In order to provide comprehensive and family centered care to patients with HIV, which includes appropriate counseling, education and referral, nurses need to understand and be able to address many social issues. These issues may affect how they plan appropriate nursing interventions.

Conduct a small group exercise with the class (15 minutes).

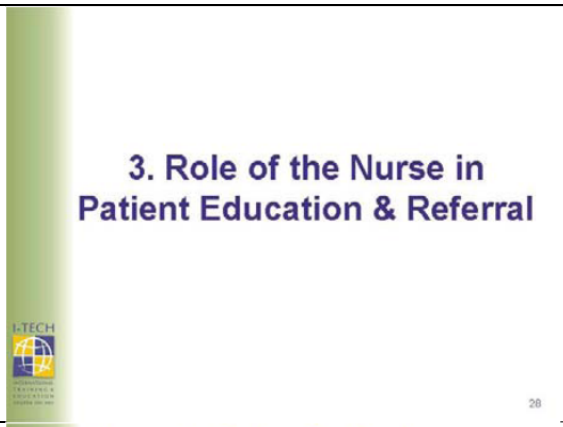
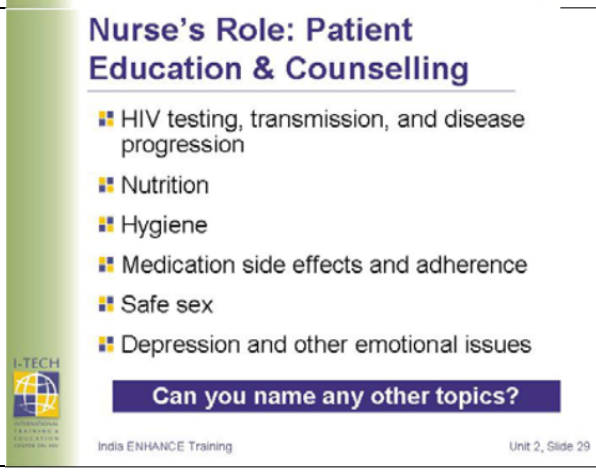
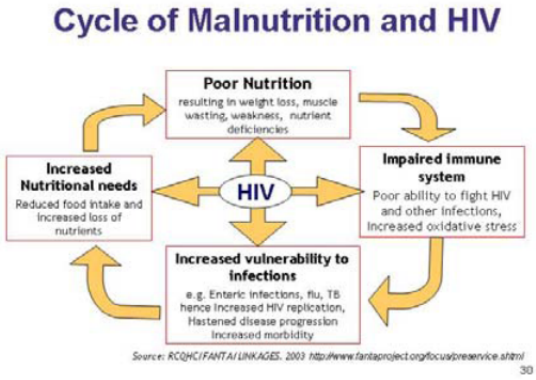
Divide the class into 6 groups. Assign each group one of the topics on the slide.

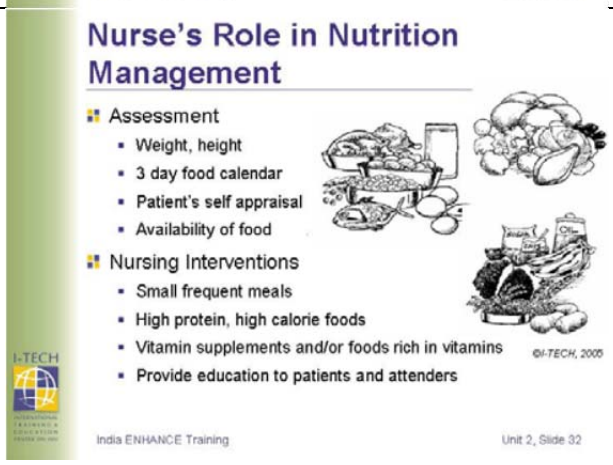
Provide each group with chart paper and markers and allow them 5 minutes to discuss their issue and note key points on the chart with reference to the questions on the slide.

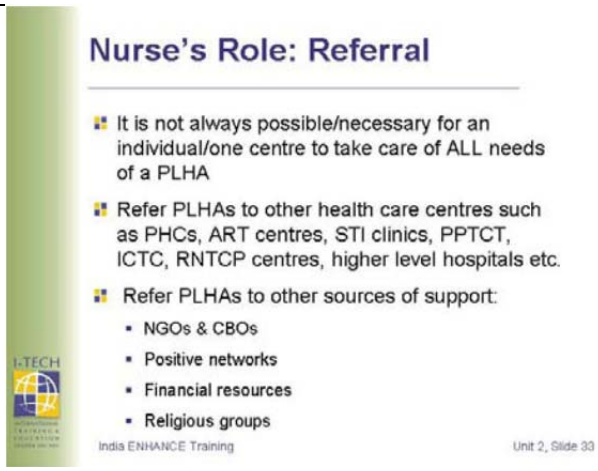
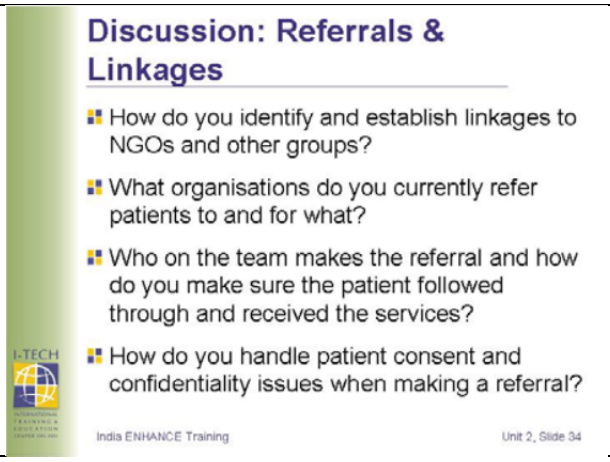
At the end of 5 minutes, allow each group 2 minutes to present their responses to the class and receive feedback. Tape charts on the wall.

Suggested Answers:

- **Low socioeconomic status**: Possible causes-caste system, lack of education and opportunities. Could impact PLHA negatively through lack of information, access to care and treatment.
- **Lack of disclosure:** May be due to self stigma, fear of rejection, shame, fear of violence, etc. Could impact PLHA negatively as it would mean fewer opportunities for external sources of support.
- **Lack of positive social support:** May be due to abandonment by family, fear of disclosing to anyone, spouse or other family members have died, etc. Could cause depression, have impact on disease progression, lower adherence etc.

	▪ **Barriers to medical care:** There may be many causes – living far from any facility, no money, too sick to travel, cannot take time off work, fear of stigma, lack of acceptance of medical treatment, etc. Impact – self-explanatory. ▪ **Exposure to violence at home and in the community:** could be related to gender issues, lack of acceptance of various sexual relationships such as homosexuals, bisexuals etc. and stigma of PLHA. Impact – self-explanatory. ▪ **Gender differences:** focus on women being the vulnerable group, male dominance, cultural practices that support multi-partner relationships for men and lack of negotiating power of women. Unequal distribution of power between men and women create barriers for women to negotiate safer sex and appropriate health care for themselves.
	A nurse not only has clinical duties to take care of patients, but is also responsible for educating patients on various topics essential for healthy living - safe sex, nutrition, and hygiene. Nurses also play an important role in referring their patients to other appropriate sources of care and support.
	**Review the topics listed in this slide on nurse's role in patient education and counseling.** Inform participants that HIV testing, HIV transmission and disease progression have already been addressed in Unit 1. Depression was reviewed in the previous slides. Nutrition will be briefly addressed in this session and safe sex, and medication side effects will be addressed in further sessions
 *Source: Nutrition and HIV/AIDS: A Training*	**This represents the vicious cycle of malnutrition and HIV where poor nutrition leads to an impaired immune system, and in turn an increase in opportunistic infections and progression of HIV, leading to an increase in nutrient needs.** **Malnutrition:** ▪ Can be directly related to HIV infection Or due to symptoms manifested as a result of infections secondary to poor immune status ▪ Treat the underlying cause of malnutrition (i.e. diarrhoea, oral manifestations of HIV, side effect of medication, depression, decreased appetite, etc.)

Manual. *2003. Regional Centre for Quality Health Care, FANTA, LINKAGES, Kampala, Uganda.* *Online:* *http://www.fantaproject.org/focus/preservice.shtml*	The figure shows that due to HIV a person can have: ▪ Poor nutrition ▪ Impaired immune system ▪ Increased vulnerability to infections ▪ Increased nutrition needs This cycle results in: ▪ Weight loss ▪ Loss of muscle tissue and body fat ▪ Vitamin and mineral deficiencies ▪ Reduced immune function and competence ▪ Increased susceptibility to secondary infections ▪ Continued rapid HIV disease progression
	The relationship between nutrition and HIV/AIDS is complex. HIV progressively damages the immune system and malnutrition itself may further compromise it, thus also increasing the susceptibility to infection. Evidence also suggests that malnourished adults and children initiating ART require adequate food to support nutritional recovery
	**Ask participants to name foods 1) high in protein, 2) high in calories, 3) rich in vitamin A, C and B and note these on a flip chart.** ▪ High Protein Foods: Dhal, Grams, Eggs, ▪ Protein drinks, Fish, Meat, Milk, Yoghurt ▪ High Calorie Foods: Nuts, Ground nuts, dried fruits, Custards, Ghee, Butter, Cooking oils, ▪ Whole fat milk products ▪ Vitamin supplements and/or foods rich in vitamins A & C such as: sprouted foods, green leafs, carrots, citrus fruits, dark orange and green, fruits ▪ Vitamin B foods: cereals, pulses, nuts, milk products, eggs, meat and green leafy vegetables Remember, no matter what treatment is implemented to address malnutrition, without access to an adequate diet and nutritional support, weight gain cannot be maintained.

	PHCs: Primary Health Care Centers ART: Antiretroviral Treatment Centers STI: Sexually Transmitted Infection Clinics PPTCT: Prevention of Parent to Child Transmission Centers ICTC: Integrated Counseling and Testing Centers NGOs: Non-Governmental Organizations CBOs: Community Based Organizations RNTCP: Revised National Tuberculosis Control Program **Ask participants to name any other people or agencies they use for referral or collaboration. Encourage them to make a directory of all possible agencies in their respective State, to which they could refer PLHA to as mentioned in this slide.**
	**Lead a group discussion on referrals and linkages using the questions in the slide. (5 minutes)** **Many trained nurses may have no experience with linkages and referrals.** **Refer participants to *Handout 1: Nurse's Role in Referrals, Linkages and Networking* in the participant manual for more details.**

Handout 3.4: Nurse's Role in Referral, Linkages and Networking

It is not always possible for a particular health care worker/health center to provide ALL of the services a PLHA might require. In order to ensure that PLHAs needs are met without duplicating or burdening health care services and personnel, PLHAs can be referred (directed to a source for help or information) to appropriate care givers (i.e. counsellors, social workers) and facilities (ICTCs, STI centres, DOTS centres, etc).

Why is referral important?

- Makes the patient feel he/she is important
- Avoids delay in getting treatment
- Makes the patient recognize the need for treatment compliance/adherence
- Prevents the spread of the infection
- Helps a partner/family member to seek medical services i.e. treatment of STI

Why must a nurse develop linkages and network?

- It avoids duplication of services
- It enhances optimal use of a service

How can a nurse develop linkages and network?

A nurse needs to be aware of all services/centers providing health services in the community, nearby locality, and in the State.

- It is preferable that in each institution a resource list of all Integrated Testing and Counseling Centers (ICTCs), Prevention of Parent to Child Transmission (PPTCT) Centers, Sexually Transmitted Infection (STI) clinics, Antiretroviral Therapy (ART) centers, Positive Networks, care and support center and other social support centers are made available, so that a nurse can make appropriate referrals when needed.
- The head nurse can either do this directly or collaborate with the social worker /counselor and doctor for this purpose.
- A nurse must be able to assess and refer patients to appropriate services once discharged and/ or whenever needed.

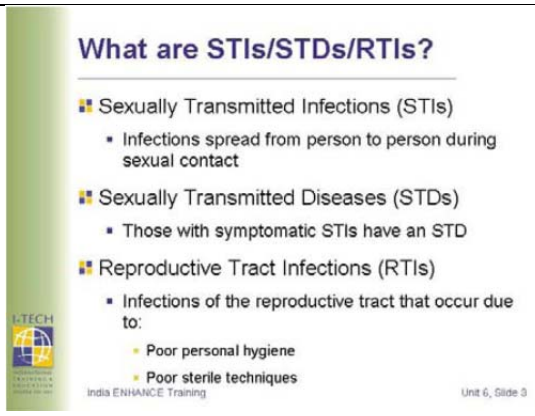
With whom can a nurse develop linkages or network?

Individuals	Groups	Institutions
Anganwadi workers Counsellors Community/social workers Doctors/physiotherapists Influential/political persons Religious persons School teachers	Non Government Organizations (NGOs) Community based organizations (CBOs) Positive Network Support groups Other social organizations Village Panchayats	Hospitals- government, private ICTCs PPTCT programmes STI clinics ART centres Care and support centres

What skills does a nurse need to develop to be able to effectively network?

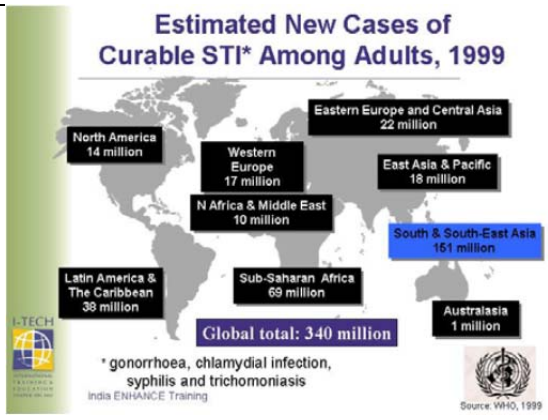
- Ability to recognize the needs of others
- Ability to get along with others
- Persuasiveness
- Commitment to help people in need
- Interpersonal communication skills
- Understanding and commitment to the rights of PLHAs

Session 3.4 : Sexually transmitted diseases



Clarify with participants that:
More than 50% of people with an STI do not present with any major sign or symptom that could make them suspects that they have an infection.
Hence it is preferable to use the term STIs rather than STDs, as STDs refer to symptomatic STIs, and we know that many are asymptomatic.

RTIs can be STIs, but can also occur:
due to poor personal hygiene of the genital tract where organisms are able to grow easily when sterile techniques are not followed by health professionals during procedures such as an abortion, inserting a copper T, during a delivery, or any other invasive procedure in the reproductive tract

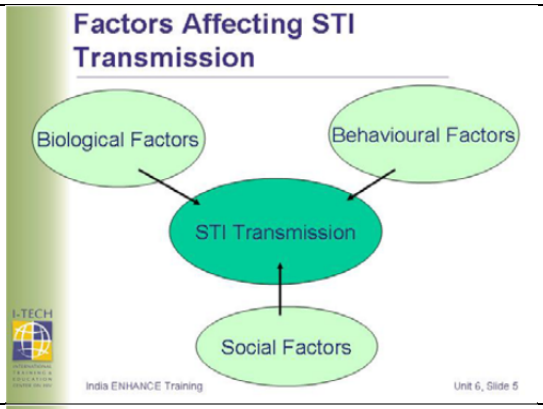
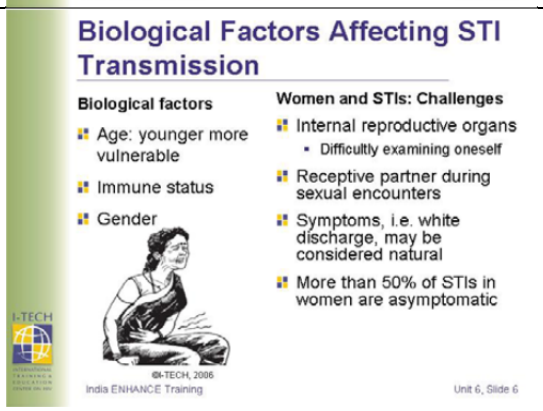
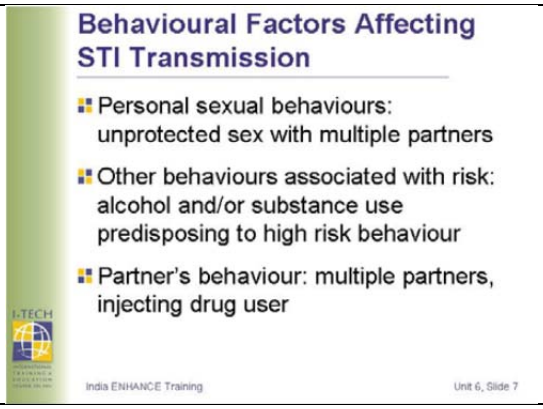


Source: World Health Organization. Global Prevalence and Incidence of Selected Curable Sexually Transmitted Infections Overview and Estimates. 2001. (Graphic source: Figure 2: Estimated New Cases of Curable STI Amoong Adults, 1999. Page 8.) *http://www.who.int/hiv/pub/sti/en/who_hiv_aids_2001.02.pdf*

According to the World Health Organisation (WHO) world prevalence is 340 million new treatable STIs in 1999.
1 million treatable STIs each year
The load burden of STIs in Asia is more than in any other part of the world and this may be another reason that this region has the highest number of people with HIV worldwide.

Globally, STIs constitute a huge health and economic burden, especially for developing countries where they account for 17% of economic loss.

- Untreated gonococcal and chlamydial infections in women will result in pelvic inflammatory disease in up to 40% of cases. One in four of these will result in infertility.
- In pregnancy, untreated early syphilis will result in:
  - stillbirth rate of 25%
  - neonatal deaths of 14%
  - an overall perinatal mortality of about 40%.
  - Worldwide, up to 4000 newborn babies become blind every year because of eye infections attributable to untreated maternal gonococcal and chlamydial infections.
  - New vaccines against human papillomavirus infection could stop the untimely death of approximately 240

	000 women from having cervical cancer every year in resource-poor settings.
	**We will discuss the three main factors affecting the transmission of STIs over the next few slides.**
 **Refer the participants to *Handout 1: Vaginal Discharge – What You Need to Know* in the Participant Manual.**	**Biological Factors:** **Age** - The vaginal mucosa and cervical tissue in young women is immature which makes them more vulnerable to STIs than older women. Women are especially at risk in cultures where they marry or become sexually active during early adolescence. On average, women become infected at a younger age than men. **Immune status** - The immune status of the host and virulence of the infective agent affect transmission of STIs. Certain STIs increase the risk of transmission of HIV. HIV, in turn, facilitates the transmission of some STIs, and worsens the complications of STIs by weakening the immune system. **Gender** - Since the mucosal surface that comes into contact with the infective agent during vaginal sexual intercourse is much greater in women than in men, women can be more easily infected than men.
	

Social factors link both gender and behavioural issues and may affect a person's risk of getting an STI:

- Low status of women

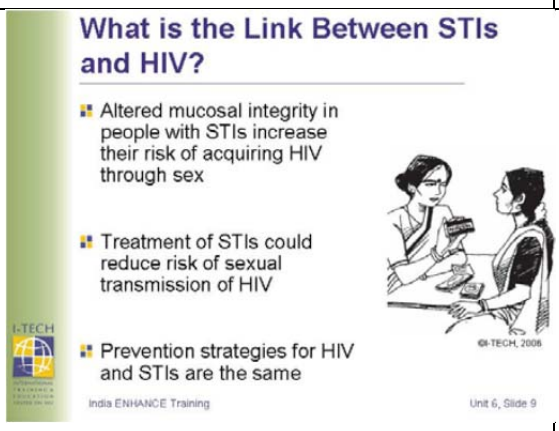
In most cultures women have very little power over sexual practices and choices, such as use of condoms.

Women tend to be economically dependent on their male partners and are therefore more likely to tolerate men's risky behaviour, i.e. multiple sexual partners, thus putting them at risk of infections.

In some societies the girl-child tends to be married off to an adult male at a very young age, thus potentially exposing the girl to STIs at a very young age.

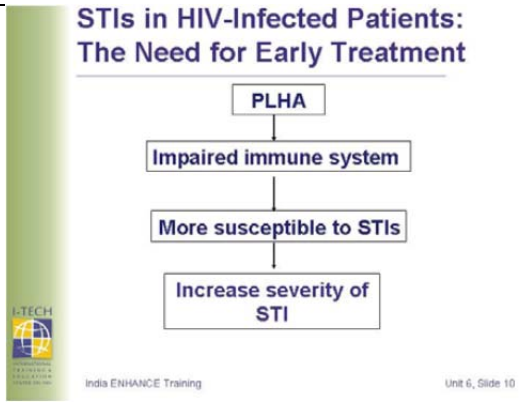
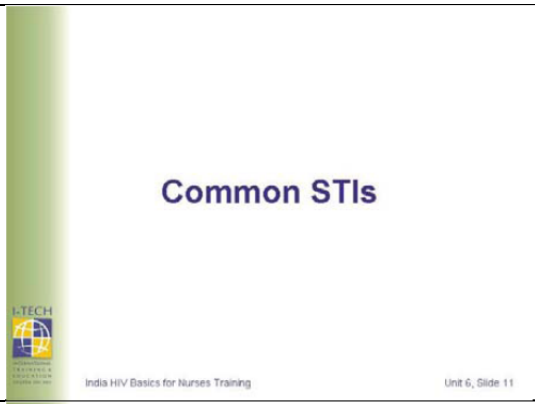
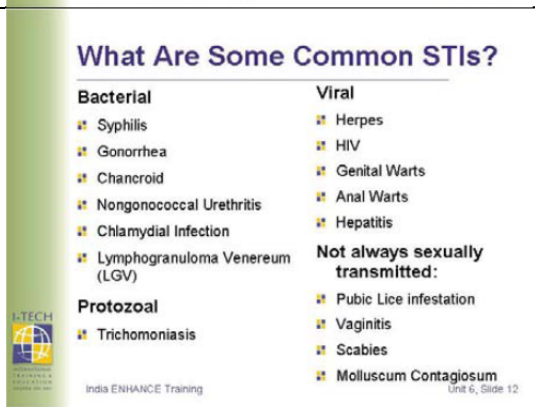
In some societies a permissive attitude is taken towards men, allowing them to have more than one sexual partner.

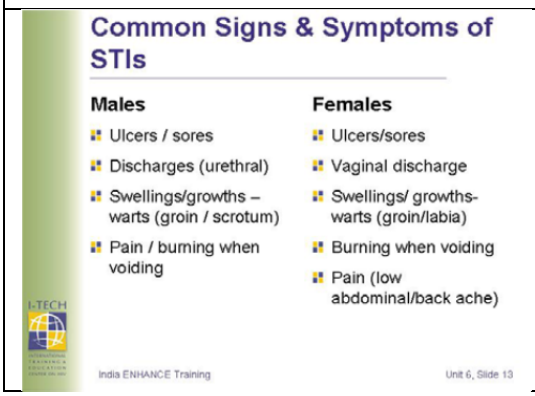
- There are many reasons why men may choose not to use condoms even when they know about the advantages. Remind participants to look through the unit on Prevention which provides them with information on condom use.
- Sexual violence tends to be directed more towards women by men, making it difficult for women to discuss STI with their male counterparts.
- Social factors such as poverty or living in remote areas could make it difficult and/or expensive for some people to access health care facilities.
- Not very much is known about STIs in the general population. Many times symptoms are not recognized, or are be ignored. Asymptomatic STIs are even more dangerous and may remain unidentified for very long periods of time.



If STIs are left untreated they could lead to increased risk of HIV transmission during sexual intercourse.

- Syphilis increases the risk of sexual transmission of HIV by 3-9 times
- Gonorrhea by 3-5 times
- Chlamydia by 3-5 times
- Genital herpes by at least 2 times.
- Fifty-two percent of sexually transmitted HIV infections among people who also have herpes simplex virus type 2 can be attributed to infection with the herpes virus. In addition, up to 95% of HIV-positive patients are seropositive for HSV-

Source: WHO. Prevention and control of sexually transmitted infections: draft global strategy: Report by the Secretariat. May 2006. http://www.who.int/reproductive-health/docs/stis_strategy.pdf	1, HSV-2, or both. The presence of an STI in a PLHA increases the likelihood he/she will contract HIV, due to inflammation or lesions in the vagina or on the penis. The virus can more easily invade the mucosa. Often STIs present before HIV and if managed appropriately, could reduce the risk of HIV - people are more likely to change their behaviour to prevent a problem which affects them now.
	**HIV makes people more susceptible to getting STIs**. PLHAs with STIs may have increased severity of symptoms. If left untreated, STIs can also have other effects not directly related to HIV such as: ▪ May spread to other systems i.e. neuro syphillis ▪ Cause infertility in both men and women ▪ Be passed from a woman to her baby during pregnancy or during birth ▪ Spread into women's reproductive organs and cause pelvic inflammatory diseases (PID) or pain in the abdomen or ectopic pregnancies ▪ Cause miscarriages, abortions, or stillbirths
	**Ask participants to list the common STIs. See answers on next slide.**
	**Inform participants that although more than 30 known STIs exist, the ones listed on the slide are the most common.** ▪ These STIs are commonly classified based on the causative organisms: bacterial, viral, and protozoal. ▪ Common STIs under each category are listed. ▪ Each STI will not be discussed but we will focus on assessment of symptoms. ▪ **Nurse needs to know symptoms in order to recognize an STI, and refer patient for proper diagnosis, treatment and follow-up.**

	Brainstorm with participants, "What are some common signs/symptoms of an STI in men? In women?" **Write their responses on the board/flip chart and then project the next slide.**
	

Handout 3.5: Vaginal Discharge – What You Need to Know

Vaginal discharge - What You Need to Know

Vaginal discharge does not automatically mean that a woman has an STI. It is important that you know the many causes of vaginal discharge so that your patients receive appropriate care and treatment:

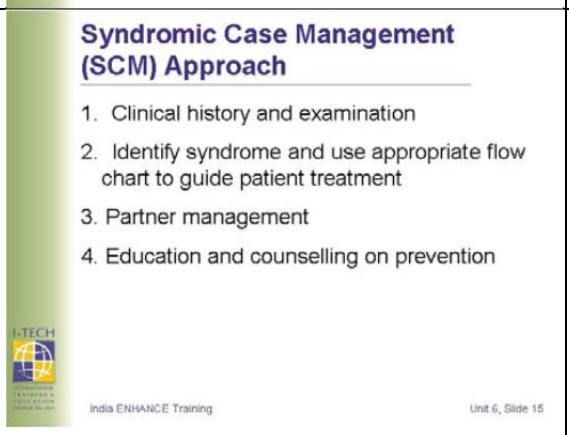
- Physiological
- Disturbance of normal flora due to:
  - Certain medications
  - Douching
  - Using tampons with light flow
- Infections that occur due to:
  - Unsafe sexual practices
  - Invasive procedures in the reproductive tract
  - Unsterile procedures during labour
  - Unsafe methods followed for termination of pregnancy

Features Associated with Causes of Vaginal Discharge:

Physiological	Mucoid, not blood strained or foul smelling and not associated with itching
Candidial infection (Thrush)	Curd like white patches / thick, curd white discharge / itching
Trichomonal vaginitis	Greenish yellow frothy foul smelling discharge / itching / redness of the genital area/ may be asymptomatic
Gonorrhoea / Chlamydia	Purulent discharge from the cervix / may be unnoticed
Puerperal Sepsis	High fever/ headache/ low abdominal pain / foul smelling/ purulent vaginal discharge
Following IUD insertion	Profuse, watery discharge usually subsides after the first menstrual period following insertion
Cancer cervix	Watery discharge, later it becomes blood stained and foul smelling
Bacterial Vaginosis	Thin / profuse / homogenous gray white discharge with a characteristic ‘fishy’ smell

Session 3.5 : Syndromic case management

Syndromic Case Management (SCM)

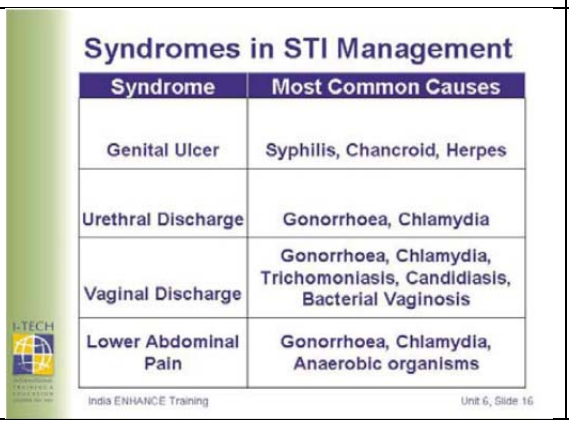


Inform participants that SCM is recommended today in India (in national guidelines) and in resource limited settings all over the world.

SCM is a systematic way of managing STIs. It consists of 4 main steps as given in the slide. Syndromic case management is based on the assumptions that:

- Symptoms of STI maybe simple, and easily recognizable.
- These symptoms may be the result of one or more infections.
- Based on the chief complaint of the patient, a thorough history, and relevant clinical examination, an appropriate flow chart is determined.
- Using the flow chart ensures accurate and complete treatment and management of the patient.

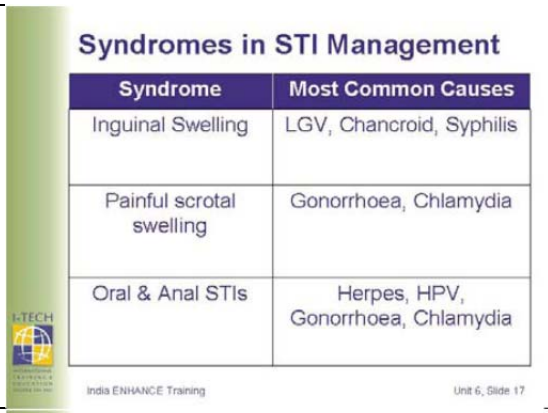
The SCM approach guides in partner management and education on prevention.
7 syndromes have been established through epidemiological studies. The next two slides show the 7 syndromes, as well as the possible causes for the syndromes.



Syndrome	Most Common Causes
Genital Ulcer	Syphilis, Chancroid, Herpes
Urethral Discharge	Gonorrhoea, Chlamydia
Vaginal Discharge	Gonorrhoea, Chlamydia, Trichomoniasis, Candidiasis, Bacterial Vaginosis
Lower Abdominal Pain	Gonorrhoea, Chlamydia, Anaerobic organisms

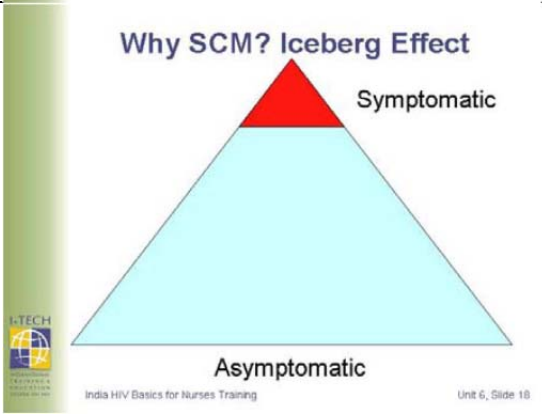
The most common STIs are grouped into 7 SYNDROMES to be approached as a group. Each of the 7 syndromes includes a group of common infections.

