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MANUAL FOR POLICY MAKERS AND TRAINERS

Field Testing Edition

A Life-Saving Skills Training Program Process



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BONNIE PEDERSEN
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THIS MANUAL IS DEDICATED TO THE MEMORY OF BONNIE PEDERSEN, CNM, FOUNDER OF THE SPECIAL PROJECTS SECTION OF THE AMERICAN COLLEGE OF NURSE-MIDWIVES MAY ALL OF US WHO ATTEND WOMEN IN CHILDBIRTH SHARE IN HER DEDICATION TO QUALITY SERVICES AND COMPASSION

MANUAL FOR POLICY MAKERS AND TRAINERS

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Table of Contents	Page
Table of Contents	i
Acknowledgments	ii
Life-Saving Skills Trainers and Project Directors	iii
Introduction	1
Life-Saving Skills (LSS) Training Program Process	5
STEP ONE LSS PROGRAM PLANNING	7
STEP TWO TRAINING NEEDS ASSESSMENT (TNA)	25
STEP THREE TRAINING SITE PREPARATION	45
STEP FOUR PREPARE FOR TRAINING	60
STEP FIVE TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN LSS TRAINING FOR MIDWIVES	125
STEP EIGHT ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN CONTINUING EDUCATION	168
References	174
Table of Contents (Annotated) Lesson Plans and Forms	176

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MANUAL FOR POLICY MAKERS AND TRAINERS

INTRODUCTION

As a result of pregnancy and childbirth, an estimated 600,000 women die each year. In developing countries, 81% of maternal mortality is from direct causes: hemorrhage, sepsis, unsafe abortion, pregnancy induced hypertension and obstructed labor.² Most of these deaths are preventable through quality maternity care, improved nutrition, family planning, access to safe abortion, available transportation and communication, rapid and safe blood services, improved education for women and girls, and improved status of women within the culture.

Life-Saving Skills (LSS) programs help midwives improve the quality of care they provide. Since 1989, trainers in many country programs have helped over 2000 midwives gain proficiency in these LSS skills. The *Life-Saving Skills Manual for Midwives* has been used in continuing education programs for experienced midwives. It has been used to strengthen pre-service for midwifery students and incorporated into basic training programs. LSS training programs may be run by ministries of health, schools of education, or midwifery associations.

Not all situations are appropriate for starting with LSS for midwives training. There may be a greater need for training auxiliary midwives, maternal and child health workers, traditional birth attendants (TBAs), or family members. ACNM has developed two additional training manuals which use LSS principles and teaching techniques. The two manuals are designed to teach skills most useful to the primary health provider in the community. *Healthy Mother Healthy Newborn (HMHN)* includes clean and safe delivery, prevention and treatment of hemorrhage, and postpartum care of the mother and newborn. *Home Based Life Saving Skills (HB LSS)* concentrates on clean and safe birth techniques, prevention of infection, immediate care of the newborn and first aid response to hemorrhage. The decision of which training best meets the needs for improving maternal and newborn outcomes depends on the situation.

On page 4, is a comparison of LSS providers³ and the training content they receive. **The overall aim of LSS is timely, correct, appropriate, and effective response for obstetric complications by all who are trained in LSS.** Problem solving using a history and physical examination, problem identification and appropriate action, and referral with stabilization and transportation, if necessary, are included in LSS training.

² Marshall M. A. and Buffington S. T. (1998) Life-Saving Skills Manual for Midwives 3rd edition p 11

³ A home birth attendant is anyone including a TBA who is attending a birth at home. Trained pregnancy care providers may be auxiliary midwives, community midwives, or others who have had some midwifery training and who may work in the hospital, maternity center, or in the community. Trained midwives may be professional midwives and nurse-midwives who have formal midwifery training and work in the hospital, maternity center, or in the community.

Education and mobilization of women, families, community members, and all providers of pregnancy care is essential in order for them to develop common perceptions of the need for and the means of intervention to prevent maternal mortality. The steps outlined in this manual would be the same for LSS, HMHN or HB LSS.

The LSS training program is designed to revise, review, and update midwifery skills and to improve the ability to perform additional life-saving skills. The emphasis is on clinical practice **with as much experience as it takes** for each individual trainee to become competent. Class discussions are held near the clinical area so they can be interrupted when a laboring woman presents with a condition where any of the clinical skills may be learned. Trainers are not interested in the **quantity** (number) of times a trainee performs a particular skill but the **quality** (proficiency) with which she performs the skill.

The *LSS Manual for Policy Makers and Trainers* is a guide for the development and management of an LSS training program. The steps (1 to 4) outlined for program planning have been developed over the duration of LSS and reflect the thoughtful experience of many trainers in many countries. Teaching LSS is described in steps 5 to 7. The last three steps (8 to 10) are guides for LSS orientation, supervision and continuing education. The authors recommend that policy makers and trainers adhere closely to the format and suggestions in the manual **until** they develop their own experience with which to compare.

In establishing a Life-Saving Skills program, there are a number of critical ingredients for success. By planning carefully prior to program startup, resources can be used well and important partners can contribute their best efforts. Planning and preparation begin with the gathering of information on existing policies, standards, and guidelines relating to midwifery practice, and on current midwifery practice. Numerous details and issues must be addressed. An advisory committee must be formed, financial costs identified, and accounting procedures agreed upon. Criteria for selecting trainers, trainees, and a training site must be agreed to and selections made. Once the major program decisions are made, the training site must be prepared and trainers trained.

Midwives should assume the major responsibility for the training of their peers. As adult learners, the trainers and trainees have much to share with one another. Midwives tend to be realistic about their resources and knowledgeable about their own culture and community. Enthusiasm and willingness to work as a team member are very important attitudes for everyone on the training team.

Midwives benefit from the cooperation and assistance of partners in the training effort. One critically important partner is a very supportive obstetrician or specially trained general physician. This physician participates in the training activities and is called upon for teaching and patient care referral. Ideally, another partner is a person who can assume administrative responsibility for running the program. Administrative

details include such things as securing and managing living accommodations for the trainees, purchasing equipment and supplies, managing the budget and financial reports, and sending letters of invitation to trainees. Having administrative support frees trainers to do what only they can do -- *teach trainees in the clinical area*. Donors are also important and valuable partners. They can help get programs started by providing funds, technical expertise, and equipment and supplies that may be difficult to obtain.

The Training of Trainers (TOT) in LSS and the training process outlined in this manual provide clinically active midwives opportunities to develop confidence and competence as trainers, by using a participatory approach in teaching. Competency based training focuses on the trainee's knowledge and the skills she must perform accurately. Clinically based training has few trainees per trainer. The trainer, who must be constantly available, spends most of her time helping midwives learn by reinforcing, giving feedback, evaluating, questioning, answering questions, demonstrating, and managing the learning process. The LSS trainer does **not** spend much time in formal classroom presentations but instead works with the trainees in clinical settings and in discussions.

Midwives who meet the selection criteria are trained in LSS. Subsequently, follow-up and support visits must be undertaken and continuing education provided. This *LSS Manual for Policy Makers and Trainers* provides detailed information on each of these aspects of program planning and preparation. In addition, sample forms related to all aspects of the program are provided for use, adaptation, or revision.

We hope we have succeeded in writing this manual in a clear, step by step method so you can easily follow the steps necessary for developing a successful LSS training program. Take and use the ideas that are helpful for your program. Use the suggestions to create your own program. Any suggestions or ideas would be gratefully received. Please send all comments to

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Comparison of LSS Providers³ and Training Content

Training	Trained Midwife	Trained Pregnancy Care Provider	Home Birth Attendant
<p>HB LSS using <i>Home Based LSS</i></p>			<p>1 Basic prevention of anemia and tetanus Good diet Iron Vitamin A tetanus toxoid</p> <p>2 Clean safe home delivery and immediate newborn care good hygiene hand washing delivery preparation clean delivery prevention of harmful practices infant care (warm dry skin to-skin cord care exclusive breast feeding eye care)</p> <p>3 Home monitoring during postpartum (monitor uterus and bladder breast feeding reduce work load)</p> <p>4 Recognition and initial management and appropriate referral of selected complications such as maternal hemorrhage infection prolonged or obstructed labor and infant resuscitation</p>
<p>HMHN using <i>Healthy Mother and Healthy Newborn Care</i></p>	<p>Topic 1 Working with the Community (antenatal nutrition/health delivery preparation postpartum outreach transportation blood donors harmful practices referral)</p> <p>Topic 2 Prevent Infection (steps of infection prevention protect mother baby and midwife)</p> <p>Topic 3 Antenatal Care (monitor fetal growth and mother's health identify problems treat and counsel)</p> <p>Topic 4 First Stage of Labor Care (emotional support position comfort fluids cleanliness monitor mother/baby)</p> <p>Topic 5 Second/Third Stage Labor (preparation position safe and clean delivery baby skin to-skin breast feeding cord/eye care deliver placenta as soon as possible monitor/massage uterus and give oxytocic)</p> <p>Topic 6 Postpartum (post delivery care for mother/baby counseling for breast feeding family planning self referral at 6 hours 3 days 2 weeks 6 weeks)</p>		
<p>LSS using <i>Life-Saving Skills Manual for Midwives</i></p>	<p>Module 2 Antenatal Risk Assessment/Management (anemia pregnancy induced hypertension eclampsia fundal height)</p> <p>Module 3 Labor Management using Partograph (monitor record interpret take action)</p> <p>Module 5 Prevention/Treatment of Hemorrhage (active management of third stage manual removal placenta bimanual compression inspection with vaginal speculum digital evacuation)</p> <p>Module 6 Resuscitation (immediate care of infant APGAR cardiopulmonary resuscitation)</p>	<p>Module 1 Introduction (maternal mortality/morbidity causes role of midwife and community)</p> <p>Module 4 Episiotomy/Repair of Lacerations (prevent cut inspect give local anesthesia repair care)</p> <p>Module 6 Resuscitation (adult cardiopulmonary resuscitation Heimlich Maneuver)</p> <p>Module 7 Prevention/Management of Sepsis (universal precautions prevent and manage infections in mother/newborn)</p> <p>Module 8 Hydration/Rehydration (shock care rehydration methods)</p> <p>Module 9 Vacuum Extraction (indications dangers procedure)</p> <p>Module 10 Labor/Delivery Problems (abnormal position/presentation uterine inertia cord prolapse) manual vacuum aspiration (postabortion care)</p>	

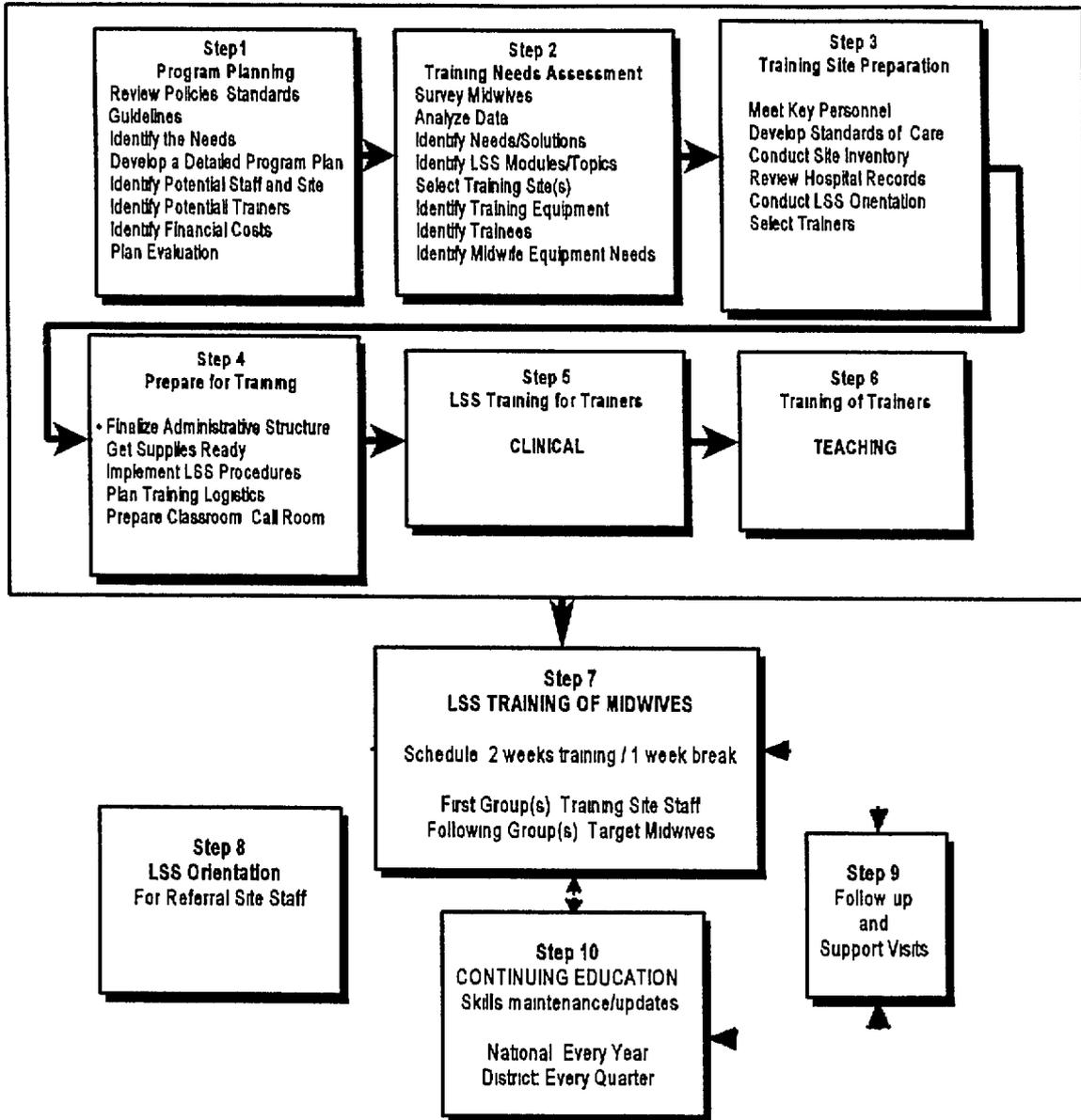
Life-Saving Skills (LSS) Program Process

Based on experience in Ghana, Uganda, Nigeria, Vietnam, and Indonesia it is critical to the success of a program that program process training be used (see page 6) This process implies the systematic development of a quality training program including preparation, training, and follow-up, and the development of a number of interlinking systems that support each other to produce an overall training and continuing education system This process requires an intensive investment of human resources and time during the setup phase as well as for ongoing monitoring and support resulting in a strong training system with people prepared to meet program goals *Each step of the system as elaborated in this manual should be followed to establish and maintain an appropriate and effective training system*

The LSS program process graphic (on the next page) gives an outline of the steps necessary to establish an in-service/continuing education training designed to focus on provider and community needs and to reflect agreed upon clinical protocols While the steps for establishing the program are quite intensive (steps 1 to 6) and require adequate time between each step, this preparatory process ensures that the institutions and personnel are ready to participate

The training itself (steps 7 and 8) was designed to also give participants sufficient time, experience, and feedback to become competent in all the skills included in the training The follow-up and support visits (step 9) and continuing education structure (step 10) support what has been taught, strengthen the system through feedback of information on continuing education needs, and contribute to the overall sustainability of the system The entire training process relies on maximum support to all those providing care to mothers and newborns

LSS PROGRAM PROCESS



LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
	Advisory Committee	9
	List of Criteria for Advisory Committee Members	10
	Review Policies	11
	Guidelines (Protocols) and Quality of Care)	11
	Identify the Needs	13
	Develop a Detailed Program Plan	14
	Memorandum or Letter of Understanding	14
	Memorandum or Letter of Understanding Checklist	15
	Launch (Initial) Meeting	16
	List of Criteria to Identify Key Participants in Launch Meeting	17
	Identify Potential Training Site, Trainers, Trainees	18
	The Training Site	18
	The Training Team	18
	The Trainees	18
	Master Trainers	19
	How Can We Train More Midwives More Quickly?	19
	Identify Financial Costs	20
	General Outline of Program Budget Items	21
	Plan Evaluation	21
	List of Possible Methods of Evaluation	24
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP ONE: LSS PROGRAM PLANNING

Prior to developing a training program, consensus must be reached at the national level that maternal and child health services can be strengthened by improving provider skills and goals for the program must be developed. In addition, agreements must be made between all involved on funding as well as roles and responsibilities. These preliminary steps are critical for the establishment of a sustainable program.⁴ The establishment of a successful LSS training program requires planning and the accomplishment of many activities in each step. Some activities will be the responsibility of decision makers. Other activities will require the cooperation of doctors, midwives, decision makers, and others working together. The activities do not always need to be accomplished in the order they are written, however, they will all need your attention before training activities can begin. The following time frame is a guide for planning for training. Each step is described in detail on the following pages.

LSS PROGRAM PROCESS TIME FRAME												
YEAR 1 / MONTH	1	2	3	4	5	6	7	8	9	10	11	12
STEP 1 Program Planning	→	→	→									
STEP 2 Training Needs Assessment				→	→							
STEP 3 Training Site Preparation					→	→						
STEP 4 Prepare for Training						→	→					
STEP 5 LSS Training for Trainers – Clinical							→	→	→			
STEP 6 LSS Training for Trainers – Teaching									→	→		
STEP 7 LSS Training										→	→	→
STEP 8 LSS Orientation for Referral Staff											→	→
STEP 9 Follow-up and Support Visits											→	→
STEP 10 Continuing Education												→

⁴ Adapted from Beck, D. et al (1997) Building Quality into a Training and Continuing Education System for Midwives: A Systems Approach, A Guide for Program Planners p 2

Advisory Committee

Establish one or two **advisory committee(s)** made up of people who have responsibility for providing the guidance necessary for an LSS program. You can provide help to ensure the **support necessary for a successful program** by identifying people who have the authority to establish policies related to administrative and technical issues and getting them to join the committee. Committee meetings are a forum for discussion and decision making.

LSS Coordinator The process for organizing and operating an LSS program begins as soon as the decision is made that LSS will be implemented. The first person identified for your LSS program is a midwife manager or coordinator (LSS coordinator). The LSS coordinator uses the *Manual for Policy Makers and Trainers* reference to identify and resolve administrative and management issues for

- establishing the LSS training program,
- preparing for the LSS training program, and
- conducting the LSS training program

The people involved in the identification of the LSS coordinator will depend upon the local situation. Ideally, a midwife will be selected. If it is not possible within the local structure to achieve this, minimally a midwife and physician should be co-partners in running the project. When the project begins with a midwife in charge, midwives receive visibility, recognition, and power.

Each country must determine whether one or two committees are needed to achieve the following on **technical, policy, and political issues**

- Communication with the medical and midwifery communities regarding the goals and objectives of LSS training
- Involvement of key ministry of health staff, obstetrical and midwifery associations, pre-service faculty in obstetrics and midwifery, and other interested groups in the program. It is recommended that one or more members of the advisory committee are themselves users of maternity care services
- Addressing technical issues such as protocols or guidelines and standards of practice for training
- Reviewing LSS curricula

- Making recommendations particular to the country's maternal health needs such as the appropriate training level, selection of equipment and antibiotics, treatment regimes for malaria and sepsis
- Ensuring that needs of trainers and trainees for housing, food, and classroom space near labor and delivery units are met

List of Criteria for Advisory Committee Members

To Identify Advisory Committee Members, Consider

- Who can influence policy decisions relating to maternal health?
- Who is held in high professional regard by midwives, obstetricians, and physicians?
- Who has experience and understanding of rural health care practices and is also influential within the medical community?
- Who has influence within the pre-service obstetrics and midwifery faculties?
- Who strongly supports action to reduce maternal mortality and morbidity?
- Who can help ensure availability of housing, food, equipment, and supplies needed by trainers and trainees?
- Who can best represent the pregnant women? Members of women's groups? Pregnant women from the community?

Review Policies

In most countries, midwives are licensed or registered under a code, set of regulations, or laws. The law usually covers them in doing what is necessary in an emergency to stabilize and refer a patient. It is important to clarify with the authorities what this means, so that midwives will in fact be able to practice the new skills they gain in the training. If they fear prosecution or peer censure, LSS midwives will not freely practice their new skills in an emergency.

In many places, midwives are legally covered to practice any skill for which they have received an appropriate continuing education training. The skills included in the competency-based Life-Saving Skills training may be covered by this regulation. In countries where midwives must show proof of periodic continuing education in order to maintain their license/registration, Life-Saving Skills training can serve to fulfill this requirement. It is a good idea for the trainers to have copies of any pertinent regulations so that midwives who are worried can read how they are protected by laws or regulations.