If a patient presents with any of the following symptoms and also has a suggestive history, then use the appropriate STI Syndrome Flow Chart.



Seven syndromes (continued)
Once the syndrome is accurately identified then the appropriate treatment is given.

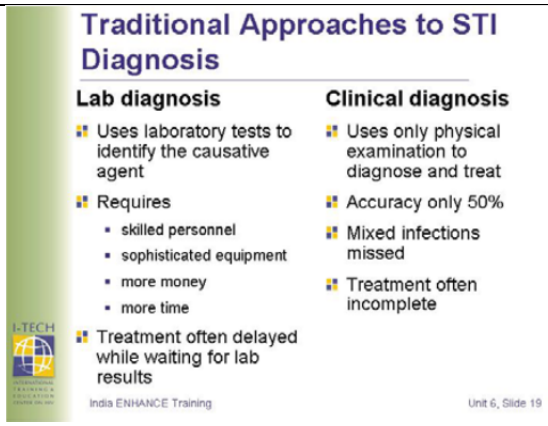
Inform participants that there are many other infections but this is the consolidated list of most common infections presently available from scientific data/research.



Majority of STIs are asymptomatic. The blue part of the triangle represents patients that are asymptomatic. The red part of the triangle represents patients that have symptoms and report to a clinic or hospital. It is important to realise that there are many people who have an STI yet are asymptomatic.
Ask participants 'How does a doctor at a hospital arrive at a diagnosis if, for example, a woman presents with excessive vaginal discharge?'
Write responses on a board/flip chart. (If you receive responses such as history, clinical examination, laboratory tests, tell participants they are right).
Answer: There are primarily two traditional methods for the diagnosis of STIs:

Etiological diagnosis
Clinical diagnosis

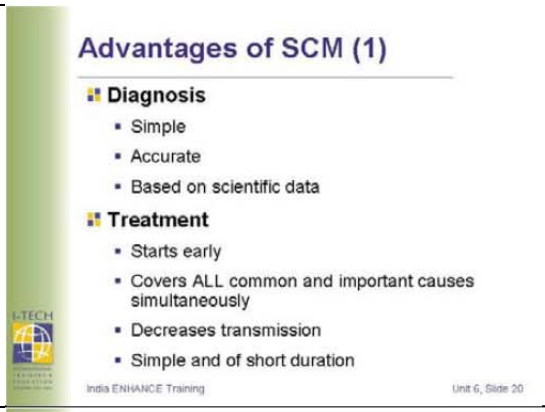
Tell participants you will be discussing the disadvantages of these two methods in the next slide.



Based on all this information, and the fact that the government setting has limited resources for many lab tests, Syndromic Case Management of STIs is recommended and followed today in India.
Inform participants that SCM is a cost effective approach to a patient with STIs based on which treatment is given:

- does not depend on laboratory data
- based on symptoms with which the patient presents
- substantiated with a good clinical history and examination

Details of the steps involved will be reviewed in the following slides.

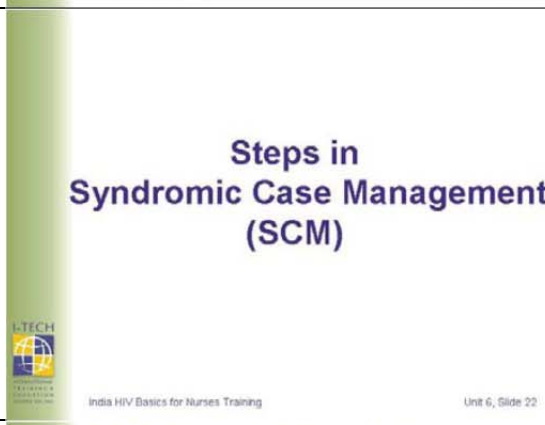


The correct flow chart is identified based on the clinical history and examination findings, then is used to facilitate further action.

Treatment is based on the guidance from the flow chart and is usually for mixed infections

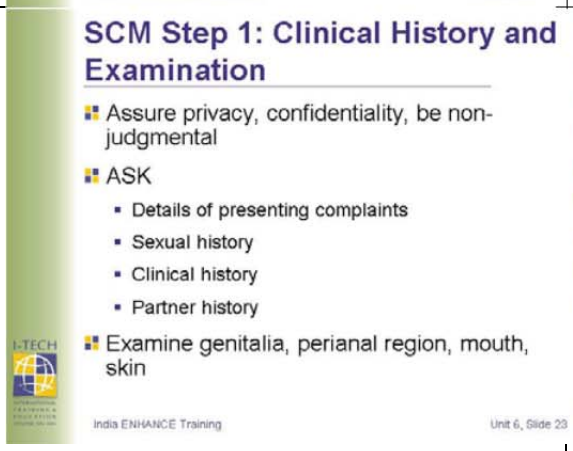
The simple diagnostic and treatment procedures increase the chance of compliance as well as follow up treatment and partner treatment.

It also advocates partner treatment – to avoid re-infection or transmission to others.



Facilitator's Notes:

The following slides illustrate the four steps in Syndromic Case Management.



Clinical History: Ask participants, "What questions would you ask if patient presents complaining of vaginal discharge?" Answer: duration, colour, consistency, amount, odour, other symptoms like itching or burning or lesions (duration, number, size, colour, character, painful or other symptoms, new or recurrence, etc.)

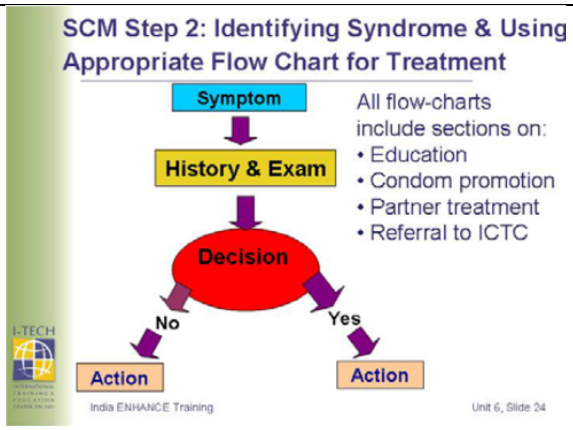
Nurse's attitude and behaviour:

- When taking the clinical history remember to greet the patient, provide privacy, be polite, and listen carefully.
- Face and look at the patient during all communication and explain what you are doing and why.
- Take consent from the patient or the person who accompanies them if they are minors, and reassure them that confidentiality will be maintained.
- Ask appropriate questions and collect

	appropriate histories as listed in the slide. **Examine and inspect:** ▪ Genitalia, perianal region, oral cavity ▪ Manual examination is also necessary (pulling back prepuce, massaging urethra, palpating nodes, etc.) ▪ Speculum examination is useful for female patients ▪ Use personal protective equipment (PPE) i.e. gloves, while examining patients. ▪ All skin as many STIs can have rash (i.e. syphilis). **Refer participants to *Handout 2: Checklist – How and What of History Taking with Patients with STIs* in the Participant Manual.**

Handout 3.6: Checklist – How and what of history taking with patients with STIs

Criteria	Done
How to take a history? ▪ Was polite	
▪ Patient greeted	
▪ Privacy provided	
▪ Faced and looked at patient	
▪ Explained why & what	
▪ Reassured confidentiality	
▪ Listened carefully and showed sensitivity	
▪ Took consent before any examination	
What information? ▪ Collected chief presenting complaints	
▪ Collected details of presenting complaints (how long/features/ associated problems)	
▪ Obtained sexual history	
▪ Past history	
▪ Partner history	
What do you ask a woman with vaginal discharge? ▪ When did the discharge start?	
▪ What is the nature of the discharge? (colour/ odour / etc)	
▪ Whether the woman is pregnant / has recently delivered?	
▪ Whether the woman is using Loop/IUD?	
▪ Whether she has burning urination or itching in the vulva?	
▪ Does she have any pain in the lower abdomen?	
Does she have any ulcer in the genital region?	
Whether the sexual partner has any sore on the genital organ or urethral discharge?	



Review steps of SCM using diagram:

- Symptom: Patient comes in with STI symptom
- History and exam: Health care provider performs history and physical exam
- Decision: Health care provider must answer a question (i.e. is discharge confirmed?, do exam findings support symptoms?).
- Exit: Health care provider chooses a path depending on whether the answer to the question is YES or NO (i.e. treatment for discharge or if no discharge, further investigation)

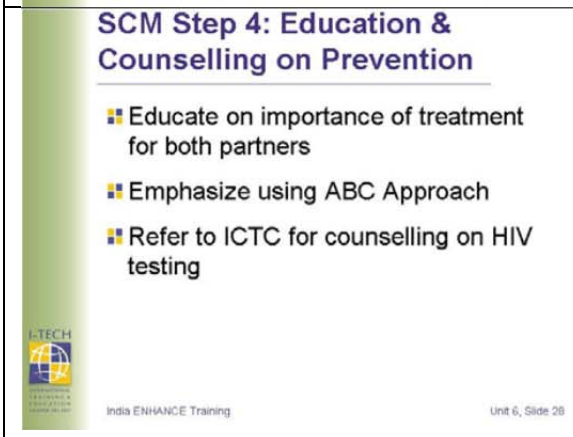
Discuss the benefits that are listed in this slide.

It is preferable to treat all partners. Therefore, the patient must be encouraged to bring the partner/s for treatment. The benefit to the patient would be:

- Prevention of further infection
- Decreased risk for HIV transmission

Abstinence from sex is preferred during treatment, but if unable to abstain, practice safer sex.

Sometimes patients will not be able to convince their partner to come for treatment despite intensive counseling.
In such cases, giving the patient a second dose for the partner to take is recommended.
However, it is always best that the partner comes to the health care facility to receive more specific examination, education, and counseling.



Education especially ABCs of prevention are important.

- A =Abstinence or delay sexual intercourse
- B = Be faithful to one partner or reduce the number of partners
- C= Use and promote condoms

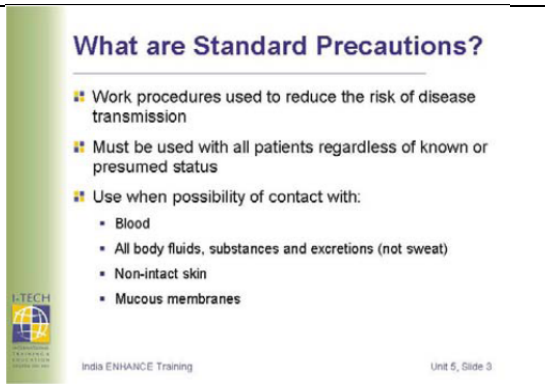
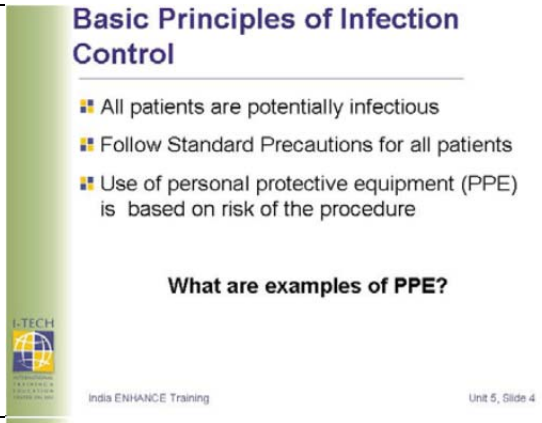
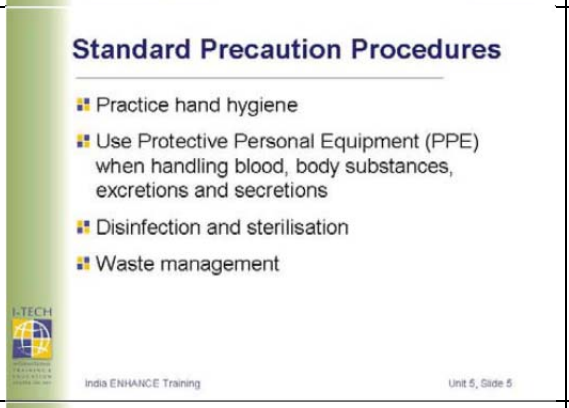
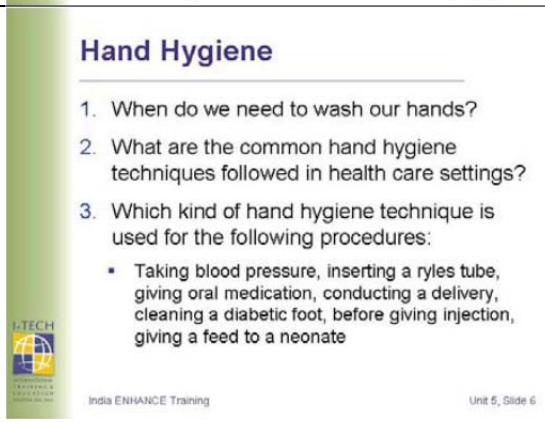
It is essential that the patient who presents with an STI is counseled regarding safe sex:

- while on the full course of treatment
- for prevention of recurrences

The benefit of counseling the patient is:

- reduce their risk of getting re-infected or infected with HIV
- refer to ICTC to get tested for HIV
- reinforce previous teaching.

Session 3.6: Standard precautions and hand hygiene:

	**Facilitator's Notes:** Standard precautions are: procedures and work practices used to reduce the risk of disease transmission because we cannot visually identify whether patients are infectious or not. Standard precautions must be used for all patients regardless of their diagnosis or presumed infectious status, and must be implemented when there is a possibility of contact with: ▪ Blood ▪ All other body fluids, substances, secretions and excretions (except sweat) ▪ Non-intact skin ▪ Mucous membranes
	All blood and body fluids, substances, secretions and excretions must be considered to be potentially infectious regardless of the perceived risk of the source! Following standard precautions is one of the basic principles of infection control. **Ask participants to name examples of PPE.** Answers include use of gloves, mask, eyewear, gowns, aprons and foot wear based on the risk of exposure to body fluids.
	**We will now discuss hand hygiene. The other points on the slide will be discussed under specific pathogens.**
	**Review questions on this slide with participants. Note responses on a flipchart and review responses participants have missed.** **Question 1: When do we need to wash hands?** Answer: Wash or decontaminate hands: ▪ After handling any blood, body fluids, secretions, excretions and contaminated items; ▪ Between contact with different patients; ▪ Between tasks and procedures on the same patient to prevent cross-contamination ▪ Between different body sites; ▪ Immediately after removing gloves ▪ Remember to use the opportunity, to inform visitors and the general public about hygiene rules and hand washing. **Question 2: What is the common hand hygiene**

	techniques followed in health care settings? Answer: ▪ Soap and water hand wash ▪ Alcohol rub ▪ Surgical hand scrub **Question 3: Discuss which type of hand wash is appropriate for the following procedures**: Answer: ▪ Taking blood pressure - Soap & water/alcohol rub ▪ Inserting a Ryle's tube - Soap & water/alcohol rub ▪ Giving oral medication - Soap &water/alcohol rub ▪ Assisting labour/ performing a delivery - Surgical scrub ▪ Cleaning a diabetic foot - Soap & water/alcohol rub ▪ Before and after giving an injection - Soap & water/alcohol rub ▪ Giving a feed to a neonate – Soap and water/alcohol rub **Refer participants to *Handout 1: Hand Hygiene* in the Participant Manual for details of various hand hygiene techniques.**

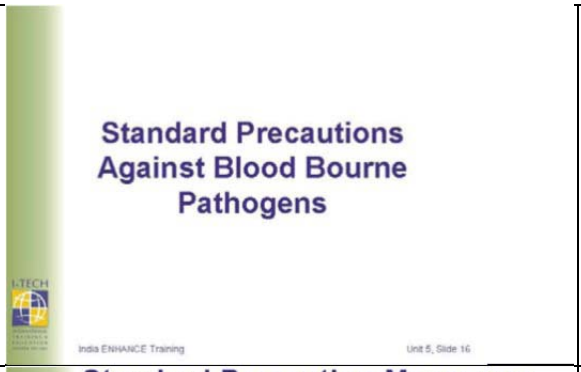
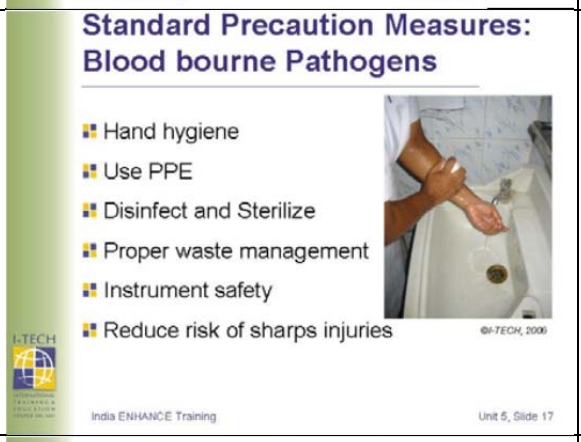
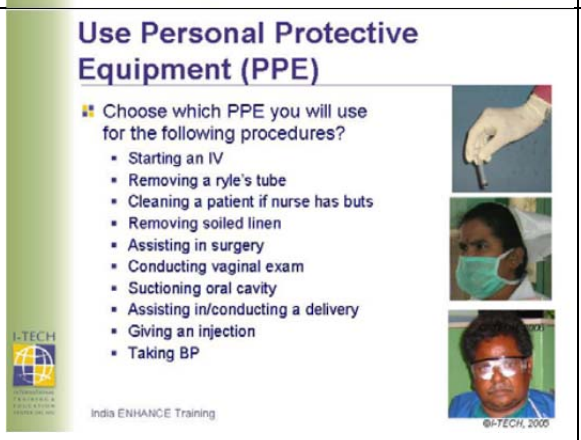
Handout 3.7: Hand Hygiene

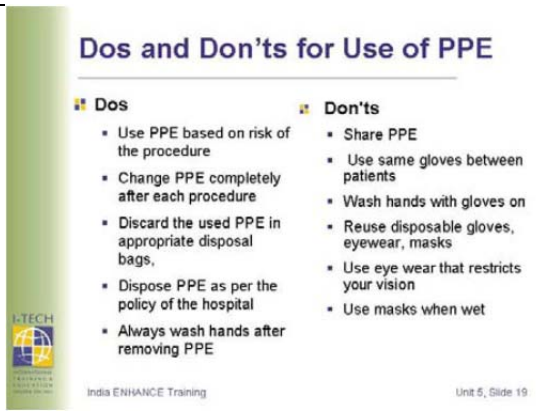
Maintaining hand hygiene is one of the simplest, but often most overlooked procedures, that can be followed to prevent infection from spreading. Hand hygiene techniques can be classified under routine soap and water wash, alcohol hand scrub, and before surgery /surgical scrub.

	Soap and water	**Alcohol rub**	**Surgical scrub**
When to use	Use this technique when hands have visible dirt	If no visible dirt on hands and before procedures needing aseptic technique	Done before surgery or procedures needing sterile technique
Effect on germs	Removes germs	Kills germs	Kills germs
How to use	Wet hands to wrist ▪ Apply soap on the palms, back of the hands, between fingers, around the thumb ▪ Clean the nails ▪ Rub for at least 15 seconds ▪ Rinse with running water ▪ Air dry or single use towel	Place 3-5 ml on dry hands ▪ Rub until dry ▪ No water or towels needed	Clean under nails with stick ▪ Wet up to elbow ▪ Use antiseptic, ▪ long acting and rub all surfaces for 2-6 minutes ▪ Rinse with running water ▪ Dry with sterile towel

	Ask participants how nurses dry their hands in their setting. **Suggest in the absence of towels, to air dry.**
	Exercise (5 minutes) **Refer participants to *Exercise 1: Steps in Hand Washing - Checklist* in the Participant Manual.** **Divide participants into pairs. Ask each pair to act out the steps of soap and water hand washing technique using the checklist provided in the exercise.** **Be sure to observe whether participants remember to remove hand accessories like bangles, watches and rings before acting out steps in hand washing.** **Debrief the exercise. Reinstate that although this is a routine technique, it needs to be performed correctly, at short intervals to be effective.**

Session 3.7: Standard precautions : blood borne pathogens.

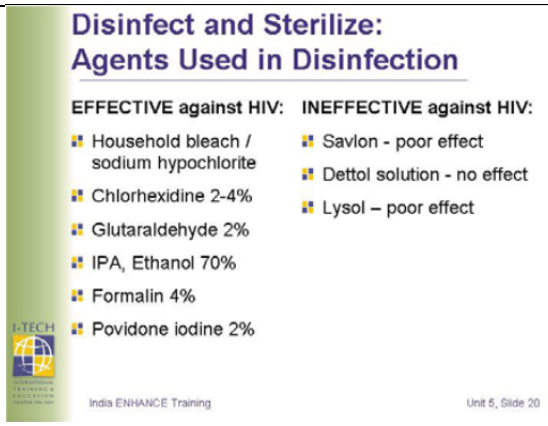
	**The following slides detail the role that nurses can take in implementing standard precautions against blood borne pathogens.**
	**The first point has already been discussed earlier in this unit - we will now cover the rest.**
	**Prepare to have 1 pair of sterile gloves for the exercise.** **Ask a participant to volunteer to demonstrate the proper technique of putting on and removing sterile gloves.** **Encourage constructive comments from the others.** **Thank the participant for the demonstration.** **State that it is acceptable but not necessary to use sterile technique to put on clean gloves.** **Read out loud the following procedures to participants and ask them to name all the PPE they would use for the procedures:** ▪ Starting an IV (gloves) ▪ Removing a Ryle's tube (gloves) ▪ Cleaning the patient if the nurse has abrasions, cuts (gloves) ▪ Removing soiled linen (gloves) ▪ Assisting in surgery (gloves, mask, cap, gowns, eye wear, foot wear) ▪ Conducting a vaginal examination (gloves) ▪ Suctioning the oral cavity (gloves, mask) ▪ Assisting in / conducting a delivery (all) ▪ Giving an injection (gloves) ▪ Taking BP (none)



Hands should not be washed with gloves on because this might allow infectious fluids on the gloves to come in direct contact with the hand through invisible microscopic tears in the material

Ask participants what they would do if PPE was not available at their place of work?

- They should request administration to provide them with protective equipment – it is their right as health care workers to protect themselves from occupational exposure to infection.
- They could use alternative material – i.e. plastic bags to protect themselves in the meanwhile



Disinfection of instruments/material/surfaces is to be encouraged to prevent transmission of diseases like bacteria, viruses and fungi to Immune compromised patients.

Alcohol disinfection is fastest and most convenient disinfectant.

Additional information on effectiveness of various disinfectants:

- Hypochlorite 1%: Contact time of minimum 20 minutes to disinfect surfaces contaminated with organic matter
- Chlorhexidine 4%: Hands scrubbed for 3-5 minutes (usually used as surgical hand scrub)
- Glutaraldehyde 2%: Contact time of minimum 20 minutes to kill TB and Hepatitis B
- Ethanol 70%: Contact time of min 10 minutes needed to be effective (however, it usually evaporates before that – so this is usually not used)

When using disinfectants, it is necessary to ensure:

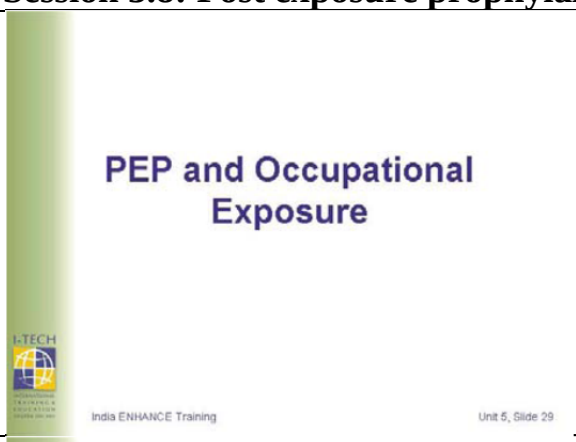
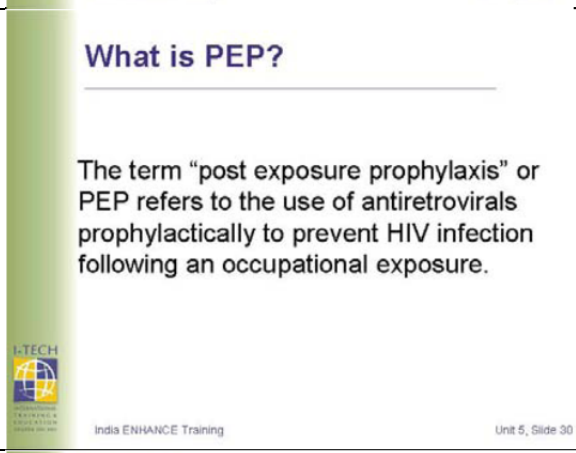
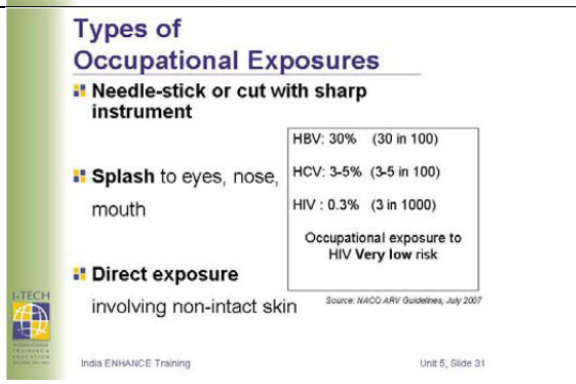
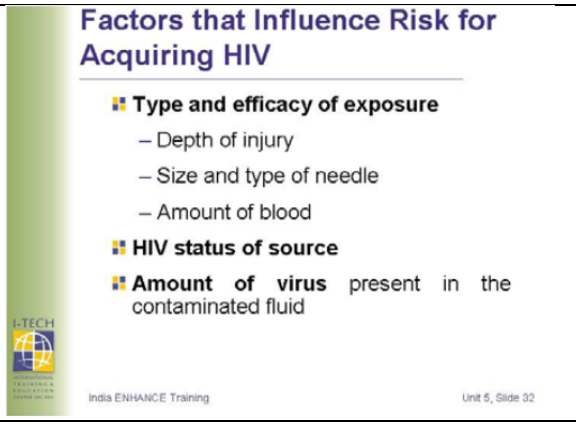
- Correct concentration of solution is used
- Adequate contact time is provided with infectious surface

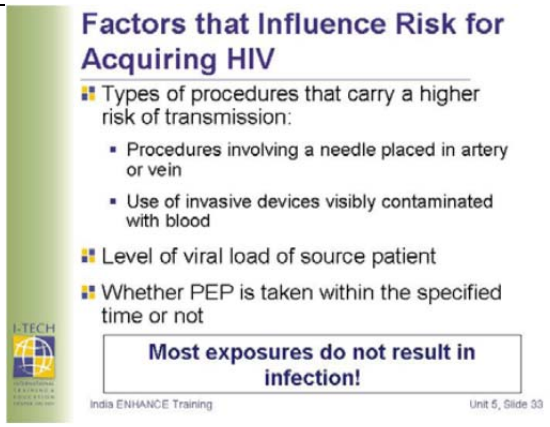
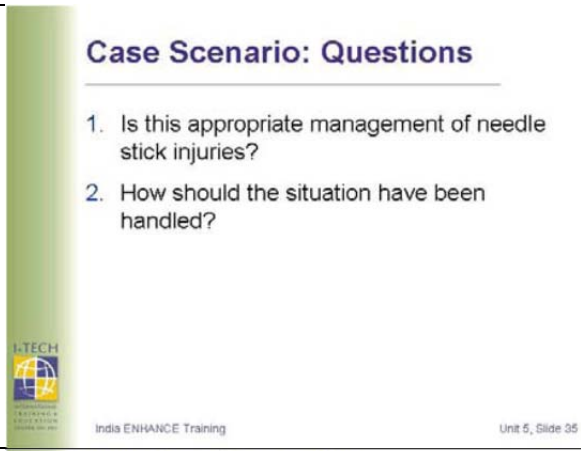
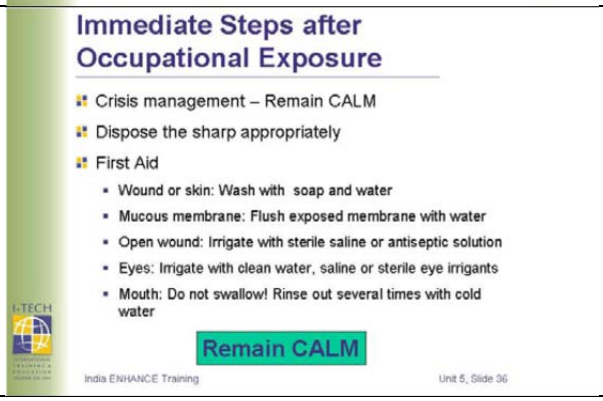
Remember to wash metal equipment well if bleach solution is used to disinfect it, as bleach could cause the metal to corrode.

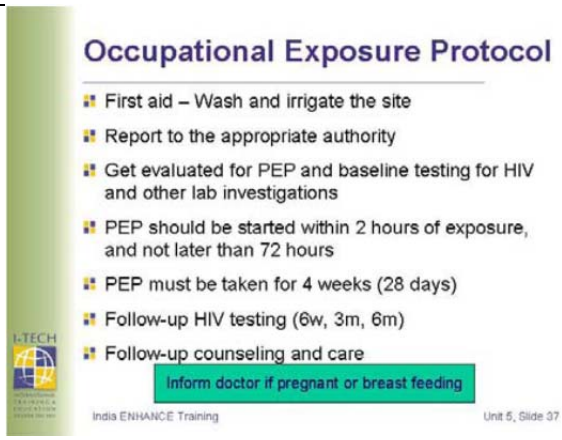
Ask participants, "What is the correct proportion for a bleach solution mix?"

Answer: 1 part of bleach to 9 parts of water

Session 3.8: Post exposure prophylaxis for HIV.

	**Facilitator's Notes:** **Ask the participants – "What does PEP stand for?"** Post exposure Prophylaxis **Ask the participants "What is the meaning of occupational exposure?"** ▪ Exposure to harmful substances/material that occurs during the course of one's work. ▪ It can place health care providers at risk for contracting HIV & other viruses including HBV and HCV.
	
 *Source: NACO. Ministry of Health and Family Welfare .Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents Including Post-exposure Prophylaxis. May 2007.*	**Give examples for each of the types of exposure and the risk of contracting HIV through it:** ▪ Percutaneous exposure involving tissue under the skin (i.e., through a needle stick or a cut) (0.1-0.5% 1-5 in 1000) ▪ Mucocutaneous exposure involving mucous membranes (i.e., through a splash to the eyes, nose, or mouth): Direct exposure involving non-intact skin (i.e., when the skin is chapped, scraped, or afflicted with dermatitis) (0.09% 9 in 10000). ▪ Inform participants that transmission can occur through contact with a body fluid capable of transmitting a virus. ▪ The statistics may be higher in places that do not have good infection control practices.
	Type and efficacy of exposure affects transmission: ▪ Percutaneous or mucocutaneous ▪ Depth of injury ▪ Size and type of Needle (hollow bore or solid instrument) ▪ Amount of blood ▪ The amount of virus present affects transmission: ▪ Amount of blood ▪ Stage of the patient in HIV cycle (primary infection, asymptomatic stage, and in the

	AIDS ▪ stage; the virus is present in higher numbers in ▪ the first and third stage and therefore have a higher risk of transmission)
	Certain procedures in the health care setting can increase risk of occupational exposure including: ▪ Placing IVs ▪ Collecting blood ▪ Working with uncooperative or disturbed patients during invasive procedures The risk of transmission increases with the frequency of performing higher risk procedures. During these high risk procedures more safety measures must be adhered to. PEP has to be taken on time as advised by the doctor for it to be effective. Other factors that affect transmission is the prevalence of infection in the specific population that is in your facility. **Ask participants how many patients in their centers are being diagnosed with HIV per month.**
	**Answer:** **Question 1:** No. Once the injury occurs, Asha should place the contaminated needle into the sharps container Question 2: ▪ Asha should remove the gloves first ▪ Asha should not squeeze the wound: instead, she should wash her hands with soap and water. ▪ Asha should report the needle stick injury to the appropriate administrative staff and follow protocols for post exposure prophylaxis.
	After exposure, immediately clean the wound under running water for 5 minutes allowing free flow of blood if any. Use the following procedures: **Do** ▪ Wash with soap and water only **Don't:** ▪ Do not squeeze or pinch the wound ▪ Do not pour any hypochlorite/strong disinfectant solution on the wound ▪ Do not put your injured area into the mouth

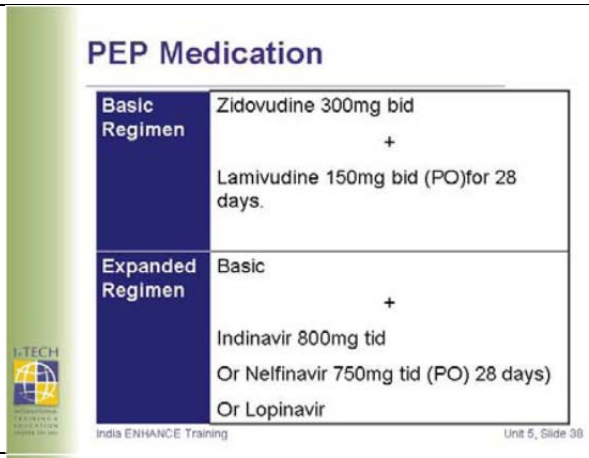


Source: NACO. Ministry of Health and Family Welfare. Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents Including Post-exposure Prophylaxis. May 2007.

Baseline HIV testing to rule out previous exposure.
If the staff is already positive, PEP will have no effect. Instead should advise follow up for possible initiation of ART treatment after evaluation and counseling.
Other lab investigations that need to be conducted are:

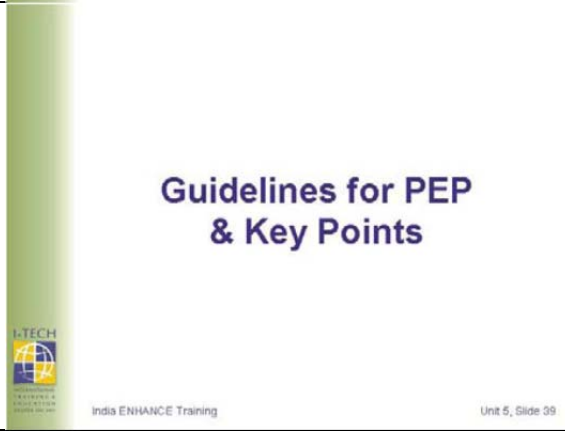
- Hemoglobin
- Platelet count
- Recticulocyte count
- WBC – Total and differential counts
- Renal function tests
- Liver function tests
- Random blood sugar

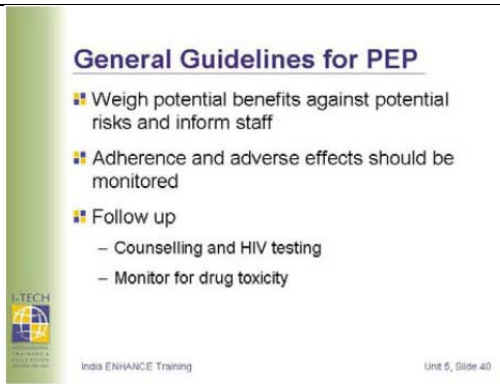
Follow up testing is recommended to detect occupational transmission as early as possible to start ART and counseling.
Pregnancy and breast feeding are not contraindications for PEP

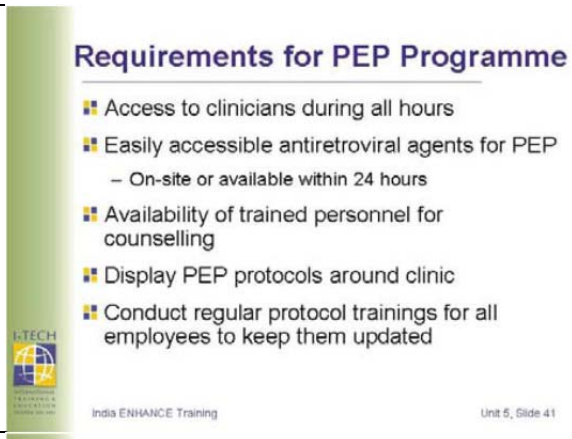


Depending on the severity of the exposure, and the status of the source, the PEP regimen is decided upon.
Source patient can be tested for HIV (with permission-if status is not known) to assist with decision making.

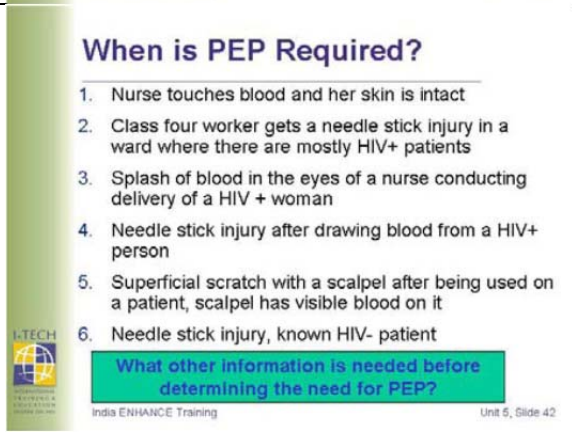
Source: NACO. Ministry of Health and Family Welfare. Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents Including Post-exposure Prophylaxis. May 2007.







Source: NACO. Ministry of Health and Family Welfare. Antiretroviral Therapy Guidelines for HIV-infected Adults and Adolescents Including Post-exposure Prophylaxis. May 2007.



This slide is animated. Inform participants that they will be provided with certain situations for which they would have to determine whether or not PEP would be required. Advance the slide statement by statement allowing time for participant response.

Answers:

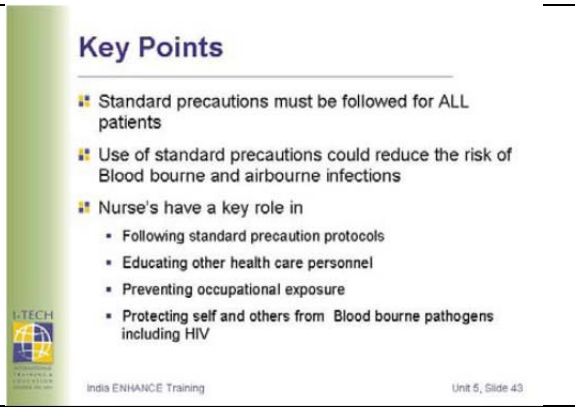
1. No
2. Yes
3. Yes
4. Yes
5. Yes
6. No

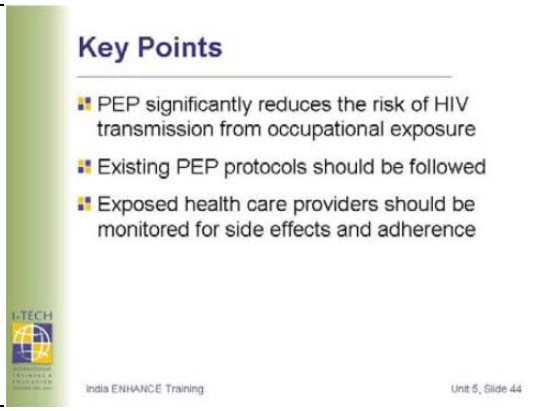
Remind participants: depth of injury, amount of body fluid exposed to, and many other factors need to be kept in mind when determining the need for PEP. There is strict protocol to be followed before PEP can be administered. This is why it is important that they report to the PEP-in-charge when they have been exposed rather than self-medicate or do nothing according to their risk perception.

Ask participants:

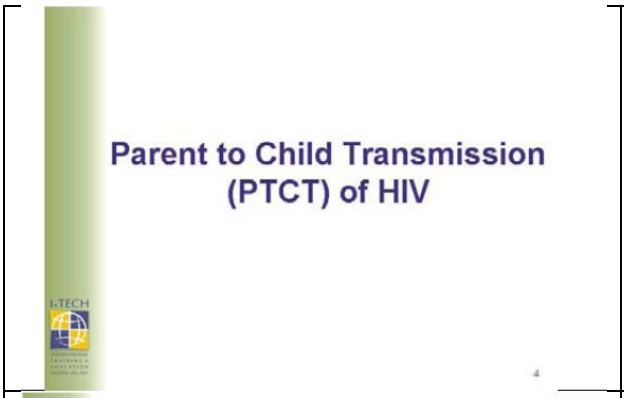
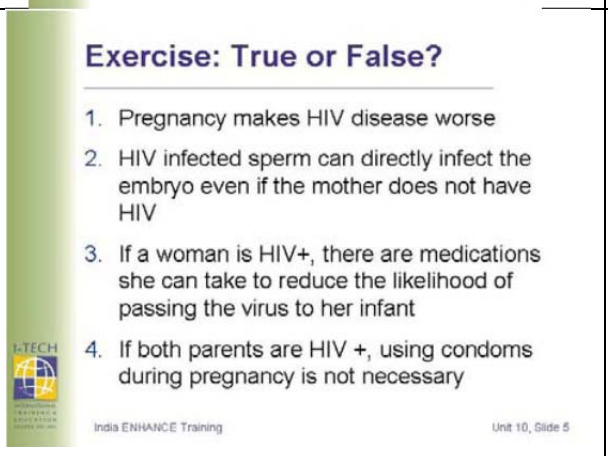
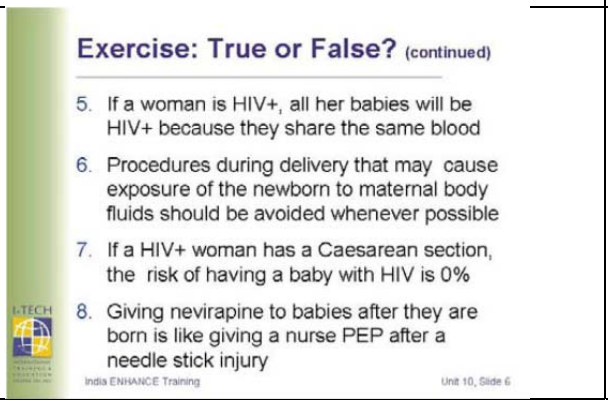
- **What are the main points you have learned from this session?**
- **What are your key responsibilities with regards to patient care from what you have learned from this session?**

Allow 5 minutes for a brief large group discussion.





Session 3.9: Parent to child transmission of HIV.

	
	**This exercise should take about 15 minutes.** **The goal of this exercise is to:** ▪ **Show participants how much they already know about HIV and pregnancy.** ▪ **Identify areas where participants may need more information in order to be able to provide effective care to their patients.** **Ask participants to close their manuals. Read out the statements in the slide and ask the participants to either stand or raise their hand if they believe the statement is true.** **Discuss participants' responses to each statement. Answers are provided in the Facilitator's Guide, *Handout 1: PPTCT True or False Statements and Answers* in the Participant Manual to guide you in the discussion.** **Answers to 1- 4:** 1. FALSE 2. FALSE 3. TRUE 4. FALSE
	**Answers to 5-8:** 5. FALSE 6. TRUE 7. FALSE 8. TRUE **Refer participants to *Handout 1: PPTCT True or False Statements and Answers* in the Participant Manual.**

Handout 3.8: PPTCT True or False Statements and Answers

1. Pregnancy makes HIV disease worse.
False - Pregnancy does not accelerate the progression of HIV disease.

2. HIV-infected sperm can directly infect the infant even if the mother does not have HIV infection.
False- Although there is HIV in male semen, there is no HIV in the sperm. Therefore, the mother could get HIV infection from the male semen but the foetus could not get HIV infection from the male's sperm. The foetus can only acquire HIV infection from exposure to the mother's blood or vaginal/cervical secretions during pregnancy, birth, or breast milk during breast feeding. Remember that about 70% of time, the foetus will not get HIV infection at all.

3. If a woman is HIV+, there are medications she can take to reduce the likelihood of passing the virus to her infant.
True- If a woman is HIV+, she can be prescribed ART depending on clinical criteria either during her pregnancy and/or during labour and delivery. She should be given ART during labour, and the baby must be given ART within 72 hours of birth. Details of ART to prevent mother to child transmission will be dealt with later in this unit. If she is on ART and her viral load is suppressed, her risk of transmission is very low, about 1 or 2%.

4. If both parents are HIV +, using condoms during pregnancy isn't necessary.
False - One partner may transmit a resistant virus to the other through sexual intercourse so it is essential that the couple practice safe sex with use of condoms.

5. If a woman is HIV positive, all her babies will be HIV infected because they share the same blood.
False - The mother and baby do not share the same blood. The mother's blood is filtered by the placenta so the baby gets oxygen and nutrients without exchange of blood. The baby can only become infected if she/he is exposed to the mother's blood. This may happen from an infection in the placenta, a maternal abruption or abdominal trauma causing bleeding into the amniotic sac, or during birth. It is also important to note that even with exposure the mother's blood during pregnancy and birth, there is only about a 30% chance of the baby becoming infected.

6. Procedures during delivery that may cause exposure of the newborn to maternal body fluids should be avoided whenever possible.
True - This includes artificial rupture of membranes, forceps or vacuum delivery, episiotomy, or vigorous suctioning of the infant.
7. If an HIV positive woman has a caesarean section (C/S), her risk of having a baby with HIV is 0%.
False - Although in some cases, when the woman's virus is not suppressed or she has advanced HIV disease, a C/S may reduce the risk of infection, it will never reduce it to 0%. The actual risk depends on the severity of disease and the actual viral load. When a woman is on ART and her viral load is fully suppressed, there does not appear to be an advantage to C/S. Also, there is a higher risk of maternal infection and mortality with C/S and the higher cost to consider.

8. Giving nevirapine to babies after they are born is like giving a nurse post-exposure prophylaxis after a needle sticks injury.

True. Giving nevirapine is like giving PEP to a nurse after a needle stick injury, although nevirapine should not be used for PEP following needle stick injuries.

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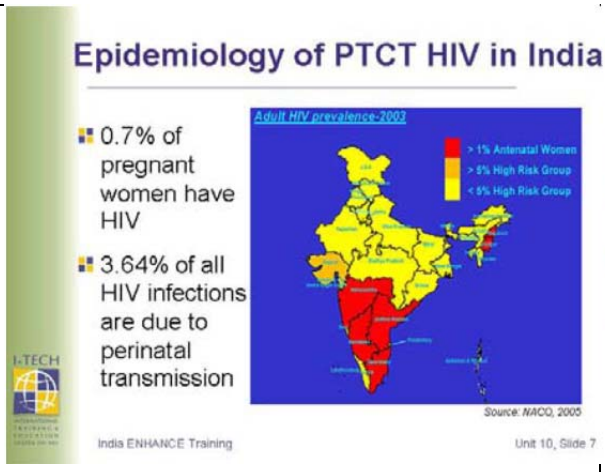


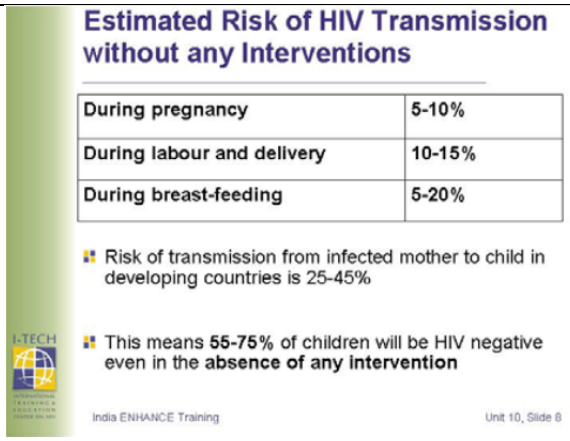
Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November 2006.

Average HIV prevalence rate in pregnant women in cities such as Hyderabad, Mumbai, Pune, Sangli, and Manipur is 2-2.5%.

Ask participants: "Why do you think the HIV prevalence rate in pregnant women is higher in cities such as Hyderabad, Mumbai, Pune, Sangli, and Manipur than in other cities?"

Answer:

- There are larger populations of high risk groups in these large cities, therefore the wives of people practicing high risk behaviours may be vulnerable to HIV infection brought home by their husbands.
- Also in these larger cities there are larger numbers of Commercial Sex Workers (CSWs) and Injection Drug Users (IDUs), who may get pregnant.

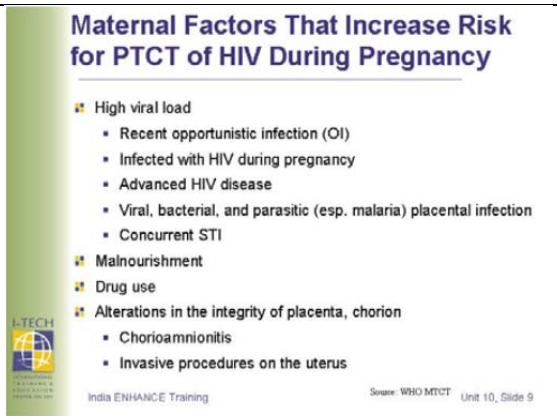
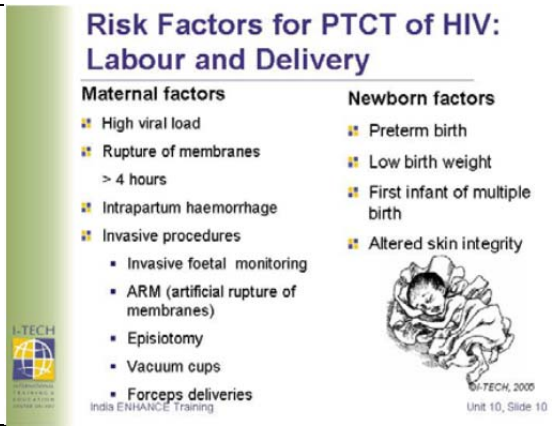


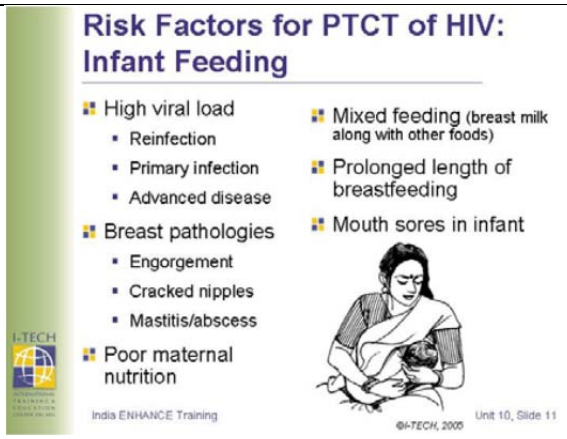
Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November 2006.

The statistics in this slide are crucial to understand where medical interventions can be put in place to reduce parent to child transmission of HIV. If we take 100 women with HIV we could expect 25-45 babies to be born with HIV if there was no intervention taken at all:

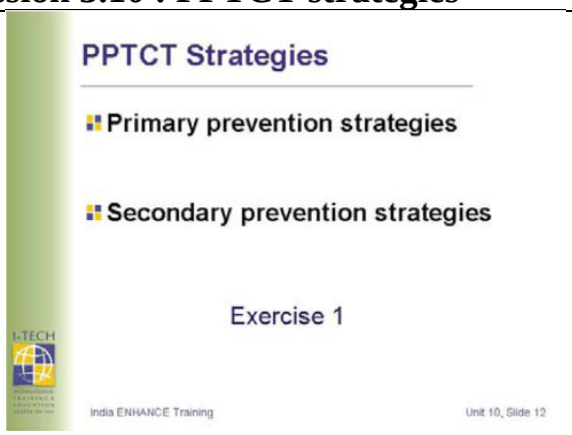
- Approximately 10-15% babies will be infected at the time of delivery which is the period of greatest risk of HIV transmission, through exposure to maternal blood and vaginal secretions - **here we can intervene.**
- Approximately 11% babies will be infected in the first 6 months of life from breastfeeding depending on duration, viral load of mother, presence of mastitis and exclusivity of breastfeeding. An additional 6-8% of babies could become infected as mother breast feeds longer - **here we can intervene.**
- Approximately 5-10% will be infected in utero. This may occur when a mother is newly infected during the pregnancy and has a high viral load, or due to internal complications where the foetus is exposed to infectious maternal fluids – **we can counsel about safer sex during pregnancy, but we cannot do anything about other factors yet.**

This slide illustrates that the majority of infants born to HIV positive mothers will NOT be HIV positive themselves. However it is important to emphasize, that even though most infants are

	not born HIV positive, they may lose one or both parents if treatment is not available, resulting in potentially great challenges for the child as they mature. **In other words, such children are not immune to the hardships of HIV.** The most important thing to remember is that the numbers given in the pie chart are averages and that there are many factors that determine individual transmission risk.
	**Ask participants: "Imagine that a woman becomes infected at about the same time she becomes pregnant. What do we know about her viral load?** **Would the viral load be high or low?"** **Answer: High. Reinforce that a high viral load could increase risk of transmission.** **Review the other factors that are listed in the slide that increase the risk of transmission from mother to foetus during pregnancy.** **Ask the participants to identify ways to explain this to mothers.** Other factors that increase the risk of transmission from mother to foetus during pregnancy are: ▪ Malnourishment of the mother during pregnancy could lead to further decrease in maternal immunity which could: ▪ Lead to higher risk of HIV transmission to the foetus ▪ Increase risk of having a low birth weight baby/preterm delivery. Both low birth weight and pre-term babies have a higher vulnerability to PTCT of HIV. ▪ Drug use could lead to high risk behavior leading to re-infection during pregnancy. It can also increase the risk of low birth weight /premature babies. ▪ Anything that interferes with the integrity of the placenta such as placental infections can increase the risk of HIV transmission. An example would be chorioamnionitis (infection of the membranes (placental tissues) and amniotic fluid).
	**Maternal Factors:** **Viral load** - the higher the viral load, the higher the risk of the baby being exposed to HIV during birth. **Ruptured membranes -** amniotic fluid is protected from HIV as HIV does not cross the placenta. Once the membranes are ruptured however, the infant could be exposed to HIV present in vaginal secretions of the mother. **Intrapartum hemorrhage** - infant will be exposed to mother's blood with HIV. **Invasive procedures** - small abrasions on the

	skin of the newborn or increased exposure of the newborn to maternal blood during these procedures (invasive foetal monitoring, ARM, episiotomy, vacuum cups or forceps deliveries). **Newborn Factors:** *Preterm birth* – skin of a premature baby is fragile and porous. *Low birth weight* - could mean lower resistance and therefore increased risk to HIV. *First infant of multiple births* - Twin A is first in the birth canal, and is exposed to higher levels of maternal fluids, bearing "brunt" of contractions. Twin B, smaller, usually slips right through the "cleaned" birth canal in minutes rather than hours. GI tract and mucous membranes are fragile- at increased risk of HIV infection from swallowing or exposure to infectious vaginal secretions.
	**With breastfeeding we are thinking about both mother and baby! Review points below with participants.** ▪ **High viral load** - With recent infection there is increased viral load (it will take 6-24 weeks for the body to make antibody to control the virus). The viral load may be in the millions, and transmission risk is increased by 15-30%. ▪ **Breast pathologies** - It increases the risk as both breast milk and blood may be swallowed by the baby. ▪ **Mixed feeding** - Microscopic bleeds in baby's gut could occur from foods other than breast milk (i.e. kanji, cow's milk, etc.) This, when followed by ingestion of breast milk could increase the chance of the HIV to enter the infant's body. ▪ Advanced disease in the mother, poor nutrition could increase the risk of transmission. ▪ Prolonged breast feeding increases the risk of HIV transmission since the chance of the baby being exposed to the virus increase. ▪ Mouth sores in infant – the virus could have direct access to the baby's blood through the sores.

Session 3.10 : PPTCT strategies



Facilitator's Notes:
Explain to participants that we will be discussing primary and secondary prevention strategies to reduce PTCT of HIV.
Explain the meaning of primary prevention and secondary prevention in the context of PPTCT:

- Primary prevention means preventing any woman of reproductive age from becoming infected with HIV. The goal of primary prevention is to decrease the chance of a woman getting infected.
- Secondary prevention means taking measures to reduce the risk of HIV transmission to the baby, either during pregnancy, labour or in the postnatal period from an HIV positive mother.

Refer participants to *Exercise 1: Small Group Exercise: Patient Education* in the Participant Manual.
This exercise will continue through the remaining steps of this session.
Divide participants into 5 groups; assign each group one case. Refer to Exercise 1 in the Facilitator's Guide for instructions on facilitating this exercise and answers to guide the discussion.

Handout 3.9: Small Group Exercise: Patient Education

Instructions:
This exercise will continue through the remaining steps of this session.

- Divide participants into 5 groups; assign each group one case.
- Give groups 5 minutes to discuss and write down main points they would consider in preventing PTCT of HIV for their particular case.
- Ask groups to select one representative that will come forward and present their main points to the large group (3-5 minutes).
- Other groups will be asked to provide feedback to the responses.
- Make sure to clarify any questions from participants

Case 1: An 18-year-old girl presents to you. She says she is likely to get married in a year's time but has fears about HIV. Her friend got married last year and discovered she was positive after her marriage, during her antenatal checkup. What points would you keep in mind when counseling her?

- *Educate ALL women before pregnancy on*
  - *– Prevention and early treatment of STIs*
  - *– Family planning methods (which offer dual protection)*
  - *– HIV and importance of early testing*
- *Refer to appropriate centers for additional support*

Case 2: A 23 year old, HIV positive woman comes for her first antenatal checkup. She is 6 weeks pregnant and you are in the OPD. What key points would you keep in mind while counseling her to prevent MTCT?

Educate the woman on the importance of:

- *Antenatal visits*
- *Diet + Vitamin & Iron supplements*
- *Avoiding invasive procedures*
- *Practicing safer sex*
- *Treating ANY infection or STI*
- *Importance of hospital delivery*
- *Continuing to monitor the progress of her HIV: CD4 counts/presence of OIs*
- *Safe feeding options for the baby*

Case 3: A 24 year old, HIV positive woman, comes to the hospital with labour pains since half an hour. What will you assess and do for her, if you were present throughout her labour period to reduce MTCT?

Assessment

- *Regular obstetrical assessment*
  - *Assess whether tested for HIV*
  - *– If not, offer pretest counseling and testing during labour*
  - *– May offer an opportunity to provide PPTCT*
- *If known HIV+, check whether she has*
  - *– Already been put on ART*
  - *– Already taken the single dose NVP (PPTCT program)*

Case 4: A 24 year old, HIV positive woman who just delivered her baby, asks you about feeding her baby. You have not seen her in the past, during her prenatal period. What points would you keep in mind while counseling her to reduce MTCT?

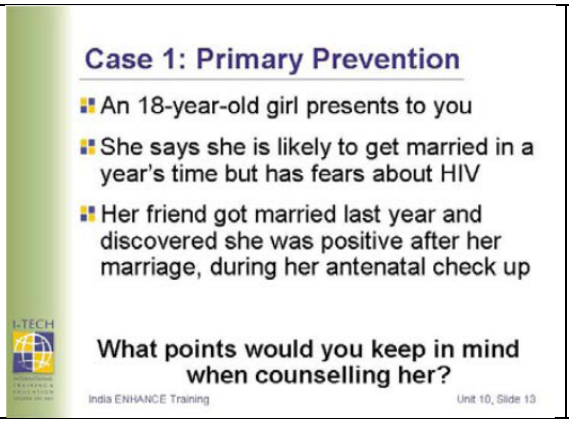
Educate mother on:

- *Exclusive breast feeding for 6 months*

- *Good hygiene*
- *Good position*
- *Giving colostrum*
- *Duration-shorter the better*
- *Not mixing feeds*
- *Express feed vs. direct BF*
- *How to stop abruptly*
- ***OR** Replacement feeding*
  – if affordable, safe, sustainable, feasible & acceptable
- *Inform about*
  – Routine postnatal care of mother
  – Evaluation to decide eligibility for ART
  – Need to report any signs of infections
- *Chest, urinary, puerperal, episiotomy or breast infections*
- *Assess risk factors for reinfection*

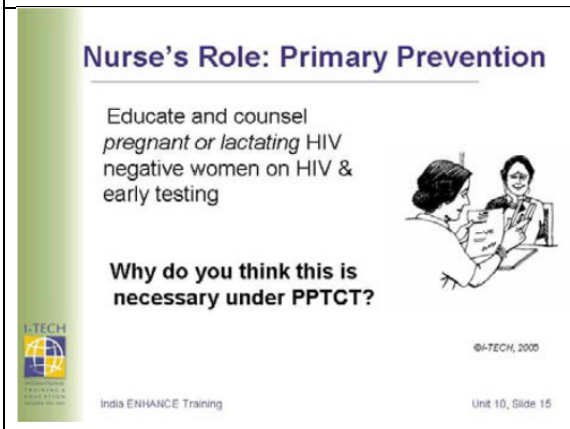
Case 5: A 24 year old, HIV positive woman has doubts about her and her baby's follow up care after delivery. What key points would you keep in mind while counseling her to reduce the risk of PTCT?