National policies for midwives and laws about midwifery practice must be reviewed, looking especially for potential legal and practice barriers. They must either include (or not forbid) such practices as the ability of midwives to

- Give antibiotics
- Perform episiotomy, give local anesthesia, and repair tears or lacerations
- Manually remove the placenta, if necessary
- Perform infant or adult resuscitation

Guidelines (Protocols) and Quality of Care

In many countries there are national or institutional guidelines (protocols) for practice. The role of each member of the health team and the treatment for various conditions or circumstances are clearly outlined in the guidelines. For example, specific procedures may be written for a woman admitted with a third trimester hemorrhage such as intravenous infusion, blood pressure check, hemoglobin count, blood type and cross match to be done while help is being called. If such guidelines are in place, it is important to review them carefully. Your advisory committee (see page 9) will want to review and compare them with the LSS manual in order to recommend ones that have the most up-to-date treatment and are the most appropriate in your environment.

It is essential that the highest standards of essential maternal health practice be incorporated into your country's LSS training program. Standards of care have been set by internationally recognized bodies such as the World Health Organization.

(WHO) Safe Motherhood Initiatives and many countries have adopted or adjusted these standards. Since the quality of care can only be evaluated when there are written and locally approved guidelines that outline the care standards, you must collect and review the existing ones and identify areas where they must be changed and approved.

The *Life-Saving Skills Manual for Midwives* includes skills checklists which can serve as the standard for performing each life-saving skill. During training, the quality of performance of each skill is evaluated using the skills checklist. You can use the same checklists to aid you in reviewing the existing guidelines (protocols). Where differences exist, either the guideline or the checklist will need to be adjusted so that the care standards and training content are consistent.

Sample protocol guidelines for the midwives of an LSS program are located in the Lesson Plans and Forms section of this manual. The guidelines for Antenatal Care are found on page 264, Monitoring Labor using the Partograph on page 268, and Postpartum Care on page 269. These can be used for review and discussion. They are meant as samples for adapting to each local situation.

Identify the Needs

There are five major causes of maternal mortality worldwide. They are hemorrhage, sepsis, unsafe abortion, pregnancy induced hypertension, and obstructed labor. Figure 1 shows the portion of all maternal deaths caused by each. Notice that *indirect causes*, that is, other existing illnesses or conditions a woman has, are also responsible for many maternal deaths.

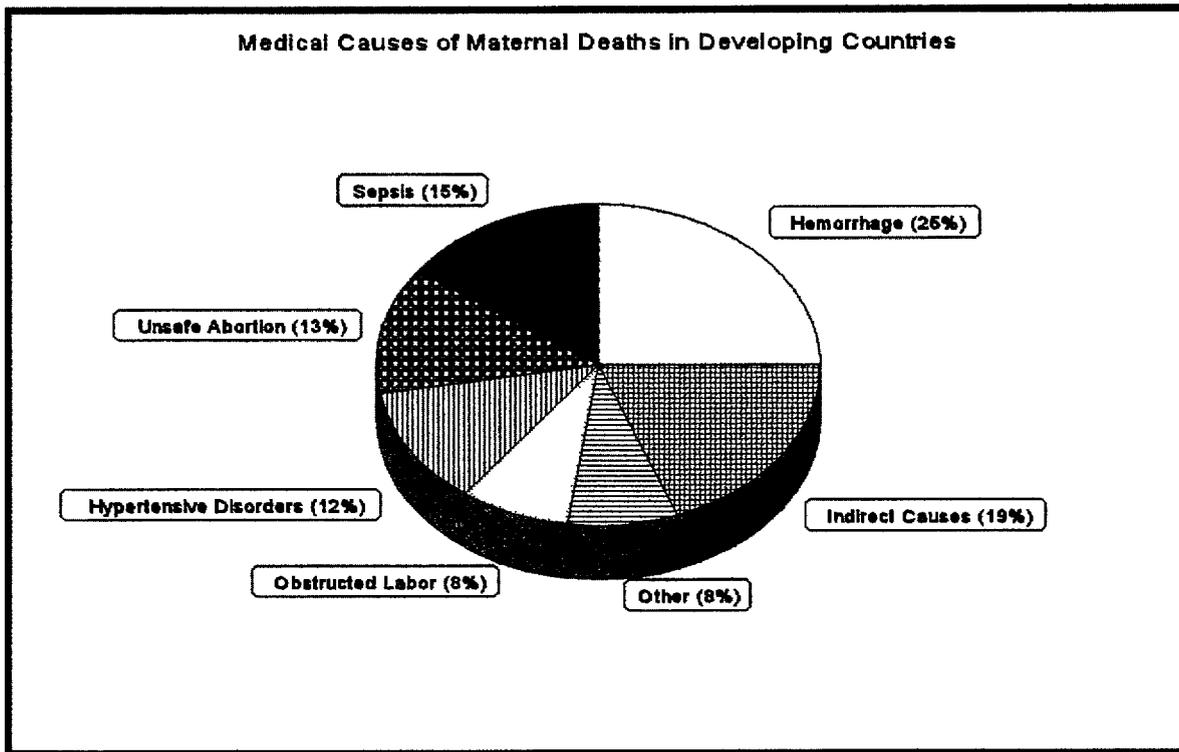


Figure 1 Medical Causes of Maternal Deaths

Source: WHO 1992

To help prevent maternal morbidity and mortality, it is essential that all women receive quality care. **Because all women have some risk of developing complications, early identification of problems and risk factors and the availability of good referral services are essential to all maternity care.**

To identify the specific training needed in your country, you must review the health problems of women and assess current midwifery practice. Life-Saving Skills (LSS) is designed to respond to the maternal health needs. You must review the health problems of women in your communities. What is the maternal mortality? Why are women dying? What is the morbidity? What are the sicknesses of the women? You

must review health information (statistics) from facilities in your area to identify problems, existing health conditions, and available equipment. You must look at what the midwife is expected to do and what the midwife actually does. You must also compare the current maternal health care with LSS care.

In every country where LSS is taught, the program is adapted to the needs of the maternal health care system. A training needs assessment, described in detail in Step Two, beginning on page 26, is conducted to learn midwives' knowledge and problem solving skills, how they practice, and what they feel they need in order to provide updated or better maternal health care. During the needs assessment, important issues commonly come to the surface. Following the training needs assessment, a decision can be made about the level of training that best meets the needs of the women of the community.

Develop a Detailed Program Plan

To develop a sustainable training system based on the maternal health needs and the skills and talent of the country's health providers, the details of the LSS training program must be written and agreed upon.

Memorandum or Letter of Understanding

Experience has shown that it is best to create a **Memorandum or Letter of Understanding** to spell out who is responsible for each aspect of the program. This document is crucial in delineating responsibility and accountability for the LSS program. It establishes clear channels of communication and financial procedures. Other responsibilities include the selection of trainers based on mutually agreed criteria, provision of technical assistance for training, a plan for trainee follow-up and updating as necessary, and procurement of teaching equipment and other supplies.

The government must agree not to rotate trained trainers and trainees from their needed posts at the training center and subcenters. *If it is agreed to use the partograph and other forms recommended in LSS, the government must commit to ongoing printing of these forms to ensure their availability.*

When the training center(s) is identified, it is important to specify clearly in the memorandum any preparation that must be done to upgrade or otherwise ensure a quality practice site. If the government, school, or agency is unable to bring the training site up to standard within the stated time frame, another site must be sought. Keep in mind that costs of bringing the training center up to standard are not training costs. These are the ongoing governmental costs of maintaining the health facility.

To avoid confusion or misunderstandings later, it is important to clarify the work and financial responsibilities of each partner. Important dates should be included in the agreement. You may wish to include a clause stating the procedure to be followed should a partner wish to withdraw from the agreement at a later date.

Memorandum of Understanding Checklist

In the Memorandum of Understanding

- Is the mechanism for money transfers from donor agency or partner to government described?
- Are accounting requirements and procedures outlined?
- Are channels of communication outlined?
- Are there mutually agreed criteria for selection of trainers?
- Is the training site(s) identified?
- Are requirements for preparation of the sites stated?
- Are important dates included? Are dates for completion of each aspect included?
- Are details of technical assistance for training outlined?
- Is responsibility assigned for provision and maintenance of training equipment and other supplies?
- Is there a plan for trainee follow-up and updating as necessary?
- Is there assurance (by government or other responsible agency) that trainers will not be rotated from their posts at the training center and subcenters for a minimum of an agreed number of years?

Launch (Initial) Meeting

The purpose of the **Launch Meeting** is to create support and interest for the LSS training program. This meeting can be held at the national and/or state (provincial) level. It serves as the formal beginning of the program. You may wish to include press coverage to publicize the new initiative.

A launch meeting helps gain support from physicians who may fear that midwives are taking on too much responsibility. It also increases support of senior nursing officers from participating institutions, officials of the nursing and midwifery council or their equivalent institution, and politicians involved in health. As the maternal mortality rate and the actual problems are presented and discussed, participants typically suggest practical solutions, such as ways to improve the referral system. They often have suggestions regarding others who should be briefed about LSS. In our experience, many problems and solutions are discussed at the launch meeting and a sense of ownership of the LSS program and its goals is created among the participants. The launch meeting is an important activity if the program is to become institutionalized (ongoing). Without support from such key people, training may cease as soon as the project is completed.

It is important that leaders and communities become knowledgeable about the scope of the problem of maternal mortality and come to realize how many of these deaths are preventable. Likewise, it is important to have widespread understanding of the impact of maternal and infant mortality and morbidity on the economic and emotional health of the family. It is important for communities and community groups to become aware of their tremendous potential to solve problems such as transportation, communication, availability of blood, and availability of emergency funds to cover services.

In the launch meeting, political and professional leaders can be encouraged to express their concerns about mortality and morbidity in the country. Physicians and government officials are invited to express their support for expanded roles for midwives in order to decrease maternal mortality. This support provides credibility for LSS among community leaders and professional support staff in nursing, pharmacy, hospital management, and pre-service education.

The launch meeting provides a forum for discussion of the selection criteria for trainers and trainees. Chances for program sustainability are increased by inviting input on the identification of an LSS coordinator who will be responsible, with the support and assistance of the advisory committee(s), for the quality and efficiency of the training. The meeting provides all concerned with an opportunity to contribute to the LSS program.

List of Criteria to Identify Key Participants in Launch Meeting

Identify Key People to Participate in the Launch Meeting

- Who are the community leaders who should participate?
- Which physicians should be encouraged to take part?
- Which institutions will be affected by the program? Who are the senior nursing officer(s), pre-service educators, administrators, and other key personnel within those institutions?
- Which government officials should be included?
- Who will represent the Nursing and Midwifery Council (or equivalent institution)?
- Which professional associations should participate and who can represent them?

Identify Potential Training Site, Trainers, Trainees

Training for LSS differs from other reproductive health training in that the site must have sufficient obstetric volume to provide opportunity for exposure to what are essentially rare events -- obstetrical emergencies

The Training Site

There are a number of factors which contribute to program success. Steps for identifying a training site are outlined in Step Two, beginning on page 39. The steps include (1) supportive staff, (2) sufficient client load, (3) clinical guidelines (protocols), and (4) availability of accommodations. It is a *must* that there be a **sufficient client load** at the training site to allow the trainees to master life-saving skills. If there are few births, the site is not appropriate for the LSS training program.

The Training Team

The **trainers working at the training site** (midwives and physicians) need commitment, a positive attitude, and the ability to problem-solve. Most important, they need to be current in practice and have excellent clinical skills. The importance of selecting mature, dedicated, and competent clinicians for the training team cannot be overstated. Observing the staff at a designated training site provides the opportunity to assess them for their sound clinical skills, interest in expanding their scope of practice, and willingness to teach new techniques. Those midwives who have the clinical respect of the physician staff and their colleagues **and** have a consistent volume of clients (births, antenatal, postpartum) each month are generally ideal candidates to be LSS trainers. Criteria for the selection of trainers can be found in Step Three, beginning on page 51. It is important that the **criteria for the selection of trainers and trainees** be presented and, where possible, agreed upon by the advisory committee.

The Trainees

Choosing trainees carefully is very important. They should be currently practicing full scope midwifery (antenatal, intrapartum, postnatal, family planning, newborn care). We recommend that a minimum of three midwives from labor and delivery units, and one midwife from each of the other units at the training site be included in the first LSS classes in order to provide faster integration of LSS knowledge and skills into the facility. It is important to give special priority to training tutors in a mixed training group including private and public sector midwives and physicians.

As each trainee shares experiences, case studies, and problems, the training is enriched. Working relations among these groups markedly improve.

The training needs assessment, found in Step Two, identifies the clinical skills midwives are performing satisfactorily and areas where they need to improve their performance. This information is used to confirm the target group of midwives for LSS training.

Master Trainers

Master trainers teach LSS Training of Trainers (TOT) and then support the new training site by helping teach and providing support and follow-up. The master trainers have excellent clinical and teaching experience that can be transferred to other training sites.

If a master training team is being formed to train other LSS trainers, hold the TOT course for the master trainers for three weeks to allow *sufficient time to learn how to teach the TOT*. Our experience has been that a master training center is best created from an experienced LSS training center. In two separate programs, experienced LSS training center teams had each conducted over 30 LSS training courses for midwives and were confident in their teaching abilities. Both teams easily stepped into their roles of master trainers.

How Can We Train More Midwives More Quickly?

Some countries have training centers at the state/province level. Some countries assist senior midwives to conduct monthly meetings for the midwives in their area, each meeting provides a discussion of one skill. Midwifery associations develop continuing education programs in conjunction with their monthly meetings. These types of meetings transfer knowledge and attitudes, the participants are then encouraged to make time at their local referral site or training center to get hands on experience performing the skill.

Life-Saving Skills training can be included in the range of continuing education programs offered as long as the ingredients of a successful program discussed above are present (trainers, training site, and client load). The private midwives in one country requested short courses so they did not need to be away from their own practice for an extended period of time and so they could choose those courses necessary for their own practices.

The training center developed this series of short term courses in LSS with only the five day course being residential

- four days for introduction, problem solving, and antenatal risk assessment
- three days for monitoring labor progress using the partograph
- three days for sepsis, infection prevention, rehydration, and resuscitation
- five days for episiotomies, lacerations, hemorrhage, and labor and delivery problems including vacuum extraction
- three days for postabortion care

Identify Financial Costs (Initial Costs and Recurring Costs)

Funds will be required to develop an LSS training program and to equip the new training center with training materials, models and clinical equipment. Some programs have found that LSS costs more than other types of training because one trainer can handle only two trainees in the clinical areas at any one time. The benefits of having up to date trained emergency obstetric staff is invaluable to those needing the services.

Initial program costs may include bringing the new training center up to standard. Purchase of oxygen equipment, surgical instruments, and establishing an emergency resuscitation kit for mother and infant, including emergency drugs, may be necessary. If models and audiovisual equipment are not available (or can not be shared through midwifery training schools, ministries of health or education, or other sources), there may be an initial investment in this training equipment. These are non-recurring costs or set-up costs, though they will reappear if or when the program is expanded.

Some costs recur with each training course. These include extra supplies used by trainees (such as gloves, suture, soap, and cleaning materials). These costs also include training allowance for trainers, vehicle and gasoline costs for follow-up and support visits, and trainee costs such as transportation to and from home, housing, food, and laundry.

Non-recurring costs are often the responsibility of the ministry of health. Training costs may be shared or come from a single source. They are often shared by ministries of health, donors, communities that have become committed to improved maternal health, and the trainees themselves. Some midwifery associations may develop an LSS training program and sustain it with members paying for their own training. In planning how to finance your program, think about how it can be made most sustainable (lasting). The more costs you are able to support through local resources, the more likely you are to be able to continue the program over time.

The list of supplies, equipment and medicines by skill are located in Step Seven, beginning on page 151. The equipment and supplies for conducting a LSS training can be found in the Lesson Plans and Forms section, beginning on page 176.

General Outline of Program Budget Items

Recurring Costs

- Training allowances
- LSS training costs accommodation, manuals
- Transportation taxi, fuel, spare parts
- Supplies office and medical including suture material
- Building maintenance, utilities, administration

Non-recurring or Investment Costs

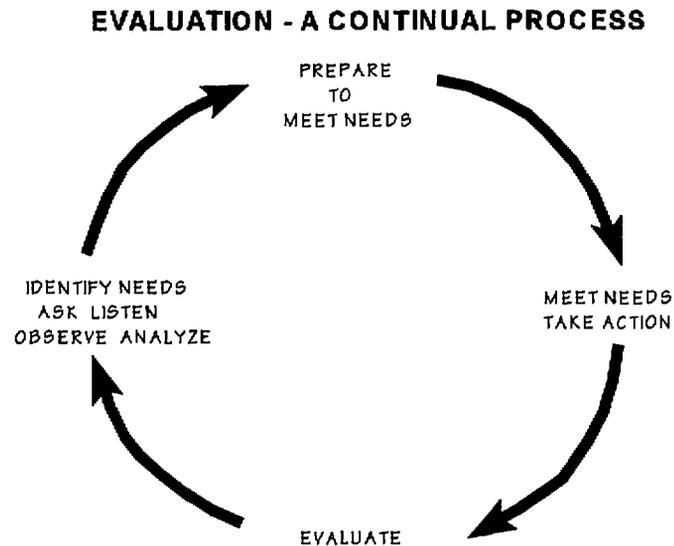
- Trained staff
- Transportation vehicles, ambulance, transport system
- Construction/rehabilitation of health facilities
- Equipment obstetric and training

Plan Evaluation

Though not specific to the LSS training, program evaluation is also a critical component of this process. Using a variety of monitoring tools including interviews of providers and clients, hospital and midwives registers, data on maternal and perinatal mortality, follow-up and support forms, and so forth, information is gathered which helps determine what has worked and what has not worked. The program can be modified accordingly at all levels including the training itself, protocols, documentation systems, and the monitoring systems.

It is important to plan the evaluation of the LSS program before starting the program. Evaluation activities before, during, and after LSS training can be thought of as a circle of activities. Evaluation is a continuous process and allows us to learn from our successes and mistakes so we can improve the program as we proceed. *Evaluation should not only measure whether we have achieved our goals, it should help us judge whether our goals were appropriate in the first place.*⁵

⁵ Werner D Bower B (1982) Helping Health Workers Learn p 9-22



Evaluation helps us learn from our successes and mistakes

It is not realistic to promise donors or ministries of health that the program will decrease maternal mortality by a certain percentage. Without extremely expensive population based surveys prior to the program, it is difficult to determine with accuracy the current mortality rate. In addition, it is very difficult to credit an increase or decrease in the maternal mortality rate to a given intervention (treatment). For example, if women cared for by LSS trained midwives had much better outcomes than before, but severe food shortages created an overall rise in deaths, the maternal mortality rate might actually increase. Even if mortality were to fall, it would be very difficult to demonstrate that LSS was responsible. Changes in deaths in a period less than 10 years cannot be measured reliably.

The LSS program can, however, promise donors and ministries meticulous evaluation of the training and trainees. A combination of pretests and post tests, clinical skills checklists, daily and final evaluations, incident reporting forms, and supervision/monitoring visits creates a system of close scrutiny of program progress, and allows program staff to make needed adjustments in the training along the way.