- *Reinforce safer sex*
- *Discuss family planning BEFORE discharge*
- *Review birth control and infection control – reinforce need for continued safer sex*
  – Dual protection to prevent and reduce further HIV infection, STIs and pregnancy
  – Data suggests hormonal contraception is less effective with ARVs
  – Access to emergency contraception
- *HIV testing for baby*
- *Routine well baby visits*
- *Need to follow standard immunization schedule for baby*
- *Need for immediate medical attention if signs and symptoms of any infection present*
- *Cotrimoxazole prophylaxis for infant*
  – All HIV exposed infants start at 4-6 weeks of age till detected as HIV

	**Call Group 1 (Case 1) forward to present their case scenario and points of discussion, invite responses from other participants (5 min) and then present the next few slides which will contain details regarding Case 1.**

Educate women who are in the reproductive age group (15-45 years) and who have not yet been infected - the goal is to prevent them from getting infected.

- Provide family planning information with emphasis on methods which provide dual protection against BOTH pregnancy and STIs/HIV.
- Provide general information on HIV transmission and encourage young women who have an increased vulnerability to contract HIV to go in for early testing.
- Refer to ICTCs for additional support and information.



Explain to the participants that the government of India's PPTCT program, seeks out ALL pregnant women (urban, rural, rich, poor, married, unmarried to be delivered by obstetricians, midwives or traditional birth attendants) to provide them with PPTCT options.

Question 1 Answers:

- Women who are pregnant, in labour, or lactating need to be targeted for primary prevention because, if they contract HIV during these times, the chances of transmitting the virus to the foetus/baby increases sharply with the increased viral load associated with primary infection.
- If a woman is found to be positive during these periods, she can be offered appropriate PPTCT services. More details are provided in the next slide.
- In India all pregnant women are counseled in groups on HIV testing and are offered the IV test. They can choose to "opt-out" of testing (that is, choosing not to be tested). This is different from mandatory testing.
- Women who opt-out are given additional counseling to encourage them to eventually consent to being tested.
- The goal is to test ALL women in order to reduce PTCT of HIV, using the interventions described in this module

Inform participants that from here on we will be dealing with secondary prevention strategies and how nurses can play a role.

Case 2: Secondary Prevention- During Pregnancy

- A 23 yrs old, HIV+ woman comes for her first antenatal check up
- She is 6 weeks pregnant; you are there in the OPD

What key points would you keep in mind while counselling her to prevent MTCT?

India ENHANCE Training — Unit 10, Slide 16

Facilitator's Notes:
Call Group 2 (Case 2) to come forward to present their case scenario and points of discussion and invite responses from other participants (5 min) and then present the next slides which contain details regarding Case 2.

Nurse's Role: Secondary Prevention in Pregnancy

Educate her on the importance of:

- Antenatal visits
- Diet + Vitamin & Iron supplements
- Avoiding invasive procedures
- Practicing safer sex
- Treating ANY infection or STI
- Importance of hospital delivery
- Continuing to monitor the progress of her HIV: CD4 counts/presence of OIs
- Safe feeding options for the baby

India ENHANCE Training — Unit 10, Slide 17

Remember that for pregnant HIV positive women:
Similar care as for pregnant HIV negative women with same number of antenatal visits is required. Pregnancy is not necessarily considered high risk. Invasive antenatal test and procedures must be avoided. (i.e. amniocentesis)

Whether positive or negative, all women should recognize the risk of initial infection, re-infection if they are already infected, and sexually transmitted infections in terms of increased burden on the immune system. Emphasize need for safer sex practices and early treatment of STIs.

Monitor progress of HIV: CD4 counts/presence of infections to assess need for ART. Stress to participants the importance of taking a comprehensive history and physical assessment during pregnancy and monitoring of symptoms

When is ART Required During Pregnancy?

WHO stage	CD4 testing not available (or pending results)	CD4 testing available
1	Do not treat	Treat if CD4 < 200 cells/ mm^3
2	Do not treat	
3	Treat	Treat if CD4 < 350 cells/ mm^3
4	Treat	Treat irrespective of CD4

India ENHANCE Training — Unit 10, Slide 18

Treatment should be started based on clinical criteria even if the woman is in the first trimester of pregnancy.
In some circumstances, delaying the start of treatment may be desirable for a woman in the first trimester of pregnancy, although, should her clinical or immune status suggest that she is severely ill, the benefits of early treatment clearly outweigh any potential risks to the foetus and therapy should not be delayed in such cases. Providing ART for all pregnant women who are eligible under NACO guidelines is ideal, however, this may not always be possible due to lack of resources.
Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November2006.

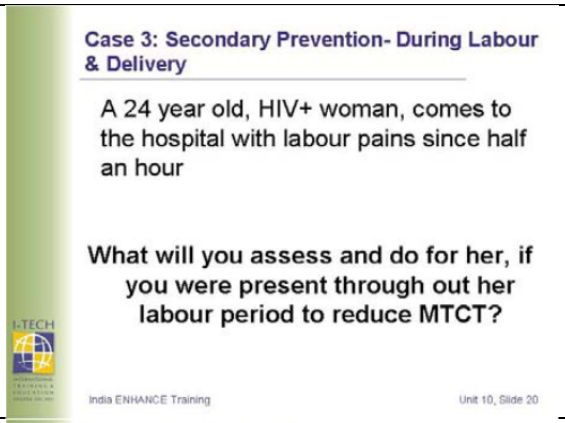
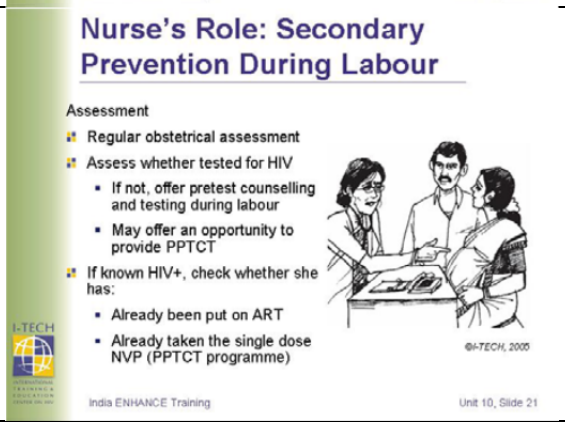
ART During Pregnancy

HIV-infected pregnant women who need ART should receive it

Choice of ART regimens:

- ART should consist of **3 or more ARVs**
- NACO first line therapy includes AZT/3TC/NVP
- **Efavirenz (EFV) is associated with birth defects**

HIV-infected pregnant women who need ARV treatment (ART) should receive it. ART should not be withheld during pregnancy unless known adverse effects outweigh benefits. There may be instances where there are not resources for women who are eligible for ART. These women can still receive short course treatment

	which will be discussed in the next few slides. Choice of ARV treatment regimens: ▪ ART should consist of **3 or more ARVs** to maximize control of HIV replication and minimize drug resistance. ▪ **Zidovudine (AZT) should be included** if possible. ▪ **Nevarapine (NVP) hepatotoxicity** occurs more commonly in women who have a CD4 count higher than 250. When NVP is used and the pregnant woman's CD4 count is >250/mm3, close monitoring of liver functions is required. ▪ **Efavirenz (EFV) is associated with birth defects**. If an HIV-infected woman becomes pregnant while receiving this drug, she should be switched to NVP if she reports within the first trimester. However if she reports after 3 months then she could continue on EFV. **The choice of ARVs may require modification** based on potential short- and long-term side effects.
	**Call Group 3 (Case 3) to come forward to present their case scenario and points of discussion and invite responses from other participants (5 min) and then present the next slides which contain details regarding Case 3.**
	Testing for HIV during labour is not mandated under India's PPTCT program. However, if unregistered cases of women present with labour pains, it is advisable to give them pre-test counseling and advise them to get tested.

If the woman presents with known HIV positive status – check whether she has either been put on regular ART or has already taken a single dose nevirapine (which may have been given to her at her 38 week antenatal visit to keep in a safe place until the onset of labour).

Refer participants to Annexure 2 for information on WHO recommendations for prophylactic ARV regimens for pregnant women in situations where criteria for ART are not fulfilled

Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November 2006.

Nurse's Role: Address Critical issues in Labour

Disclosure
- To women if HIV + status just diagnosed
- To delivery team
- To spouse and other family members

Confidentiality
Emotional support
ARV
Mode of delivery: Vaginal vs. C- Section

Brainstorm the following with participants:

Question 1: If you learn through testing that the woman is positive only at the time of labour, when would you inform her of her positive status?

Question 2: How would you handle the situation?

Remind participants that in India, women would normally be advised to put the baby to the breast soon after birth.

Delivery can be an emotional time for pregnant women. Be extremely sensitive and respectful.

Disclosure:

- This is an ethical issue and needs to be handled at the discretion of each delivery team. It is advisable however that the woman is not put under unnecessary duress during the time of labour and that she is the first person to be informed of her positive sero-status.
- It is advisable that the delivery team be aware of the woman's HIV sero-status so that they provide her and the baby with single dose nevirapine, and do not perform any procedures that would increase the risk of PTCT.
- Consult the woman before disclosing her serostatus to her spouse/family.
- Be sure to administer ARV per PPTCT protocol at your site at the onset of labour or after the rupture of membranes and record the time of administration.

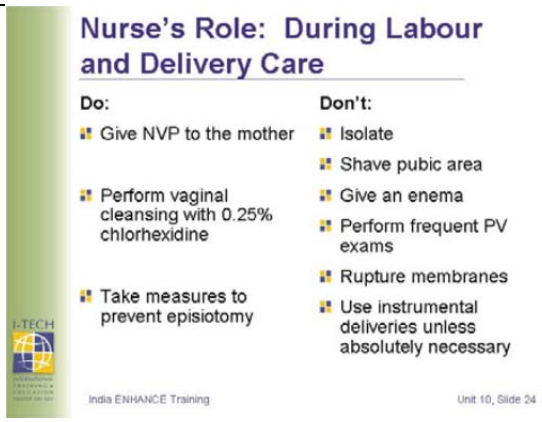
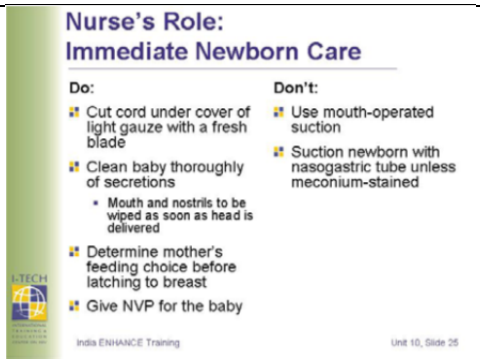
Ask participants if they would advise HIV positive women to go for a caesarean section over vaginal delivery. Wait for their answers and then explain using notes below:

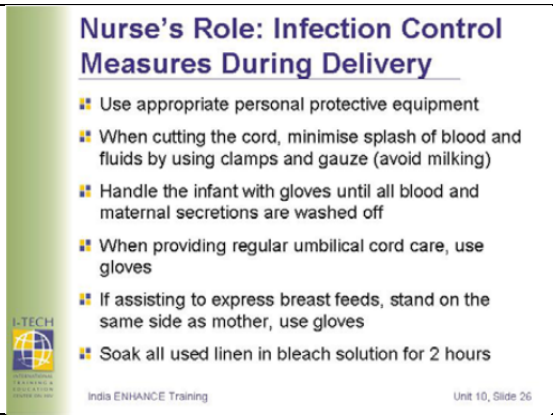
Caesarean section is not necessarily advised for HIV positive women. It is:

- NOT a standard PPTCT intervention
- Not available or safe in many settings
- Not routinely performed for women with HIV infection in developing countries

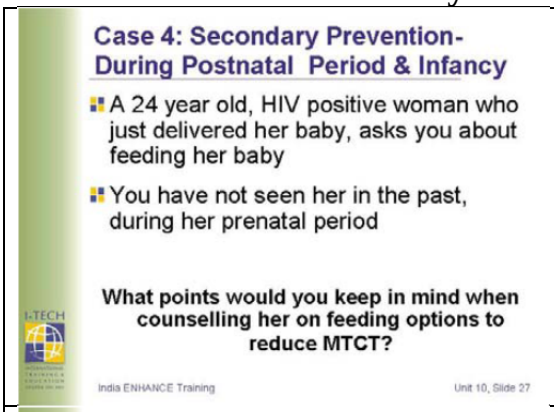
Caesarean sections are only performed:

- Electively when viral load is very high

	▪ As an emergency for obstetrical complications /foetal distress
	**Review this list with participants asking them the reasons behind these recommendations. Note that many nurses will not have experience working in labour and delivery.** **DO:** ▪ NVP: 200 mg single dose 4 hours before onset of labour can be given to the mother. ▪ Vaginal cleansing with chlorhexidine has been shown to decrease the viral load in the vaginal canal and thus reduce the risk of HIV infection to the baby during natural (vaginal) child birth. ▪ Avoid episiotomies as far as possible. However in the case of a primigravida (first pregnancy) it may be absolutely necessary to perform an episiotomy. In such cases, take measures such as good perineal support, and give a small episiotomy when the perineum is bulging to reduce the amount of blood the baby could be exposed to during delivery. ▪ **If episiotomy is necessary, do not use same scissors for cutting umbilical cord!** **DON'T** ▪ Give an enema – **Ask participants "Why should you not give an enema to an HIV positive woman at the time of labour"? Answer: An enema can cause rupture of membranes which would increase the risk of PTCT.** ▪ Instrumental deliveries could increase the risk of trauma to the skin of the baby. Secondly, it could also mean more exposure to maternal blood to the baby. This could further increase the risk of PTCT.
	**DO** ▪ Prevent baby's contact with mother's blood and secretions as much as possible and handle baby carefully at bathing. ▪ If baby bath is not given, dab the baby dry with a clean sterile towel to remove all maternal secretions. Clean the eyes with a sterile cotton swab soaked in normal saline. ▪ Feeding choices are discussed in detail later in the unit. ▪ Give single dose NVP 2 mg/kg within 72 hours of birth **DON'T** ▪ Suctioning can cause trauma and should be avoided via nasogastric tube unless indicated for medical reasons. ▪ **Remind participants that blood, and vaginal secretions have high concentrations of HIV and that infants will have those secretions in his/her**

	mouth - and make the connection between avoiding suctioning as the catheter may actually "push" virus into the baby.
	Protect staff from contact with mother's and baby's secretions as much as possible to prevent occupational exposure to HIV; and follow standard procedures for care of umbilical stump

Session 3.11 : Secondary PPTCT strategies



Facilitator's Notes:
Call Group 4 (Case 4) to come forward to present their case scenario and points of discussion and invite responses from other participants (5 min) and then present the next slides which contain details regarding Case 4.

Brainstorm the following with participants:
Question 1: Why should nurses stress the importance of EXCLUSIVE breastfeeding to HIV positive mothers?
Answer 1: Feeds apart from breast milk cause microscopic ulcers in a baby's gut. Once these ulcers form, HIV which might be present in breast milk can enter the baby's blood stream directly through them. This exponentially increases the risk of the baby acquiring HIV. Although breast milk may contain the virus, when given exclusively – the integrity of the baby's gut is preserved, thus reducing the risk of HIV acquisition when compared to mixed feeding. "Mixed feeding i.e. breast milk and formula feeds combined is the most hazardous form of infant feeding." (*Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November 2006.)*
Question 2: What are cultural issues that may serve as barriers to male involvement?
Answer 2: For an HIV positive mother, it is extremely important that she feel supported by others in her family including her husband when making decisions that could put the child at risk of acquiring HIV.
However in India, traditionally, feeding options are decided by the women of the house – including grandmothers. There is often embarrassment amongst men when breastfeeding is brought up – as it is considered a "woman's problem". This could limit feeding decisions and burden of the responsibility of unfavourable outcomes solely on the mother.
When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life, with early abrupt stopping at 6 months of age.
If breastfeeding exclusively, minimize HIV risk to baby through the following: Use only breast milk for the period of breastfeeding. Not even water, tea, or kanji to be given.
The highest risk of HIV transmission during lactation occurs in women who acquire HIV while breastfeeding.
Refer participants to *Handout 2: Replacement Feeding Checklist* in the Participant Manual.

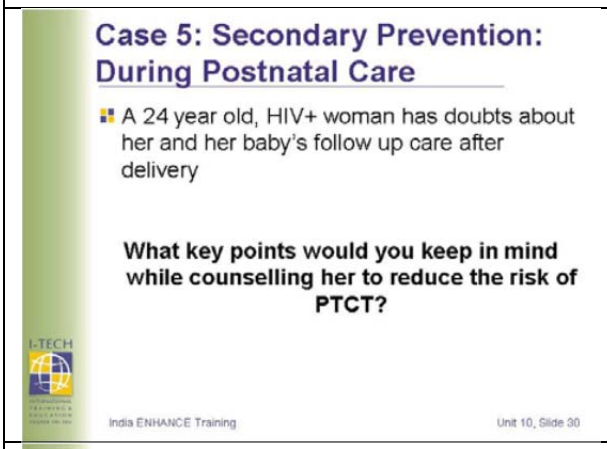
Handout 3.10: Replacement Feeding Checklist

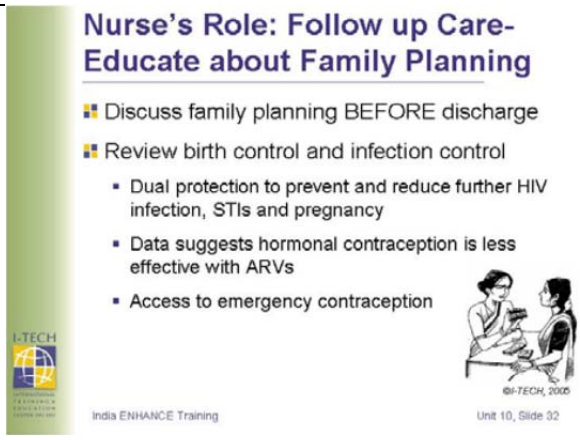
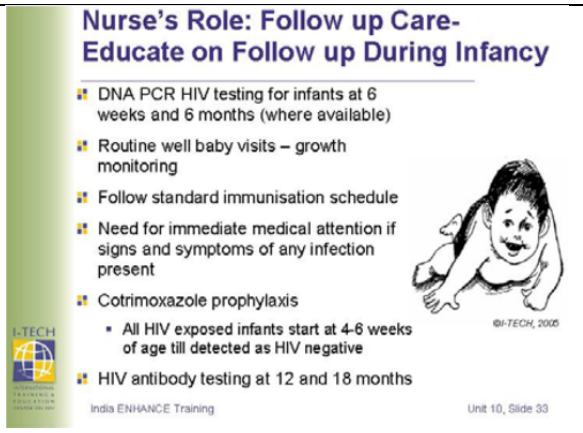
	YES	NO
Can she afford to buy enough milk/milk powder?		
Does she have access to clean water?		
Can she prepare milk safely? Boil the water Make the correct concentration of milk if using the tin milk		
Can she clean and sterilize the feeding articles?		
Will she have enough support from significant others in the family?		
Does she know how much of milk the baby can be given ▪ each time ▪ for a day ▪ how often		

If answers are "No", see what patient education/ linkages can be provided to support replacement feeding OR advise safe breastfeeding.

Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November 2006.

Inform participants on the importance of educating on the points listed in the slide if a mother opts to breast feed her baby.
The risks of HIV transmission especially if combined with ART may be less than 0.5% if exclusive breast feeding is done.
Good hygiene: it is important that the mother is told to have a daily bath, and a change of clothes especially the inner clothes. The mother need not clean the breasts every time she feeds the baby. This helps maintain the oily secretions and thus the integrity of the nipple.
Good position: The correct position is leaning forward slightly, head of the baby must be slightly extended and the mouth of the baby completely grasping the areola of the breasts. This will help prevent cracked nipples.
Feeding colostrum: Although colostrum has a very high content of HIV, it can protect the baby from several infections. Thus it is safer to give it than not.
The shorter the duration of breast feeding, the lesser the risk of HIV transmission. However if a woman decides to breast feed, then she must be told it is better to feed exclusive breast milk till 6 months of age and then to move to weaning foods, rather than to continue to breast feed for longer periods.
Exclusive breast feeding or exclusive replacement feeds are the only two options

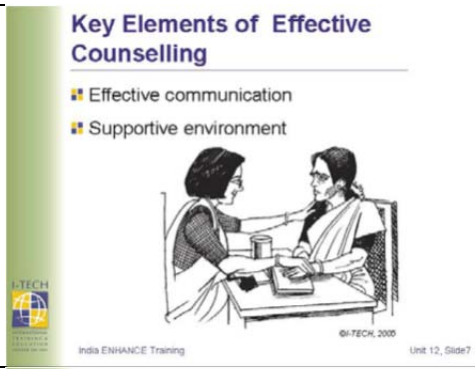
	for feeding a baby born to a mother who is HIV positive. Mixing breast milk and replacement feeds increases the risk of transmission. **Express feed versus direct BF**: Options depend on the mothers' capacity to express breast feeds, give it safely to the baby (so as not to cause diarrhoea or even aspiration). The biggest risk of giving expressed breast milk is when it is not given in a hygienic manner thus increasing the risk for diarrhoeal episodes in the baby. On the other hand if DBF were given the risks of cracked nipples could occur, but with good position during feeding as well as maintenance of personal hygiene, this risk could be minimized. How to stops abruptly: The mother can be encourage to express breast feeds two weeks prior to stopping it (i.e. at 5 1/2 months) and to feed with a spoon or paladai or cup. This reduces the number of feeds and the letdown reflex. The amount of breast milk reduces, and the baby gets accustomed to feeding from a cup. Night feeds can be gradually stopped too.
	**Call Group 5 (Case 5), to come forward to present their case scenario and points of discussion, invite responses from other participants (5 min) and then present the next slides which contain details regarding Case 5.**
	Ask participants how discharge instructions may be different if women have HIV? (heightened awareness of infection; otherwise the same) ▪ Inform participants that they need to tell mothers to report to the doctor if they have any illnesses or infections. ▪ Nurses should optimise health and medical evaluation: ▪ Attention to possible increased risk for infections due to HIV (chest, urinary, puerperal, episiotomy or breast infections). ▪ Consider OI treatment and Prophylaxis - Cotrimoxazole for women with WHO Clinical ▪ Stage III and IV. Pneumonia is the most common opportunistic infection in the peripartum. Monitor carefully for PCP and

	community acquired pneumonia. ▪ Continue on ART if patient is eligible (if on ART while pregnant) or commence on ART if patient is eligible (if ART was not started while pregnant). ▪ It may be necessary to ask a woman to come in for follow-up more frequently if she has just started ARV, if it was a complicated or difficult delivery, or if an underlying illness such as diabetes, hypertension or severe anaemia is present.
	This is the perfect time to discuss family planning. This may be challenging if cultural barriers exist, or depending on whether the pregnancy was planned or not. While it is essential to be respectful, this may represent an important opportunity to address the needs of the HIV infected woman one-on-one in a nonjudgmental atmosphere. Explain the term dual protection – 1) Protection from HIV through use of condom and 2) protection from getting pregnant through use of other contraceptives such as the pill, etc. Inform women about the facilities available for emergency contraception if needed (also called the morning after pill).
 *Source: NACO. Indian Academy of Paediatrics. Guidelines for HIV Care and Treatment in Infants and Children. November 2006*	**Diagnosis of HIV in infants:** HIV DNA PCR at 6 weeks and 6 months (where available) HIV antibody testing at 12 and 18 months The goal is to diagnose babies who are HIV positive in order to provide timely treatment. Give all standard immunizations as per schedule. **Tell parents that if the baby is sick, not to wait for the scheduled visit to bring them to the hospital.** **Sick children born to an HIV-positive mother should be evaluated immediately for diagnosis and treatment.** **Signs and symptoms of HIV infection in the infant:** ▪ Fever ▪ Failure to gain weight (may suggest HIV and/or malnutrition) ▪ Lymphadenopathy ▪ Loss of milestones ▪ Hepatosplenomegaly ▪ Recurrent/recalcitrant infections ▪ Otitis media ▪ Candidiasis (Most infants have thrush, so this is not a reliable indicator of HIV infection.) ▪ Parotid enlargement **Cotrimoxazole prophylaxis:** Infants who

	may be HIV infected are at high risk of acquiring PCP. Cotrimoxazole prevents PCP, which has high morbidity and mortality for children with HIV. The highest incidence is 3 to 6 months of age before the baby is accurately diagnosed. Infants exposed to HIV should start cotrimoxazole at 4 to 6 weeks (starting earlier may interfere with bilirubin conjugation). Cotrimoxazole is continued until the baby is detected as HIV negative. .

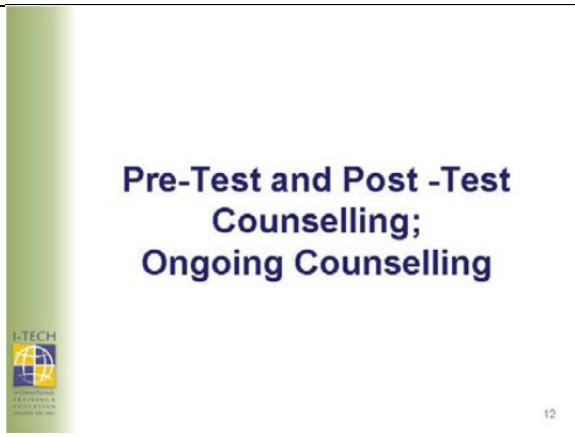
Session 3.12 : Elements of Counseling in HIV

Counselling "**Confidential** dialogue between a **person and a care provider** aimed at enabling the person to **cope with stress** and **make personal decisions** related to HIV/AIDS." "The counselling process includes an **evaluation of personal risk** of HIV transmission and facilitation of preventive behaviour." India ENHANCE Training WHO/GPA, May 1994 Unit 12, Slide3	**Brainstorm the following question with participants "How is counseling different from patient education"?** **Write their responses on the board/ flip chart, and then project the next slide.**
Counselling & Education Patient education ▪ Assesses understanding of health related information ▪ Gives valuable information about disease and treatment ▪ Facilitates confidence in self care Counselling ▪ Includes patient education ▪ Helps PLHA identify feelings, risky behaviours, readiness to change behaviour ▪ Guides PLHA to establish a plan. ▪ Facilitates clear thinking and decision making. India ENHANCE Training Unit 12, Slide4	**Ask participants, "Why do we need to counsel patients?" Wait for their responses and then project the next slide.**
Why Counsel? Facilitate decision to undergo HIV test Provide psychological, social and emotional support Prevent transmission of HIV ▪ Provide information about risk behaviours ▪ Assist in development of personal skills needed for behaviour change ▪ Adopt and negotiate safe sexual practices Motivate people to take good care of their health Support adherence to treatment goals India ENHANCE Training Unit 12, Slide5	**This slide is animated.** **Ask participants to answer the question in the title and then click the "down" arrow to advance the slide till all the points are displayed.** **Discuss the patient's attitudes, beliefs, and potential obstacles. Once we know the patient's point of view we can provide information, educate on the pertinent issues, and then counsel to facilitate patients to problem solve.**
Elements of Counselling 6	

	**Inform participants that this section highlights key points to keep in mind with regards to the messages, the nonverbal messages, tone, and questioning techniques during counseling.**
	In order for communication to be effective, adhere to the concepts listed in the slide.
	Ask participants to give one or two examples of how a message could be given, or stated, in a positive vs. negative way: Example: Safer sex practices will help protect yourself as well as protect others. ***Versus,*** If you do not practice safe sex, you could get an STI and you could transmit HIV to others. Example: Taking your ART exactly as prescribed every day will prevent you from developing resistance to the medications and keep you healthy for a longer period of time. ***Versus,*** If you do not take your ART exactly as prescribed every day, you will get resistance to HIV, and the medications will not work for you.
	The key elements of a supportive environment: **Timing:** Patient's readiness for the information and counseling. Time of the day and its relation to the patient's physical state of mind. **Place**: Privacy, especially when sensitive and private matters are discussed. Choose a place where there is less distraction, i.e. just rearranging the position of the table and chair away from the door can reduce distraction from people passing by the door. **Acknowledge the feelings of the patient**: ▪ Assess the main concerns of the patient. ▪ Prioritize concerns according to the patient's view point. ▪ Deal with each of them based on PLHAs priority. ▪ Remember that you do not have to complete all the concerns in one session unless the

	patient feels the need. **Begin with less intimidating/less sensitive issues:** Always begin a session with topics that the patient is comfortable with discussing, such as for his/her work rather than sexual history. Once the patient feels comfortable and has developed a trusting relationship, the nurse can address the more sensitive issues.
	Hospital based nurses will usually be involved in ongoing counseling. **Ask participants what topics might be included in healthy life style counseling. Write the points on the board / flip chart and acknowledge their contribution. Include the topics below if not brought up by participants:** ▪ Nutritious diet ▪ Personal hygiene ▪ Exercise ▪ Quit smoking, drugs or alcohol ▪ Participate in hobbies, family events, temple or church and other activities that promote joy and well being ▪ Find meaningful work or volunteer helping others **Ask participants what topics might be included in end of life counseling. Write the points on the board / flip chart and acknowledge their contribution. Include the topics below if not brought up by participants:** ▪ Identifying resources ▪ Pain management ▪ Symptom management ▪ Exploring emotions **Emphasis that once counseling skills are developed, counseling sessions can be brief and occur at bedside, during other encounters with patients and each time patient comes to ward.**

Session 3.13: Pre and Post test Counseling, Ongoing counseling

	**Facilitator's Notes:** Explain to participants that the aim of this step is to familiarize them with what happens during pre and post- test counseling, and give them an introduction to ongoing counseling which will be covered in detail in later in the presentation. Conduct a short role play (5 minutes) with another facilitator that models how to conduct pre-test counseling. One person plays the role of the nurse and the other, the client. ***Use Handout 1:*** ***Steps in Pre-Test Counseling*** to guide you in the steps of pre-test counseling. You could make up a scenario or use the suggestions below for role of the patient: ▪ Sexually active unmarried woman ▪ Pregnant woman who does not think she is at risk of HIV **Debrief the role play.** First ask participants to give feedback on what went well and suggestions on what could have been done differently, and then provide your own feedback (5 minutes). Inform participants that they will be doing similar role plays a later in the unit, as well as giving feedback to other participants.