Methods to use in evaluating the LSS program include (1) ask the people, (2) watch the midwives, and (3) look at the statistics. To *ask the people*, interview community women, families and leaders regarding the care they receive from the midwife. To *watch the midwives*, you can repeat the training needs assessment (Step Two). This will allow you to identify any changes or strengthening that are needed in the training. Information from routine supervision and support visits will be useful as well. It is also important to measure the midwives' level of job

satisfaction To *look at the statistics*, you might review the LSS midwives' maternal and child health statistics that have been sent to the government and compare them with communities where the midwives have not been trained You might also look for changes in infection rates, neonatal mortality, and possibly maternal deaths within the institution that serves as the training site Methods should be kept simple, rates and statistics are only as good as the recording and the mathematics

Communities can evaluate the LSS program Saving the lives of women and newborns is an important issue for any community Many times community members do not realize what a valuable role they can play in saving the lives of women In most developing countries, 60 to 80% of births occur in the home and the majority are attended by untrained community or family members Since emergencies are unpredictable and unexpected, the women and their families are unprepared to deal with the crisis

LSS midwives can help community leaders learn problem solving skills and how they can contribute Recognizing a problem, making a decision, and taking action are responses that require information Midwives can give community members information about the nature of pregnancy and birth, what makes a potential problem, and how to take action when it is decided that there is an emergency that threatens the life of the mother or her newborn

Family members are the first persons to make a decision when there is an emergency in their particular family -- deciding *there is a problem* They are the first ones to take action in preventing maternal mortality Members of the community and community based caregivers can help organize support services The LSS midwife can help them organize support services She can stress the important role that women play in the family, community, and nation She can meet with women, other community groups, and informal gatherings to discuss why and how the majority of maternal deaths are preventable She can help women set goals and plan ways to help families learn important danger signs, why good nutrition is important, what other care is useful for pregnant women, and the value of well nourished, healthy girls She can also help them evaluate their actions and the effects of the program at the community level

After she has worked with them for some time, the LSS midwife can help the community evaluate whether they have

- healthier community women,
- greater newborn survival rates and a better chance newborns will achieve their life potential,
- contributed to the community's well being by improving women's health and productivity, and
- less pain and suffering from childbirth

It is very important to continue evaluating the results of the training and the program at all levels. It is also important that the midwives and health care systems they work for have information on how well LSS and general midwifery skills are being maintained.

List of Possible Methods of Evaluation

- Review midwife records for each birth, each emergency procedure, and each death
- Review records for each infant's condition, including immunizations
- Review the LSS midwives' community maternal and child health statistics that have been sent to the government and compare them with communities where the midwives have not been trained
- Interview community women, families and leaders about the care received from the midwives
- Interview the midwives about their use of new skills, the ease with which they use them, and their satisfaction with their level of competence. Look at their incident report forms
- Schedule regular post-training knowledge and skills evaluations of the midwives
- Encourage LSS midwives to help their communities evaluate the effects of LSS

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO:	TRAINING NEEDS ASSESSMENT (TNA)	25
	Plan and Prepare to Conduct the Survey	26
	Decide What Information Is Needed	27
	Request Approval for the TNA	27
	Form a Planning and Implementation Team	27
	Develop the Budget	29
	TNA Budget Categories List	29
	Sample Plan for a TNA Survey	30
	Conduct Orientation for Interviewers	31
	Explain the Purpose of the TNA	31
	Look at and Review the TNA Form	31
	Discuss the Survey Steps	32
	Conduct the Survey	33
	Hospital Training Site Survey	33
	Analyze Data	33
	Write a Report of Findings	34
	Example of a List of Some Findings from a Survey ..	34
	Identify Training Needs and Solutions	35
	Identify Life-Saving Skills (LSS)	36
	Selection of Training Site(s)	39
	Supportive Staff	39
	Client Load	40
	Clinical Guidelines (Protocols)	40
	Accommodations	42
	Identify Equipment for Life-Saving Skills	43
	Training Supplies: Equipment and Materials	43
	Midwife's Equipment	44
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP TWO: TRAINING NEEDS ASSESSMENT

Once there is consensus to conduct LSS training, a needs assessment is important to refine perceived needs and to better target interventions to be undertaken. The training needs assessment (TNA) should include a profile of community needs and the demands placed on the providers. This is complemented by a profile of provider skills, knowledge, equipment on hand, referral patterns, and a description of the provider's practice. In addition, information is collected to identify potential training sites. From these findings, decisions can be made on which facilities can serve as training sites, how many trainers are needed, how many participants per class, and what equipment is needed.

The analysis of the assessment will help to *establish the training program content, curriculum, and length of training*. For example, is hemorrhage a problem? If so, LSS Manual Module 5 **Prevention and Treatment of Hemorrhage** should be included in the training. Is postpartum infection a problem? If so, Module 7 **Prevention and Management of Sepsis** should be included in the training. Do midwives deliver only 20% of the women? If so, community integration or postpartum outreach from *Healthy Mother and Health Newborn Care* may be needed or the *Home Based LSS* program may be the choice. The analysis will provide information for **developing the design of the training program** (see page 4). For example, a three-tiered approach (community, health center, and hospital) may be needed in order to assist the woman and her family enter the health care system for appropriate obstetrical emergency care.

Plan and Prepare to Conduct the Survey

It is important to survey midwives working in a variety of settings (hospitals, clinics, community health centers, private practice) to identify both felt and observed training and equipment needs. Ways to survey and assess job performance include interviews, reviewing records, and observation of performance. Because the scope of practice may vary markedly between areas where physicians are readily available and areas without physicians, you will need to evaluate a cross section of the practicing midwives at training center and subcenter levels and the community level. The training needs assessment form has been developed to help you do this in an organized and consistent way. Many details must be planned and important decisions made. Thorough preparation will help to ensure that the survey goes smoothly.

Decide What Information Is Needed

Begin by thinking about **why** you want to do the training needs assessment. You may want to identify parts of the midwives' jobs they are performing satisfactorily and the parts that can be improved through LSS training. You may want to know what equipment is available and functioning to care for pregnant and delivering women and what critical equipment is missing and needs to be provided. (This information is very useful when outlining your budget requirements.) You may want to get the midwives' views and learn about the problems they are experiencing. You are likely to want baseline information for use in measuring improvements in midwifery services. Once you have listed the reasons for doing the TNA, read through the training needs assessment form, (beginning on page 245). Adapt and revise the form to allow you to collect the information you need.

List of Goals or Reasons for Conducting TNA (sample)

- Find out problems/needs of pregnant women and families
- Develop criteria for selection of trainers
- Identify potential training site
- Assess midwives' clinical skills and knowledge
- Identify midwives' equipment needs
- Identify potential training site equipment needs
- Identify training equipment needs
- Assess current role of midwives and how this relates to current policies and scope of work for midwives. Are there any obstacles to midwives providing emergency and life-saving procedures?

Request Approval for the TNA

You will need to get approval from the appropriate authorities before all plans are completed for the TNA, probably after you have prepared the draft goals, the TNA form, and the budget. The steps and timing will vary according to the local situation.

Form a Planning and Implementation Team

Form a TNA planning team that includes decision makers, supervisors and midwives. This may be a new group or may be the advisory committee members. The team will select those who will conduct the survey. They will set the dates, send the invitations, provide the orientation, or identify those to do the orientation, and prepare all materials. The planning team arranges transportation for the

survey, briefs administration, and coordinates the meeting to collect and analyze the data. Details they will need to cover include the following:

How many to survey? The team will need to decide how many midwives/institutions will be surveyed. If the total number of midwives and institutions available is small (for example, when there are only five midwives in a district), all of them might be included in the survey. If there are many, select a percentage of the midwives/institutions. It is usually possible to survey twenty-five percent of midwives and institutions in a district of average size. The greater the number of midwives you can survey in a district or area, the more representative the survey information will be.

Who will conduct the survey? The training needs assessment is best conducted by senior midwives who have received orientation in using the assessment form and have practice in data collection using verbal, written, and observation methods. It is ideal for senior midwives, while performing the assessment, to do spot checks to ensure that the collection of data proceeds smoothly and that there are no problems.

What arrangements must be made? Logistic needs must be identified and arrangements made. This includes arranging for survey team members to be available for the time required for orientation and carrying out the survey. Communication between the planning and implementation team, the survey team, and the midwives and institutions to be visited is essential to ensure that everyone is available at the agreed times. Be sure invitations and other correspondence actually reach the people to whom they are addressed. Schedule an orientation for the survey team, including one or two days of practice using the TNA form.

What materials will be needed for the survey? Once the content of the assessment has been agreed upon, it is important to prepare the TNA form in advance. Make sure there are sufficient copies for orientation and practice in addition to the number needed for the survey. You may need to translate the form into a local language. If this is the case, plan for time to test the translation before making photocopies for the orientation and the survey. You will need access to a photocopy machine, paper, stapler, and staples. You will need pens, pencils, and a clipboard for each survey team member.

How to select midwives for the survey? In making the selection, you will need to consider accessibility, time, and money. You may need to survey midwives on a local bus route, or midwives in close proximity to each other. You may need to survey midwives at hospitals, if there is not enough time and money to actually conduct a survey of midwives in all situations. The important thing is to find out what the midwives know, what they are doing, and what they want to do.

A simple way to select midwives for a survey is

- 1 Write the name of each midwife working in the survey area on a small piece of paper
- 2 Fold those papers and put them into a container
- 3 Once you have decided on the number of midwives you will survey, ask someone to draw the same number of papers from the container
- 4 Write a list of each name drawn. These are the midwives you will survey

Develop the Budget

What will it cost? List the categories of expenses (see sample below), then consider each category in detail. Think about how much transport will be needed and how much it will cost. Consider how many interviewers will be required to collect the information and what they will need to do their work. They may need per diem, salary, identification tags, and so forth. Think about the stationary that will be needed and about the cost for copying survey forms. You will need writing materials and small office equipment both for the survey and for the analysis. Are there any other costs for the analysis?

Training Needs Assessment Budget Categories List (sample)

- Per diem
- Supplies such as stationary
- Reference materials
- Transportation
- Postage, telephone, and fax
- Rental of facilities and equipment
- Support staff such as secretary

Time needed to complete the TNA is difficult to estimate. The estimated time is never long enough. Time must be allowed for each person to actually find, interview, observe, and record information for each midwife. Time must be allowed for putting together the information, writing conclusions, making recommendations, writing the report, and presenting the information. One program's plan for a survey is outlined below. You can use it to discuss with others when making your plan.

Sample Plan for a TNA Survey

1 Plan the TNA

- Draft the TNA goals, decide what information is needed
- Get approval for the survey
- Form a planning team that will select survey team members, decide how many to survey, and identify midwives/institutions for survey The team will also decide how the survey information will be analyzed and complete the arrangements
- Develop the budget
- Draft the TNA form, deciding what to assess
- Select dates for survey

2 Prepare for the TNA

- Get approvals for budget, TNA form, and survey date Send invitations and information
- Prepare orientation for the use of the TNA form Send follow-up invitations and final information on date, time and place for orientation
- Make copies of the TNA form and prepare packets with all materials
- Brief administrators on plans and what is expected
- Arrange logistics, communicate with those to be surveyed
- Collect materials, arrange for photocopying, and so forth
- Conduct orientation for interviewers

3 Conduct Survey

- Give assignments, time schedule, and expected date of completion
- Provide per diem, hotel information, and other information as needed
- Arrange for spot checks the first day(s) to ensure that instructions were clear
- Hold a data collection meeting to collect TNA forms, review initial impressions, and share the objectives, process, and initial impressions with the administration

4 Data Analysis

- Collect all forms
- Compile the data in each section according to the major sections of the TNA form
- Identify problems/needs of the community, midwives, other providers
- List possible solutions for each problem/need

5 Write Report

- Describe the current situation of maternal mortality/morbidity, role of midwives and obstacles
- List recommendations for training, equipment, follow-up
- Develop a summary of sites assessed activities, staff, cases
- List suggested trainees
- Identify suggested training site(s)

Conduct Orientation for Interviewers

Before the survey team members go to the field to collect data, they must be very clear about every aspect of their task. At least two days should be scheduled for the orientation activity. Interviewers should review the skills they will use. They must become familiar with the survey form and be clear about how they will proceed. They can identify any questions or procedures they are unclear about, and possibly help to foresee difficulties in gathering the data. Each interviewer should practice using the TNA form so she is familiar with it and understands each section. Logistical arrangements, a schedule for field visits, and the date for a meeting to collect the forms and discuss field experiences and impressions should all be addressed. To ensure interviewers are ready to conduct interviews and make observations, the following should be included in the orientation:

Explain the Purpose of the TNA

Outline the reasons for the assessment as identified during planning. Explain that interviewers will collect information in the same way from each midwife and that the information will be compiled to give a picture of the overall situation. Although interviewers will find different levels of skill, the task is not to identify individual midwives who are not doing their job well, but rather to identify what and who needs to be included in the training. The TNA also identifies what equipment must be provided to the midwife to assist her perform the skills.

Look at and Review the TNA Form

Go through each section of the form and describe how it should be used. Have the interviewers practice using the form. You might have them begin by interviewing each other. Organize practice for them in the clinical setting. Encourage them to identify any problems or points that are unclear. Where problems are identified, agree on necessary changes. Where a need for a consistent way of asking or observing is identified, work for agreement on how it will be done.

Discuss the Survey Steps

The interviewer will use the following steps in order to obtain information required for making decisions about the LSS Training. This information is used to plan and implement the entire training program.

Introduce the survey The interviewer must set a friendly and trusting environment for the interview. When she first meets the person she is interviewing, it is important to introduce herself and take some time to speak with the interviewee, so that she feels **comfortable**. Encourage the interviewers to identify ways to accomplish this.

Explain why you are doing this interview The interviewee should know why this interview is being done. Many times a person being interviewed will feel like she is being tested. ***This is not a test***. Tell the interviewee that this interview will provide information to plan a training program. When information is available on what knowledge and skills the midwives need, the training program can be planned. The focus of the training will be to ***strengthen the life-saving skills*** of each midwife. Tell them it is hoped that the training will be done at hospitals in the area and that training will begin on (mention projected date).

Conduct the survey Have the interviewers practice conducting the survey, perhaps beginning with each other. They can get the feeling of how it feels to be asked questions and practice asking questions. Insights can be gained by the interviewee as well as by the interviewer. They should also practice in a clinic, health center, or hospital setting with a midwife who is not included in the survey.

After the initial practice, encourage discussion of how best to ask questions and whether it was difficult to remember responses. Discuss the importance of asking questions the same way in all interviews so the information gathered by all interviewees can be compared. Ask how the interviewee felt and how midwives being interviewed in the field can be made to feel at ease during the interview process. Ask the interviewers to describe their experiences in recording the responses and discuss how to do this accurately.

Ask how the interviewers approached the task of reviewing records in the practice interview. Will all midwives being interviewed have the same records kept the same way? How can the records be reviewed most efficiently? How did they go about collecting the information on equipment and supplies and what problems did they experience in doing this? Was it possible to actually see each item of equipment?

The interviewers should observe the midwife's performance as she cares for antenatal or laboring clients, or demonstrates her routine for infection prevention. These observations should be recorded on the appropriate skills checklist. The interviewers should take the LSS Manual or a copy of several skills checklists to the interview. The interviewers should practice using skills checklists to record their observations prior to the actual survey.

Say good-bye When she has finished collecting all the information, the interviewer should thank the midwife for her time and patience in answering all the questions. Let her know that she will be able to get more information about the results of the assessment through local health staff meetings.

Conduct the Survey

Everyone participating in the survey meets at the agreed time. Either at the beginning of the survey or at the end of the orientation described above, present the schedule for the field visits. Give each interviewer her assignment and make sure she is clear about transportation arrangements as well as per diem or lodging arrangements. Distribute TNA forms, pencils, identification tags, and any other needed equipment and supplies. Proceed with the survey.

Hospital Training Site Survey

Some interviewers may also conduct a survey of hospital training sites using the hospital training site survey found on page 261. In that case, hold an additional session for those who will be involved to discuss how they will proceed. In that session, discuss the importance of developing good relationships with the staff of potential training sites.

Analyze Data

When data collection is complete, hold a meeting to collect the TNA forms, review initial impressions, and share information with key personnel on the objectives, process, and initial impressions that were found. This meeting can also serve as a preliminary forum for discussion of LSS with the understanding that a more in-depth meeting will follow once the TNA results are compiled. You will have decided who will do the in-depth analysis. The person(s) with that responsibility compiles the data in each section according to the major sections of the TNA form and writes a report.

Write a Report of Findings

Write a brief report of the findings in each section, both positive findings and those indicating some need for improvement. Make a list of the findings relating to the midwives information on the TNA form and also findings from the institutions. You will find a sample list of findings in the box below.

Plan how you will distribute the information, perhaps through meetings with the Ministry of Health or even a planning workshop with the advisory committee. It may be helpful to include a member of the survey team as part of the presentation group. Possibly the presentation of results and discussion can occur at the time of the site preparation described in Step Three, page 49.

Example of a List of Some Findings from a Survey

- 1 Out of 100 midwives 100 were trained to use the partograph, 6 use the partograph, 100 want refresher
- 2 Partograph used by 6 midwives 24 partographs reviewed had missing information (cervical dilatation every 4 hours in active phase marked on 4, full dilatation marked on 9, time of rupture of membranes marked on 6, urination noted on 2)
- 3 87 of 100 midwives said that they were trained in episiotomy repair 74 do perform repairs and 58 want refresher
- 4 80 of 100 midwives said they were trained to perform antenatal risk screening, 77 do the screening, 58 request a refresher
- 5 93 of 100 midwives were trained to use gloves as universal precaution 83 wear gloves, 16 request refresher
- 6 36 of 100 the midwives said they would perform a vaginal exam on a woman with heavy antenatal (30 weeks gestation) vaginal bleeding (this is contraindicated)
- 7 92 of 100 midwives knew how to start an IV and knew to refer cases of postpartum bleeding
- 8 25 of 100 midwives knew other aspects of postpartum bleeding (fundal massage controlled cord traction, application of oxytocin)
- 9 83 of 100 midwives were trained in manual removal of the placenta 71 do it, and 48 request refresher

Identify Training Needs and Solutions

When all the findings are compiled, look at them to answer questions regarding the needs of the midwives. You can identify areas of practice where they are performing poorly and the skills they need. You can see what equipment will have to be replaced and what supplies are short or unavailable.

The baseline information data in the TNA form (see page 245) is used to develop a profile of the midwives who would best benefit from LSS, would continue working to use the skills, and their learning needs. The profile developed includes distance to referral, plans to remain at work site for three to five years, sufficient clients to use the skills, and the ability to keep up to date.

Also, depending on the time, cost, and distance for a referral, decisions may be made to expand the options for treatment for the LSS Midwife with impossible circumstances or no referral options. Some of these are individualized during training, but the recognition that it is necessary and the changing or expanding of the options for treatment need to be done when the guidelines (protocols) are reviewed. During the analysis of the TNA findings in one area, it was found that transport was very expensive in some areas making it difficult for midwives to refer clients. The guidelines for treatment were expanded to allow the midwife to provide additional care where transport was almost impossible.

The statistics information in the TNA form (see page 246) is used to find out what the midwives are doing, how many and what kind of referrals, and to tailor the training to fit those needs. We assume we have a representative sample of all midwives in the TNA. For instance, in one area the survey found that the community midwives were doing very few (0 to 5) deliveries in a month. The question was whether to teach episiotomies, or find out how many deliveries there were each month in the community to see if midwives could access more women if they knew how to do episiotomies. It was found that postpartum hemorrhage (PPH) was the problem so a postpartum care program was developed.

Identify Life-Saving Skills

To identify the life-saving skills midwives or other providers need to learn, you can use the following *Skills By Provider⁶ and Training* checklists. The checklists outline the skills by training and provider (Checklist "A" for home birth attendant, checklist "B" for trained midwife and trained pregnancy care provider, and "C" for trained midwife). For example, the TNA findings show that most women with postpartum hemorrhage arrive at the first line of referral without stabilization (no bimanual compression, bladder full, baby not breast feeding, no rehydration fluids). From this information, there may be need for home birth attendant training emphasis on home monitoring during the postpartum period, and recognition and initial management of postpartum hemorrhage. You can see that these two topics have been marked in the checklist "A" on this page. You can use this checklist to record which modules and skills should be included in the training.

Skills by Provider and Training -- Checklist A

Training	Home Birth Attendant	YES	NO	COMMENTS
HB LSS using Home Based LSS	1 Basic prevention of anemia and tetanus • advise nutrition iron Vitamin A, tetanus toxoid			
	2 Clean safe home delivery and immediate newborn care • personal hygiene hand washing delivery preparation safe position good nutrition clean delivery prevention of harmful practices • warm dry skin-to-skin cord care exclusive breast feeding eye care			
	3 Home monitoring during postpartum • monitor uterus and bladder breast feeding reduce work load	✓		
	4 Recognition and initial management and appropriate referral of selected complications such as maternal hemorrhage infection prolonged or obstructed labor and infant resuscitation • postpartum hemorrhage bimanual compression hydrate • infant resuscitation warm dry position stimulate mouth to mouth fever sponge bath hydrate • prolonged or obstructed labor position hydrate	✓		

⁶ Provider definitions: A home birth attendant is anyone including a TBA who attends a birth at home. Trained pregnancy care providers may be auxiliary midwives, community midwives, or others who have had some midwifery training and may work in the hospital, maternity center, or in the community. Trained midwives may be professional midwives and nurse-midwives who have formal midwifery training and work in the hospital, maternity center, or in the community.