Handout 3.11: Steps in Pre-Test Counseling

Identify need for being tested

Identify why the person has come for testing. Address the need. In the past, testing was advocated for persons who presented with the following risk behaviors/factors as listed in the box.

Persons who can be referred for HIV testing:

- Any one who is concerned, or worried about the possibility of having HIV
- Any one with STI, TB, HBV, HCV, AIDS –like illness or illness consistent with AIDS and their partners
- Pregnant women
- Injecting drug users (IDUs)
- Men having sex with men (MSM) or bisexual men
- Recipients of blood , blood products and or organs
- Donors - blood, sperm or organ
- Infants born to HIV infected or high risk mothers
- Any one with multiple sexual partners –sex for money, pleasure or drugs
- Partners of homosexuals, bisexuals, IDUs or of any HIV positive individual
- **Today any person can present for an HIV testing and the person need not have any risk factor or behavior in order to be tested**

ii. Appraise the person's risk status

A list of some questions that you can ask the person to identify their risk status:

- Are you sexually active? If yes, when was your last sexual contact?
- Have you ever injected any drugs intravenously and if so, do you share needles?
- Do you have sex with more than one person?
- Do you have sex with men or women or both?
- Do you have oral, anal or vaginal sex without using a condom?
- Do you have any ulcers? Sores? Abnormal or excessive discharge from the vagina or urethra? Any swelling in your private parts?
- Does your partner have a history of having multiple sex partners? Injecting drug use? Taking other drugs? Receiving blood transfusion?

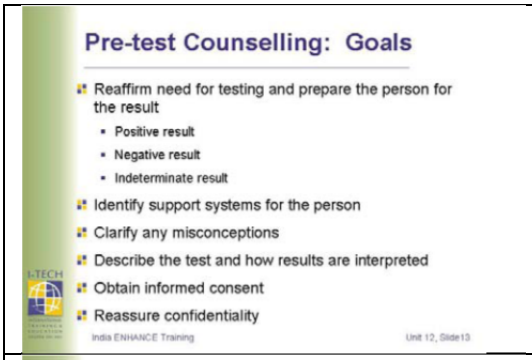
iii. Provide needed information during pretest counseling after assessment of the person's knowledge:

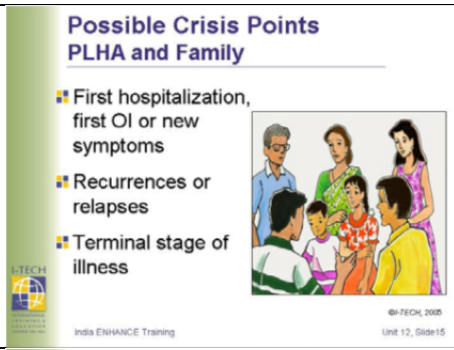
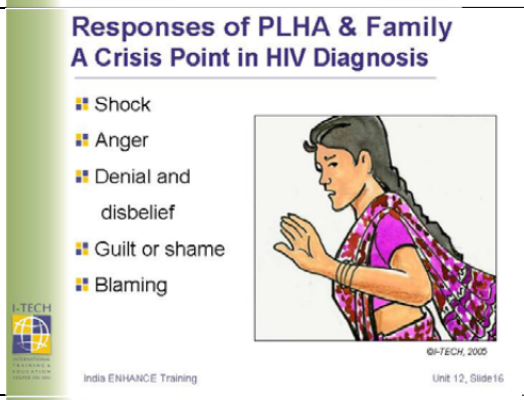
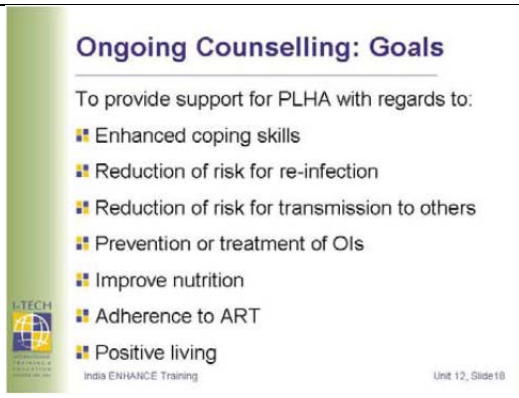
- The purpose of HIV testing
- The limitation of HIV testing
- Consequences of testing result
- Methods of prevention
- Importance of early medical intervention
- Causes, spread, treatment and prognosis of HIV and AIDS
- How confidentiality will be maintained: A PID (Patient Identification number) will be given to the person when he/she goes for testing in the laboratory. Only the counselor will be aware of the name.

iv. Inform the person of the required tests and how the tests will take to be interpreted:
Inform that in ICTCs all the services that includes counseling and testing are free. Rapid tests are done here, and the person can get the result within 45 minutes.

- For symptomatic persons: the blood test should be reactive with two different kits.
- For asymptomatic persons: the blood test should be reactive with three different kits.
- For those with risk behaviors and no reactive blood test, they need to be asked to return for further testing after 3 months, 6 months.

Get the consent form signed by the person if he/she is willing to do the test. Ask them to return on the same day for the test result.

	**Review the goals of pre-test counseling and recap those covered during the role play.**
	Highlight the goals of post-test counseling. Emphasis that a nurse may not have a role in immediate post-test counseling, as in India, this is usually handled by the counsellor at the ICTC. But, during the follow up period, the nurse will play a vital role in providing psychosocial support to PLHAs. Show video titled: *Sexually Transmitted Infection Care Trigger Scenarios (Botswana, 2005) HIV Post- Test Counseling.* This is provided on the supplementary DVD title:

	Clinical Mentoring Toolkit. ▪ Ask participants to pay close attention to how the nurse is interacting with her patient and the different techniques she employs to discuss sensitive issues. ▪ After the video conduct a 2-3 minute debrief discussion: ▪ Does the nurse clearly explain the test results? ▪ Does the nurse address all of the patient's main concerns? ▪ Does the nurse take steps to guide the patient towards proper management of his condition? ▪ How could the nurse have done a better job/what would you have done differently?
	The slide lists critical points of HIV disease. These are times when a nurse would need to support and may need to counsel a PLHA or the family of a PLHA.
	**Explain to participants that, "In the video we saw one person's reaction to a HIV positive diagnosis. People have different responses to crises. The time of diagnosis of HIV can be a crisis for any person."** People may not respond to a HIV diagnosis in the sequence listed on the slide. PLHAs and their families can also feel these emotions during any time of the disease progression and not only at the time of diagnosis.
	

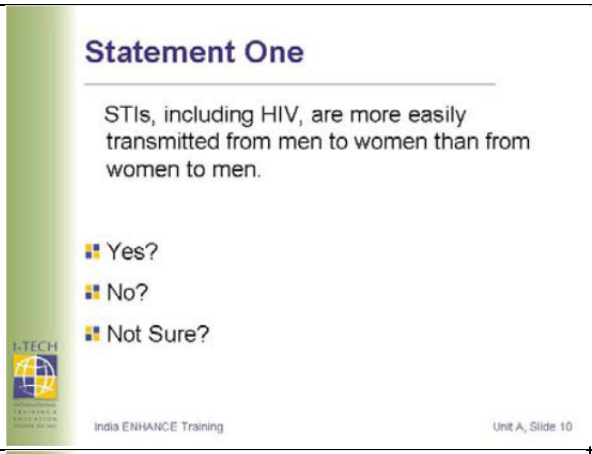
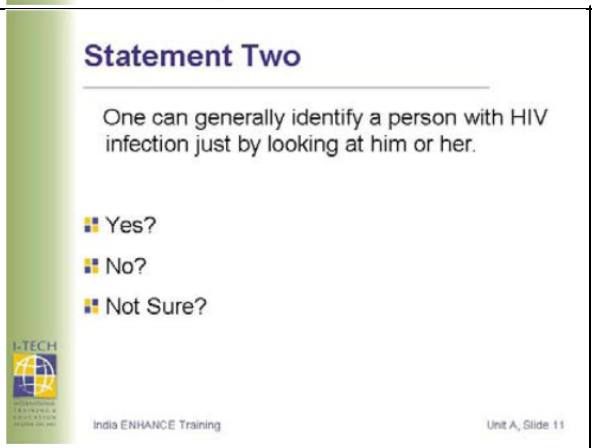
EXERCISE

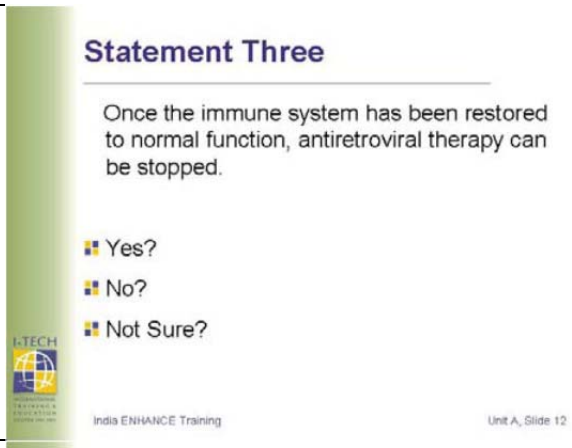
Exercise 3.1 : " We know more than we do"

The purpose of this exercise is for trainers to find out how much the group knows about HIV and AIDS.

Instructions:

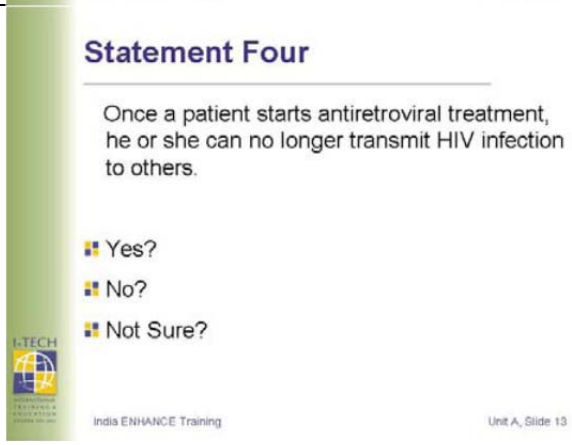
- **Divide participants into 5 groups.**
- **Hand each group one set of cards (each group should get 1 'Yes' card, 1 'No' card, and 1 'Not sure' card).**
- **Instruct them that statements will be projected on the screen in the following slides. Groups then have 2 minutes to discuss their response and will have to keep the corresponding card ready.**
- **On signal, all groups will have to hold up the card that reflects their answer at the same time.**
- **Ask groups to share the reason behind their answers, especially if there are different answers from different groups.**
- **Give the class the correct answer. Use the Facilitator's Notes to help facilitate a short discussion, correcting any misinformation at this time, but do not attempt to teach the subject fully.**
- **Proceed in this manner with all statements.**

	**Facilitator's Notes:** **Answer: Yes** ▪ HIV is 8-10 times more likely to be transmitted from male to female than female to male. ▪ During sexual intercourse a larger surface area of vaginal mucosa is exposed to infected semen. ▪ This increases women's susceptibility to HIV infection ▪ The presence of other STIs in women increases the risk of HIV transmission four-fold.
	**Facilitator's Notes:** **Answer: No** ▪ People with HIV can appear (and actually can be) very healthy. ▪ They can also have illnesses opportunistic infections) that HIV negative individuals have, such as TB or pneumonia. ▪ Thus, although there are certain infections and symptoms associated with HIV disease, it is impossible to tell just by looking at someone if they are HIV positive. ▪ Confirmation can be got only through blood tests.



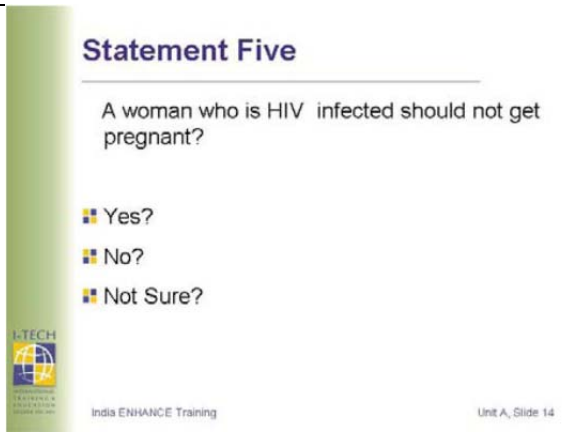
Facilitator's Notes:
Answer: No

- Antiretroviral treatment should not be stopped unless issues of toxicity or poor adherence develop.
- Once ART is started, it is for life.



Facilitator's Notes:
Answer: No

- This statement is a wrong and dangerous assumption!
- Although viral loads in HIV positive individuals may become so low that they cannot be detected, this does not mean the virus cannot be passed to another person.
- The virus still exists because there is no cure for HIV.
- There is also the possibility that an individual can pass a resistant virus or a new strain of virus on to someone



Facilitator's Notes:
Answer: It is debatable.

- This statement may generate a lot of discussion because of people's assumptions about passing the virus on to an unborn child.
- The goal is to find out what participants know about HIV and their assumptions about people who live with HIV, and NOT to judge them.
- An HIV-positive woman who is pregnant will not necessarily pass the virus on to her child.
- There are interventions available to further reduce the risk.
- It is her and her family's choice whether or not she should get pregnant.

Exercise 3.2: Clinical Staging Cases

Instructions:

- Advance through the slides case by case.
- Allow participants 2 minutes to read each case and answer the questions.
- Discuss each case as a large group as participants share their answers to the related questions.
- Encourage participants to use Handouts 2 and 3 as references.

Case 1 Sunil, a 35-year-old HIV positive male is admitted to the ward with a history of persistent diarrhoea since five months. His stool exam reveals cryptosporidium.

Questions:

1. Which is Sunil's clinical stage of HIV infection?
   Stage 4
2. Why? What are your reasons for stating so?
   Due to diagnosis of the opportunistic infection cryptosporidiosis.

Case 2 Rani, a 24-year-old student was raped. Two weeks later she went to the doctor complaining of fever, malaise, fatigue, and swollen lymph nodes. At that time, she was diagnosed with influenza. One month later, she is now asymptomatic and has come for an HIV test – her result is positive.

Questions:

1. Which clinical stage of HIV is Rani in NOW?
   Stage 1
2. Was the diagnosis made 6 weeks ago correct?
   No, she was misdiagnosed with influenza.
3. If not, what should the diagnosis have been?
   The correct diagnosis was primary HIV infection.
4. What type of HIV test should have been done when Rani came in first?
   Either an antigen based test or a PCR test.

Case 3 Susheela, a young woman comes to the clinic complaining of fever for 6 weeks. From her previous record, you see that six months ago she weighed 54 kg. She now weighs 46 kg. She has scars on her back that are due to herpes zoster. Her HIV test performed now comes out positive.

Question:

1. Which is Susheela's clinical stage of HIV infection?
   Stage 4
2. Why? What are your reasons for stating so?
   Due to fever for more than one month PLUS >10% body weight loss. This combination of factors leads to the diagnosis of HIV Wasting Syndrome which is classified under Stage 4. The herpes zoster scars are not considered in the staging – as only PRESENT clinical condition should be considered. (The presence of current herpes zoster alone would put her in stage 2).

Case 4 Ravi is a 29 year old male patient known to have HIV who was admitted to the hospital with complaints of fever and cough for 2 weeks and weight loss (he weighed 70 kg 6 months ago and now weighs 64 kg). Chest x-ray and sputum AFB results are not yet available.

Question:

1. Which is Ravi's clinical stage of HIV infection?

   Stage 2

2. Why? What are your reasons for stating so?

   Fever and cough for less than one month and weight loss < 10% of body weight put him in clinical stage 2. Symptoms are suggestive of TB but we do not have a definitive diagnosis.

3. If Ravi is diagnosed with TB, in what clinical stage would that put him?

   A diagnosis of TB would put him in clinical stage 3.

Exercise 3.3: Case Studies: Applying syndromic case management

Instructions:

- Divide participants into two groups and assign each one of the two cases given below. Ask them to go through the flow charts in the annexure. They can take turns in reading the flowcharts and discuss them
- Then they have 10 minutes to read the case, discuss the question, and note down their answers.
- Inform groups to choose one person to read out the case to the class and another one to present their findings.
- Ask participants to listen closely when the other group presents their case and share any additional points they may have with the large group.
- Ensure that answers are correct by referring to the appropriate flowchart in the Additional Resource Materials provided at the end of this unit.

Case 1: Rani, a recently married 23 year old woman presents with dull, persistent lower abdominal pain. She is not sure of increased vaginal discharge, and her periods are of normal cycle. She has never been pregnant.

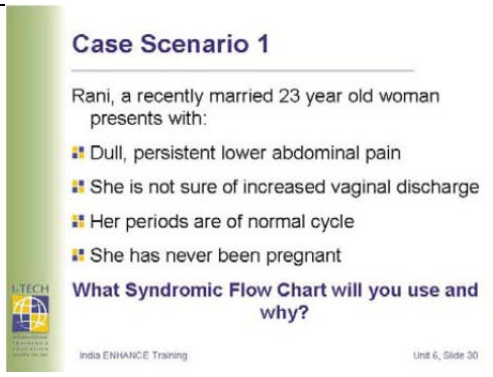
Q: How would you apply the Syndromic Case Management approach to her case?

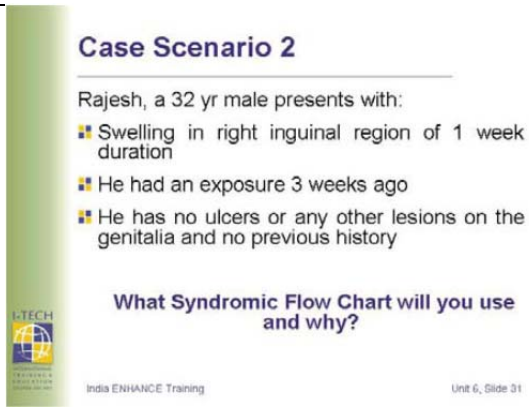
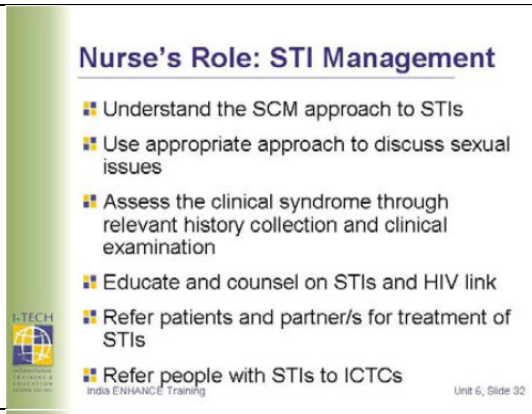
Refer to flowchart on Lower Abdominal Pain in Females: Annexure 3.1.

Case 2: Rajesh, a 32 yr male presents with swelling in right inguinal region of 1 week duration. He had an exposure 3 weeks ago. He has no ulcers or any other lesions on the genitalia and no previous history.

Q: How would you apply the Syndromic Case Management approach to his case?

Refer to flowchart on Inguinal Bubo: Annexure 3.2. India

	**Select 3 volunteers from the appropriate group to:** **1) Read out the case study** **2) Present which Syndromic Flow Chart they would suggest using and why** **3) Review steps involved in the corresponding flow chart to the large group.** **Ask the other group if they have any additional points to share.** **Refer participants to *Annexure 1: Management of Lower Abdominal Pain in Females* in the Additional Resources section of the Participant Manual.**

	Common points in the flow chart are history, clinical examination, education on prevention, partner management and follow up. The only significant difference lies in the treatment section.
	**Select 3 volunteers from the appropriate group to:** ▪ **read out the case study** ▪ **Present which Syndromic Flow Chart they would suggest using and why** ▪ **Review steps involved in the corresponding flow chart to the large group.** **Ask the other group if they have any additional points to share.** **Refer participants to *Annexure 2: Management of Inguinal Bubo* in the Additional Resources section of the Participant Manual.** Common points in the flow chart are history, clinical examination, education on prevention, partner management and follow up. The only significant difference lies in the treatment section **Ask participants:** ▪ **What are the main points you have learned from this session?** ▪ **What are your key responsibilities with regards to patient care from what you have learned from this session?** **Allow 1 minute for a brief large group discussion.**
	**Discuss nursing implications with participants.**
	Present key points and answer any remaining questions. **Direct participants to Additional Reference Materials provided at the end of the Participant Manual. This is intended to be used as a reference material for participants to review on their own time.**

Exercise 3.4: Steps in Hand Washing - Checklist

Procedure	Done
Ensure short finger nails	
Ensure water supply/ alcohol hand - rub solution	
Remove accessories from hands	
Pour soap solution / alcohol rub into hand or apply soap uniformly on the hand	
Scrub both hands Scrub palms and fingers Scrub back of hands Scrub fingers and knuckles Scrub thumbs Scrub finger tips and nails Scrub wrists and up to elbows if needed	
Wash hands ensuring removal of soap from all applied areas / if using alcohol rub, rub all surfaces till dry (Do not wash with water)	
Air dry or dry using clean towels	

Exercise 3.5: Situational Guide - Cleaning up a Blood Spill on the Floor

Facilitator Instructions:

1. You will need the following equipment for this exercise:
    - Tomato sauce/red paint
    - Plastic apron
    - Disposable shoe covers
    - Clean towel/gauze/cotton
    - Hypochlorite solution
    - Yellow bin
    - Mop
    - Water + Soap
    - Buckets
2. Refer participants to Exercise 3.5 in their Participants' Handbook.
3. Ask them to review the steps for cleaning up a blood spill on the floor.
4. Spread the red substance on the floor.
5. Ask for one volunteer to demonstrate the proper way to clean up a blood spill on the floor.
6. Set all other items on a table for the volunteer to access/use.
7. After the volunteer completes the task, ask participants, "What cleaning items used by staff are likely to contaminate other items in the environment?" Answer: Items frequently causing contamination include utility gloves, buckets, buckets, mops, and rags.

Proper Technique

1. Wear appropriate personal protective equipment: plastic apron, shoes and disposable gloves.
2. Put a towel / gauze / cotton over the spill area to cover it completely.
3. Pour hypochlorite solution 1% over the covered cloth to soak it completely.
4. Leave the solution on the cloth for another 30 minutes without disturbance.
5. Carefully lift the cloth from the floor, mopping the whole spill onto the cloth and dispose into the yellow bin.
6. Using a routine mop and soap water solution swipe the area and wash the mop and hang it out to dry.
7. Remove gloves and dispose into red bin.
8. Wash hands under running water with soap and dry hands.

Exercise 3.6: HIV and Pregnancy Case Study

Instructions:
- Allow participants 5 minutes to read the case study on their own and prepare their answers.
- Review the answers to questions as a large group

Case Scenario: Mrs. B has been on ART for just six months. She is feeling much better and would like to have another child. Her husband's HIV status is unknown. She approaches you for advice.

Questions:

1. What advice will you give Mrs. B?
   - *Discuss HER feelings and whether or not she wants another child, feels strong enough to care for another child, and if she getting pressure from others.*
   - *Does she have concerns about disclosure, stigma?*
   - *Will she be able to access good antenatal care and continue receiving ART and ART follow up care? Will she be able to stay on ART?*
   - *Will she be able to deliver in a hospital experienced with delivering HIV positive mothers?*

2. What are the medical implications?
   Remember that pregnancy does not appear to hasten HIV progression, and that as long as Mrs. B remains immunologically stable on ART, has few side effects from ART, her HIV positive status should not have a negative impact on the pregnancy.

3. How will you proceed with your counseling?
   - *Discuss benefits of referring her husband for testing.*
   - *Review risk of sexual transmission and need for safe sex*
   - *Review risk of vertical transmission during pregnancy and birth if she stays on ART with excellent adherence and also if she does not stay on ART.*
   - *Discuss infant feeding options and risk of transmission.*

ROLE PLAYS

Role Play: 3.1: Typical Patient Questions

Patients often have many questions about HIV/AIDS and nurses need to know how to answer these questions. Nurses will get better as they learn more and with experience. The purpose of this exercise is to help participants practice their knowledge and communication skills.

Instructions:

Part I of Activity (10 minutes):

- Break up the participants into pairs.
- Ask one participant to play the role of a PLHA asking the nurse a common question as listed in the exercise.
- The other participant will play the role of a nurse.
- After question one, alternate roles for question two and again for each of the four questions.
- Pairs should discuss and decide how best to respond to the patient's question.
- Encourage participants to respond to the questions as they would to a real patient.
- Walk around the classroom and ensure that pairs are working on the exercise – clarify any questions raised.

Part II of the Activity (15 minutes):

- Ask 4 pairs of volunteers to come up one by one and role play one question each in front of the class. Use the corresponding slides in the presentation.
- Give each pair 2 minutes to perform the role play and then spend 2 minutes debriefing each role play. Ask for feedback from:
  - Role players (i.e., How do you think it went? How did it feel playing these roles?)
  - Observers (i.e., What did you observe? What do you think went well? What else could the nurse have said or done differently?).
  - Remind the observers when giving feedback to:
    - Be respectful. Remember, it is hard to be in the nurse position!
    - Emphasis the positive aspects of the patient education session. Use the "masala dosa" method of giving feedback by giving constructive suggestions wrapped in positive feedback.
  - Remind receivers of feedback not be defensive.
- The answers provided below are just a guide for you to facilitate the discussion. Use information that has been given in this unit to supplement the points below. Remind participants that apart from providing facts, they should also provide emotional support to PLHAs when answering questions like these.

Questions:

1. What is the difference between HIV and AIDS?

   HIV is a virus, AIDS is the end stage of the disease caused by HIV.

2. How could I have gotten HIV infection if I had sex with no one else but my wife?

   Discuss all the routes of HIV transmission, how it is not transmitted, and the need for bringing the wife in for testing

3. I came here because of my TB, why are you asking me to go for an HIV test?

   Explain that often people have HIV without even knowing it. Someone with HIV picks up infections like TB more easily than others. As a precaution, it is necessary for people to get tested so that they can receive treatment and support if the result is positive. If results are negative, people still need to be educated about primary prevention strategies.

4. How much time do I have to live now that I have HIV infection?

Provide a simplified explanation of HIV disease progression, emphasizing variability across PLHAs and the need for observing risk reduction strategies (e.g. safer sex), proper nutrition, and hygiene.

Role Play 3.2 (a): Counseling Role Plays

Instructions:

- This activity will take about 70 minutes to complete.
- Divide participants into five small groups of 4 or 5. Assign each group a case.
- Ask groups to choose one person to play the role of the patient and another, the counselor. Remaining group members will be observers.
- Tell groups that the patient and counselor will meet as if they were having a regular visit.
- Allow groups 10 minutes to plan and practice the role play using the guidelines provided under their case. Remind participants that *all* the points listed *do not* need to be covered in one session and are simply a guide as to how to proceed
- Each group will be given 3 to 5 minutes to perform the role-play for the larger group.
- Advance through the corresponding slides.
- The observers in the group should use *Exercise 1 (b): Counseling Assessment Tool* - while the role play is being performed and conduct a debrief session where they will be asked to provide feedback. When giving feedback remind observers to:
  - Be respectful. Remember, it is hard to be in the counselor position!
  - Emphasis the positive aspects of the counseling session.
  - Offer gentle, constructive suggestions to improve what didn't work so well.
  - Avoid being too critical since this is only a practice session.
  - Avoid using terms like 'should have' 'must have', etc.
- Ask each group to role play their case to the larger group in order. Case 1 will go first. Display the corresponding slides.
- Stop the role play when you, as the facilitator, feel the important points have been covered.
- De-brief the role play and ask for feedback from:
  1) Role players (i.e., How do you think it went? How did it feel taking on the role?)
  2) Observers using assessment tool (i.e., What did you observe? What do you think went well? What else could the counselor have said or done differently?).
- Highlight important concepts for each counseling situation using the suggestions below and provide your feedback.

Case 1: Sita a 20 year old woman comes to the ART clinic. She received a positive HIV test result 2 weeks ago. You check her laboratory investigations, and find all are within normal limits. Her CD4 count is 475. She asks you. 'What should I do to stay healthy?'

Demonstrate how you would counsel her.

Important points to keep in mind when counseling:

- *Need for ongoing counseling and follow-up medical care*
- *Patient's knowledge related to HIV infection and progression of disease*
- *Counseling the partner and the family*
- *Personal, family, social implications*
- *Risk factors for re-infection or transmission to others*
- *Practising safe sex*

Enhancing self-esteem

- *Avoiding alcohol, drugs and smoking*
- *Use separate tooth brushes razors, blades etc.*
- *Patient's overall health and nutrition status*
- *Social support*
- *Legal advice*

- *Referral for screening and treatment of STIs*
- *Family planning counseling*
- *Special services for pregnant women - PPTCT*
- *Treatment plan and future plans*
- *Initiation of appropriate early treatment*
- *Reinforcement of the concept of hope*

Case 2: Ravi a 25 yr old HIV + man reports to the medicine outpatient department with white patches on his tongue, throat, pain on swallowing, and weight loss.
Demonstrate how you would counsel her.
Important points to keep in mind when counseling:
- *Eosophogeal candidiasis in immune compromised persons*
- *Patient's knowledge*
- *OI is a sign of advancing disease, need for treatment*
- *Whether the patient has been on ART or OI prophylaxis in past*
- *History of adherence to ART and/or prophylaxis*
- *If previously on ART, what was his adherence ability, any barriers to adherence*
- *Knowledge regarding benefits of ART, OI prophylaxis*
- *Source of food and fluids*
- *Nutritional assessment and intervention*
- *Importance of adequate hydration and calorie intake*
- *Soft, bland diet*
- *Measures to reduce mouth and throat pain*
- *Oral hygiene*
- *Dietary measures*
- *OI management and treatment options*
- *Educate and counsel on treatment for esophageal candidiasis*
- *OI prevention and prophylaxis*
- *HIV treatment and implications of no treatment*
- *Formulate plan for follow-up*

Case 3: Sofia, a 42 year old woman, diagnosed with HIV infection 5 years ago is admitted with one month history of poor appetite, diarrhea and weight loss. She pleads with you 'Please help me gain some weight and get my energy back'.

Demonstrate how you would counsel her.
Important points to keep in mind when counseling:
- *Patient's history of treatment for her HIV*
- *History of adherence to care and treatment*
- *Patient's knowledge of the causes and treatment of G.I. infections*
- *Knowledge related to safe food and nutrition*
- *Food hygiene*
- *Foods that must be avoided*
- *How to prevent diarrhoea, and care at home when she has diarrhea*
- *When to come to the doctor*
- *Ability to access safe food and fluids*
- *Check for available resources, i.e. support person, financial status, nutrition support and availability of good nutrition sources as well as portable water*

Case 4 Sundari, a 28 year old woman, was recently diagnosed with HIV and is admitted to the hospital with advanced HIV and wasting syndrome. She is depressed and suicidal. She has disclosed her status only to her husband, and really does not know much about HIV disease. She is sure she is going to die.