For example, 83 of 100 midwives were trained in manual removal of the placenta, 71 do it, and 48 request refresher as on page 34. A recommendation is made to include manual removal of the placenta as a skill in the training. In checklist "B" below, manual removal of the placenta is marked with a ✓ in the column labeled yes.

Skills by Provider and Training -- Checklist B

Training	Trained Midwife	Trained Pregnancy Care Provider	YES	NO	COMMENTS	
<i>HMHN using Healthy Mother and Healthy Newborn</i>	Topic 1 Working with the Community • antenatal nutrition/health delivery preparation postpartum outreach transportation blood donors harmful practices referral					
	Topic 2 Prevent Infection • steps of infection prevention protect mother baby and midwife					
	Topic 3 Antenatal Care • monitor fetal growth and mother's health identify problems treat and counsel					
	Topic 4 First Stage of Labor Care • emotional support position comfort fluids cleanliness monitor mother/baby					
	Topic 5 Second Third Stage Labor • preparation position safe/clean delivery baby skin-to-skin breast feeding cord/eye care deliver placenta as soon as possible monitor/massage uterus oxytocic					
	Topic 6 Postpartum • postdelivery care for mother/baby at 6 hours 3 days 2 weeks 6 weeks counseling for breast feeding family planning baby/self referral					
<i>LSS using Life-Saving Skills Manual for Midwives</i>	Module 2 Antenatal Risk Assessment/Management • history physical exam screen and manage anemia/pregnancy induced hypertension/eclampsia monitor fundal height plot/interpret antenatal risk assessment tool					
	Module 3 Labor Management using Partograph • history physical exam monitor record interpret identify/manage problems					
	Module 5 Prevention/Treatment of Hemorrhage • identify/manage bleeding antepartum intrapartum postpartum • perform active management of third stage manual removal placenta bimanual compression inspection with vaginal speculum digital evacuation			✓		
	Module 6 Resuscitation • immediate care of newborn at birth APGAR infant cardiopulmonary resuscitation					

Another example might be that the TNA findings are that “trained midwives are referring women in the second stage of labor ” A recommendation may be made for additional training in episiotomies, delivery problems ,and vacuum extraction These topics are marked with a ✓ in the column labeled “yes” in checklist “C”

Skills by Provider and Training -- Checklist C

Training	Trained Midwife	YES	NO	COMMENTS
LSS using <i>Life-Saving Skills Manual for Midwives</i>	Module 1 Introduction to Maternal Mortality • Problem Solving			
	Module 4 Episiotomies and Repair of Lacerations • Prevent lacerations			
	• Give local anesthesia	✓		
	• Perform episiotomy cervical and vaginal inspection	✓		
	• Repair with needle holder tissue forceps/gloves	✓		
	Module 6 Resuscitation • Adult CPR			
	• Heimlich Maneuver			
	Module 7 Prevent and Manage Sepsis • Prevention and treatment of sepsis antenatal intrapartum postpartum postabortion			
	• Universal precautions			
	Module 8 Hydration and Rehydration • Prevent identify and manage shock			
	• Rehydration methods			
	Module 9 Vacuum Extraction • Identify indications dangers	✓		
	• Perform procedure	✓		
	Module 10 Other Emergencies • Labor/Delivery Problems	✓		
	• Manual Vacuum Aspiration			
• Perform Symphysiotomy				

You can use these checklists to record which topics and skills should be included in the training

Once the information from the TNA highlights the topics and skills needed, the LSS training content can be tailored for the needs of providers. It is essential for the midwife to have the clinical volume to maintain the skills once trained. In one area the midwife had limited clinical volume, averaging about one delivery per month, the training content was modified to reinforce her knowledge of normal aspects of antenatal, labor and delivery, and postpartum care, as well as some aspects of LSS. Focus was given to community integration as well as counseling skills using the *Healthy Mother and Healthy Newborn Care* manual. Later, when the clinical volume increased, additional skills were taught.

Analysis and use of the information collected on the midwives' equipment and supplies is discussed in the section titled Identify Equipment for Life-Saving Skills, beginning on page 43. Use of the findings from the hospital training site section of the TNA form is discussed in the section titled Selection of Training Site(s), below.

Selection of Training Site(s)

Location of training is a decision which needs to be made early. The availability of appropriate facilities will dictate where LSS training is held. Begin to develop lines of communication and provide an introduction to the LSS training program with hospital administration and staff. To assure availability of adequate clinical experiences for participants, the hospital training site must have available 12 to 15 births per participant trained during the training period (usually two weeks). In addition, potential training sites should be assessed to determine clinical protocols being used and modifications needed, adequate staffing to cover trainers when teaching, staff interest in participating in a training program, equipment available, documentation systems being used, and facilities to accommodate students on site. Assess possible training site facilities for (1) supportive staff, (2) sufficient client load, (3) clinical guidelines (protocols), and (4) availability of accommodations. It is important to also find out the number of other training programs using the training site and find out their schedule, case load needed, and possibilities of sharing experiences. Except for staff attitudes of support, the information is collected using the training needs assessment, hospital training site form on page 261 to 263.

Supportive Staff

Staff support and interest in teaching are key to the effectiveness of an LSS training site. Staff willingness to cover when trainers are teaching is key to the long term success of program. It is important for the training site to have strong midwifery leaders who are highly respected by physicians. A supportive obstetrician-gynecologist who recognizes the expanded role and responsibilities of the midwife as a critical ingredient in decreasing maternal mortality can promote

and guide the training. Such a physician may assist with adapting guidelines (protocols), supporting the midwife trainers and trainees, and ensuring that trainees get adequate experience. This physician may participate in the training by providing clinical supervision and assistance, teaching selected sessions, and possibly also providing translation expertise in the adaptation of the LSS materials to the local language.

Language can be a significant challenge in LSS training. Translation of materials must be done by people proficient in medical translation. When using training consultants without local language proficiency, the LSS training requires several translators to ensure accuracy, rest for translators, and no missed clinical opportunities.

The midwifery staff must be sufficient in number and have sound clinical skills, should be anxious to expand their scope of practice, and must be both capable and willing to share their skills and knowledge. The hospital administration must agree for trainers and key maternal health personnel to participate in the training. This commitment by the hospital administration is essential because the trainers and maternal health staff must move from work unit to classroom to other units, depending on the availability of clients. The trainers and other staff are expected to teach and perform their regular work tasks. Administrators tend to be supportive when they are aware of both the demands and advantages of LSS training before it begins.

Another important staff member is the individual responsible for handling payments such as travel expenses from place of work to training site and return, per diem if appropriate, and so forth. It is best if the trainers can be spared these budget responsibilities though they have managed them in some of the LSS Programs.

The training site should be selected for lack of competition for deliveries. If medical students, residents, interns, or midwifery students are competing with the LSS training program, the delivery volume will have to be increased markedly.

Client Load

Clinical training (on the job) involves a lot of clinical opportunities for practice. A client load large enough to provide clinical experiences is a necessity. LSS experience has been that the number of antenatal and delivery clients increases once LSS training is established. The hospital training site must offer full pregnancy services including antenatal, intrapartum, and postpartum. If cesarean sections are not conducted on site, a referral site must be near enough for trainees to participate in this activity.

In a two week training course (13 days), it is possible to train between six and eight midwives to the level of competence in all skills, provided the annual delivery case load is at least 2500. This gives **12 deliveries per trainee if there are 8 trainees** and **16 deliveries per trainee if there are 6 trainees** (See box below). Six to eight trainees is a good class size.

Calculating hospital training site capacity for trainees				
number of deliveries		number of trainees		
annual	two weeks			
2500	96	8	6	4
2000	76		6	4
1500	56			4

If training takes place where there are fewer deliveries, there will not be enough experience in the 13 days to ensure sufficient learning opportunities. If the annual client load is 1500, you can provide **12 deliveries to each of 4 trainees** in a two week training. It is *essential to have a minimum of 12 deliveries per trainee*. It is wise to have a backup plan, in case someone does not get enough clients for experience or is a slow learner. Plan for that person to be invited back between training courses when trainers can offer a high volume of clients and a high level of support. In LSS training experience thus far, between two and five percent of trainees need this extra assistance.

Clinical Guidelines (Protocols)

A fundamental aspect of improving the quality of services provided by midwives is the establishment of clear clinical guidelines (protocols). For LSS training to function efficiently, protocols must be established at the institutional level. These clinical protocols are agreed upon during site preparation. It is also important to subsequently agree upon these standardized protocols, if they do not already exist, at the district and national levels. Some countries have safe motherhood protocols, and other have guides for midwives. Once protocols are written and published, there must be a system for implementation, monitoring, and regular review in order to keep them current so they can serve as a monitoring tool for quality care. Sample guidelines (protocols) can be found on page 264.

The training site becomes a model of practice for trainees who are usually from outlying areas. Therefore, it is important that systems be in place and working to use the partograph for monitoring labor progress, do referral procedures using the guidelines (protocols), handle emergency drugs on the units, provide blood transfusions, ensure that emergency packs are available for cesarean sections, and so forth. Commitments to upgrade the training site(s) to LSS training standards should be included in any memorandum or letter of understanding (See Step One, page 14)

Accommodations

Residential accommodations at the training site are another important part of the assessment. The training is organized to allow for maximum clinical practice in a short time frame. LSS is designed as a two week residential training because midwives find it difficult to be away from their work sites longer. To take advantage of all clinical learning opportunities, the classroom needs to be close to the labor and delivery unit. The classroom also needs to be large enough to accommodate trainers and trainees for discussions, demonstrations, and skill practice. It should provide privacy and be in a relatively quiet place.

Schools close to the hospital may have facilities for sleep rooms and meals. Other things to check on include availability of a caterer (food), quiet space for daytime sleepers who have been up all night, a study area with electricity and without mosquitoes, laundry, running water, transportation, and an on-call room. The hospital may have staff housing or unused units available as accommodation. Sometimes a house or hotel must be used.

Identify Equipment and Materials for Life-Saving Skills

Equipment at the training site and at the midwives' places of work must be considered. The basic equipment necessary to perform LSS is not much different from the equipment most midwives use every day. It is essential that the equipment at the midwife's job site be in working order so she is able to perform the skills she has learned. The information collected in the training needs assessment section on equipment provides information about the equipment needs of the midwives who were interviewed and gives a general picture of the status of equipment at trainees' job sites. The equipment used in LSS training may be borrowed from the hospital unit (possibly a delivery set) or from a school of midwifery (maybe a pelvic model).

Training Supplies Equipment and Materials

The training equipment and supplies needed are listed on page 262. Availability of training equipment for teaching LSS is assessed during the TNA. Hospital training site information from points 7 and 8 of the TNA are used to inventory available teaching equipment and supplies, such as an infant resuscitation model or video machine. Compare what is available with the list on page 271 to identify what must be ordered. Since resources are often shared among units and schools, it is wise to find out what equipment is available at other units such as the midwifery training school and the health education unit. Costs can be kept down by making use of what is available at the midwifery schools and other health units. Sometimes new equipment can be shared by the LSS training site and the midwifery school.

The printed training materials are the *Life-Saving Skills Manual for Midwives* and the accompanying *LSS A Clinical Practice Guide*, worksheets of the partograph, and for the trainers, the *Manual for Policy Makers and Trainers*. If it is decided to use *Healthy Mother and Healthy Newborn Care* and the accompanying *A Guide for Caregivers* or *Home Based LSS*, you may still want the previously mentioned training materials as reference. All of the manuals include objectives for each topic, the course content, case studies, review questions, and checklists. LSS lesson plans are included in the *Manual for Policy Makers and Trainers* beginning on page 180. Other references and texts can be made available during training by borrowing them from a medical, nursing, or midwifery school library if they are not available otherwise.

Midwife's Equipment

The LSS midwife may need to receive equipment to supplement what she has available so that she is able to perform all the skills she has learned. Data from the TNA provides a general picture of equipment that is available, but the equipment needs of individual midwives will depend upon the content of the training and each midwife's inventory of the equipment available at her place of work.

To create a basic equipment list for the midwives trained in your LSS program, review the basic equipment for the LSS midwife on pages 151 to 152 and remove any items used for skills not included in the training. (For example, if vacuum extraction will not be taught, items used for this procedure should be removed from the list.) Note that the inventory form found on pages 281 to 282 will need revision to reflect any changes with the basic equipment list.

During her registration for LSS, each midwife trainee completes an inventory of her work site. Her inventory can be compared with the basic equipment list to identify specific equipment needed.

It is important that midwife trainees coming from the public sector understand that the equipment they receive belongs to the health unit they work in and is not theirs to keep. The goal is always to do the greatest good for the largest number of women. Equipment should not be sitting on the shelf in the home of an LSS midwife.

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE:	TRAINING SITE PREPARATION	45
	Site Preparation Schedule for Training Site Personnel	47
	Workshop Schedule for Training Site Preparation	47
	Meet Key Personnel and Develop Guidelines of Care	47
	Conduct Overview of LSS	48
	LSS Overview	48
	Review Training Needs Assessment Results	49
	Decide on Administrative Structure	49
	Review Guidelines (Protocols) of Care	50
	Finalize Criteria for Selection of Trainers	50
	List of LSS Training Coordinator Tasks	50
	LSS Trainer Tasks	51
	List of Trainer Tasks	51
	Criteria for Selection of LSS Trainers	51
	List of Selection Criteria	52
	Trainer to Trainee Ratio	52
	Select LSS Trainers	53
	List of Training Team Leader Tasks	54
	Conduct Training Site Inventory	54
	Review Hospital Records	54
	Hospital Records Review Form	55
	Conduct Workshop for Training Site Personnel	56
	Preparation Plan for LSS Training	56
	LSS Procedures	57
	Finalize Residential Arrangements	57
	Finalize On-Call Room	57
	Finalize Classroom	58
	Site Preparation Final Meeting	59
	Meeting Agenda	59
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP THREE: TRAINING SITE PREPARATION

Upon completion of analysis of the TNA data and decisions about the structure of the training system, site preparation can be done. This activity requires one week at each training site. It provides an opportunity to review the results of the TNA, to ensure everyone at the facility understands the training program, and to finalize agreements about clinical protocols and procedures for use of the partograph and infection prevention. Trainers may be selected during this week or later when the training center is being prepared. It is important for discussions to take place during the site preparation to ensure that administrators and potential trainers understand the time commitment required and the need to provide additional staff to release trainers from some of their previous responsibilities.

Site preparation also includes an equipment and supplies inventory, review of hospital records, decisions about logistics, and discussions about the training center administrative structure. Including all key departments during this process orients them to the program and facilitates the establishment and running of the center. A key component of site preparation is an orientation workshop (see Step 8, page 153) for all staff in the antenatal, labor and delivery, and postpartum wards of the hospital to ensure that all are using the same skills and techniques that will be taught to the LSS trainees. A potential weakness of a training program is when the staff at the training facility practice differently from what training participants are taught. Through the orientation workshop training, consistency can be assured between the learning environments in the classroom and the hospital wards. Potential conflict between trainers and other hospital staff can be averted.

When participants LEARN and SEE the same thing being practiced by the staff in the training facility as is being taught in the classroom, they learn better

The ideal training site allows a trainee to practice skills she has learned and provides adequate supervision throughout the time she is in the facility. Permanent staff at the site are key supporters of LSS training experiences and model the skills and attitudes being learned. All the equipment a trainee is being trained to use is available to her while she is at the training site. The antepartum assessment form and the partograph are used routinely.

Site Preparation Schedule for Training Site Personnel

Among the factors that contribute to a successful LSS program, the staff at the training site is the most important. If the members of the training site staff are oriented to the LSS program, they are likely to be supportive and willing to assist trainees. The workshop is designed to provide an orientation to LSS and training in selected life-saving skills to staff of the training site. If system changes are required to introduce the partograph and antenatal assessment, these changes are introduced in the workshop. Plan a one week orientation and training workshop for each training site.

Workshop Schedule for Training Site Preparation

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
KEY PERSONNEL MEETING •OVERVIEW LSS •REVIEW TNA RESULTS •ADMINISTRATIVE STRUCTURE •GUIDELINES OF CARE •FINALIZE CRITERIA FOR SELECTION OF TRAINERS	LSS ORIENTATION WORKSHOP		PREPARE FOR LSS TRAINING •SELECT TRAINERS •IMPLEMENT PROCEDURES •PLAN LOGISTICS	IMPLEMENT LSS PROCEDURES IN CLINICAL AREA
	MATERNAL MORTALITY AND MORBIDITY OVERVIEW OF LSS	TRAINING PROBLEM SOLVING AND REFERRAL PROCEDURES		
	TRAINING MONITORING LABOR USING THE PARTOGRAPH		TRAINING ANTENATAL ASSESSMENT OF PROBLEMS IN PREGNANCY	
	LUNCH	LUNCH		
CONDUCT SITE INVENTORY IN CLINICAL AREAS IF NOT COMPLETED REVIEW RECORDS	INFANT RESUSCITATION	TRAINING INFECTION PREVENTION PROCEDURES	IMPLEMENT LSS PROCEDURES IN CLINICAL AREA	

Meet Key Personnel and Develop Guidelines (Protocols) of Care

Meet with key training site personnel (administrators, physicians, midwives, and other staff) to give them an idea of the objectives for the week and to confirm their institution's role in the LSS program. Provide them a draft schedule for the week and revise it as you work together. During the meeting (1) give an overview of Life-Saving Skills, (2) review the Training Needs Assessment results, (3) discuss

an administrative structure, (4) review guidelines (protocols) of care, updating them them and making any needed modifications, and (5) finalize criteria for selection of trainers

Conduct Overview of LSS

Give an overview of Life-Saving Skills. Usually some of the training site staff are involved in the early discussions about LSS. Some of the senior midwives may have been part of the training needs assessment team. Even so, it is important to provide background information on how LSS has developed to this point. Provide a copy of the assessment report to serve as a reference for sharing information with other members of the staff.

LSS Overview (sample)

LSS is a program for teaching new (or updating previously learned) clinical skills to adult learners who present for continuing education with significant clinical and life experience. In LSS, the trainers and participants are partners in the process of learning. Adults learn skills at differing rates. Therefore, LSS uses

- A competency based training approach. Participants proceed at an individual rate to master skills, completing the process only when the skill being demonstrated has been done satisfactorily.

- Skills checklists. For each skill there is a checklist which the participants use in the clinical area. The steps of each skill have been analyzed and written into an organized list. The participants use the checklists to study, practice and learn the skill. Either the trainer, a participating physician, or a participant colleague is asked by the participant to observe as the skill is performed. The observer assesses the skill by checking the items on the list to determine whether it was completed in a satisfactory manner or if improvement is needed. Each clinical experience then becomes an opportunity to reinforce and strengthen or correct the skill being learned. The majority of participants (95 to 98%) gain mastery of all requisite skills during the training session. Those requiring additional practice will be given an opportunity to stay on until they and their trainers feel they have mastered the skill(s).

- Problem solving as a management process by which information is systematically obtained to make informed decisions and to plan for care. LSS teaches a four step problem solving method that includes

ASK and LISTEN - Questions are asked to learn critical information about personal medical and obstetrical history, status of current pregnancy and problems.

LOOK and FEEL - Physical examination skills are used to obtain necessary data about this pregnancy and current health status.

IDENTIFY the PROBLEM - A decision is made about the client's problem(s) based on the findings from the two previous steps.

TAKE ACTION - Care, education and counseling are provided, laboratory testing is done, referral and further follow-up are done as indicated. The recording of all information completes the process.

- **Records and Record Keeping** The importance of keeping thorough and detailed records cannot be overstated. Every woman matters, and every pregnancy should have its own record. Records provide a history of practice, a means of identifying quality care, and documentation of care as a reference for follow-up and support.
- **Infection Prevention** Consistent and thorough infection prevention measures to protect providers and mothers are learned and instituted by the trainees.
- **The partograph** Appropriate timing of referrals and intervention to prevent obstructed labor, postpartum hemorrhage, infection, or ruptured uterus requires the careful documentation of the progress of each labor. Midwives learn to use the partograph during LSS training and are provided sufficient forms for their use. During site preparation for LSS, training site staff have the opportunity to implement use of the partograph.
- **Risk assessment** The LSS program emphasizes the many needs of women and uses education and family involvement to include the woman in her own care. LSS includes the skills a midwife needs for identification of women at risk (child bearing age, pregnant and postpartum), cardiopulmonary resuscitation, the provision of important components of antenatal care (anemia screening, nutrition education, tetanus toxoid immunizations, estimation of fetal size/dates, pre-eclampsia screening) and recording all such information.

Review the Training Needs Assessment Results

Discuss the findings and observations of the TNA. Discuss the recommendations for the training program curriculum including the skills identified. Provide information about any other training offered and its program plan. Present and discuss a list of equipment and supplies required for the training and the status of the midwives' equipment using the information from the TNA findings. Describe the timing of events for the LSS training referring to the beginning of the manual on page 8.

Decide on Administrative Structure

Discuss the need to design and implement an administrative structure for the training center. For example, one LSS program set up a special committee with a director, treasurer, training team leader, and secretary to handle the administration. Another LSS program set up a structure in which the hospital administrator managed the finances, the senior nursing officer in charge managed the residential facilities, and the assistant to the medical officer dealt with technical issues. Staff in each program needs to look at its own situation and set up a structure appropriate for their institution.

Review Guidelines (Protocols) of Care

For LSS training to function efficiently, protocols (guidelines) must be established at the institutional level. Discuss the standards that guide the institution's midwives in making decisions about the care they provide. Guidelines (protocols) outline the care all women will receive during pregnancy, intrapartum and postpartum. Guidelines can only be evaluated when they are written. Review available guidelines currently in use in the institution (this may have been completed by the advisory committee). Update or revise them as necessary.

Some sample guidelines can be found on pages 264 to 270. They must be adapted to your situation. The consultants, physician staff, and senior midwives may review the guidelines, make changes, write additional information, and reach consensus on the care to be given. The process for adapting may include using the skills identified during the TNA analysis.

Finalize Criteria for Selection of Trainers

Successful trainers of LSS are very special people. They need to be clinically competent and confident. In order to teach advanced midwifery skills, trainers need to be active in clinical practice. Midwives (LSS coordinator, training team leader, and trainers) and a backup obstetrician or physician with obstetric experience make the perfect training team. It is important to have an obstetrician/physician as a member of the training team to assist with training, provide technical support for management of emergencies, participate in orientation of staff at training sites, assist with protocol changes, and provide LSS updates to the medical community.

LSS Training Coordinator Tasks

The LSS coordinator is a midwife, trainer, and manager. The identification process for a LSS coordinator will depend upon the local situation.

List of LSS Coordinator Tasks (sample)

- Establish the LSS training program: orient advisory committee, hire staff, find location for office, define program needs, submit and track requests, obtain equipment and supplies.
- Prepare for the LSS training program: assist with TNA, site preparation, orientation of training and support staff and training preparation.
- Conduct the LSS training program: plan for different classes, monitor trainer and trainee performance, report progress.
- Coordinate supervision and continuing education: monitor program progress through follow-up and support visits, plan continuing education.

Ideally, a midwife will be selected. If it is not possible within the local structure to achieve this, minimally a midwife and physician should be partners in running the project. When the project begins with a midwife in charge, midwives receive visibility, recognition, and power. In this role, the midwife coordinates the program between training centers (if more than one training center). She must be able to travel. The LSS coordinator uses the *Manual for Policy Makers and Trainers* reference to identify and resolve administrative and management issues.

LSS Trainer Tasks

Review the job description of the midwives at the district, health center and community levels. Once you are clear about the midwife's tasks, you can decide what tasks you want the LSS trainer to perform. With a midwife as their role model, trainees gain confidence that they can perform the skills because they can see the *trainer midwife* performing them. You must also consider the situation of potential trainers. Will it be possible for the LSS trainer to leave her training site to provide follow-up and support to the LSS midwife at her work place? Is it possible for the LSS trainer to maintain a register and report on training activities or is a secretary needed? Once the tasks have been listed, you can write selection guidelines. Suggested roles and tasks for the LSS trainer can be found below.

List of Trainer Tasks (sample)

- Perform LSS with competence and confidence
- Implement Life-Saving Skills training activities
- Assess learning needs of the midwife using written and clinical examination
- Teach LSS using adult teaching methodology
- Evaluate midwife trainee performance using the skills checklist and follow-up discussion
- Provide support and supervision during training
- Provide follow-up and support after training at the midwife's work place
- Maintain LSS midwives register and report on training activities

Criteria for Selection of LSS Trainers

Ideally the training team will have a midwife coordinator, an obstetrician (or general physician with special training in obstetrics), a midwifery tutor, and several very experienced clinical midwives. All members of the team should be currently practicing. Having a midwifery tutor on the training team helps to assure that Life-Saving Skills will move quickly into the pre-service (basic) training curriculum.

The selection criteria for trainers should include the minimum requirements for training as a LSS midwife. These criteria help identify midwives who are most likely

to succeed as trainees and LSS midwives. They can include education background, academic standing, type and length of work experience, and priorities. They should be adapted to your program situation.

List of Selection Criteria (sample)

Selection Criteria for an LSS <u>MIDWIFE</u>
<input type="checkbox"/> Registered midwife <input type="checkbox"/> Satisfactory academic standing <input type="checkbox"/> Two years' clinical experience as a midwife <input type="checkbox"/> No restrictions on age, sex, race, or citizenship <input type="checkbox"/> Clinically active (does at least five deliveries or five antenatal visits or five postpartum exams per week) and plans to remain at place of work for the next three years
Selection Criteria for an LSS <u>TRAINER</u> (In Addition to the LSS Midwife)
<input type="checkbox"/> Has a mature personality is kind, responsible, honest, and shows good judgement <input type="checkbox"/> Is interested in helping others, humble, feels equal -- not superior -- to others <input type="checkbox"/> Works well with mothers, children, and other health workers <input type="checkbox"/> Must be able to leave her home in order to travel to midwife work places <input type="checkbox"/> Is clinically competent and confident

Clinically active, competent, and confident trainers are the key to a successful training program. It is ESSENTIAL that the midwives selected as trainers are practicing clinically as midwives. To qualify as clinically active, a midwife should perform at least five antenatal examinations or at least five deliveries or at least five postpartum examinations in a week.

Trainer to Trainee Ratio

In clinically based training, each trainer must work with a limited number of trainees. At a given time, one trainer can help no more than two trainees. Because the midwife who works in a rural area will not be able to contact a colleague or doctor for advice during an emergency, she must have sufficient opportunities to perform the skills over and over until she feels comfortable, confident, and competent. The trainer supports her as she develops skills.

When they first begin, trainers may need to be supervised by an obstetrician, doctor, or a master LSS trainer who will provide guidance and support until they feel confident. LSS trainers may teach a particular topic, such as hemorrhage, cover clinical experience in their area, such as antenatal, and carry out their normal

clinical duties. See the section on training site selection, on page 40, for information on the impact that client load has on the number of trainees. If the client load will permit eight trainees to receive sufficient experience, then you would want to select eight midwives to be trainers. By the time the site preparation is complete (see page 46), the prospective midwife trainers have usually been chosen.

LSS Training Team Experience

LSS Trainers continue full time job responsibilities AND teach on the job. The team of trainers make a schedule that allows each to take class responsibility when free from other work.

In a program with six trainees per course, the midwife team comes from the following areas: antenatal (1), postpartum (1), clinical midwife instructor (1), and labor and delivery (3). The team leader is one of the three labor and delivery midwives. It is important to have an obstetrician or physician as a member of the training team to assist with training, orient training site personnel, and provide LSS updates to the medical community.

In some places, LSS trainers have trained their own staff in LSS, thus relieving the trainers of some on-call duties. LSS trainers continue to carry the responsibility of "signing off" skills as the trainees demonstrate competence.

In LSS experience, trainers plan their own routine so they are able to teach and at the same time perform their own job.

Select LSS Trainers

The final selection of the trainers is critical to the success of the training, therefore, clear criteria must be used. Trainers should have good communication skills and, ideally, be the peers of the trainees. Use the agreed selection criteria and your observation of the midwives' clinical skills during the site preparation workshop activities to select prospective LSS trainers. The training team should be composed of a balance of staff from the antenatal, labor and delivery, and postpartum wards.

A **LSS training team leader** is selected from the selected LSS trainers by the LSS trainers usually during the TOT. The training team leader is responsible for the overall LSS training at her training site including team meetings, trainer schedules,

trainee accommodations and meals, training equipment and classroom, and supervision schedule

List of Training Team Leader Tasks (sample)

- Participates as an advisory committee member
- Assists LSS coordinator organize and implement LSS training
- Assigns responsibility for LSS activities at training site
- Confirms completion of planned activities
- Assumes responsibility for LSS training at training site
- Participates as an LSS trainer
- Organizes support and follow-up for LSS midwives

Conduct Training Site Inventory (or Review if Done During TNA)

The TNA, Part VI - Hospital Training Site form, page 261, is used when visiting potential training sites. In addition to reviewing equipment and supplies, midwives working at the site are interviewed to find out their training needs. This is an opportunity to observe infection prevention methods, review records (antenatal, labor partograph, delivery and postpartum), and ask and answer questions to find out if anything is needed to perform Life-Saving Skills. If the actual assessment was done earlier, it only needs to be reviewed and discussed during the training site preparation. It is important to visit all clinical areas to be used during LSS training.

Review Hospital Records Antenatal, Intrapartum, Postpartum

The importance of keeping thorough and detailed records cannot be overstated. Every woman matters and every pregnancy should be recorded. Records provide a history of practice, a means of identifying quality care, and document care for follow-up and support. In addition to review of unit records, it is essential to ensure that hospital record books are documenting useful information for reporting and follow-up of LSS midwives. The records may have been reviewed during the TNA interview with selected midwives. To assess the records at the training site, use the hospital records review form shown below.

Hospital Records Review Form (sample)**Hospital Records Review**

Review five records for each of the following and ✓ the box if the information is written correctly, X the box if no information or if not written correctly

Antenatal record

- gravida, para, birth and abortion history
- expected date of delivery
- anemia and diet history
- hemorrhage history
- weight
- blood pressure
- fundal height
- weeks by dates (gestation)
- routine tetanus toxoid, iron, folic acid and Vitamin C

Partograph

- time of admission
- fetal heart rate
- membranes ruptured, liquor, molding
- cervical dilatation and complete dilatation
- descent of head
- contractions
- pulse, blood pressure, urine

Delivery record

- time of oxytocic
- time of birth
- time of delivery of placenta
- blood loss
- APGAR
- midwife's name

Conduct Workshop for Training Site Personnel

The workshop is conducted for key personnel to ensure that the clinical unit procedure and the staff are role models for the LSS training. The antenatal unit must use problem solving processes to identify problems in pregnancy. The labor and delivery unit(s) must use the partograph to follow the progress of labor and to identify problems. All units, including postpartum and surgery, must use infection prevention procedures for the protection of the mother, baby, and midwife.

The training techniques used in this workshop are the same as for LSS for trainers and midwives. The methods are adult learning and participatory, competency based training. This gives the staff some experience of LSS training.

Review the TNA information to identify LSS skills and procedures the staff need to learn. The topics most often presented are (1) implementation and correct use of the partograph, (2) problem solving management processes and referral procedures, (3) antenatal assessment for problems in pregnancy, (4) infant resuscitation, and (5) implementation of infection prevention procedures. Demonstrations and discussions are conducted using materials from the *Life-Saving Skills Manual for Midwives*. Participants are given written information. They are asked to assist staff in their unit learn the skills, especially by demonstrating them. Participants' clinical skills are observed in each clinical area including antenatal, labor and delivery, postpartum, and surgery.

Preparation Plan for LSS Training

The training site staff must model good practice as they monitor labor by using the partograph, carrying out infection prevention measures, doing antenatal risk assessment and routinely using the problem solving process. Throughout competency based LSS training, midwife trainees are carefully supervised and supported as they practice and learn life-saving skills. The staff at the clinical site must be competent and confident to guide these trainees. They must use the same equipment the trainee midwives use to perform LSS. Therefore, each training site must implement LSS procedures and organize logistics for training. Living arrangements and preparation of an on-call room and classroom facilities must be completed. The time required to make the preparations will depend on the individual situation. Since all the staff need time to become comfortable and confident in performing the LSS procedures, it is advisable to plan for one to three months of preparation time.

LSS Procedures

The staff in charge of each clinical area takes responsibility for organizing "in unit" training as necessary to ensure all become knowledgeable and skilled in the procedures. Additional equipment or supplies should be obtained if necessary. In various programs, the clinical area required physical renovations, equipment had to be ordered, extra training was necessary for some of the staff, or physicians using the clinical area needed to be updated. The process should not be rushed because an organized clinical unit is essential for successful LSS training.

To become competent and confident in LSS, trainees need good role models and practice in LSS. The trainers are good role models. The staff in the clinical area who are doing LSS in all their job related activities and who relate as equals and friends to the women they care for are good role models as well.

If midwives are to provide LSS to women in their community, LSS training must provide first-hand, actual experiences. Trainees need to practice caring for women with the same conditions as the clients they care for at their own places of work. Experienced midwives know that one does not schedule a postpartum hemorrhage, a retained placenta, or a pre-eclamptic seizure. The midwife trainees must be close at hand and available for these experiences.

Finalize Residential Arrangements

The living arrangements for trainees will depend on the physical environment of the training site. There may be an empty unit, a section of a ward, staff housing, student facilities or other suitable space close to the clinical area that can serve as living space for trainees during LSS. All of the spaces mentioned have been used in various programs. They all have been satisfactory arrangements.

Finalize On-Call Room

The necessity of this room actually depends on the location of the residential arrangements. Sometimes an unused room is available. Sometimes a private client room can be set aside as a call room. It is good to have a call room, where a midwife trainee or the trainer can rest or study a little while waiting. Keep in mind that daytime activities continue even though some of the class and training staff may have been up during the night. If the sleeping area has a telephone or is fairly close to the delivery unit, a call room may not even be necessary.

Finalize Classroom

The classroom must be within walking distance of the clinical site(s) It must be large enough to accommodate the group of trainees and trainers for discussions, demonstrations, and skills practice It should allow for privacy and be in a relatively quiet area

Classroom practice helps trainees become comfortable using new skills, but by itself is not adequate Clinical experience should be scheduled as soon as possible to allow trainees to practice skills in a clinical setting Much of the clinical experience can not be scheduled Therefore, a call schedule is designed to provide ample time for skills practice Discussions and demonstrations should always be interrupted to accommodate clinical skills practice when a pregnant or postpartum woman presents

Site Preparation Final Meeting

This meeting is held with future trainers, LSS coordinator, and if selected the training team leader to clarify results of the week's activities, review the agreements that have been reached, and make future plans. An example of an agenda for this meeting can be found below.

Meeting Agenda (sample)

SITE PREPARATION FINAL MEETING AGENDA

- 1 Confirm list of needed supplies
- 2 Discuss infection prevention procedures (status and suggested changes)
- 3 Remind staff to practice antenatal history taking
- 4 Remind staff to practice antenatal physical examination
- 5 Discuss the partograph
 - a keep on file in the labor ward,
 - b keep practicing,
 - c hold weekly conferences about labor management using partograph
- 6 Confirm selection of trainers and training team leader
- 7 Discuss the delivery records (if changes are planned or needed)
- 8 Review logistics for TOT (any assistance needed to arrange and confirm availability) including
 - a meals,
 - b laundry,
 - c accommodation,
 - d classroom,
 - e on-call sleep room
- 9 Confirm need for any guidelines (protocols) of practice not yet approved or clarified
- 10 Confirm that LSS trainee midwives may take priority over other students (Discuss how our LSS trainees also help other students through observation of techniques, use of checklist, and as role models)
- 11 Confirm use of midwifery, nursing, medical, or hospital library
- 12 Give LSS modules (if available) to trainers
- 13 Discuss training schedule
- 14 Discuss any other issues that came up during the week
- 15 Verify that a letter will be sent that will confirm all agreements and include training schedule
- 16 Discuss how to contact each other, if needed, before the TOT starts

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
	Finalize Administrative Structure	61
	Get Supplies Ready	61
	Finalize System for LSS Participant Notification	62
	Invitation Criteria	62
	Prepare the Training Environment	62
	Prepare Training Site as LSS Role Model	63
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP FOUR: PREPARE FOR TRAINING

The process of establishing a training center can take between one and three months. This time is critical to allow implementation of clinical procedures, protocols, and documentation procedures agreed upon during site preparation. In addition, the selection of the trainers can be finalized, needed supplies and equipment ordered, systems to select and organize participants established, the training center administrative structure and procedures finalized, and the physical spaces prepared. It is very important for LSS procedures to be routine before training begins so trainees see the staff practicing the same procedures they will learn during their LSS training.

Finalize Administrative Structure

Organizing and implementing the LSS training begins as soon as the coordinator is identified. The **LSS coordinator**, usually chosen before or during the site preparation activities (Step Three)

- assigns responsibility for LSS activities
- follows up to make sure assigned activities are completed
- ensures that all planned preparation activities are carried out
- works with the institution's key personnel to address administrative issues

At the same time, the staff in labor and delivery unit, antenatal clinic, postpartum unit, and other areas implement the partograph, infection prevention and the guidelines (protocols) of care procedures. Many administrative and management issues are likely to arise as you begin the process of establishing the LSS training.

Get Supplies Ready

During the site preparation week, a list of supplies and equipment was prepared. These items must be ordered and distributed. The supplies and equipment for the midwife trainees are inventoried and stored until time for distribution.

Management of supplies and equipment is a large task. Ordering should be completed early in the preparation process since unscheduled and unexpected events may occur. For example, as preparations were being made for one training, a shipment was received at the airport during a very heavy rainstorm. When the materials were brought to the training site, everything was very wet. Many helpers were needed to unpack and dry everything in the shipment.

Finalize the System for LSS Participant Notification

Someone will need to be responsible for participant notification. The LSS coordinator may take on the responsibility or may delegate it to a secretary or assistant. For each training course, a list of all participants, including their names and addresses, is needed so that letters of invitation, information, and reminders can be sent. The method(s) used to contact participants will depend on what is most successful in your area. Letters by mail, short wave messages, phone calls, and commercial radio announcements have all been used with success. Once the schedule for a course has been completed, notify participants in advance, allowing them enough time to prepare for being away from their duty post and to arrange their journey. Be sure the invitation includes all the information the participants need.

Invitation Criteria (Sample)

Does the invitation to LSS Training participants include information on

- the location of and directions to the training site?
- the date and time of registration?
- the program training dates, training sequence, and daily schedules?
- policies regarding absence and illness?
- availability of housing?
- availability of transportation or travel allowance?
- financial arrangements?
- uniforms and personal effects they will need at the training site?

Prepare the Training Environment

Space requirements for the training program were discussed and decided during the site preparation week. These include the on-call room, classroom, storage room, office space, and the areas for trainee lodging and food. The rooms or areas to be used must now be prepared. Perhaps the classroom floor needs to be washed and the furniture rearranged. It may be necessary to do some renovation or to borrow furniture from other locations. For one training program, an unused ward was prepared for trainee lodging and a caterer was hired to prepare the food on site. In another training program, trainees stayed at a small guest house close to the hospital and took their meals in the hospital cafeteria. Make whatever preparations are needed to ensure the facilities are ready for the trainees.

Prepare Training Site as LSS Role Model

Selected staff from the antenatal, labor/delivery, and postpartum units participated in the site preparation week and returned with responsibility for organizing "in unit" training as necessary for all unit staff. This training should now be provided. In addition, a list of equipment and supplies needed to practice LSS was made, see page 271. The items must now be procured. It may be necessary to purchase or repair equipment.

In one program, the delivery room was in need of major renovations before implementation of LSS procedures was appropriate. In another program, the senior nursing officer needed to be convinced to increase her hospital supply order so that sufficient soap, chlorine and gloves would be available to meet the increased need when training began. (It took six months to actually get the supplies because the process for increasing the supply order was so time consuming.)

The staff in charge of each unit should make a list of what must be done and plan how to accomplish it. The administration and LSS training coordinator can assist to ensure that everything is completed in a timely fashion. This process can not be rushed and support is essential to ensure that clinical units are organized and modeling LSS.

The staff need encouragement and support. They may be learning new procedures or reorganizing their work areas in order to have everything ready for "guests" (trainees). The normal activities of each unit are also continuing. This is a very busy and usually exciting time for a soon-to-be training site. It is almost like anticipating the arrival of a new baby!

The training coordinator must also be alert for those who are not too thrilled with these activities. Some staff may fear they will not be "good enough." Others may want to be selected for some responsibility but have not been chosen. Still others may feel the training is just going to make extra work for the staff.