Demonstrate how you would counsel her.
Important points to keep in mind when counseling:

- *Possibility of self harm*
- *Patient's need to express her fear, desperation and sense of loss*
- *Potential for recovery, in even severely immune-compromised patients*
- *Increase hope and optimism which can lead to more active involvement in care*
- *Establish a positive outlook, which can lead to improved immune response*
- *Extent of understanding and support from husband*
- *Need for intense and on-going counseling and education*
- *HIV disease progression, treatment options*
- *Appropriate coping and social skills training*
- *Refer for psychotherapy/pharmacological treatment for depression*
- *Encourage:*
    - *Balanced diet*
    - *Exercise*
    - *Traditional remedies*

Case 5: Ashish is a 22 year old driver who travels frequently. He is determined to be eligible for free ART. He comes to the ART center for counseling related to starting his medication.

Demonstrate how you would counsel him.
Important points to keep in mind when counseling:

- *Knowledge related to ARVs*
- *Particular regimen being prescribed*
- *Dosing*
    - *Side effects*
- *What to do if a dose is missed*
- *Possible barriers to adherence*
- *Unpredictable schedule and frequent travel*
- *Adherence readiness*
- *Need for further counseling*
- *Available resources*
- *Primary and other support persons, marital status*
- *Community, religious or other organizational support*
- *Financial status*
- *Disclosure status*
- *Transportation and ability for ongoing follow-up visits*
- *Importance of uninterrupted supply of medication*
- *Regular follow-up and monitoring*
- *Prevention of transmission or re-infection*
- *Understanding of HIV transmission, risk reduction, treatment options*
- *Attitudes regarding HIV care, including cultural impact*

3.2 (b): Counseling Assessment Checklist

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	
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	
Summarizing	
▪ Takes time to summarize information obtained from client	
▪ Checks with client to ensure understanding of important ▪ concerns and issues	

ANNEXURES:

The following seven STI Syndromic Flowcharts are from:

National AIDS Control Organisation, Maternal Health Division, Ministry of Health and Family Welfare, government of India. National Guidelines on Prevention, Management and Control of Reproductive Track Infections include Sexually Transmitted Infections. November 2006.

Annexure 3.1: STI Syndrome Flowchart – Management of Lower Abdominal Pain in Females:

Flowchart : Management of Lower abdominal pain in females

SYNDROME: LOWER ABDOMINAL PAIN

Pelvic inflammatory disease

Causative Organisms
- *Neisseria gonorrheae*
- *Chlamydia trachomatis*
- *Mycoplasma,Gardnerella,* Anaerobic bacteria (Bacteroides sp,gram positive cocci)

History
- Lower abdominal pain
- Fever
- Vaginal discharge
- Menstrual irregularities like heavy, irregular vaginal bleeding
- Dysmenorrhoea
- Dyspareunia
- Dysuria, tenesmus
- Low backache
- Contraceptive use like IUD

Examination
- General examination: temperature, pulse, blood pressure
- Per speculum examination: vaginal/cervical discharge, congestion or ulcers
- Per abdominal examination: lower abdominal tenderness or guarding
- Pelvic examination: Uterine/adnexal tenderness, cervical movement tenderness,

Note: A urine pregnancy test should be done in all women suspected of having PID to rule out ectopic pregnancy.

Laboratory Investigations
If available
- Wet smear examination
- Gram stain for gonorrhea
- Complet blood count and ESR
- Urine microscopy for pus cells

Differential diagnosis
- Ectopic pregnancy
- Twisted ovarian cyst
- Ovarian tumor
- Appendicitis
- Abdominal tuberculosis

Treatment (Out patient treatment)

In mild or moderate PID (in the absence of tubo ovarian abscess), outpatient treatment can be given.Therapy is required to cover *Neisseria gonorrheae, Chlamydia trachomatis* and anaerobes.
- Tab. Cefixim 400 mg orally BD for 7 days + Tab. Metronidazole 400mg orally, twice daily for 14 days
  +
- Doxycycline, 100mg orally, twice a day for 2 weeks (to treat chlamydial infection)
- Tab. Ibuprofen 400mg orally, three times a day for 3-5 days
- Tab. Ranitidine 150mg orally , twice daily to prevent gastritis
- Remove intra uterine device, if present, under antibiotic cover of 24-48 hours
- Advise abstinence during the course of treatment and educate on correct and consistent use of condoms
- Observe for 3 days. If no improvement (i.e. absence of fever, reduction in abdominal tenderness, reduction in cervical movement, adnexal and uterine tenderness) or if symptoms worsen, refer for inpatient treatment.

Caution: PID can be a serious condition. Refer the client to the hospital if she does not respond to treatment within 3 days and even earlier if her condition worsens.

Syndrome specific guidelines for partner management
- Treat all partners in past 2 months
- Treat male partners for urethral discharge (gonorrhea and chlamydia)
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Inform about the complications if left untreated and sequelae
- Schedule return visit after 3 days, 7 days and 14 days to ensure compliance

Management of Pregnant Women
Though PID is rare in pregnancy,
- Any pregnant woman suspected to have PID should be referred to district hospital for hospitalization and treated with a parenteral regimen which would be safe in pregnancy.
- Doxycycline is contraindicated in pregnancy.
- Note: Metronidazole is generally not recommended during the first three months of pregnancy. However, it should not be withheld for a severely acute PID, which represents an emergency.

Hospitalization of clients with acute PID should be seriously considered when:
- The diagnosis is uncertain
- Surgical emergencies e.g. appendicitis or ectopic pregnancy cannot be excluded
- A pelvic abscess is suspected
- Severe illness precludes management on an outpatient basis
- The woman is pregnant
- The client is unable to follow or tolerate an outpatient regimen
- The client has failed to respond to outpatient therapy

Note: All patients requiring hospitalization for inpatient treatment should be referred to the district hospital

Annexure 3.2: STI Syndromic Flowchart – Management of Inguinal Bubo

Flowchart : Management of inguinal bubo

SYNDROME: INGUINAL BUBO

RTIs/STIs: LGV, CHANCROID

Causative Organisms
- *Chlamydia trachomatis* serovars *L1, L2, L3*, causative agent of lympho granuloma venerum (LGV)
- *Haemophilus ducreyi* causative agent of chancroid

History
- Swelling in inguinal region which may be painful
- Preceding history of genital ulcer or discharge
- Sexual exposure of either partner including high risk practices like oro-genital sex etc
- Systemic symptoms like malaise, fever

Examination
Look for
- Localized enlargement of lymph nodes in groin which may be tender and fluctuant
- Inflammation of skin over the swelling
- Presence of multiple sinuses
- Edema of genitals and lower limbs
- Presence of genital ulcer or urethral discharge and if present refer to respective flowchart

Laboratory Investigations
Diagnosis is on clinical grounds

Differential diagnosis
- Mycobacterium tuberculosis, filariasis
- Any acute infection of skin of pubic area, genitals, buttocks, anus and lower limbs can also cause inguinal swelling

If malignancy or tuberculosis is suspected refer to higher centre

Treatment

Start Cap. Doxycycline 100mg orally (to cover LGV), twice daily for 21 days and refer to higher centre as early as possible.
+
Tab Azithromycin 1g orally single dose or
Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid

Note:
- *A bubo should never be incised and drained at the primary health centre, even if it is fluctuant, as there is a high risk of a fistula formation and chronicity. If bubo becomes fluctuant always refer for aspiration to higher centre.*
- *In severe cases with vulval edema in females, surgical intervention in the form of vulvectomy may be required for which they should be referred to higher centre.*

Syndrome specific guidelines for partner management
- Treat all partners in last 3 months
- Partners should be treated for chancroid and lymphogranuloma venerum
- Tab Azithromycin 1g orally single dose to cover chancroid
  +
  Cap Doxycycline 100mg orally, twice daily for 21 days to cover LGV
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate on correct and consistent use
- Refer for voluntary counseling and testing for HIV, syphilis and Hepatitis B
- Schedule return visit after 7 days

Management of pregnant partner
- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant and lactating women should be treated with the erythromycin regimen, and consideration should be given to the addition of a parenteral amino glycoside (e.g., gentamicin)

Tab. Erythromycin base, 500mg orally, 4 times daily for 21 days and refer to higher centre.

(Erythromycin estolate is contraindicated in pregnancy due to hepatotoxicity. Erythromycin base or erythromycin ethyl succinate should be given)

Annexure 3.3: STI Syndromic Flowchart – Management of Painful Scrotal Swelling

Flowchart: Management of Scrotal Swelling

SYNDROME: SCROTAL SWELLING

RTIs/STIs : GONORRHEA, CHLAMYDIAL

Causative Organisms
- *Neisseria gonorrhoeae*
- *Chlamydia trachomatis*

History of
- Swelling and pain in scrotal region
- Pain or burning while passing urine
- Systemic symptoms like malaise, fever
- Sexual exposure including high risk practices like oro-genital sex

Examination
Look for
- Scrotal swelling
- Tenderness of the epididymis and vas deferens
- Redness and edema of the overlying skin
- Associated urethral discharge/genital ulcer/inguinal lymph nodes and if present refer to the respective flowchart
- A transillumination test to rule out hydrocoele should be done.

Laboratory Investigations
(If available)
- Gram stain examination of the urethral smear will show gram-negative intracellular diplococci in case of complicated gonococcal infection
- In non-gonococcal urethritis more than 5 neutrophils per oil immersion field in the urethral smear or more than 10 neutrophils per high power field in the sediment of the first void urine are observed

Differential diagnosis (non RTIs/STIs)
Infections causing scrotal swelling:
Tuberculosis, filariasis, coliforms, pseudomonas, mumps virus infection.

Non infectious causes:
Trauma, Hernia, Hydrocoele, Testicular torsion, and Testicular tumors

Treatment
- Treat for both gonococcal and chlamydial infections
  Tab Cefixim 400 mg orally BD for 7 days Plus
  Cap. Doxycycline 100mg orally, twice daily for 14 days and refer to higher centre as early as possible since complicated gonococcal infection needs parental and longer duration of treatment
- Supportive therapy to reduce pain (bed rest, scrotal elevation with T-bandage and analgesics)

Note
If quick and effective therapy is not given, damage and scarring of testicular tissues may result causing sub fertility

Syndrome specific guidelines for partner management
Partner needs to be treated depending on the clinical findings

Management protocol in case the partner is pregnant
- Depending on the clinical findings in the pregnant partner (whether vaginal discharge or endocervical discharge or PID is present) the drug regimens should be used.
- Doxycycline is contraindicated in pregnancy
- Erythromycin base/Amoxicillin can be used in pregnancy.

Annexure 3.4: STI Syndromic Flowchart – Management of Genital Ulcers

SYNDROME: GENITAL ULCERS

RTIs/STIs: SYPHILIS | CHANCROID | GENITAL HERPES

Causative Organisms

- *Treponema pallidum* (syphilis)
- *Haemophilus ducreyi* (chancroid)
- *Klebsiella granulomatis* (granuloma inguinale)
- *Chlamydia trachomatis* (lymphogranuloma venerum)
- *Herpes simplex* (genital herpes)

History

- Genital ulcer/vesicles
- Burning sensation in the genital region
- Sexual exposure of either partner including high risk practices like oro-genital sex

Examination

- Presence of vesicles
- Presence of genital ulcer- single or multiple
- Associated inguinal lymph node swelling and if present refer to respective flowchart

Ulcer characteristics:

- Painful vesicles/ulcers, single or multiple - Herpes simplex
- Painless ulcer with shotty lymph node - Syphilis
- Painless ulcer with inguinal lymph nodes - Granuloma inguinale and LGV
- Painful ulcer usually single sometimes associated with painful bubo - Chancroid

Laboratory Investigations

RPR test for syphilis

For further investigations refer to higher centre

Treatment

- If vesicles or multiple painful ulcers are present treat for herpes with Tab. Acyclovir 400mg orally, three times a day for 7 days
- If vesicles are not seen and only ulcer is seen, treat for syphilis and chancroid and counsel on herpes genitalis

To cover syphilis

Inj Benzathine penicillin 2.4 million IU IM after test dose in two divided doses(with emergency tray ready)

(In individuals allergic or intolerant to penicillin, Doxycycline 100mg orally, twice daily for 14 days)

+

Tab Azithromycin 1g orally single dose or

Tab. Ciprofloxacin 500mg orally, twice a day for three days to cover chancroid

Treatment should be extended beyond 7 days if ulcers have not epithelialized i.e. formed a new layer of skin over the sore)

Refer to higher centre

- If not responding to treatment
- Genital ulcers co-existent with HIV
- Recurrent lesions

Syndrome specific guidelines for partner management

- Treat all partners in last 3 months
- Partners should be treated for syphilis and chancroid
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Schedule return visit after 7 days

Management of Pregnant Women

- Quinolones (like ofloxacin, ciprofloxacin), doxycycline, sulfonamides are contraindicated in pregnant women.
- Pregnant women who test positive for RPR should be considered infected unless adequate treatment is documented in the medical records and sequential serologic antibody titers have declined.

  Inj Benzathine penicillin 2.4 million IU IM after test dose (with emergency tray ready)
- **A second dose of benzathine penicillin 2.4 million units IM should be administered 1 week after the initial dose for women who have primary, secondary, or early latent syphilis.**
- **Pregnant women who are allergic to penicillin should be treated with erythromycin and the neonate should be treated for syphilis after delivery.**
- **Tab. Erythromycin 500mg orally four times a day for 15 days**

  (Note: Erythromycin estolate is contraindicated in pregnancy because of drug related hepatotoxicity. Only Erythromycin base or erythromycin ethyl succinate should be used in pregnancy)
- All pregnant women should be asked history of genital herpes and examined carefully for herpetic lesions.
- Women without symptoms or signs of genital herpes or its prodrome can deliver vaginally.
- Women with genital herpetic lesions at the onset of labour should be delivered by caesarean section to prevent neonatal herpes.
- Acyclovir may be administered orally to pregnant women with first episode genital herpes or severe recurrent herpes.

Annexure 3.5: STI Syndromic Flowchart – Management of Urethral Discharge in Males

SYNDROME: URETHRAL DISCHARGE IN MALES

RTIs/STIs: GONORRHEA, CHLAMYDIAL INFECTION, TRICHOMONIASIS

Causative Organisms
- *Neisseria gonorrhoeae*
- *Chlamydia trachomatis*
- *Trichomonas vaginalis*

History of
- Urethral discharge
- Pain or burning while passing urine, increased frequency of urination
- Sexual exposure of either partner including high risk practices like oro-genital sex

Examination
Look for
- The urethral meatus for redness and swelling
- If urethral discharge is not seen, then gently massage the urethra from the ventral part of the penis towards the meatus and look for thick, creamy greenish-yellow or mucoid discharge

Laboratory Investigations (if available)
- Gram stain examination of the urethral smear will show gram-negative intracellular diplococci in case of gonorrhea,
- In non-gonococcal urethritis more than 5 neutrophils per oil immersion field (1000X) in the urethral smear or more than 10 neutrophils per high power field in the sediment of the first void urine are observed

Treatment

As dual infection is common, the treatment for urethral discharge should adequately cover therapy for both, gonorrhea and chlamydial infections.

Recommended regimen for uncomplicated gonorrhea + chlamydia

Uncomplicated infections indicate that the disease is limited to the anogenital region (anterior urethritis and proctitis) and not complicated.
- Tab. Cefixim 400 mg orally orally, single dose under supervision Plus
  Tab Azithromycin 1 gram orally
- Advise the client to return after 7 days of start of therapy

When symptoms persist or recur after adequate treatment for gonorrhea and chlamydia in the index client and partner(s), they should be treated for *T. vaginalis*.

If discharge or only dysuria persists after 7 days
- Tab. Secnidazole 2gm orally, single dose (to treat for *T. vaginalis*)

If the symptoms still persists
- Refer to higher centre as early as possible

If individuals are allergic to Azithromycin , give Erytromycin 500 mg four times a day for 7 days

Syndrome specific guidelines for partner management
- Treat all recent partners
- Treat female partners (for gonorrhea and chlamydia) on same lines after ruling out pregnancy and history of allergies
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Refer for voluntary counseling and testing for HIV, Syphilis and Hepatitis B
- Schedule return visit after 7 days

Management of pregnant partner

Pregnant partners of male clients with urethral discharge should be examined by doing a per speculum as well as per vaginal examination and should be treated for gonococcal as well as chlamydial infections.
- Cephalosporins to cover gonococcal infection are safe and effective in pregnancy
  - Tab. Cefixime 400mg orally, single dose or
  - Ceftriaxone 125mg by intramuscular injection
    +
  - Tab. Erythromycin 500mg orally four times a day for seven days or
  - Cap Amoxicillin 500mg orally, three times a day for seven days
    to cover chlamydial infection
- Quinolones (like ofloxacin, ciprofloxacin), doxycycline are contraindicated in pregnant women.

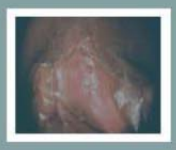
Follow up

After seven days
- To see reports of tests done for HIV, syphilis and Hepatitis B
- If symptoms persist, to assess whether it is due to treatment failure or re-infection
- For prompt referral if required

Annexure 3.6: STI Syndromic Flowchart – Management of Vaginal Discharge in Females

Flowchart : Management of vaginal discharge in females

SYNDROME: VAGINAL DISCHARGE



VAGINITIS

TRICHOMONIASIS

CERVICAL HERPES

CERVICITIS

Causative Organisms
Vaginitis
- *Trichomonas vaginalis* (TV)
- *Candida albicans*
- *Gardnerella vaginalis, Mycoplasma* causing bacterial vaginosis (BV)

Causative Organisms
Cervicitis
- *Neisseria Gonorrheae*
- *Chlamydia trachomatis*
- *Trichomonas vaginalis*
- *Herpes simplex virus*

History
- Menstrual history to rule out pregnancy
- Nature and type of discharge (amount, smell, color, consistency)
- Genital itching
- Burning while passing urine, increased frequency
- Presence of any ulcer, swelling on the vulval or inguinal region
- Genital complaints in sexual partners
- Low backache

Examination
- Per speculum examination to differentiate between vaginitis and cervicits.
  a) Vaginitis:
  Trichomoniasis - greenish frothy discharge
  Candidiasis - curdy white discharge
  Bacterial vaginosis – adherent discharge
  Mixed infections may present with atypical discharge
  b) Cervicitis:
  Cervical erosion /cervical ulcer/ mucopurulent cervical discharge
- Bimanual pelvic examination to rule out pelvic inflammatory disease
- If Speculum examination is not possible or client is hesitant treat both for vaginitis and cervicitis

Laboratory Investigations
(if available)
- Wet mount microscopy of the discharge for Trichomonas vaginalis and clue cells
- 10% KOH preparation for Candida albicans
- Gram stain of vaginal smear for clue cells seen in bacterial vaginosis
- Gram stain of endocervical smear to detect gonococci

Treatment
Vaginitis (TV+BV+Candida)
- Tab. Secnidazole 2gm orally, single dose or
  Tab. Tinidazole 500mg orally, twice daily for 5 days
- Tab. Metoclopropramide taken 30 minutes before Tab. Secnidazole, to prevent gastric intolerance
- Treat for candidiasis with Tab Fluconazole 150mg orally single dose or local Clotrimazole 500mg vaginal pessaries once

Treatment for cervical infection (chlamydia and gonorrhea)
- Tab cefixim 400 mg orally, single dose
- Plus Azithromnycin 1 gram, 1 hour before lunch. If vomiting within 1 hour, give anti-emetic and repeat

  - If vaginitis and cervicitis are present treat for both
  - Instruct client to avoid douching
  - Pregnancy, diabetes, HIV may also be influencing factors and should be considered in recurrent infections
  - Follow-up after one week

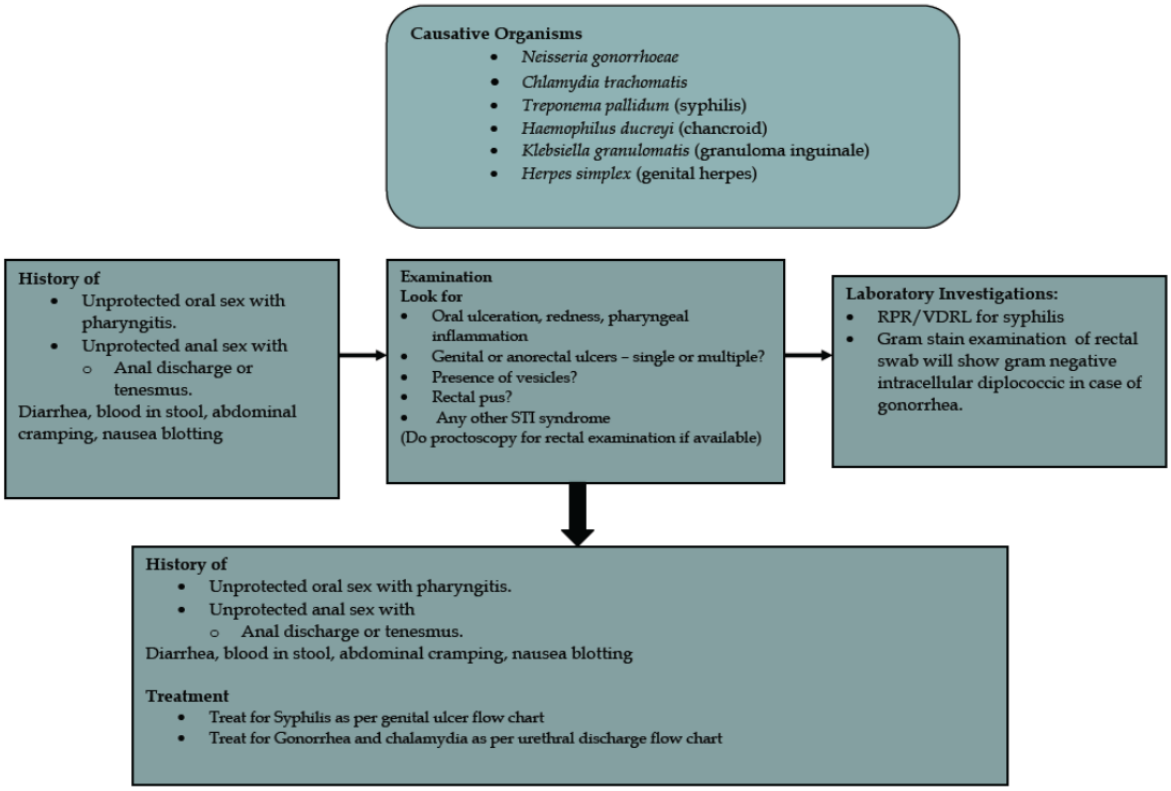
Management in pregnant women
Per speculum examination should be done to rule out pregnancy complications like abortion, premature rupture of membranes
Treatment for vaginitis (TV+BV+Candida)
In first trimester of pregnancy
- Local treatment with Clotrimazole vaginal pessary/cream only for candidiasis. Oral Flucanozole is contraindicated in pregnancy.
- Metronidazole pessaries or cream intravaginally if trichomoniasis or BV is suspected.

In second and third trimester oral metronidazole can be given
- Tab. Secnidazole 2gm orally, single dose or
  Tab. Tinidazole 500mg orally, twice daily for 5 days
- Tab. Metoclopropramide taken 30 minutes before Tab. Metronidazole, to prevent gastric intolerance

Specific guidelines for partner management
- Treat current partner only if no improvement after initial treatment
- If partner is symptomatic, treat client and partner using above protocols
- Advise sexual abstinence during the course of treatment
- Provide condoms, educate about correct and consistent use
- Schedule return visit after 7 days

Annexure 3.7: STI Syndromic Flowchart – Management of Oral & Anal STIs

Flowchart: Management of Oral & Anal STIs



Annexure 3.8 :Management of Anogenital warts, Molluscum contagiosum and Ectoparasitic infection

Perivulval warts

Penile warts

Perianal warts

Causative Organism: Virus: Human Papilloma Virus (HPV)

Clinical features: Single or multiple soft, painless, pink in color, “cauliflower” like growths which appear around the anus, vulvo-vaginal area, penis, urethra and perineum. Warts could appear in other forms such as papules which may be keratinized.

Diagnosis: Presumptive diagnosis by history of exposure followed by signs and symptoms.

Differential diagnosis

i. Condyloma lata of syphilis
ii. Molluscum contagiousm

Treatment

Recommended regimens:

Penile and Perianal warts

- 20% Podophyllin in compound tincture of benzoin applied to the warts, while carefully protecting the surrounding area with Vaseline, to be washed off after 3 hours. It should not be used on extensive areas per session.
- Treatment should be repeated weekly till the lesions resolve completely.

Note: Podophyllin is contra-indicated in pregnancy. Treatment should be given under medical supervision. Clients should be warned against self-medication.

Cervical warts

- Podophyllin is contra-indicated.
- Biopsy of warts to rule out malignant change.
- Cryo cauterization is the treatment of choice.
- Cervical cytology should be periodically done in the sexual partner(s) of men with genital warts.

Molluscum contagiosum

Causative Organism: Pox virus

Clinical features: Multiple, smooth, glistening, globular papules of varying size from a pinhead to a split pea can appear anywhere on the body. Sexually transmitted lesions on or around genitals can be seen. The lesions are not painful except when secondary infection sets in. When the lesions are squeezed, a cheesy material comes out.

Diagnosis: Diagnosis is based on the above clinical features.

Treatment:

- Individual lesions usually regress without treatment in 9-12 months.
- Each lesion should be thoroughly opened with a fine needle or scalpel. The contents should be exposed and the inner wall touched with 25% phenol solution or 30% trichloracetic acid.

Pediculosis pubis

Causative Organism: Lice - Phthirus pubis

Clinical features: There may be small red papules with a tiny central clot caused by lice irritation.

General or local urticaria with skin thickening may or may not be present. Eczema and Impetigo may be present.

Treatment

Recommended regimen:

- Permethrin 1% creme rinse applied to affected areas & washed off after 10 min.

Special instructions

Retreatment is indicated after 7 days if lice are found or eggs observed at the hair-skin junction.

Clothing or bed linen that may have been contaminated by the client should be washed and well dried or dry cleaned.

Sexual partner must also be treated along the same lines.

Scabies

Causative Organism: Mite - Sarcoptes Scabiei

Clinical Features: Severe pruritis (itching), which becomes worse at night. Other members of family also affected (apart from sexual transmission to the partner, other members may get infected through contact with infected clothes, linen or towels).

Complications:

- Eczematization with or without secondary infection
- Urticaria
- Glomerulonephritis
- Contact dermatitis to antiscabetic drug

Diagnosis: The burrow is the diagnostic sign. It can be seen as a slightly elevated grayish dotted line in the skin, best seen in the soft part of the skin.

Treatment

Recommended regimens:

- Permethrin cream (5%) applied to all areas of the body from the neck down and washed off after 8--14 hours.
- Benzyl benzoate 25% lotion, to be applied all over the body, below the neck, after a bath, for two consecutive nights. Client should bathe in the morning, and have a change of clothing. Bed linen is to be disinfected.

Special instructions

- Clothing or bed linen that may have been contaminated by the client should be washed and well dried or dry cleaned.
- Sexual partner must also be treated along the same lines.

Source: NACO, Ministry of Health and Family Welfare. Government of India. National Guidelines on Prevention, Management and Control of Reproductive Tract Infections including Sexually Transmitted Infections. November 2006

Annexure 3.9: Personal Protective Equipment (PPE)

PPE	When to wear	Points to keep in mind
Gloves	**Wear sterile gloves when** Handling sterile supplies Doing invasive procedures **Wear clean gloves when** Handing blood or body fluids. **Wear utility gloves when** cleaning or managing waste	**Wearing clean or sterile gloves** ▪ Wash hands. ▪ Slip each hand into glove, pulling it snugly over the fingers to ensure a good fit. ▪ Pull glove over the wrist as far as it will go to maximize coverage. ▪ Grasp the glove by the other gloved hand and remove first glove by turning the glove inside out as it is pulled over the hand. (This will keep the contaminated areas away from your skin). ▪ During removal of the second glove, avoid touching the outer surface by slipping the fingers of the ungloved hand under the glove and pulling it inside out as it is pulled over the hand, effectively sealing the first glove inside. ▪ Dispose of the used gloves in a lined waste container or disinfect as per standard protocol ▪ Sterilise gloves before re-use for invasive procedures. **Utility gloves** ▪ Do not use them to touch patients, patient care items, or anything near patients. ▪ Use the same utility gloves for the same tasks ▪ Use separate gloves for dirty and clean tasks. ▪ Wash with detergent and bleach and leave to dry at the end of the shift.
Eye Wear (goggles, visor, face shield)	Wear eye wear when it is anticipated that infectious body fluids may splash and come in contact with the eye	The eyewear surrounds the rim of the whole eyes without any gap. ▪ Disinfect if there is a splash of potentially infectious fluid on it ▪ Wash thoroughly before reuse. ▪ If eyewear is not available make use of the face shield /visor. It costs approximately Rs. 100-150 and can be easily disinfected.
Gowns and Aprons	Protect skin when risk of splashing or spraying of blood or body fluid contact is expected using impervious/ plastic gowns. Prevent soiling of clothing during procedures that may involve contact with blood or body fluids.	Gowns need to be thick enough so that blood will not soak through easily ▪ Cotton gowns are inappropriate as the cloth absorbs dirt very easily and needs to be disinfected and cleaned daily ▪ Aprons need to be water resistant preferably made of plastic. ▪ Wash hands after removal of gowns/aprons ▪ Disinfect as per standard protocol o Soak in bleaching solution (1%) for 20 minutes, then wash and sun dry ▪ OT and labour room gowns would need to be sterilized
Masks (cloth and paper)	Protect mouth and nose from potential splashes of infectious fluid Use when handling patients with respiratory infections	Cover both the nose and the mouth during procedures and patient-care activities ▪ While wearing a mask, make sure it is: ▪ Fit properly over the nose, mouth, lower face, and below the jaw line in a tight enough fit (face seal) to

	Doing any invasive procedures Conducting delivery	prevent air leakage around the edges. ▪ Changed for each procedure. ▪ Replaced if wet or contaminated. ▪ Not worn under the chin or dangling around the neck after use. ▪ When removing, hold masks by the strings/ties as the center of the mask is most contaminated ▪ Dispose immediately after use. ▪ Wash hands after disposing the mask
Caps	Used to keep the hair and scalp covered so that flakes of skin and hair are not shed into the wound during surgery	Should be large enough to cover all hair
Footwear	Worn during procedures and patient-care activities when large-particle droplet spatter or sprays of blood or body fluids is anticipated	Slippers are not sufficient protection ▪ If foot wear does not completely cover the foot then put a plastic cover over it and secure this with a rubber band ▪ Footwear should be fluid proof ▪ They should be washable and easily disinfected (Plastic or sandak)

Using Appropriate PPE during Common Nursing Procedures

Type of exposure	Examples of common nursing Procedures	Protection required
Low risk (Chance of direct contact with infectious body fluids is minimal)	Bed making, Back care, Sponge bath, Mouth care, Minor wound dressing, Perineal care, Injections, Lumbar puncture, Taking temperature, BP	Gloves helpful but not Necessary
Medium risk (Chance of direct contact with infectious body fluid is moderate i.e. probable contact with blood, splash unlikely)	Insertion and removal of IV needles, PV examination, Dressing large wounds, Handling blood spills or specimens, Intubation, Suctioning, Collecting blood	Use gloves with waterproof aprons, For intubation wear gloves, mask, goggles and apron
High risk (Chance of direct contact as well as splash of infectious body fluid is high, uncontrolled bleeding)	Vaginal delivery, Uncontrolled bleeding, Surgery, Endoscopy, Dental procedures	ALL PPE Surgical gloves, Apron, Masks, Protective eyewear, Foot wear

Dos and Don’ts for Use of PPE

Do	Don’ts
Use PPE based on risk of procedure Change PPE completely after each procedure Discard the used PPE in appropriate disposal bags Dispose PPE as per the policy of the hospital Always wash hands after removing PPE Educate and train all junior and auxiliary staff in the use of PPE	Share PPE Use same gloves between patients Reuse disposable gloves, eyewear, masks Use eye wear that restricts your vision Use masks when wet

Annexure 3.10: Guidelines for Disinfection and Sterilization

Do	Do Not
Remove gloves, if appropriate	**Do not** panic
Wash the exposed site thoroughly with running water	**Do not** put pricked finger in mouth
Irrigate with water or saline if exposure sites are eyes or mouth	**Do not** squeeze wound to bleed it
Wash skin with soap and water	**Do not** use bleach, chlorine, alcohol, betadine, iodine or other antiseptics/detergents on the wound

Step 1: Management of Exposure Site – First Aid

For skin – if the skin is broken after a needle-stick or sharp instrument:

- Immediately wash the wound and surrounding skin with water and soap, and rinse. Do not scrub.
- Do not use antiseptics or skin washes (bleach, chlorine, alcohol, betadine) After a splash of blood or body fluids
- To unbroken skin:
  - Wash the area immediately
  - Do not use antiseptics
- For the eye :
  - Irrigate exposed eye immediately with water or normal saline
  - Sit in a chair, tilt head back and ask a colleague to gently pour water or normal saline over the eye.
  - If wearing contact lens, leave them in place while irrigating, as they form a barrier over the eye and will help protect it. Once the eye is cleaned, remove the contact lens and clean them in the normal manner. This will make them safe to wear again
  - Do not use soap or disinfectant on the eye.
- For mouth:
  - Spit fluid out immediately
  - Rinse the mouth thoroughly, using water or saline and spit again. Repeat this process several times
  - Do not use soap or disinfectant in the mouth

PEP must be initiated as soon as possible, preferably within 2 hours

Consult the designated physician of the institution for management of the exposure immediately.