For example, one program experienced difficulty in implementing the partograph when the labor staff reported that each woman came in "fully dilated" and there was no time to chart on the partograph. The training coordinator looked carefully at this situation and conducted a series of problem solving meetings with the labor staff. Eventually they made their own decision and the partograph was adopted.

Change is usually not easy for people. Each person views it in his or her own way. It is essential that those responsible for making the changes take into consideration the feelings and needs of their coworkers. The ability to make changes, to plan, analyze, and take action is basic to the self-reliance of every person, team, and training site institution. Planning skills are very important for staff who are to become leaders, trainers, and organizers in their institution or team. It is essential that staff are included in the planning process of the LSS Training. Invite staff members from the units that will be affected by LSS to discuss their doubts and make their needs known. This will promote an automatic flow of communication about LSS throughout the institution even before informational meetings begin.

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE:	TRAINING FOR TRAINERS -- CLINICAL	65
	LSS Training	67
	LSS Trainers' Clinical Practice ..	68
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN	LIFE-SAVING SKILLS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP FIVE: TRAINING OF TRAINERS -- CLINICAL

The *Training of Trainers (TOT)* for the clinical portion takes approximately two weeks and uses the same methods as trainers are expected to model when they themselves conduct training. This is LSS training and the trainers are master trainers. TOT - Clinical uses competency based training, participatory learning methods, and adult learning principles. The transfer of this training approach is equally important to ensuring the quality of the training team and success of the training as is the review of clinical content.

People learn
80% of what they **hear, see, and do**,
40% of what they hear and see,
20% of what they just hear

The participatory approach is critical
to **EFFECTIVE** absorption
and the participants' ability to apply
what they have learned

The goal of the LSS program is to expand the skills of midwives in a direct effort to decrease maternal/neonatal mortality and morbidity. The LSS program features (1) a supportive environment at policy level, (2) a committed obstetrician/physician supporting the training of midwives, (3) a training site with sufficient deliveries, and (4) trainers who model life-saving skills and competent midwifery practice. Successful LSS trainers are very special people. They need to be clinically competent and confident. In order to teach these skills, trainers need to be active in clinical practice and competent in LSS.

Competency based training focuses on learning by doing and emphasizes the most essential steps required to do a skill well. These steps are listed in a skills checklist which can be used as a teaching and evaluation tool. Competency based learning recognizes that adults learn at different speeds and have different skills. The midwives have been working for many years and may originally hesitate to try new skills. After the first few days in the LSS training course, midwife trainees generally feel very comfortable and request more opportunity for clinical practice with the new skills. The training does not focus on "tests" but primarily uses skills checklists which allows each

learner to evaluate her own performance. The checklist is an easy way for trainers and participants to determine when a participant has reached competency, (when the participant can perform each step of a skill at 100%) Each clinical experience becomes an opportunity to reinforce and strengthen or correct the skill being learned.

LSS Training

LSS trainers must first be competent and confident LSS midwives. Confidence in this case implies that not only are they able to do a skill, but are also confident to teach it. This is usually accomplished by giving the trainers a two to three month internship period after the clinical TOT to allow them time to practice what they have learned and gain confidence. (In one program, due to time constraints this internship period was not possible. As a result, trainers expressed great concern about having to conduct training immediately and required extra support beyond the first class.) Since the success of the training depends largely on the trainers, it is critical to give them support and sufficient time to absorb and integrate any new skills they have received.

The first step in becoming an LSS trainer is to learn critical emergency skills. Each skill has a list of essential steps. Because each skill is *life saving*, all steps must be performed 100% correctly. No step can be forgotten. The majority of midwife trainees (95 to 98%) gain mastery of all required skills during the two week LSS training session. In a situation where a midwife or her trainer feel some skills require more practice, time is arranged to permit this. The decision to obtain additional practice comes just as much from the midwife as from the trainer. Those requiring continuing practice will be given an opportunity to remain at the training site until they and their trainers feel they have mastered the skills.

LSS training for prospective trainers usually lasts two weeks. The training is conducted in exactly the same way as the LSS training for midwives so the trainers can experience the approach and begin to model it. The emphasis is on clinical practice *with as many experiences as it takes for each participant* to become competent. See Step Seven for details of the LSS training for midwives.

LSS Trainers' Clinical Practice

Following this first training, the prospective LSS trainers return to their work place and continue to practice LSS for two to three months before they attend a Training of Trainers (TOT) -- Teaching to learn how to teach LSS. They should be allowed at least this amount of time to practice their new skills *without* any responsibility for trainees in order to gain competence and confidence. Clinically active, competent, confident trainers are the key to a successful training program.

During this time of practice, the trainers may ask someone to observe them using the skills checklists. They can ask their coworkers, the obstetricians, and other LSS trainers for assistance if necessary. This practice time allows the trainers to become more comfortable with the skills and with their role. They can even begin to teach their coworkers and midwifery, nursing, or medical students who are working on their units. New trainers should explore all opportunities to practice, share information, and observe each other.

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
	Schedule for Training of Trainers (TOT) Teaching	70
	Goal, Objectives, Common Terms, Introduction	71
	• Topic 1 Competency Based Teaching and Learning	77
	Skills Checklists	77
	Review Questions	78
	Case Studies	82
	Demonstration/Return Demonstration	83
	Clinical Learning Observation, Modeling and Coaching	84
	Visual Aids	85
	Skills Practice Chart	87
	Learning Activity. Practice Teaching	89
	Skills Checklist Using Review Questions to Conduct a Discussion	90
	Skills Checklist Conducting a Case Study	91
	Skills Checklist Conducting a Demonstration	92
	Skills Checklist Clinical Learning Observation, Modeling, and Coaching	93
	• Topic 2 Finding Out About the Midwife	94
	Who Is She? What Equipment and Supplies Does She Have?	95
	Learning Activity Getting to Know the Midwife	95
	LSS Participant Registration and Inventory Form	96
	What Midwifery Skills Does She Have?	99
	Learning Activity Teaching Demonstration Using Skills Checklist	100
	• Topic 3 Evaluating the Midwife Were the Trainers Successful?	101
	Training Evaluation	102
	Assessing Pretest and Post Test Knowledge	103
	Learning Activity Create a Written Examination	104
	Assessing Clinical Skills	105
	Trainers' Evaluation	106
	Ways to Include Trainees in Evaluation During LSS Training	106
	Learning Activity Assessing Clinical Skills	108
	Training Report	109
	• Topic 4 Roles and Responsibilities of LSS Trainer	110
	LSS Trainer Tasks	111
	Materials and Equipment	112
	Training Schedule and Timing of Classes	113
	Sample LSS Training Timetables	116
	Learning Activity. Write LSS Training Schedule	120
	• Topic 5 Trainers' Work Plans	121
	Learning Activity Plan Tasks for LSS Training	122
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

SCHEDULE TRAINING OF TRAINERS (TOT) -- TEACHING ⁷

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	SUN
0700		Rounds Team 1	Rounds Team 2	Rounds Team 3	Rounds Team 4	Rounds all	
0800	Welcome Introduction (Team 3)	Rounds Report Team 1	Rounds Report Team 2	Rounds Report Team 3	Rounds Report Team 4	Rounds Report all	
0810	Logistics/Schedule Overview of LSS (Team 4) Written Pretest	Review	Review	Review	Review	Review	
0825		Topic 2 Finding out about the Midwife	Topic 3 Evaluating Were the Trainers successful?	Topic 4 LSS Trainer Roles/Responsibilities	Topic 5 Workplan Review Task List	Post Test and Skills Checklist Review	
1000	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1015	Maternal Mortality Worldwide Maternal Mortality in County (Team 1) Tour (Team 2)	Topic 1 Practice Teaching (Teams 1 3)	Topic 3 Evaluating group work Write test (Teams 1 2) Follow-up (Teams 3 4) Assessing clinical skills (all)	Review LSS Training Schedule	Group Work Write list of tasks in order of occurrence	Closing	
1200	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
1330	Topic 1 Competency Based Teaching and Learning	Topic 1 Practice Teaching (Teams 2 4)	Above presentations 10 minutes each 10 minutes discussion	Anemia Screening Demo (Team 1) PIH Screening Demo (Team 2) Fetal Growth Monitoring Demo (Team 3)	Assign responsibility for each task and the date task is to be completed for LSS Training		
1500	BREAK	BREAK	BREAK	BREAK	BREAK		
1515	Topic 1 Practice Teaching Team 1 Mod 5 Case Study Team 2 Mod 7 Case Study Team 3 Mod 4 Episiotomy Demo Team 4-Infant CPR Demo All Partograph Observation/ Coaching	Topic 1 Practice Teaching (all)	As needed for above presentations.	Using the Safe Motherhood Protocols (or guidelines) present management in the following case studies Module 2 & 5 (4) Module 7 & 8 (all)	Discuss training task list		
HOME WORK	Read/Write Topic 2	Read / Write Topic 3	Read Topic 4	Read Topic 5	Review All Topics Final Evaluation		
1800	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE	
CALL	TEAM 1	TEAM 2	TEAM 3	TEAM 4	TEAM all		

⁷ The LSS TOT -- Clinical teaches the potential trainers life-saving skills they become LSS midwives It is best for the potential trainers to practice their LSS for 2 to 3 months BEFORE the LSS TOT -- Teaching (learning to teach LSS)

STEP SIX: TRAINING OF TRAINERS -- TEACHING

Training of Trainers (TOT) -- Teaching is conducted after the prospective trainers are competent and confident in the practice of life-saving skills (after the internship). TOT - Teaching is a one week course designed to help the trainers develop the skills necessary to *teach life-saving skills*. The schedule on the preceding page gives an overview of the information covered. The trainers are on-call in order to document competence and confidence in conducting LSS. The teams check each other off clinically on specific skills. TOT -- Teaching provides information that helps each trainer prepare to conduct LSS training for midwives and carry out the other responsibilities and duties of a trainer.

In this section, teaching methods are discussed and practiced. There are checklists for the teaching methods. Program schedules (time tables) and plans for teaching lessons are discussed. Schedules are arranged so that two trainers per day teach while the remainder can continue with their clinical responsibilities. Sample forms used in actual LSS programs are provided. These may be adapted to individual needs or copied (See the blank forms beginning on page 280.)

Goal

The LSS midwife who has been selected as a trainer will learn to prepare for, conduct, and evaluate a LSS training course for midwives.

Objectives

By the end of the TOT, the LSS trainer will be able to

- 1 demonstrate competence and confidence performing life-saving skills
- 2 describe the local maternal mortality and morbidity problems
- 3 demonstrate competency based teaching methods using adult learning and participatory approaches
- 4 identify the learning needs of a midwife using written and clinical assessment
- 5 demonstrate the use of the *Life-Saving Skills Manual for Midwives* in performing, teaching, and evaluating Life-Saving Skills
- 6 develop a plan for an LSS training course

Common Terms Used in LSS Training Programs

Adult Learning - a process in which people gain information/skills or change attitudes, remembering their own experiences. They are encouraged to recall experiences, to "figure things out", to learn from the solutions they find for problems

Competency Based Training - enables the midwife to correctly perform all steps of a clearly defined task and to be able to adequately provide care to support a procedure. In a clinical situation, the learner demonstrates the ability to carry out a skill correctly (competence)

Critical Knowledge - the information necessary to perform all steps of a skill correctly. The trainee must understand clearly the exact information necessary for performing a skill

Evaluation - assessment of achievement(s) pertaining to knowledge, attitudes, skills, or behaviors, finding out how much a trainee has done or learned, for example, by comparing what the trainee is able to do before and after training

LSS Trainer - a practicing midwife competent and confident in performing life-saving skills, trained in competency based training and participatory learning methods, and using adult learning principles to teach life-saving skills

Master LSS Trainer - an LSS trainer, a member of a senior LSS training team trained to teach a group of LSS midwives to be an LSS training team (organize, manage and teach LSS)

Monitor - to observe in order to ensure learning. A senior midwife or LSS trainer "monitors" a trainee in order to make sure a procedure is done correctly. Someone who monitors may help a trainee if the trainee needs assistance. A supervisor monitors in order to make sure procedures are performed competently

Participatory Approach - a process of active involvement, discussion of experiences, sharing ideas, thinking about information, and planning for action

Problem Solving - a process of gathering information on a question or situation, identifying the best way to change that situation in a positive way, and taking action to bring about a positive change. In LSS, the problem solving method is an organized way of giving care that includes **ASK and LISTEN, LOOK and SEE, IDENTIFY the PROBLEM, and TAKE APPROPRIATE ACTION**

Teamwork - two or more persons forming a group to help each other do activities. The term describes the way LSS trainers communicate and act with each other, allowing each of them time to teach trainees. They watch out for and support each other by giving advice when it is needed, helping perform tasks of another trainer's job, and so forth.

Introduction

There are many ways to teach and learn. In LSS training, two things are very important: (1) each training program should be designed according to the special needs, problems, and situation of the area, and (2) each course should be adapted (changed) in order to use the experiences of each new group of trainees. The training methods, the persons teaching, and the persons learning are the elements that influence the effectiveness of a training course. It is important to find out and build on what the trainees already know.

Active clinicians make ideal trainers

A clinician can be taught to be a skilled trainer, it is more difficult to train a teacher to be a skilled clinician.

To make sure that critical knowledge is learned and clinical skills are performed competently, the LSS TOT provides opportunities for the trainers to confirm and develop confidence and competence in **performing** and **teaching** life-saving skills. The LSS trainer learns the skills in the very same manner she will teach LSS to others. She also learns about and gains experience in the trainer's roles and responsibilities.

Helping Midwives Learn

One of the most important qualities (characteristics) of adult learning is that it encourages the learner to draw upon life experience to solve problems. The midwife has had many experiences in her life. She has helped many women deliver. She can use the knowledge and wisdom gained in those experiences to identify what was successful and what was not. The midwife can usually identify what she needs to learn and in this approach to learning she is encouraged to do so.

To teach critical knowledge, LSS uses review questions and case studies. Trainees share with each other their clinical experiences about topics being discussed. They do this during class discussions and sometimes in the evening.

(For example, see the midwife's story in the LSS manual, Module 5 **Prevention and Treatment of Hemorrhage**, page 5 41) Demonstrations and return demonstrations teach skills, knowledge, and attitudes in a real life setting by modeling quality care Learning is encouraged as the midwife searches for causes and solutions to problems (problem solving) Actual clinical experience, with the aid of skills checklists, is used to develop competence The whole emphasis is on learning by building upon the midwife's experience

When helping adults learn, it is important to realize

- adults have many experiences and have learned much from life They learn well from their peers *Help them to share their own experience and create a situation where they are encouraged to talk with and learn from each other*
- adults are interested and learn quickly about those things that are relevant to their lives *Encourage them to consider and discuss how new information relates to their work and life*
- adults have a sense of personal dignity *Communicate respect for the trainee and for everyone who works at the training site*
- as adults mature, their powers of observation and reasoning often grow stronger *Encourage trainees to observe, reason and solve problems*

The effective LSS trainer works **with** the trainees and focuses on helping them to learn by building on their own and others' experience

Life-Saving Skills (LSS) are advanced midwifery skills The training focus is on specific skills that will help midwives save lives It emphasizes clinical practice **with as much experience as it takes for each participant to become skilled** Class sessions are held in or near the clinical area so that discussions can be interrupted when a laboring woman is admitted with need for any of the clinical skills to be learned The group moves into the labor or delivery area to see trainers demonstrate skills or watch trainees practice particular skills

REMEMBER HOW PEOPLE LEARN

People remember
20% of what they HEAR
40% of what they HEAR and SEE
and 80% of what they DO THEMSELVES

The *Life-Saving Skills Manual for Midwives* is designed to help the midwife become competent in performing a given set of skills by **DOING THEM**. The number of times a particular skill is practiced is not as important as the **quality** with which the skill is performed.

In many countries education has concentrated on having midwifery students perform a certain number of deliveries, attend an identified number of antenatal clients, or start a stated number of intravenous infusions. A system based on *quantity* of experience (number of times a skill is practiced) does not take into account that we all learn at different paces and with a variety of learning styles. In a quantity based system, a slow student may not be competent when she graduates even though she has completed the required number of experiences. On the other hand, a fast learner may be bored by having to repeatedly perform skills at which she is very competent. Fast learners could better use their time gaining additional skills and knowledge.

In LSS competency based training, trainees take an active role in directing, pacing and monitoring their own learning. The trainee decides **when** she is ready to perform a skill without trainer assistance (though the trainer may still be present to monitor the performance). This approach encourages the kind of discussion between trainees and trainers that is important for adult learners. It gives the trainee a chance to share and learn more from her own experiences.

For competency based learning to occur, the training program must be very flexible. If a trainee does not receive the variety and amount of clinical experience she needs in the time given for clinical practice, arrangements are made for her to stay longer or return at another time to get the experience she needs. Participants will need to stay longer if either the midwife or the trainer feels more experience is needed to achieve competency.

Trainees should not be made to feel that they are stupid or incompetent when more experience is needed. Explain that everyone learns differently. Everyone has had different experiences. There is no right way or right amount of time for learning. Also, there is no way to make sure enough clinical opportunities will occur during a training period so all participants can gain competency.

The goal of LSS training is to have confident, competent midwives who can practice advanced midwifery skills and save the lives of women and newborns. Many midwife trainees have been out of the classroom for several years and are often quite frightened about studying again. Encourage these participants. Explain to each class that all of us continue to learn until we die. We are never too old to learn. Experienced midwives have valuable experiences to share. Past experiences enrich the learning for everyone and also help to keep the training very practical and focused on the problems and emergencies found in those situations.

Competency Based Training

States exactly what it is that midwives must learn

Provides critical knowledge instruction

Helps midwives learn one thing well before going on to the next

Requires each midwife to demonstrate competency

Topic 1 Competency Based Teaching and Learning

Trainers, in meeting the learning objectives of this topic, will be able to use the *Life-Saving Skills Manual for Midwives* to

- 1 review critical knowledge using the review questions
- 2 demonstrate the use of case studies in developing problem solving skills
- 3 conduct clinical demonstrations to teach a step by step approach in performing a skill
- 4 monitor skill performance using the skills checklists
- 5 demonstrate and discuss the use of the skills practice chart and the skills checklist in competency based LSS training
- 6 organize and monitor a training session using the lesson plans and the skills checklists

Several methods and tools are used to help the midwives learn life-saving skills. As you discuss and practice using these tools and methods, keep in mind that the **essential learning experience** is clinical practice which provides the midwife with opportunities similar to those she will find in her own place of work. Review questions, case studies, and demonstrations provide reinforcement and a way to repeat or review what has happened during a clinical opportunity. Look at the lesson plans starting on page 180 to see how these methods are used in teaching LSS.

Skills Checklists

Skill assessment is the key to evaluating competence. By assessing trainee performance, you can identify and help trainees who need additional help. You will find skills assessment sheets (checklists) at the end of each topic in Modules 2 to 10 of the *Life-Saving Skills Manual for Midwives*. Each skill taught in a module is broken down into steps and each step is listed. The trainer and trainee are asked to evaluate whether each step of the skill was performed satisfactorily or needs improvement.

Preparation - Review the skills checklists to make sure that you, as the trainer, **know all** of the steps and can **perform all** of the steps correctly. Whenever you observe a skill being performed, have the trainee's skills checklist available so you can immediately make notes.

Procedure - Complete the skills checklist as soon as possible following a clinical experience while all the details are still fresh in your mind. Discuss it with the trainee at the end of **each** clinical experience. The checklist serves as an excellent way for both of you to share how things went and what may need to be done differently next time. It gives you the opportunity to discuss alternate ways of doing something, perhaps demonstrating with a model. It gives the trainee time to ask questions she could not ask while the client was receiving care.

Make notes on the checklist each time the midwife practices a particular skill so that she will know what she needs to study more and what steps of the skill she needs to concentrate on next time. This is also a valuable way for trainers to communicate with each other. A trainer coming on duty can review the checklists of the midwife participants she is working with that day to see what skills are giving the learner problems, which parts of a given skill need particular help, and any helpful comments that were offered by previous trainers to aid in improving performances.

Review Questions

The review questions in the LSS manual help the trainee review and learn critical knowledge. They can serve as an outline for a presentation on a topic or as a guide for the review. Some questions will encourage the trainee to apply her knowledge to different situations. Trainers can ask additional questions to help stimulate a trainee's motivation and interest or to draw upon her experiences. The trainer can use questions to evaluate how much trainees know and have understood or to start a discussion. Questions often stimulate trainees to search for solutions and additional information. Questions also motivate sharing of clinical experiences.