Annexure 3.11: Factors Increasing the Risk of MTC HIV Transmission

Maternal Factors	**Obstetrical Factors**	**Infant Factors**	**Infant Feeding Factors**
High viral load Recent infection Advanced disease	Rupture of membranes >4 Hours	Prematurity	Breast feeding
Poor Nutrition	Invasive procedures on uterus during pregnancy	First infant of multiple birth	Mixed feeding
Concurrent STIs/OIs	Invasive foetal monitoring Artificial rupture of Membranes	Immature GI Tract	Maternal breast pathologies (mastitis)
Placental infection (esp. malaria)	Intrapartum haemorrhage	Low birth weight	Longer duration of breast feeding
Drug use	Instrument delivery Episiotomy Vaginal vs. C-section	Altered skin Integrity	Maternal HIV infection during lactation Poor maternal Nutrition

Annexure 3.12: Nurse's Role during Pregnancy, Labour, Delivery, and Postnatal period in the care of HIV positive women

1. Pregnancy in HIV Positive Women

Educate the woman on the importance of:

Testing for HIV
Antenatal visits
Diet + Vitamin & Iron supplements
Avoiding invasive procedures
Practicing safer sex
Treating ANY infection/STI/RTI
Importance of hospital delivery: indications for vaginal versus caesarean section
Continuing to monitor the progress of her HIV: CD4 counts/presence of OIs

2. Labour and Delivery in HIV Positive Women

Regular obstetrical assessment – attendance to ANC

- Assess whether tested for HIV
  - If not, offer pre-test counseling and testing during labour
- If known HIV+, check whether she has
  - Already been put on ART
  - Already taken the single dose NVP (PPTCT programme)
- Disclosure
  - To women if HIV + status just diagnosed
  - To delivery team
  - To spouse and other family members
- Assure confidentiality
- Emotional support
- Nevirapine
- Mode of delivery
  - Vaginal delivery in the hospital
  - Caesarean section indicated only electively before labour begins when viral load high or as an emergency for obstetrical causes/foetal distress

Do's and Don'ts during Labour and Delivery in HIV+ Pregnant Women

Do	Don't
For mother during labour ▪ Give NVP 200 mg 4 hours before onset of labour ▪ Perform vaginal cleansing with 0.25% Chlorhexidine ▪ Take measures to prevent episiotomy **For newborn care** ▪ Cut cord under cover of light gauze with a fresh blade ▪ Clean baby thoroughly of secretions ▪ Determine mother's feeding choice before latching to breast ▪ Give single dose NVP 2mg/kg for the baby	**For mother during labour** ▪ Isolate ▪ Shave pubic area ▪ Give an enema ▪ Perform frequent PV exams ▪ Rupture membranes ▪ Use instrumental deliveries unless absolutely necessary **For newborn care** ▪ Use mouth-operated suction ▪ Suction newborn with nasogastric tube unless meconium-stained

Infection control precautions at the time of labour and delivery in an HIV+ woman

- Use appropriate personal protective equipment
- When cutting the cord, minimize splash of blood and fluids by using clamps and gauze

- Handle the baby with gloves until bathed
- When providing regular umbilical cord care, use gloves
- If assisting to express breast feeds, stand on the same side as mother, use gloves
- Soak all used linen in bleach solution for 2 hours

If these precautions are taken, there is no need to be fearful of conducting or assisting in a normal delivery for HIV positive women!

3. During Breast Feeding and Postnatal Period in HIV Positive Women

Feeding options should continue to depend on the mother's individual circumstances including her health status and the local situation, but should take greater consideration of the health services available and the counseling and support she is likely to receive.

Educate mother on:

- Feeding options
  - Exclusive breast feeding for 6 months OR
  - At 6 months if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breast feeding with additional complementary foods is recommended while the mother and baby continue to be regularly assessed OR
  - Replacement feeding if affordable, safe, sustainable, feasible, and acceptable right from birth
- Safe breast feeding practices
  - Good hygiene
  - Good position
  - Give colostrum
  - Duration-shorter the better
- **Never to mix feeds (never give breast milk along with other feeds such as cows milk or formula)**
  - Option of expressing breast feed compared to direct feed
- How to stop breast feeding abruptly

Follow up care of mother:

- Inform about
  - Routine postnatal care of mother
  - Evaluation to decide eligibility for ART
  - Need to report any signs of infections - chest, urinary, puerperal, episiotomy or breast infections
- Assess risk factors for reinfection

Reinforce safer sex

- Discuss family planning BEFORE discharge
- Review birth control and infection control
  - Dual protection to prevent and reduce further HIV infection, STIs, and pregnancy
  - Data suggests hormonal contraception is less effective with ARVs
  - Access to emergency contraception

Follow up care of baby born to HIV positive women:

- DNA PCR HIV testing for infants at 6 weeks and 6 months (where available)
- Routine well baby visits
- Follow standard immunization schedule with the following notes:
  - BCG should not be given in symptomatic HIV-infected children

    - HiB vaccine should be given to all who are confirmed HIV-infected on the basis of 2 positive DNA PCR tests done at 6 weeks of age
- Need for immediate medical attention if signs and symptoms of any infection present
- Cotrimoxazole prophylaxis
    - All HIV exposed infants start at 4-6 weeks of age till detected as HIV negative
    - Recommended dose is 5 mg/kg/day as a single dose
- HIV antibody testing at 12 and 18 month visit

Annexure 3.13: Key Elements of Effective Counseling

In order to be effective counselors, we need to put into practice effective communication. As HIV infection has many implications on the physical, emotional, social, and spiritual well-being of a person, this communication needs to occur within a supportive environment. The components of effective communication and a supportive environment are listed below in the table.

Effective communication	**Supportive environment**
Message ▪ Be positive, focused ▪ Make the listener comfortable ▪ Ask for a feedback ▪ Emphasis important points Listening / Non-verbal communication ▪ Maintain eye contact and smile ▪ Lean toward the person, say "yes" "hmm" and "OK" ▪ Do not hesitate to touch the person when needed Tone ▪ Use a tone of voice that encourages communication ▪ Utilize praise and encouragement more Questioning technique ▪ Use open ended questions and state them clearly ▪ Wait for answers rather than speaking immediately ▪ Repeat questions when not understood	Timing ▪ Be sure patient is ready for the information and counseling ▪ Schedule at a convenient time for the patient Place: Ensure privacy and comfort Acknowledge the feelings of the patient. ▪ Assess the main concerns of the patient ▪ Address concerns based on the patient's priorities Begin with less intimidating/less sensitive issues ▪ Start with topics that the patient is comfortable discussing, i.e. his/her work rather than the sexual history

Using positive messages while communicating with PLHAs is more effective than using negative messages. When giving messages, always try and frame them so that they are positive rather than negative.

Examples of Positive and Negative Messages

Positive Messages	**Negative Messages**
Using condoms will help you be free of STIs.	Not using condoms could put you at risk of getting STIs.
Safer sex practices will help protect yourself as well as protect others.	If you do not practice safe sex, you could get an STI and you could transmit HIV to others.
Taking your ART exactly as prescribed every day will prevent you from developing resistance to the medications and keep you healthy for a longer period of time.	If you do not take your ART exactly as prescribed every day, you will get resistance to HIV, and the medications will not work for you.

Annexure 3.14: Avoiding Counseling Mistakes

Counseling is not an easy task, and skills will improve with practice. Use the tips below to help avoid simple counseling mistakes.

Do	**Don't**
Encourage spontaneous expression of feelings and needs	Control
Be neutral to allow patients to express concerns	Judge
Ask patients what they think they can change/do better next Time	Moralize
Find out the person's fears, anxieties	Label
Tell the facts gently to the patient	Give false reassurance
Help patient identify options Guide patients in making decisions	Advise
Ask open ended, non-accusatory questions	Interrogate
Help patients identify their own strengths Acknowledge resources of the patient	Encourage dependence
Encourage patient to list concerns Guide patient to prioritize concerns Provide factual information to the patient Help patient identify steps of action for identified concerns	Cajole (trying to persuade the patient to accept new behavior by flattery or lies)

SECTION IV

INTRODUCTION TO PERFORMANCE STANDARDS

Exercise 4.1 : The Land scape

Objective
To stimulate participants to think about daily changes and the barriers and facilitating factors in the change management process.

Materials

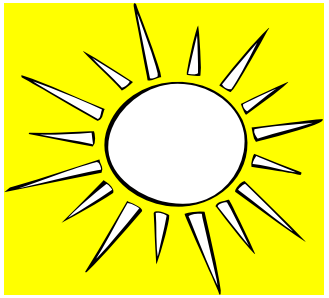
Landscape drawing (see page 1-18) on a flipchart, transparency or presentation graphic

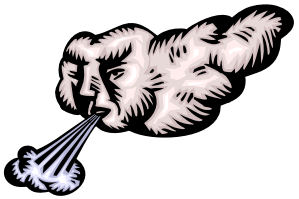
Instructions for the Facilitator
Use this exercise to introduce the concept of a change management process before the participants work on finishing their operational action plans. Using the sample landscape drawing provided, prepare in advance a flipchart page that contains the same elements; put the sample on a transparency or use the presentation graphic available on the CD-ROM. Have the drawing "hidden" (or covered) until the exercise begins.

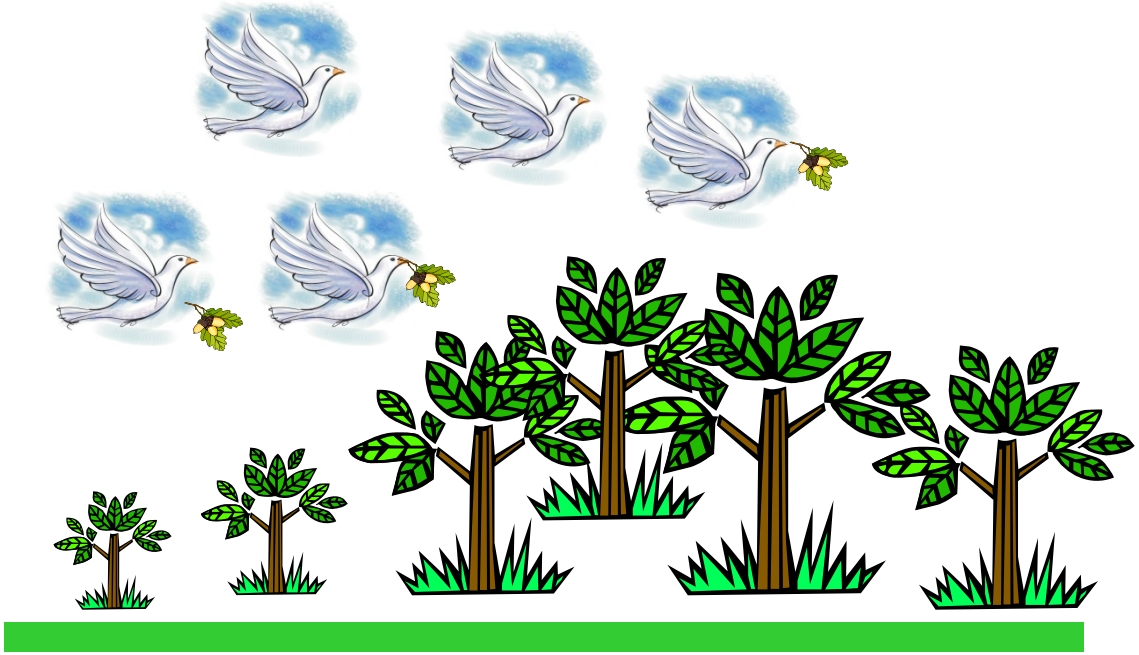
Procedure
1. Show the drawing and ask the participants what they see in the drawing.
2. Allow time for the participants to look at the landscape and start telling what they see. They will probably say things like "it is a landscape" or "there are trees (birds, clouds, sun)" until they have described all the elements in the drawing.
3. Next, ask them what they think this landscape represents. They will probably give responses such as "nature cycle" or "there are areas where trees are growing better than the others." Keep probing for additional ideas about the elements they describe.
4. Then discuss the drawing and make a comparison between changes in nature and the changes that they will need to implement in their facilities when they return.

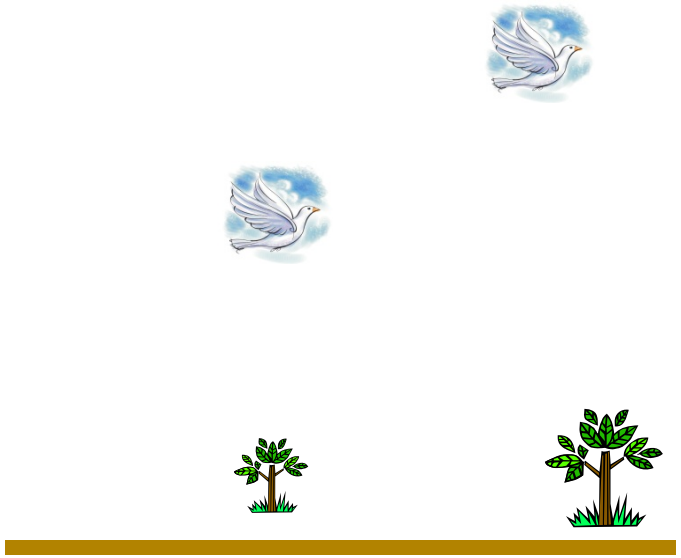
Discussion Questions
1. How easy is it to make changes? How easy is it to change what we have been doing for years, and to replace old habits with new practices?
2. What are the obstacles to making changes? Can we anticipate some of them and strategize ways to overcome them? Are there obstacles that we cannot anticipate?
3. What are the factors that will help you in implementing new changes in infection prevention?
4. What are possible barriers to implementing changes in infection prevention practices?

Summarize the Main Points
It is important to keep in mind that changes occur every day in life and in nature. There are factors that facilitate change, such as team building and teamwork, knowledge and skills, leadership, standards and goals. There are also factors that make change difficult, such as people who are not trained, do not understand why changes are needed or do not feel they have a role in the process. Change is also difficult when the changes are not explained or when they are made by a few individuals rather than by a team. It is important to try to anticipate obstacles, have a clear goal, work in teams and be persistent. When we make small changes and see results, it creates momentum for other changes.









ANNEXURES

Annexure 1: Guidelines for supervising clinical practice

INTRODUCTION
Clinical practice with patients/clients is a critical component of training, during which learners must be adequately supervised by teachers or clinical preceptors who have been specifically trained for this purpose.

Adequate supervision means that teachers or clinical preceptors should be assigned a small group of learners (preferably not more than four to six learners per teacher and/or clinical preceptor) for whom they will be responsible during each visit to a clinical training site. This means that, while at the clinical training site, the teacher and/or clinical preceptor must not leave the learners unsupervised.

Teachers or clinical preceptors will spend time with learners at clinical training sites to guide and support the application of knowledge and development of skills. This will involve demonstrating particular skills with clients/patients, supervising learners to perform these skills and assessing competency using the relevant **skills checklists**.

When in the clinical area, teachers or clinical preceptors will also guide learners to:
- Be accountable for their actions.
- Recognize and respect the privacy and dignity of the women for whom they provide care.
- Use appropriate interpersonal communication skills when providing care.
- Apply recommended infection prevention practices.

To help ensure that learners gain as much as possible during their time at clinical training sites, it is suggested that the following structure be followed

PRE AND POST CLINICAL PRACTICE MEETINGS
The teacher or clinical preceptor should meet with her group of learners at the beginning of each clinical practice session to:

- Review each learner's Clinical Experience Log Book (Record of Skills) to identify individual learning needs.

- Determine which ward or area of the hospital/clinic the learners will be assigned. If, for example, all learners in the group require experience in a particular skill (e.g. use of the partograph) they should be assigned to the labor ward. Otherwise, learners should be assigned to a ward or area based on individual learning needs; for example, learners who require experience in managing pre-eclampsia/eclampsia should be assigned to care for women with this condition, and those requiring experience in postpartum examination and care to the postpartum ward. When learners from one group are assigned to different wards, the teacher and/or clinical preceptor must divide her time appropriately between them to ensure that they are adequately supervised.

The teacher or clinical preceptor should also meet with her group of learners at the end of the clinical practice session. At least half an hour should be allowed for these meetings, the purpose of which should be to:

- Discuss clients/patients for whom learners have provided care, with emphasis on, when possible, the management of complications, including presenting symptom(s), assessment, diagnosis, treatment, and outcome;
- Discuss factors that facilitated clinical practice and factors that made it difficult, including how to overcome difficulties;

- Discuss other issues, as identified by both teacher and learners; and Have learners present weekly case studies

PRESENTATION OF CASE STUDIES
Learners will prepare a weekly case study when in clinical practice according to the guidelines provided in the Clinical Experience Log Book. Each learner should be allowed 15 minutes to present a case study on one day of each week spent in clinical practice. During the presentation of case studies, teachers and/or clinical preceptors should use this opportunity to assess the clinical decision-making skills of learners.

RECORDING CLINICAL EXPERIENCE
Each learner will have a Clinical Experience Log Book containing a "Record of Skills." Teachers or clinical preceptors will be responsible for rating the performance of learners, for each of the skills listed on the "Record of Skills", using the following criteria:

- **M** = performed competently with models
- **S** = performed with client/patient under supervision of teacher or clinical preceptor
- **C** = performed competently with client/patient

The teacher or clinical preceptor will use the relevant **skills checklist** to determine whether learners are competent in a particular skill. It is expected that all learners will achieve competency, either with clients/patients or using models (e.g., for skills that learners have not had an opportunity to perform with clients/patients). It is important for teachers or clinical preceptors to remember, however, that some learners may take longer than others to become competent in the required skills. Learners will be responsible for recording each birth that they attend on the "Births Attended" sheet in the Log Book.

Annexure 2 : MID and POST-COURSE KNOWLEDGE ASSESSMENT QUESTIONNAIRE

INSTRUCTIONS:

Write the letter of the single **best** answer to each question in the blank next to the corresponding number on the attached answer sheet.

FAMILY PLANNING AND COUNSELING

1. The World Health Organization recommends that women wait how long after a live birth to attempt pregnancy again?
   a. 18 months
   b. 24 months
   c. 36 months

2. What is the best contraception for a woman who is 4 months postpartum, only breastfeeding and her menses has not resumed?
   a. Combined oral contraception
   b. Lactation amenorrhea method
   c. Withdrawal

3. Family planning improves the health of mothers and children because
   a. It helps limit population growth
   b. It decreases the risk of having a low birth weight baby
   c. Smaller families are easier to manage

4. During counseling using the GATHER method, it is important to:
   a. Tell the woman about every contraceptive method available
   b. Find out which method the woman is interested in
   c. Tell the woman not to worry about side effects

5. Of the following, the most important part of counseling is:
   a. Identifying the woman=s concerns about using contraceptives and answering her questions
   b. Obtaining formal consent for the procedure from the client
   c. Describing adverse side effects to the client

6. The IUD is the best choice for a woman who :
   a. Has AIDS and is not on antiretroviral therapy
   b. Has heavy menstrual flow and anemia
   c. Wants many years of contraceptive protection

7. Which of the following is TRUE about the IUD?
   a. The IUD itself does not increase the risk of pelvic infections
   b. An IUD must be removed if a pelvic infection occurs
   c. The IUD prevents pregnancy by causing abortion

MANAGEMENT OF SHOCK

8. Rapid initial assessment should be carried out
   a. Only on women who present with abdominal pain and vaginal bleeding
   b. Only on women who present with vaginal bleeding
   c. On all women of childbearing age who present with a problem

9. A woman who suffers shock as a result of an obstetric emergency may have

a. A fast, weak pulse
b. Low blood pressure
c. All of the above

10. The cause of immediate postpartum hemorrhage is due to
    a. Hypertension and weakness
    b. Hypotension and hypovolemia
    c. Atonic uterus

BLEEDING DURING PREGNANCY AND LABOR

11. The presenting symptoms for threatened abortion include
    a. Heavy vaginal bleeding, dilated cervix and uterus larger than dates
    b. Light vaginal bleeding, closed cervix and uterus that corresponds to dates
    c. Heavy vaginal bleeding, dilated cervix and uterus that corresponds to dates

12. Assessment of a woman who presents with vaginal bleeding after 22 weeks of pregnancy should
    a. Include immediate vaginal examination
    b. Exclude immediate vaginal examination
    c. Be limited to abdominal examination

13. Abruptio placentae is:
    a. The detachment of an abnormally located placenta from the uterus before the fetus is delivered
    b. The detachment of an normally located placenta from the uterus before the fetus is delivered
    c. The detachment of an normally located placenta from the uterus after the fetus is delivered

BLEEDING AFTER CHILDBIRTH

14. Postpartum hemorrhage is defined as
    a. Sudden bleeding after childbirth
    b. Vaginal bleeding in excess of 300 mL after childbirth
    c. Vaginal bleeding in excess of 500 ml after childbirth

15. Continuous slow bleeding or sudden bleeding after childbirth
    a. Requires early and aggressive intervention
    b. Should be monitored closely for 24 hours before treatment
    c. Should be measured accurately and treated when more than 500 ml of blood is lost

16. If the cervix is dilated in the case of delayed (secondary) postpartum hemorrhage
    a. Manual exploration of the uterus should be performed to remove large clots and placental fragments
    b. Manual vacuum aspiration should be performed to evacuate the uterus
    c. Dilatation and curettage should be performed to evacuate the uterus

MANAGEMENT OF THIRD STAGE OF LABOR

17. If a retained placenta is undelivered after 30 minutes of oxytocin administration and controlled cord traction and the uterus is contracted
    a. More aggressive controlled cord traction should be attempted
    b. Controlled cord traction and fundal pressure should be attempted
    c. Manual removal should be attempted

HEADACHES, BLURRED VISION, CONVULSIONS, LOSS OF CONSCIOUSNESS OR ELEVATED BLOOD PRESSURE

18. Diastolic blood pressure 90 mm Hg or more before 20 weeks of gestation is symptomatic of
    a. Mild pre-eclampsia
    b. Chronic hypertension
    c. Superimposed mild pre-eclampsia
    d. Pregnancy-induced hypertension

19. Elevated blood pressure and proteinuria in pregnancy define
    a. Pre-eclampsia
    b. Chronic hypertension
    c. Pyelonephritis

20. In a patient with hypertension and proteinuria, severe headache is a symptom of
    a. Mild pre-eclampsia
    b. Moderate pre-eclampsia
    c. Severe pre-eclampsia

21. The loading dose of magnesium sulfate is given via
    a. IV over 5 minutes, followed by deep im injection into each buttock
    b. IV over 5 minutes, followed by deep IM injection into one buttock
    c. IV bolus, followed by deep IM injection into each buttock

22. The presenting signs and symptoms of eclampsia include:
    a. Convulsions, diastolic blood pressure of 90 mm hg or more after 20 weeks gestation and proteinuria of 2+ or more
    b. Headache, stiff neck, blurred vision and diastolic blood pressure of 90 mm Hg or more
    c. Headache, stiff neck, photophobia and diastolic blood pressure of 90 mm Hg or more

23. The management of mild pre-eclampsia should include
    a. Anticonvulsive and antihypertensive therapy
    b. Sedatives and tranquilizers
    c. No medications

24. The drug of choice for preventing and treating convulsions in severe pre-eclampsia and eclampsia is
    a. Diazepam
    b. Magnesium sulfate
    c. Hydralazine

25. An antihypertensive drug should be given for hypertension in severe pre-eclampsia or eclampsia if diastolic blood pressure is
    a. Between 100 and 110 mm Hg
    b. 110 mm Hg or more
    c. 115 mm Hg or more

NORMAL LABOR AND CHILDBIRTH

26. Plotting on the partograph should begin
    a. In the active phase of the first stage of labor
    b. In the latent phase
    c. When the woman is admitted to the labor ward

27. Unsatisfactory progress of labor should be suspected if
    a. The latent phase is longer than 4 hours
    b. Cervical dilatation is plotted to the right of the alert line on the partograph
    c. Cervical dilation is plotted to the left of the alert line on the partograph

28. A partograph records
    a. Dilatation and effacement from 4 cm. until 10 cm
    b. Dilatation and effacement from 3 cm. until 10 cm
    c. Descent of fetal head and dilatation from 4 cm until 10 cm

29. Active management of the third stage of labor is
    a. Only for women who have a history of postpartum hemorrhage
    b. Only for women who experience bleeding
    c. For all women in labor
30. Vaginal examination should be conducted during labor:
    a. At the initial assessment and again when the woman is fully dilated
    b. At the initial assessment and then every 4 hours, unless otherwise indicated
    c. At the initial assessment and then every 2 hours, unless otherwise indicated

31. Contaminated instruments in the labor ward should immediately be
    a. Soaked in 0.5% chlorine solution for 10 minutes
    b. Soaked in 0.5% chlorine solution for 30 minutes
    c. Washed with soap and water and soaked in 0.5% chlorine solution for 10 minutes

32. Before applying controlled cord traction during active management of the third stage of labor
    a. Oxytocin is administered intramuscularly and the attendant waits for the uterus to contract
    b. The mother is asked to push
    c. Pressure is applied to the fundus

33. Examination of the vagina and perineum after delivery:
    a. Should be conducted only if the woman has excessive bleeding
    b. Is an essential part of care for all women
    c. Should be conducted only if the woman suffered perineal trauma

34. Breast pain and tenderness 3 to 5 days after childbirth is usually due to
    a. Breast abscess
    b. Mastitis
    c. Breast engorgement

35. Signs of Puerperal sepsis include the following
    a. Fever, abdominal tenderness, foul smelling lochia any time before the 42nd day following birth
    b. Fever, abdominal tenderness, foul smelling lochia at any time after the 42nd day following birth
    c. At any time between the onset of rupture of membranes or labor

NEWBORN CARE

36. The FIRST step in thermal protection for the newborn includes
    a. Drying the baby thoroughly immediately after birth
    b. Drying the baby thoroughly after the cord has been cut
    c. Covering the baby with a clean, dry cloth immediately after birth

37. When using a bag and mask to resuscitate a newborn:
    a. The baby's neck must be slightly extended to open the airway
    b. The mask must cover the mouth, nose and chin

c. All of the above

38. The newborn loses heat:
    a. If the surface of the body is wet
    b. If the newborn is near a cold wall or window
    c. All of the above

39. Breastfeeding should be initiated within:
    a. 30 minutes
    b. 1 hour
    c. Two hours

40. Which of the following is TRUE about newborns and resuscitation?
    a. Most babies do not have trouble, so there's no need to be vigilant
    b. Because the baby receives oxygenated blood from the umbilical cord, you need not immediately start respirations if the baby is not breathing
    c. A baby can die or become brain damaged if respirations are not initiated very quickly

INFECTION PREVENTION

41. When taking blood samples or establishing an intravenous line
    a. It is not necessary to wear gloves
    b. New examination gloves should be worn
    c. Sterile surgical gloves should be worn

42. Decontamination of surgical instruments by soaking in 0.5% chlorine solution for 10 minutes prior to cleaning:
    a. Completely kills all microorganisms, including bacterial endospores
    b. Rapidly kills viruses such as HIV and hepatitis b
    c. Does not need to done if instruments are thoroughly washed and rinsed

ANSWERS

FAMILY PLANNING AND COUNSELING

1. The World Health Organization recommends that women wait how long after a live birth to attempt pregnancy again?

d. 18 months
e. 24 months
f. 36 months

2. What is the best contraception for a woman who is 4 months postpartum, only breastfeeding and her menses has not resumed?

a) Combined oral contraception
b) Lactation amenorrhea method
c) Withdrawal

3. Family planning improves the health of mothers and children because

A. It helps limit population growth
B. It decreases the risk of having a low birth weight baby
C. Smaller families are easier to manage