Preparation - When planning the training schedule, allow one hour for a discussion of the review questions at the beginning of each topic. Assign the trainees to read the review questions and write the answers as a homework activity. A page number is included at the end of each review question to help the reader find additional information relating to that question. Suggest that answers be written in pencil. Arrange the seating in a circle, making sure the participants have a place to write. The trainer should review the questions to be sure she has the answers written *before* she conducts the session.

Procedure - Begin by introducing the topic and the way the session will be organized. Usually, a review question is read and answered by one trainee. Additional answers can be offered by other trainees. Be sure you, the trainer, know the answers to the questions. Encourage **active participation** by inviting trainees to contribute their experiences and ideas. See the skills checklist, Using Review Questions to Conduct a Discussion on page 90. The type of questions you will use depends on what you are trying to do.

Questions to find out what the trainees know To find out what the trainees know about a specific midwifery topic, ask questions that have "correct" answers. You will expect a trainee to respond with "yes" or "no" or to explain, identify, or name something. For example, if you ask "How many times does the normal fetal heart beat in a minute?", you will expect the answer of 120 to 160.

Questions to find out what the trainees think Sometimes there is not a simple, correct answer. The trainer has to encourage the trainees to **think for themselves**. For example, "What would be the best method of teaching a pregnant woman about foods that are high in iron?" This question asks a trainee to give her ideas. The trainer may ask why that method, what other methods could be used, or invite her to suggest other methods. The trainee is asked to state her opinion, defend it, find other ways, and learn new possibilities. Encourage the trainee midwives to think creatively and offer new solutions to old problems.

If a response is not correct or appropriate, you may say *that is wrong* and give the correct answer. This usually makes a trainee feel uncomfortable. She may not be interested in learning more.

OR

If a response is not correct or appropriate, you may ask questions to give *hints*. It is better to ask her additional questions to find the correct response. You can ask questions to give the trainee hints or clues to the best or correct answer. This helps her remember the facts necessary to respond correctly. You can also ask the trainee to clarify a response or to "say more" when she has given an incomplete answer.

Read the examples on the next pages.

For example

Trainer *Why does a retained placenta cause postpartum hemorrhage?*

Trainee The woman bleeds too much

Trainer *Right But why does the woman bleed too much?*

Trainee The retained placenta does not let the uterus contract

Trainer *You are partly right, but can you tell me why the uterus continues to bleed?*

Trainee Well, the placenta is in the uterus, so the uterus can not contract and get smaller

Trainer *Where is the bleeding coming from or what part of the uterus is bleeding?*

Trainee The part of the uterus where the placenta was attached

Trainer *Right Now why is the woman bleeding?*

Trainee After delivery of the placenta, the uterus usually contracts and squeezes the area where the placenta was attached. As the uterus gets smaller, the bleeding area gets smaller and the bleeding stops. When the retained placenta stops the uterus from contracting and getting smaller, the bleeding continues. After the retained placenta is removed, sometimes the uterus is too tired, contractions are not good and the bleeding continues, requiring more treatment.

Ask reasons for answers You can also ask a trainee to give **reasons** for her answers. This helps you find out if she really understands her first answer. When a trainee has answered one question correctly, you can ask her or other trainees to expand on the response. In this way, you can find out how far their understanding goes.

Trainer *What may happen if the postpartum bleeding is too much?*

Trainee The woman may go in to shock and die.

Trainer *Good. Can you tell me anything more about it?*

Trainee The blood pressure will go down, the pulse will be fast, the woman may feel cold with wet skin, the woman will be weak.

Trainer *Yes! What can you do to help? (and continue until the response is complete)*

An important part of this procedure is to summarize the main points

Case Studies

Case studies help learners develop knowledge and attitudes. They help midwives learn problem solving skills that allow them to work out practical ways to manage the case study problem and other problems.

A case study gives the midwife basic information about a problem. She studies the information and uses her problem solving skills to find answers. Case studies can be used for class discussions. The trainer presents the case and asks questions to encourage active, creative thinking. Alternatively, trainees can read and answer case study questions individually. Case studies can also be used as the basis for a small group problem solving activity.

Trainers can write their own case studies. The best way to write a new case study is to base it on information from a client's record. This keeps it very practical and realistic.

Preparation - When planning the training schedule, allow two hours for classroom discussion for a case study. Assign the trainees to read the case study and answer the questions as homework. Suggest that answers be written in pencil. The discussion is best when seating can be arranged in a circle with places for the trainees to write.

Procedure - When conducting a case study discussion, begin by introducing the topic and describe the way the discussion will proceed. A paragraph can be read by one of the trainees or the trainer. Answers are offered by trainees. Encourage **active participation** by asking *what if*, *how*, and *why*. When sufficient information has been discussed, summarize the answers. If the trainees do not come up with the best or all of the answers, add to what they have said. A case study discussion should be active and timely. Do not allow long periods of silence. You can add or even answer questions when it seems the trainees are not following or may not really understand the questions. Do not allow the trainees to become embarrassed if they give incorrect answers. Remind them that everyone is here to learn.

By the end of the discussion, the information written in the trainees' manuals should be correct. Encourage trainees to make any necessary changes in their written responses. Continue this process through the case study. Encourage all trainees to participate. At the end of the case study, the trainer or a trainee reviews the problem solving steps, summarizes the topic and asks for any additional questions. See skills checklist "Conducting a Case Study" on page 91.

Demonstration/Return Demonstration

This teaching method helps trainees develop skills, knowledge and attitudes. It helps them learn to use a step by step approach in performing a skill. It can also be used to review a midwife's performance.

A demonstration is often done first in the classroom. As the trainer performs each step of the skill demonstration, she describes what she is doing. She then asks a midwife trainee to give a return demonstration, also describing each step as it is done. It is very useful for the trainer and trainees to follow the skills checklist when watching or doing a skill demonstration. The steps are listed on the checklist in the order they are to be performed. The trainees learn by seeing, listening, doing, and receiving comments on their performance.

Preparation - When planning the training schedule, allow one hour for most demonstrations. Allow enough time for the trainees to practice and return demonstrations in the classroom or in a clinical area. Assign reading of the selected content and skills checklists in the relevant module as homework. Request that trainees bring the module to the demonstration. Prepare seating so everyone can see. (If the demonstration is in a clinical setting, seating is not provided.)

Gather equipment and supplies that are used in the actual setting. For example, if the demonstration is active management of third stage, use equipment and supplies similar to what the trainee midwife will have available at her place of work. If the demonstration is with a client, explain to the client what you would like to do. Make sure the client understands and agrees to be part of the demonstration.

Procedure - Before beginning, explain the purpose of the demonstration. Tell the trainees that they will be expected to critique the demonstration, using the skills checklist. They will all be asked to demonstrate the skill later. If you are not demonstrating on a client, explain the situation before you begin. Do each step of the procedure clearly and slowly, describing your actions as stated on the skills checklist. Answer questions about the steps. Summarize and discuss the steps at the end of the demonstration. Ask for a volunteer to demonstrate to the others. Gently correct any mistakes. Encourage questions and discussion. See the skills checklist "Conducting a Demonstration" on page 92.

Clinical Learning Observation, Modeling, and Coaching

Observation, modeling, and coaching help the learner develop skills, knowledge and attitudes, learning by doing in the work setting. The locations for clinical learning include antenatal, labor, delivery, postpartum, newborn nursery, and operating (surgery) units. Clinical learning allows a trainer to watch a trainee apply skills and to review trainee performance. This is **observation**.

In a clinical setting with real clients, the trainer has the challenge of being a teacher while maintaining a healing environment for the client. Patience and experience serve as the trainer's best guide for when to help and when to wait. Most of the time a quiet, gentle suggestion is sufficient. This is **coaching**. If the midwife trainee is approaching a skill, or a step in the skill, in a manner that will be harmful to the client, the trainer must assist immediately. Occasionally, the trainer may need to continue the procedure herself. New skills that are complicated may best be performed by the trainer the first time with the midwife trainee assisting. Some of these skills can first be demonstrated in a classroom setting to give the trainee time to learn the steps in the skill. After sufficient practice, the midwife trainee will perform the skill as well as the trainer.

Trainees observe and learn from the behavior and performance of their trainers and peers. This is **modeling**. Topics not on the training schedule are taught even without a skills checklist or identified objectives. The trainer's friendly greetings to clinic staff, the calm respectful and caring questioning of a client, the capable manner in which she feels a mother's contractions, or the quiet words of advice are all noted and learned. Trainees sometimes see and choose to practice not-so-good behavior. As a trainer, remember that every action performed is closely observed and many times copied or modeled. This is an advantage if our actions and performance are worthy of copying.

Preparation - When preparing the schedule of activities, allow adequate opportunities for clinical experience. It is usually necessary to schedule people on-call during the days, and nights too. Make this schedule with the trainees in order to allow for individual needs. For example, one trainee may be skilled in episiotomy repair, but in need of additional opportunities to use the partograph. Make sure the clinical staff have the schedule so that they will know who, when, and where to call trainees.

Procedure - Wear appropriate protective clothing and be sure you are familiar with the clinical site (Ideally, the trainer is a service provider at this site and can help to get instruments, medicines, and other supplies as they are needed) Help make the client comfortable and clean up after a procedure Place yourself in a good position to observe, coach, and assist a trainee as she cares for the client Scrub in for procedures and wear sterile gloves when appropriate See skills checklist "Clinical Learning Observation, Modeling and Coaching" on page 93

Visual Aids

Various pictures, drawings, models, and equipment help the trainee take an active part in her learning Visual aids may be a list written on the chalkboard, a model in the classroom, or a chart on the wall A client who has the condition that is being discussed is often the most appropriate visual aid Visual aids are **not a replacement for direct experience**

Chalkboards are not expensive and can usually be made They provide a place to write a list, make a simple drawing, or make an outline for the day's activities If possible, write the information on the board before you need to use it Position the chalkboard so that everyone can see it You can use colored chalk to emphasize the main points Write clearly in letters large enough to be read from any place in the room There are **two cautions when using a chalkboard** (1) Do not put too much information on the chalkboard at one time (2) Do not stand with your back to the trainees and talk to the chalkboard White boards or newsprint can be used for the same purpose Newsprint is a good choice when you want to save the drawing or information for future reference

Teaching Models can be simple and inexpensive. Here are a few examples used and some actually created by LSS trainers. Additional suggestions are listed in the lesson plans beginning on page 180.

- **Birth Problem Pants** - In Module 3 **Monitoring Labor Progress** and Module 10 **Other Emergencies**, labor and birth are discussed. You can make learning about birth problems more life-like by using a pair of "birthing pants." The pants are cut at the crotch (groin area) and elastic is sewn around the opening to form a "birth opening." A trainer or trainee acting as the client wears a second pair of pants under the "birthing pants." She places the "baby" in her clothing and "positions the baby for delivery."

In this way, one trainee can learn how it really feels, for example, when asked to get on "your hands and knees" in order to manage a prolapsed cord. At the same time, another trainee practices managing the situation. It also helps the trainee figure out how best to explain to the mother what she needs to do.

- **Laminated Partograph Chart** - The partograph is discussed in Module 3 **Monitoring Labor Progress**. A large chart is used when introducing and practicing the plotting skills on the graph. The larger graph makes it easier to make the marks and others in the room can learn by watching. Once the trainee is comfortable with plotting on this large chart, she begins to practice on paper charts **before** using a real chart in the labor ward. A plastic coated partograph can be purchased (see ordering equipment, pages 195 and 276) or a partograph chart can be painted on a blackboard.
- **Real people or things** - Inspection of the placenta for ragged membranes is discussed in Module 5 **Prevention and Management of Hemorrhage**. It is best to use a recently delivered placenta to allow the trainees to **experience** how difficult it can actually be to see where membranes are missing. When a model of a placenta is used, the edges are quite even and smooth, making it difficult to explain about the irregular edges normally seen on a placenta.
- **Other models that require "doing" as well as "seeing"** - A realistic way to practice using a needle holder and tissue forceps when repairing an episiotomy is to use a piece of foam sponge. The foam tends to stretch and pull apart like tissue. The trainee must take care with the placement and tension of the suture in order to avoid tearing or bunching up the "tissue."

**VISUAL AIDS
MUST NEVER REPLACE DIRECT CLINICAL EXPERIENCE**

Skills Practice Chart

What is it? The skills practice chart is a record of the learning opportunities for each trainee. This information is reviewed daily to make sure that all trainees are receiving skill opportunities. The number of times a skill is performed or observed is used **only to make sure trainees are receiving sufficient experiences**. It is **not a method to evaluate** competence. Sometimes, participants may be on-call and there are no deliveries or opportunities to learn. The call schedule may need to be readjusted during the training in order to offer additional time to those needing additional learning opportunities.

How is it used? It is posted in the classroom or labor ward. Use a large piece of paper to write the names of all midwife participants across the top of the chart in the row marked "name", just like in the sample below. The skills or skill numbers are written along the side. Every time a trainee participates in a skill, she records whether she performed "P", assisted "A", or observed "O", the skill. Learning can take place every time a trainee participates. It is reviewed daily to make sure that the trainees are receiving sufficient opportunities to learn skills.

SKILLS PRACTICE CHART (sample)

Instructions Make a mark each time you participate in a skill opportunity
 P = PERFORMED, A = ASSISTED, O = OBSERVED A brief description of each skill is listed at the end of this sample chart

MIDWIFE NAME/SKILL	<i>Inuwa</i>	<i>Isus</i>	<i>Inasil</i>	<i>Ireggna</i>	<i>Inumrah</i>	<i>Hamsa</i>	<i>Ayahac</i>	<i>Arod</i>
1 ANTENATAL								
2 PARTOGRAPH								
3 DELIVERY								
4 EPISIOTOMY								
5 THIRD STAGE								
6 MANUAL REMOVE PLACENTA								
7 CPR								
8 PREVENT INFECTION								
9 POSTABORTION CARE								
10 SEPSIS								
11 INTRAVENOUS								
12 ORAL HYDRATION								
13 V E								
14 OTHERS								

KEY

- | | |
|--|---|
| 1 Conduct a quality antenatal examination Module 2 | 8 Perform infection prevention steps Module 7 |
| 2 Monitoring labour progress using the partograph Module 3 | 9 Provide postabortion care, Module 7 |
| 3 Conduct a normal delivery, Module 3 | 10 Conduct sepsis evaluation, Module 7 |
| 4 Perform and repair episiotomy Module 4 | 11 Perform intravenous infusion Module 8 |
| 5 Active management of third stage of labor Module 5 | 12 Administer oral rehydration Module 8 |
| 6 Manual removal of a placenta Module 5 | 13 Vacuum Extraction Module 9 |
| 7 Newborn resuscitation Module 6 | 14 Other Emergencies Module 10 |

LEARNING ACTIVITY Practice Teaching

Assign teams of two TOT participants to prepare a presentation for their co-participants using the topics listed below

The observers (TOT participants acting as observers) will **use the skills checklist** found in the module to ensure the steps in the skill are covered step by step

The checklists for teaching methods found on the next four pages are used for preparation by the presenting TOT participants and for feedback by the TOT trainers

- a Case Study - Hemorrhage in Module 5
 - b Case Study - Sepsis in Module 7
 - c Demonstration - Episiotomy in Module 4
 - d Demonstration - Infant Resuscitation in Module 6
 - e Observation & Coaching - Partograph in Module 3
 - f Observation & Coaching - Delivery in Module 3
-

**CLINICALLY ACTIVE, COMPETENT AND CONFIDENT TRAINERS
ARE THE KEYS TO A SUCCESSFUL TRAINING PROGRAM**

SKILLS CHECKLIST USING REVIEW QUESTIONS TO CONDUCT A DISCUSSION

Checklist purpose

- 1 The midwife should use it as a guide for checking her own skills
- 2 The supervisor uses it when evaluating how well the midwife performs

Instructions

- 1 After observing/performing write a rating for each step ✓ =satisfactory OR ✗ =needs improvement
- 2 Add any comments in the comments section below

	Date	Date	Date	Date
STEPS				
Preparation				
1 Assign homework				
2 Arrange circle seating with places for writing				
Procedure				
1 Introduce topic and the way the session will be organized				
2 Read a question				
3 Encourage answers				
4 Ask questions to find out what trainee(s) know				
5 Ask questions to find out what trainee(s) think				
6 Give hints/clues to the best/correct answer				
7 Ask for reasons for answer(s)				
8 Use visual aids as appropriate				

COMMENTS

SKILLS CHECKLIST CONDUCTING A CASE STUDY

Checklist purpose

- 1 The midwife should use it as a guide for checking her own skills
- 2 The supervisor uses it when evaluating how well the midwife performs

Instructions

- 1 After observing/performing write a rating for each step ✓ =satisfactory OR X =needs improvement
- 2 Add any comments in the comments section below

	Date	Date	Date	Date
STEPS				
Preparation				
1 Assign homework				
2 Prepare a circle seating arrangement and ease for writing				
Procedure				
1 Explain the purpose and topic				
2 Read a paragraph				
3 Encourage trainees to offer possible answers				
4 Ask questions what if, how, why, or what more history, physical exam, laboratory do I need?				
5 Sum up answers				
6 Make sure trainees write any necessary changes in their answers				
7 Continue through case study				
8 Discuss how to record history, physical, laboratory, referral				
9 Encourage all trainees to participate				
10 Give brief conclusion of problem solving and a summary of the topic				
11 Thank the group for their participation				

COMMENTS

SKILLS CHECKLIST CONDUCTING A DEMONSTRATION

Checklist purpose

- 1 The midwife should use it as a guide for checking her own skills
- 2 The supervisor uses it when evaluating how well the midwife performs

Instructions

- 1 After observing/performing write a rating for each step ✓ =satisfactory OR ✗ =needs improvement
- 2 Add any comments in the comments section below

	Date	Date	Date	Date
STEPS				
Preparation				
1 Assign homework				
2 Prepare seating so all can see for classroom demonstration				
3 Seating is not provided for clinical demonstration, the client understands, agrees to demonstration				
4 Equipment and materials are available				
Procedure				
1 Explain the purpose and topic				
2 Explain the situation, if there is not an actual client				
3 Show how to do each step as stated on skills checklist				
4 Say what you are doing as you begin each step				
5 Ask if there are any questions				
6 Request return demonstration by trainee midwife Ask for volunteer(s) to do the demonstration without saying what they are doing as they begin each step (just as though they were performing the skill)				
7 Ask observers for feedback				
8 Answer any questions				

COMMENTS

SKILLS CHECKLIST CLINICAL LEARNING Observation, Modeling, and Coaching

Checklist purpose

- 1 The midwife should use it as a guide for checking her own skills
- 2 The supervisor uses it when evaluating how well the midwife performs

Instructions

- 1 After observing/performing write a rating for each step ✓ =satisfactory OR ✗ =needs improvement
- 2 Add any comments in the comments section below

	Date	Date	Date	Date
STEPS				
Preparation				
1 Have skills checklist available				
2 Prepare for procedure with clinical staff				
3 Review skill's practice chart				
Procedure				
1 Wear appropriate protective clothing				
2 Be available and in good position to observe/coach				
3 Find any needed instrument or medicine				
4 Scrub in for procedures needing sterile gloves				
5 Assist with procedure as necessary				
6 Help to make client comfortable, clean up equipment, explain procedure to client, and record information				
7 Provide immediate feedback using skills checklist				
Ask midwife how she felt she did				
Praise satisfactory points Discuss any questions				
Offer suggestion(s) for areas needing improvement				
Plan next step in midwives' experience(s)				
Complete checklist				
8 Make sure trainee notes information on skills practice chart				

COMMENTS

Topic 2 Finding Out About the Midwife

Trainers, in meeting the learning objectives of this topic, will be able to

- 1 discuss the registration and inventory form
- 2 demonstrate the clinical assessment of a midwife as she conducts basic midwifery skills
- 3 explain why demonstration of basic midwifery skills by the trainee is important at the beginning of the LSS training course

LSS training is a continuing education activity. It builds upon the midwife's abilities. In a competency based training program, a trainee's learning needs related to skills, attitudes, and knowledge are identified through individual assessment. The assessment is the basis on which her learning objectives are formulated. The trainer finds out exactly what the midwife can do by watching her perform skills. Knowledge is assessed in a written pretest. LSS training helps the midwife review and upgrade existing skills and offers her new knowledge and skills.