4. During counseling using the GATHER method, it is important to:

a. tell the woman about every contraceptive method available
B. FIND OUT WHICH METHOD THE WOMAN IS INTERESTED IN
c. tell the woman not to worry about side effects

5. Of the following, the **most** important part of counseling is:

a. **IDENTIFYING THE WOMAN'S CONCERNS ABOUT USING CONTRACEPTIVES AND ANSWERING HER QUESTIONS**
b. obtaining formal consent for the procedure from the client
c. describing adverse side effects to the client

6. The IUD is the best choice for a woman who :

a. has AIDS and is **not** on antiretroviral therapy
b. has heavy menstrual flow and anemia
c. WANTS MANY YEARS OF CONTRACEPTIVE PROTECTION

7. Which of the following is **TRUE** about the IUD?

a. THE IUD ITSELF DOES NOT INCREASE THE RISK OF PELVIC INFECTIONS
b. an IUD must be removed if a pelvic infection occurs
C**.** The IUD prevents pregnancy by causing abortion

MANAGEMENT OF SHOCK

8. Rapid initial assessment should be carried out

a) only on women who present with abdominal pain and vaginal bleeding
b) only on women who present with vaginal bleeding
c) ON ALL WOMEN OF CHILDBEARING AGE WHO PRESENT WITH A PROBLEM

9. A woman who suffers shock as a result of an obstetric emergency may have

a) a fast, weak pulse
b) low blood pressure
c) ALL OF THE ABOVE

10. The cause of immediate postpartum hemorrhage is due to

a) hypertension and weakness
b) hypotension and hypovolemia
c) **ATONIC UTERUS**

BLEEDING DURING PREGNANCY AND LABOR

11. The presenting symptoms for threatened abortion include

a) heavy vaginal bleeding, dilated cervix and uterus larger than dates
b) LIGHT VAGINAL BLEEDING, CLOSED CERVIX AND UTERUS THAT CORRESPONDS TO DATES
c) heavy vaginal bleeding, dilated cervix and uterus that corresponds to dates

12. Assessment of a woman who presents with vaginal bleeding after 22 weeks of pregnancy should

a) include immediate vaginal examination
b) EXCLUDE IMMEDIATE VAGINAL EXAMINATION
c) be limited to abdominal examination

13. Abruptio placentae is:

a) the detachment of an abnormally located placenta from the uterus before the fetus is delivered
b) THE DETACHMENT OF AN NORMALLY LOCATED PLACENTA FROM THE UTERUS BEFORE THE FETUS IS DELIVERED
c) the detachment of an normally located placenta from the uterus after the fetus is delivered

BLEEDING AFTER CHILDBIRTH

14. Postpartum hemorrhage is defined as

a) sudden bleeding after childbirth
b) vaginal bleeding in excess of 300 mL after childbirth
c) VAGINAL BLEEDING IN EXCESS OF 500 ML AFTER CHILDBIRTH

15. Continuous slow bleeding or sudden bleeding after childbirth

a) **REQUIRES EARLY AND AGGRESSIVE INTERVENTION**
b) should be monitored closely for 24 hours before treatment
c) should be measured accurately and treated when more than 500 ml of blood is lost

16. If the cervix is dilated in the case of delayed (secondary) postpartum hemorrhage

a) **MANUAL EXPLORATION OF THE UTERUS SHOULD BE PERFORMED TO REMOVE LARGE CLOTS AND PLACENTAL FRAGMENTS**
b) manual vacuum aspiration should be performed to evacuate the uterus
c) dilatation and curettage should be performed to evacuate the uterus

MANAGEMENT OF THIRD STAGE OF LABOR

17. If a retained placenta is undelivered after 30 minutes of oxytocin administration and controlled cord traction and the uterus is contracted

a) more aggressive controlled cord traction should be attempted
b) controlled cord traction and fundal pressure should be attempted
c) **MANUAL REMOVAL SHOULD BE ATTEMPTED**

HEADACHES, BLURRED VISION, CONVULSIONS, LOSS OF CONSCIOUSNESS OR ELEVATED BLOOD PRESSURE

18. Diastolic blood pressure 90 mm Hg or more before 20 weeks of gestation is symptomatic of
a) Mild pre-eclampsia
b) **CHRONIC HYPERTENSION**
c) Superimposed mild pre-eclampsia
d) Pregnancy-induced hypertension

19. Elevated blood pressure and proteinuria in pregnancy define
a) **PRE-ECLAMPSIA**
b) Chronic hypertension
c) Pyelonephritis

20. In a patient with hypertension and proteinuria, severe headache is a symptom of
a) Mild pre-eclampsia
b) Moderate pre-eclampsia
c) **SEVERE PRE-ECLAMPSIA**

21. The loading dose of magnesium sulfate is given via
a) **IV OVER 5 MINUTES, FOLLOWED BY DEEP IM INJECTION INTO EACH BUTTOCK**
b) IV over 5 minutes, followed by deep IM injection into one buttock
C) IV bolus, followed by deep IM injection into each buttock

22. The presenting signs and symptoms of eclampsia include:
a) **CONVULSIONS, DIASTOLIC BLOOD PRESSURE OF 90 MM HG OR MORE AFTER 20 WEEKS GESTATION AND PROTEINURIA OF 2+ OR MORE**
b) headache, stiff neck, blurred vision and diastolic blood pressure of 90 mm Hg or more
c) headache, stiff neck, photophobia and diastolic blood pressure of 90 mm Hg or more

23. The management of mild pre-eclampsia should include

a) anticonvulsive and antihypertensive therapy
b) sedatives and tranquilizers
c) NO MEDICATIONS

24. The drug of choice for preventing and treating convulsions in severe pre-eclampsia and eclampsia is
a) Diazepam
b) **MAGNESIUM SULFATE**
c) Hydralazine

25. An antihypertensive drug should be given for hypertension in severe pre-eclampsia or eclampsia if diastolic blood pressure is
a) between 100 and 110 mm Hg
b) 110 MM HG OR MORE
c) 115 mm Hg or more

NORMAL LABOR AND CHILDBIRTH

26. Plotting on the partograph should begin
a) IN THE ACTIVE PHASE OF THE FIRST STAGE OF LABOR
b) in the latent phase
c) when the woman is admitted to the labor ward

27. Unsatisfactory progress of labor should be suspected if
a) The latent phase is longer than 4 hours
b) **CERVICAL DILATATION IS PLOTTED TO THE RIGHT OF THE ALERT LINE ON THE PARTOGRAPH**
c) Cervical dilation is plotted to the left of the alert line on the partograph

28. A partograph records
a) Dilatation and effacement from 4 cm. until 10 cm
b) Dilatation and effacement from 3 cm. until 10 cm
c) **DESCENT OF FETAL HEAD AND DILATATION FROM 4 CM UNTIL 10 CM**

29. Active management of the third stage of labor is
a) only for women who have a history of postpartum hemorrhage
b) only for women who experience bleeding
c) FOR ALL WOMEN IN LABOR

30. Vaginal examination should be conducted during labor:
a) at the initial assessment and again when the woman is fully dilated
b) AT THE INITIAL ASSESSMENT AND THEN EVERY 4 HOURS, UNLESS OTHERWISE INDICATED
c) at the initial assessment and then every 2 hours, unless otherwise indicated

31. Contaminated instruments in the labor ward should immediately be
a) **SOAKED IN 0.5% CHLORINE SOLUTION FOR 10 MINUTES**
b) soaked in 0.5% chlorine solution for 30 minutes
c) washed with soap and water and soaked in 0.5% chlorine solution for 10 minutes

32. Before applying controlled cord traction during active management of the third stage of labor

a) OXYTOCIN IS ADMINISTERED INTRAMUSCULARLY AND THE ATTENDANT WAITS FOR THE UTERUS TO CONTRACT
b) the mother is asked to push
c) pressure is applied to the fundus

33. Examination of the vagina and perineum after delivery:
a) should be conducted only if the woman has excessive bleeding
b) IS AN ESSENTIAL PART OF CARE FOR ALL WOMEN
c) should be conducted only if the woman suffered perineal trauma

34. Breast pain and tenderness 3 to 5 days after childbirth is usually due to
a) breast abscess
b) mastitis
c) BREAST ENGORGEMENT

35. Signs of Puerperal sepsis include the following
a) **FEVER, ABDOMINAL TENDERNESS, FOUL SMELLING LOCHIA ANY TIME BEFORE THE 42ND DAY FOLLOWING BIRTH**
b) fever, abdominal tenderness, foul smelling lochia at any time after the 42nd day following birth
c) at any time between the onset of rupture of membranes or labor

NEWBORN CARE

36. The FIRST step in thermal protection for the newborn includes
a) DRYING THE BABY THOROUGHLY IMMEDIATELY AFTER BIRTH
b) drying the baby thoroughly after the cord has been cut
c) covering the baby with a clean, dry cloth immediately after birth

37. When using a bag and mask to resuscitate a newborn:
a) the baby's neck must be slightly extended to open the airway
b) the mask must cover the mouth, nose and chin
c) ALL OF THE ABOVE

38. The newborn loses heat:
a) if the surface of the body is wet
b) if the newborn is near a cold wall or window
c) ALL OF THE ABOVE

39. Breastfeeding should be initiated within:
a) 30 minutes
b) 1 hour
c) Two hours

40. Which of the following is TRUE about newborns and resuscitation?
a) Most babies do not have trouble, so there's no need to be vigilant
b) Because the baby receives oxygenated blood from the umbilical cord, you need not immediately start respirations if the baby is not breathing
c) A baby can die or become brain damaged if respirations are not initiated very quickly

INFECTION PREVENTION

41. When taking blood samples or establishing an intravenous line
   a) it is not necessary to wear gloves
   b) NEW EXAMINATION GLOVES SHOULD BE WORN
   c) sterile surgical gloves should be worn

42. Decontamination of surgical instruments by soaking in 0.5% chlorine solution for 10 minutes prior to cleaning:
   (a) completely kills all microorganisms, including bacterial endospores
   (b) RAPIDLY KILLS VIRUSES SUCH AS HIV AND HEPATITIS B
   (c) does not need to done if instruments are thoroughly washed and rinsed

Annexure 3 : Objective Structured Clinical Examination (OSCE)

Station 1 : Active management of third stage of labor

Questions

The following steps are essential to the ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR (AMTSL). Number each step according to the correct sequence of the steps.

ORDER PERFORMED	TASKS
	Massage the uterus
	Perform controlled cord traction
	Examine the placenta
	Administer a uterotonic drug

Pass 4/4 Student Score ____/4 Pass Yes No

Examiner Key

ORDER PERFORMED	TASKS
3	Massage the uterus
2	Perform controlled cord traction
4	Examine the placenta
1	Administer a uterotonic drug

Station 2 : Management of Antenatal Complications

Case Study

Ms. Smith, a 35 year old G2P0010 is being seen by you today for a routine prenatal visit at 37 weeks gestation. Her previous prenatal records contain the following pertinent findings:

Initial Physical Examination at first prenatal visit

Gestation	14 weeks
Weight	75Kg
Height	160CM
BP	110/70
Urine	Trace glucose and proteinuria
Reflexes	2+
Edema	None

Examination at 36 weeks Gestation

Weight	95Kg
BP	120/82
Urine	+1 proteinurea
Reflexes	2+
Edema	Trace pitting

Examination today

Weight	97Kg
BP	140/100
Urine	+3proteinurea
Reflexes	3+
Edema	Generalized edema to hands, ankles and face

Questions

State the MOST LIKELY diagnosis as a result of these physical findings in the space below

_____

Which of the following questions of Ms. Smith are MOST important (Select all that apply)

1. Are you having Headaches? ☐
2. Are you having any pain in your abdomen? ☐
3. Are you having any blurred vision? ☐
4. Have you been eating lots of salt? ☐
5. Is your baby moving ☐

Which of the following NEXT steps is MOST appropriate? (Select only one)

1. Refer immediately to obstetrician ☐
2. Counsel and send home on low salt diet ☐
3. Send to lab for further studies. Advise bed rest at home ☐

If Ms. Smith begins convulsing while in the clinic, which is your immediate action?

1. Refer immediately to obstetrician ☐
2. Administer Magnesium Sulfate IM, _____mg ☐
3. Call for help and start an IV line ☐

Examiner Key

State the MOST LIKELY diagnosis as a result of these physical findings in the space below

__PREECLAMPSIA_____

Which of the following questions of Ms. Smith are MOST important (Select all that apply)

1. Are you having Headaches? X
2. Are you having any pain in your abdomen? X
3. Are you having any blurred vision? X
4. Have you been eating lots of salt? ☐
5. Is your baby moving X

Which of the following NEXT steps is MOST appropriate? (Select only one)

1. Refer immediately to obstetrician X
2. Counsel and send home on low salt diet ☐
3. Send to lab for further studies. Advise bed rest at home ☐

If Ms. Smith begins convulsing while in the clinic, which is your immediate action?

1. Refer immediately to obstetrician ☐
2. Administer Magnesium Sulfate IM, ___5_mg X
3. Call for help and start an IV line ☐

Instructions for Participant

- Read the case study at the top of the page
- Answer each of the questions given the information that was provided in the case.

Pass Score = 9/11

Student Score = _____

Pass Yes No

Station 3 : Newborn Life Support

Participant # _____ Date _____

TASK		Safe/Effective Completion of Task	
		Yes	**No**
1.	Checks bag, mask and oxygen supply (when prompted by trainer)	1	0
2.	Dries newborn/ removes wet towels		
3.	Positions newborn, suctions mouth and nose	1	0
4.	Dry, stimulate the baby	1	0
5.	Gives positive pressure ventilation	1	0
6.	Ensures effective lung inflation	1	0
Knowledge Assessment			
7.	Able to state they must initiate the first breath within a minute	1	0
8.	Can identify rate of ventilation (40-60/min)	1	0
9.	Reevaluates breathing, heart rate, color and tone (Examiner provides information upon request)	1	0
10.	Identifies criteria for stopping resuscitation	1	0
11.	States that they only suction if meconium is present	1	0

Pass Score _*7/10*

Student Score _____

Pass Fail

Comments/ Remediation Plan:

_____
_____
_____
_____
_____
_____

Examiner Signature _____

Medical Equipment & Supplies List

- Newborn model
- Resuscitation bag and mask
- Oxygen source with flow meter (may simulate)
- Wall Clock
- Light source
- Newborn stethoscope
- Suction
- Towels
- gloves

Examiner Instructions

- Ask participant to explain the process for checking that equipment is available and fully functional
- If asked by participant, state that the newborn was born at 35 weeks gestation following a rapid labor. The infant has not made any attempt to cry, is floppy and blue.
- When participant checks newborn heart rate, state that is less than 60 beats/minute.
- Step 3-Ask the participant if they suction if meconium is NOT present-they should say 'No'. Only suction if meconium is present.
- Step 6-during the demonstration, ask the participant how much time they have to initiate the first breath, they should respond that respirations should be started within the first minute. It's important they understand the importance of the 'golden minute', document answer in line 7
- Step 6-Also ask the participant to identify the correct rate for ventilation, document in line 8
- Following a short period of correct ventilation, state that the infant is now breathing, pink with good muscle tone.

Participant Instructions

- Participant should ask examiner for information regarding the newborn status that is needed in order to make appropriate clinical decisions.
- 10 minutes to complete station

Station 4 : Management of Intrapartum Complications

Questions

For each of the following scenarios involving laboring women, select whether you believe it to be NORMAL or ABNORMAL. For those that you believe are ABNORMAL, State WHY and describe the MOST appropriate response in one to two sentences.

	LABOR SCENARIO			
1.	A woman comes to the hospital 16 hours after her contractions have started. Exam reveals: 2CMs dilated 3 contractions in 10 minutes	NORMAL ABNORMAL	☐ ☐	WHY: Appropriate Response if ABNORMAL:
2.	A woman is admitted in labor at 4CM dilation. Five hours later she is 6CM dilated.	NORMAL ABNORMAL	☐ ☐	WHY: Appropriate Response if ABNORMAL:
3.	A G1P0 progresses to 10CM dilation. Abdominal examination, you can easily palpate the fetal occiput.	NORMAL ABNORMAL	☐ ☐	WHY: Appropriate Response if ABNORMAL:

Examiner Key

For each of the following scenarios involving laboring women, select whether you believe it to be NORMAL or ABNORMAL. For those that you believe are ABNORMAL, State WHY and describe the MOST appropriate response in one to two sentences.

	LABOR SCENARIO			
1.	A woman comes to the hospital 16 hours after her contractions have started. Exam reveals: 2CMs dilated 3 contractions in 10 minutes	NORMAL **ABNORMAL**	☐ **X**	WHY: Prolonged latent phase of labor Appropriate Response if ABNORMAL: ▪ Hydration ▪ Therapeutic Rest
2.	A woman is admitted in labor at 4CM dilation. Five hours later she is 6CM dilated.	NORMAL **ABNORMAL**	☐ **X**	WHY: Protracted/Prolonged Labor Appropriate Response if ABNORMAL: ▪ Associated with ALERT on the partograph, monitor closely. ▪ Consider obstetrical consultation ▪ Consider labor augmentation
3.	A G1P0 progresses to 10CM dilation. Abdominal examination, you can easily palpate the fetal occiput.	NORMAL **ABNORMAL**	☐ **X**	WHY: Failure to descend Appropriate Response if ABNORMAL: ▪ Associated with ACTION on the partograph ▪ Consult with obstetrician

Pass Score 7/9 Student Score ____/9 Pass Yes No

Station 5 : Using a Partograph

Case Study

Ms. Happiness is a 21 year old G1P0 who was admitted to the hospital in active labor today at 9:00 AM. On admission history, she states that she woke up at 3AM feeling contractions that she describes as cramps. The cramping became stronger at 6AM so she asked her husband to bring her to the hospital. Physical examination upon admission reveals the following:

Vital Signs

Temperature	**38C**
Pulse	**100**
BP	**110/70**

Pelvic

Cervical Dilation	**5CM**
Membranes	**Intact**

Abdominal

Contractions	**3 contractions in 10 minutes lasting 60 seconds**
Descent	**3/5 (Sinciput easily felt, Occiput felt)**
FHR	**140**

Urine

Voided 300CC,

Negative for protein and acetone

At 12 PM, Ms. Happiness reports a gush of amniotic fluid. On inspection, you note clear fluid. Pelvic examination reveals that her cervix is 6CM. On abdominal exam the fetus has descended to 1/5 (Sinciput high, Occiput easily felt) with 4 contractions in 10 minutes lasting 60sec. FHR is 155BPM

At 3PM, Ms Happiness expresses an urge to bear down. She is now 9CMs dilated. She goes on to deliver a healthy 3.5KG baby girl an hour later.

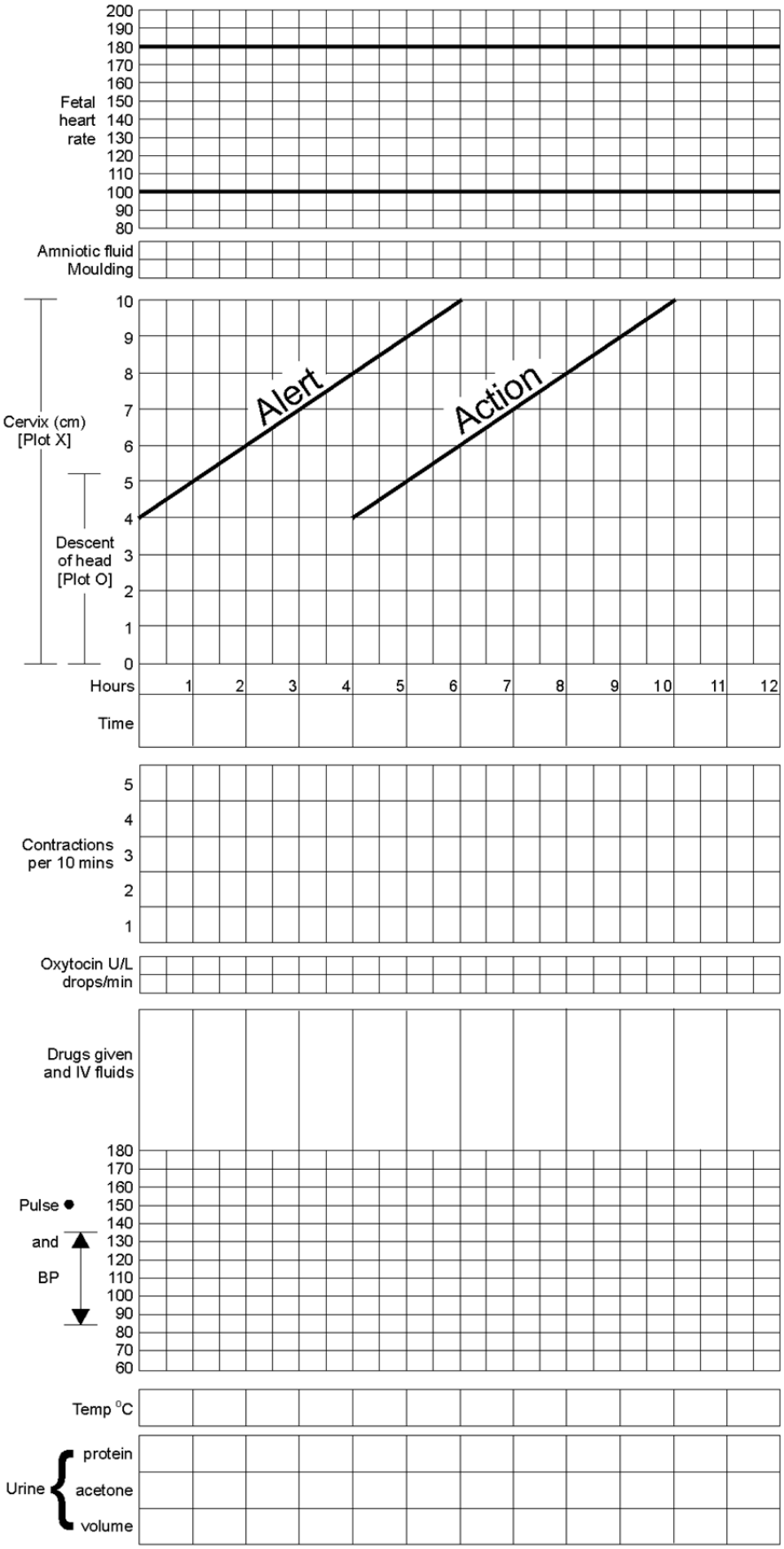
Questions

1. **Please use the attached partograph to plot essential information for the client described in the case above.**
2. **Please identify each of the following partograph findings as NORMAL, a cause for ALERT or immediate ACTION:**

		NORMAL	ALERT	ACTION
A	The FHR at 12PM			
B	The dilation at 9AM			
C	The dilation at 12PM			
D	The maternal pulse at 9AM			
E	The Urine findings at 9AM			

Name Gravida Para Hospital number

Date of admission Time of admission Ruptured membranes hours



Maternal & Neonatal Health

Using a Partograph

Examiner Key

Questions

1. **Please use the attached partograph to plot essential information for the client described in the case above.**
2. **Please identify each of the following partograph findings as NORMAL, a cause for ALERT or immediate ACTION:**

		NORMAL	ALERT	ACTION
A	The FHR at 12PM	X		
B	The dilation at 9AM	X		
C	The dilation at 12PM		X	
D	The maternal pulse at 9AM	X		
E	The Urine findings at 9AM	X		

Pass Score 4/5

Pass: Yes No

Station 6 : Management of Postnatal Complications

Case Study

Ms. Jones is a 24 year old G7P6016 who delivered a 4.5KG infant girl 24 hours ago following an 18 hour labor with oxytocin augmentation for a secondary arrest in dilation. Ms Jones did not require an episiotomy but had a second degree laceration which was repaired by the midwife.

Questions

Which of the following postnatal complications is Ms. Jones at MOST risk? (Select only one)

1. Perineal infection ☐
2. Postpartum hemorrhage ☐
3. Prolapsed uterus ☐
4. Delayed pre-eclampsia ☐

Which of following patient findings on today's visit are causes for concern (Select all that apply)

	Finding	Concern
Gestation at Delivery	42 Weeks	Yes☐ No☐
Maternal Height	162 CM	Yes☐ No☐
Maternal Weight	45KG	Yes☐ No☐
BP	120/70	Yes☐ No☐
Urine	Trace Protein	Yes☐ No☐
Edema to lower extremities	+ 2	Yes☐ No☐
Uterine fundus	3 fingers above umbilicus	Yes☐ No☐
Breasts	Soft, no milk expressed	Yes☐ No☐
Perineum	Tender, moderate edema, sutures intact	Yes☐ No☐
Lochea	Rubra- clots expressed	Yes☐ No☐
Hemoglobin	7.9 g/dl	Yes☐ No☐

Examiner Key

Which of the following postnatal complications is Ms. Jones at MOST risk? (Select only one)

1. Perineal infection ☐
2. Postpartum hemorrhage **X**
3. Prolapsed uterus ☐
4. Delayed pre-eclampsia ☐

Which of following patient findings on today's visit are causes for concern (Select all that apply)

	Finding	Concern
Gestation at Delivery	42 Weeks	Yes☐ No **X**
Maternal Height	162 CM	Yes☐ No **X**
Maternal Weight	45KG	Yes **X** No☐
BP	120/70	Yes☐ No **X**
Urine	Trace Protein	Yes☐ No **X**
Edema to lower extremities	+ 2	Yes☐ No **X**
Uterine fundus	3 fingers above umbilicus	Yes **X** No☐
Breasts	Soft, no milk expressed	Yes☐ No **X**
Perineum	Tender, moderate edema, sutures intact	Yes☐ No **X**
Lochea	Rubra- clots expressed	Yes **X** No☐
Hemoglobin	7.9 g/dl	Yes **X** No☐

Pass Score = 10/12

Student Score = _____

Pass Yes No

Annexure 4 : PARTICIPANT ASSIGNMENT SIGNUP SHEET – FACILITATION SKILLS

S.No	Topic	Time	Placement	Participants name	Signature
1.	Infection prevention	40 mins	Session 14 : Week 2 : Day 1, Afternoon		
2.	Importance of Antenatal Care and preparation for ANC	30 mins	Session 15 : Week 2 : Day 2, Morning		
3.	ANC – History taking	45 mins	Session 15 : Week 2 : Day 2, Morning		
4.	ANC – interventions	45 mins	Session 17 : Week 2 : Day 3, Morning		
5.	ANC counseling	30 mins	Session 17 : Week 2 : Day 3, Morning		
6.	Care during labour – assessment and care in labour .	45 mins	Session 18 : Week 2 : Day 3, Afternoon		
7.	Care during labor and delivery – true and false labour pains. Partograph	60 mins	Session 19 : Week 2 : Day 4, Morning		
8.	Monitoring and management of third and fourth stage of labour	30 mins	Session 21 : Week 2 : Day 5, Morning		
9.	Care after delivery - postpartum care Care during first, second and third postpartum visits.	30 mins	Session 22: Week 2 : Day 5, Afternoon		
10.	Management of complications during pregnancy, labour and postpartum period	15 mins	Session 23 : Week 2 : Day 6, Morning		
11.	Ensuring quality of care	45 mins	Session 24 : Week 2 : Day 6, Afternoon		
12.	▪ India Family Planning Program and GOI policies for FP service provision.	30 mins	Session 33 : Week 5: Day 5, Morning		
13.	Technical overview of modern family planning methods	60 mins	Session 33 : Week 5: Day 5, Morning		
14.	Hormonal methods of contraception COCs POPs	60 mins	Session 33 : Week 5: Day 5, Morning		
15.	Barrier methods	60 mins	Session 34 : Week 5: Day 5, Afternoon		
16.	Postpartum Family Planning and LAM	45 mins	Session 34 : Week 5: Day 5, Afternoon		
17.	Discuss modern approaches to IUCD	30 mins	Session 35 : Week 5: Day 6, Morning		
18.	Elements of counseling and communication skills	30 mins	Session 36 : Week 5: Day 6, Afternoon		
19.	Elements of FP counseling & post partum FP counseling,	45 mins	Session 36 : Week 5: Day 6, Afternoon		
20.	▪ Magnitude of HIV ▪ What are HIV & AIDS? ▪ HIV transmission. ▪ HIV testing and diagnosis. HIV disease progression and	90 mins	Session 37 : Week 6: Day 1, Morning		

Annexure 5 : PARTICIPANT ASSIGNMENT SIGNUP SHEET – DEMONSTRATION SKILLS

S.No	Topic	Time	Placement	Participants name	Signature
1.	Hand washing, Decontamination and high – level	25 mins	Session 14 : Week 2 : Day 1, Afternoon		
2.	Processing of Instruments.	20 mins	Session 14 : Week 2 : Day 1, Afternoon		
3.	Detection of pregnancy.	15 mins	Session 15 : Week 2 : Day 2, Morning		
4.	ANC – General examination	30 mins	Session 15 : Week 2 : Day 2, Morning		
5.	ANC – abdominal examination.	30 mins	Session 16 : Week 2 : Day 2, Afternoon		
6.	ANC – Laboratory investigations	15 mins	Session 17 : Week 2 : Day 3, Morning		
7.	Assessment of woman in labour	30 mins	Session 18 : Week 2 : Day 3, Afternoon		
8.	Vaginal examination during labour	30 mins	Session 18 : Week 2 : Day 3, Afternoon		
9.	Management of first and second stage of labour	60 mins	Session 19 : Week 2 : Day 4, Morning		
10.	Active management of third stage of labour.	30 mins	Session 21 : Week 2 : Day 5, Morning		
11.	Management during the fourth stage of labour .	30 mins	Session 21 : Week 2 : Day 5, Morning		
12.	Resuscitation of newborn	30 mins	Session 21 : Week 2 : Day 5, Morning		
13.	Setting up an IV line	15 mins	Session 23 : Week 2 : Day 6, Morning		
14.	Giving deep intramuscular injections.	15 mins	Session 23 : Week 2 : Day 6, Morning		
15.	Catheterization	15 mins	Session 24 : Week 2 : Day 6, Afternoon		

Annexure 6 : Competency Tracking Sheet for Participants

Use to document summative assessment results for each participant in the course. Tick each skill after you observe it performed competently in practice.

S. NO	SKILL																		
	Participant Names																		
1.	Facilitation Skills																		
2.	Demonstration Skills																		
3.	Coaching Skills																		
4.	Antenatal assessment																		
5.	Management of normal delivery and AMTSL																		
6.	Essential Newborn Care																		
7.	Newborn resuscitation																		
8.	Immediate Postpartum Care																		
9.	Copper T insertion																		
10.	Family planning counseling																		
11.	Passing Score on OSCE Exam																		