It is essential to observe the midwife in practice. These observations form the baseline from which both the trainer and midwife decide what needs to be learned. Use selected skills checklists to observe the midwife, then talk with her. Together, identify the skills she can perform and the skills or steps of skills she needs more time to learn. The method for doing an assessment is discussed later in this section.

Take time to talk with each midwife trainee. Your communication begins a process in which mutual respect for each other's work develops. Midwives (trainers and trainees) can learn a lot from each other.

Midwives have a lot of experience in pregnancy care and delivery. The LSS course content should help the midwife gain new information and skills. An update of midwifery skills should be provided only when the clinical and written assessments indicate there is a need.

Who Is She? What Equipment and Supplies Does She Have for Her Work?

The midwife should complete a registration and inventory form before, or soon after, she arrives at the training site. This form is used to collect information about her specific situation. The information may be used to compare and evaluate the midwife's situation after training when she returns to her facility. Some of the information may be used to provide equipment that will enable the midwife to perform the new skills she learns.

The registration and inventory form gives you information about the midwife, including her name, address, pre-service education, and places of practice. The inventory tells you about her available supplies and equipment. It will also tell you something about the midwife's procedures and practices. This information may be used during follow-up visits to see if the LSS midwife is using equipment or supplies issued to her. When visiting the LSS midwife after training, the supervisor can observe whether she has implemented new procedures, such as infection prevention routines, or if new records and reference materials are being used.

LEARNING ACTIVITY Getting to Know the Midwife

Look at the registration and inventory form on the next pages. Write your answers below.

Describe the midwife, who is she?

What equipment needs to be replaced or supplied?

What changes need to be made in the care of instruments?

Are there other problems that need attention?

LSS PARTICIPANT REGISTRATION AND INVENTORY FORM

TRAINING CENTER NAME Wankaade TRAINING GROUP NUMBER 22

1 NAME Yram O 2 AGE 29 (YEARS) 3 MARRIED/SINGLE

4 MAILING ADDRESS P O Box 1002, Village yahe

5 EDUCATION BASIC SCHOOL 12 (NUMBER OF YEARS)
 NURSING 3 (NUMBER OF YEARS)
 MIDWIFERY 1 (NUMBER OF YEARS)
 OTHER FORMAL TRAINING FP COURSE FOR 3 MONTHS IN 1995

6 NAME OF PLACE OF WORK YAHE CLINIC

7 ADDRESS AND DIRECTIONS TO PLACE OF WORK GO EAST ON THE ROAD NUMBER 29 TO MILEPOST 15 TURN RIGHT ON GRAVEL ROAD, CROSS TWO BRIDGES, TURN RIGHT AT THE CHURCH MY CLINIC IS ON THE LEFT

8 WHAT IS YOUR WORK POSITION STAFF MIDWIFE

9 HOW LONG HAVE YOU WORKED AT THE PLACE YOU ARE NOW? 3 YEARS AND 2 MONTHS

10 HOW FAR OR HOW LONG DOES IT TAKE TO GO TO YOUR CLOSEST REFERRAL SITE?
IT TAKES ABOUT ONE HOUR, IF IT IS NOT THE RAINY SEASON

11 HOW MANY DELIVERIES DO YOU ATTEND EACH MONTH? ABOUT 10 TO 12 DELIVERIES

12 APPROXIMATELY HOW MANY EPISIOTOMIES DO YOU DO IN ONE MONTH? 1 OR LESS

13 DO YOU USE THE PARTOGRAPH? NO

14 SINCE YOU COMPLETED MIDWIFERY TRAINING, HAVE YOU EVER

A MANUALLY REMOVED A PLACENTA? YES HOW OFTEN AND WHEN? ONCE, LAST YEAR

B USED BIMANUAL COMPRESSION? NO HOW OFTEN AND WHEN? --

C STARTED AN INTRAVENOUS INFUSION? YES HOW OFTEN AND WHEN? ONCE A WEEK

D USED A VACUUM EXTRACTOR? NO HOW OFTEN AND WHEN? _____

E GIVEN LOCAL ANESTHESIA? NO HOW OFTEN AND WHEN? -

F PERFORMED INFANT RESUSCITATION? NO HOW OFTEN AND WHEN? -

LSS REGISTRATION AND INVENTORY FORM, Page 2

- 15 Below is a list of equipment and supplies. Please (A) put a ✓ (tick) in the second column after each item that you have and (B) if you have the item, put the number (in working condition and not broken) you have in the third column.

COLUMN ONE	COLUMN 2	COLUMN 3
ITEM	✓ (TICK) IF YOU HAVE THE ITEM	IF YES, list how many you have
1 HEMOSTAT/ARTERY FORCEPS	✓	1
2A. SCISSORS FOR CORD	--	
2B SCISSORS FOR EPISIOTOMY	✓	NOT SHARP
3 FETAL STETHOSCOPE PINARD, OTHER	✓	1
4 BLOOD PRESSURE APPARATUS	✓	BROKEN
5 ADULT STETHOSCOPE	✓	1
6 SUCKER, SUCTION BULB, OR DELEE	--	
7 URINARY URETHRAL CATHETER	✓	2
8 RECTAL TUBE	✓	2
9 PROTECTIVE APRON	✓	1 TORN
10 SURGICAL GLOVES	--	MOTHER BRINGS
11 HEAVY GLOVES FOR CLEANING	--	
12 TOWEL FOR CLEAN DELIVERY OR DRYING BABY	--	MOTHER BRINGS
13 SYRINGES AND NEEDLES	✓	MANY
14 INSTRUMENT TRAY WITH COVER	--	
15 KIDNEY OR PLACENTA BASIN	✓	2
16 REFLEX OR PERCUSSION HAMMER	--	
17 MEASURING TAPE	--	
18 VAGINAL SPECULUM	--	
19 SUTURE, what kind?	--	
20 SUTURE NEEDLES	✓	2 BENT
21 NEEDLE HOLDER	--	
22 TISSUE/THUMB FORCEPS, without teeth	--	
23 SUTURE SCISSORS	--	

LSS REGISTRATION AND INVENTORY FORM, Page 3

COLUMN ONE	COLUMN 2	COLUMN 3
24 SPONGE HOLDING FORCEPS WITHOUT TEETH	--	
25 ORAL AIRWAY ADULT, INFANT	--	
26 URINE TESTING KIT	--	
27 TOWELS OR DRAPES FOR SUTURING	✓	2
28 BABY WEIGHT SCALE	✓	1
29 ADULT WEIGHT SCALE	✓	BROKEN
30 HEIGHT MEASURE	✓	PAINTED ON WALL
31 HEMOGLOBIN MEASURE, what kind	--	
32 INTRAVENOUS FLUIDS AND GIVING SETS	✓	5 BOTTLES, SETS
33 OXYTOCICS	✓	ENOUGH
34 ANTIBIOTICS	✓	PENICILLIN INJECTION
35 STERILIZATION EQUIPMENT, what kind? Steamer, boiler or autoclave (pressure cooker)	✓	STEAMER

What Midwifery Skills Does She Have?

Assessment of each trainee's midwifery skills at the beginning of the training gives the trainer and the trainee midwife information on what skills she can perform competently. Each trainee midwife can then be given the opportunity to update skills, or steps in a skill, that need improvement. Use the skills checklist found in the *Life-Saving Skills Manual for Midwives*, Module 3 **Monitor Labor Progress**, Second Stage of Labor on page 366 to assess each trainee.

A skills checklist is a tool for use in observing a midwife's performance. These observations are like a clinical test. They should be used before training begins. Going to the midwives' work place and observing performance is the ideal. However, it is not usually possible to go to each work place. It is also not always possible to watch each midwife perform all of the skills on the checklists at the start of a training course.

When a midwife conducts a delivery, she demonstrates many of the basic midwifery skills. Observe each midwife as often as possible when she comes for LSS training. Use the checklist to make your observations as you watch her perform midwifery skills. Offer assistance and advice during the procedure. *Take every chance available to teach when you are evaluating the skills of a midwife.* The learning environment is fruitful when the trainer is helpful and caring.

When the midwife completes the skill, allow her time to read the skills checklists found in her LSS Manual and in the *Clinical Practice Guide*. Give her time to evaluate herself. Encourage her to tell you how she felt about her performance. Take advantage of all opportunities to listen, explain, and help. Discuss your observations with the midwife. This method of discussion between the trainer and the midwife begins the process of learning from each other.

LEARNING ACTIVITY Teaching Demonstration**USING THE SKILLS CHECKLIST**

During the TOT course, the following demonstration is conducted

In a classroom or clinical area, LSS Trainer A conducts an antenatal revisit history and physical examination as if she were a midwife trainee coming for LSS Training. LSS Trainer C provides feedback *using the skills checklist* to the one conducting the demonstration (Trainer A). The other LSS Trainers are asked to observe using the appropriate skills checklist. After the demonstration and feedback session, discuss the experience using the following questions:

How did Trainer A feel she did?

How did Trainer C discuss the needs to improve?

What clinical practice will Trainer A need now?

How did each observer feel Trainer A did?

How did each observer feel Trainer C did as an observer? as a teacher?

Topic 3: Evaluating the Midwife Were the Trainers Successful?

Trainers, in meeting the learning objectives of this topic, will be able to

- 1 discuss the use of LSS pretests and post tests and how to develop them
- 2 identify and demonstrate evaluation skills
- 3 demonstrate use of the skills checklist to monitor skill performance

Whether or not competency has been achieved by trainees is decided by their written responses and clinical performance. If the trainees can competently perform a procedure taught by the trainers, then the trainers are successful. If the trainees respond accurately on the written test, then the trainers are successful. If the trainees have learned, then the trainers' performance is good. **The trainers' success is measured by the competence of the trainees.** The competence demonstrated during training, at the end of training, and at the place of work (work site) on follow-up visits confirms the success of the trainers and the training.

Remember that each trainee learns at her own pace. Each trainee's competence is evaluated individually. Trainees are not compared. Each has her own starting point and learning pace. Some will have farther to go during a training than others. To judge success, you must focus on the progress and the competence each trainee has acquired. Some trainees may become fully competent in the two week training. Some may need to continue practicing at the training site, some may need to continue at their place of work.

Providing all trainees with identical learning experiences
is like a physician writing the same prescription for all patients

Evaluation of trainees, training materials, and the ways of teaching are continuous steps in a training program. Tests (written and clinical) are used to assess where trainees are now. They are used to provide immediate and continuous feedback on progress, to assess competency (mastery), and to evaluate training and trainers (materials and experiences).

Information received during evaluation has both immediate and long-term importance. During the training course, trainees provide and receive feedback on their progress toward meeting the objectives. The trainee who is progressing slowly plans with her trainer for additional experience. The trainee who is progressing at a faster pace can help others or seek out additional experiences to broaden her learning.

Evaluation information is also used by the training staff as they plan future classes, change materials, and vary teaching methods. If trainees have difficulty with a topic, the training staff should review the way the topic is presented and how it is taught. Changes should be made until the trainees are competent (that is, they are knowledgeable about the topic and able to perform the skills).

The *Life-Saving Skills Manual for Midwives* includes evaluation materials. Review questions and case studies help trainers assess knowledge and problem solving skills of the trainees. The modules also contain skills checklists. The trainee and trainer both write their observations on the checklist to follow the trainee's progress in skill performance.

Training Evaluation

LSS training provides a learning experience in critical and emergency care. The skills being taught must be performed 100%. This is a **LIFE-SAVING** training. Each skill has a list of essential steps. All steps must be done completely. No essential step can be forgotten. The skills checklist helps both the trainer and trainee to monitor performance. The trainee rates and is rated "satisfactory" or "needs improvement" for each step in the skill. A satisfactory performance is a competent performance. Each trainee is expected to achieve a competent performance for all of the steps in each skill. For example, one essential step in the checklist for Active Management of Third Stage is to support or hold the uterus while applying cord traction (Module 5 **Prevention and Treatment of Hemorrhage**). It would be impossible to say the skill was 80% satisfactory if in fact the midwife did all of the other steps but DID NOT support or hold the uterus. The trainer must have gentle patience to encourage and guide each midwife trainee through each step of a skill, remembering that the goal is to help the midwife trainee complete each step in the skill satisfactorily. Evaluate your training by how many trainees achieve competency.

When observing a trainee, provide encouragement. Coach and assist her as she learns each step of the skill. Suggest how and where a trainee can improve her performance. Arrange additional experience in the skills needing improvement.

The trainee may find it less stressful to work with a classmate when practicing a more troublesome skill. This is to be encouraged provided the classmate is competent in the skill.

The trainer should try to help the trainee be the most competent midwife she can be. Competency based training should offer an atmosphere of "winners." Everyone attending the training will, in her own time, perform the skills satisfactorily and become competent.

The trainee's skills checklists provide the training program staff with information about testing and the experiences she has had. When the competent trainee becomes an LSS midwife, she continues to use the skills checklists for reference at her place of work. She records life-saving skills performed by filling out an incident form. (See page 145 for information on the incident form.) The trainer uses skills checklists for evaluation when following up the LSS midwife.

Assessing Pretest and Post Test Knowledge

Knowledge recall is a **must** for problem solving. At the start of the training, a written pretest is given to find out the midwife's knowledge level. Remember that some of the trainees may have been out of school for a long time. Testing may be a threatening experience. Some may feel worried that they will do poorly. To make the experience less stressful, the written pretest may be self-graded or the answers reviewed as a group. Help the trainees understand that evaluation methods are used to help them identify what they need to learn.

During group discussions and clinical practice, a trainee's progress is followed by the trainer. Each module's review questions and case studies help the trainee follow her own progress. Finally, post tests tell both the trainee and trainer about the trainee's progress toward competency. The post test also evaluates the training and the trainers. Record the results on a form such as the sample training report form found at the end of this section.

Developing a written test Knowledge is a must for skill performance and problem solving. In order to compare the trainee's knowledge before the training activity (pretest) and after the training activity (post test), we suggest using the very same written test. Questions in a written test should reflect the objectives of LSS training. To make the test, you can use some of the review questions. You can write your own questions. The test should not be too long, ten to fifteen questions are enough. Use the same questions for the pretest and post test so that you can compare and see the progress in knowledge. Make sure that each question you use reflects information from an objective and that the answer is written in the LSS Manual.

If you decide to write questions, you should be aware of advantages and disadvantages of various types:

Short answer questions ask trainees to make lists, explain causes or fill in some missing information. These require the midwife to recall knowledge and they are fairly easy to grade.

Multiple choice questions test knowledge recall. They are a little more difficult to write in order to offer a fair choice of answers. They also allow the trainee to guess if she does not know the answer. She might guess correctly even when she is uncertain.

Case study questions are a form of short answer questions. They might be difficult to write, answer, and correct if they are too long. You can write a short description of a problem and ask for specific information, such as "What is the problem?" Case study questions are more difficult to correct than multiple choice questions but is a method used to test the application of knowledge.

When you complete the writing of your test, ask a coworker or LSS trainer to "take the test" to make sure that the questions are understood. Look up every answer in an LSS manual to make sure that the answer can be found.

LEARNING ACTIVITY Create a Written Examination

Write a pretest for LSS training. Include the page number(s) in the LSS manual where each answer can be found.

Assessing Clinical Skills

Skill assessment is the key to evaluating competence in a competency based training program. Only by watching a trainee's performance can you decide if she is gaining the skills necessary to save lives. Skill assessment is a continuous process throughout the training.

The trainer and trainee follow the trainee's progress by reviewing the checklists each time a skill is performed. The trainee meets with a trainer(s) at least twice during the training to talk about her overall clinical performance. Many times this is an opportunity to listen to the trainee's previous experiences and to find out how she sees her learning being helpful at her place of work. Sometimes acquiring additional skills presents problems if the community does not want or feel comfortable about the skill. For example, in one LSS training a midwife shared that she was feeling confident and competent in episiotomy repair methods, however, the women in her community did not allow an episiotomy to be made or a laceration to be repaired. She wondered how she would be able to use this skill, since she now understood how very important it is to repair lacerations.

At the end of the training, the assessment of clinical performance is recorded according to skill on the training report form, such as the one found at the end of this section.

Trainers' Evaluation

Evaluation of the trainers occurs as a two way process during training. Trainers and trainees all take part in evaluating each other and the training. This is good preparation for trainees who will help other people work toward change. Evaluation during training needs to be encouraged in all directions. The trainers evaluate the trainees, the trainers evaluate each other, the trainees evaluate the trainers and the trainees evaluate each other.

There are many advantages to involving trainees in the evaluation process.

Evaluation by trainees helps trainers learn how effective and appropriate their teaching is.

Two way evaluation helps trainers relate to trainees as equals.

Two way evaluation helps everyone gain confidence and courage to question the accepted norms.

Taking part in an evaluation during LSS training gives the trainees the practice and skill they will need for evaluating their own work.

Ways to Include Trainees in Evaluation During LSS Training

In the following suggested evaluation methods, both trainees and trainers will quickly discover how difficult it is for most people to accept criticism. When offering criticism, be sure to comment on the good as well as the bad. Remember to mention the good things **first**. A good rule is to mention three positive things before describing a problem or missed step.

Short evaluation discussions can be held at the end of each class or day. You can ask the trainees questions such as: What was the most useful or interesting thing you learned today? What do you wish had been different? Which of the learning activities did you find most helpful? At first it may be hard for trainees to speak up, but if you make it very clear that you welcome comments and suggestions, trainees can become good evaluators by the end of LSS training.

Trainees can test themselves by asking each other about what they have learned. The review questions or the case studies in the LSS manual can help them find out how well they understand and whether they can apply what was covered in class. At first, trainees may find it difficult to think of good questions, but with helpful suggestions, many will become quite skillful at this.

A **written evaluation** by both trainees and trainers, at the end of each week, can be read and discussed by the trainees and trainers. This evaluation can cover classes, activities, any concerns, complaints, problems, and outstanding events that come to mind. Sometimes it is easier for one to write thoughts or ideas, rather than speaking about them in a group. See the sample weekly evaluation form on page 285.

A **written final evaluation** of the course by the trainees is used to improve the training. See the sample final evaluation form on page 286. The review of this information takes extra time, but it helps the trainers become better each time they teach. The final evaluation may cover the following aspects of teaching:

- Coverage of planned topics/content
- Participation by all trainees
- Appropriateness of the teaching aids and methods used
- Relationship between material covered and trainees' experiences
- Relationship between material covered and felt learning needs
- Fairness and friendliness
- Clear and simple communication
- Frequent review of important points
- What trainees learned and how they feel about the LSS training

Remember for evaluation to be useful, it must be simple. It cannot cover every aspect of training in depth. Evaluation is needed if we are to move forward because it allows us to learn from our successes and mistakes.

TRAINING REPORT - LIFE-SAVING SKILLS (sample)

NAME	OPPORTUNITIES FOR CLINICAL PRACTICE/ASSIST													CLINICAL COMPETENCY DEMONSTRATED													EXAM		
	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9	10	11	12	13	PRE	POST	
The	9	8	8	5	9	3	8	9	3	3	6	9	1	✓	✓	✘	✓	✓	✓	✓	✓	✓	✓	✓	✓	✘	51%	92%	
Aro	4	5	5	2	2	1	6	5	3	2	5	5	0	✓	✓	✓	✓	✓	✓	✓	✓	✓	✘	✓	✓	✘	59%	99%	
Isu	5	8	9	4	5	2	8	8	2	4	5	4	2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	64%	95%	
Ian	5	4	9	4	6	3	7	4	3	2	4	3	2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	70%	97%	
Write total number of CLINICAL OPPORTUNITIES														Write ✓ = competent, ✘ = needs additional practice															
1 Conduct a quality antenatal examination, Module 2														1 Antenatal anemia, toxemia, fetal growth monitoring															
2 Monitor labor progress using the partograph, Module 3														2 Labor Progress history, exam, use partograph															
3 Conduct a normal delivery, Module 3														3 Episiotomy/Lacerations, Inspection, Repair															
4 Perform and repair episiotomy, Module 4														4 Active Management of Third Stage															
5 Actively manage third stage of labor, Module 5														5 Manual Removal of Placenta															
6 Manually remove a placenta, Module 5														6 Bimanual Compression of the Uterus															
7 Resuscitate newborn at birth, Module 6														7 Infant Resuscitation															
8 Perform infection prevention steps, Module 7														8 Infection Prevention Care															
9 Provide postabortion care, Module 7														9 Postabortion Care															
10 Conduct sepsis evaluation, Module 7														10 Incision and Drainage of Breast Abscess															
11 Perform intravenous infusion, Module 8														11 Intravenous Infusion															
12 Administer oral rehydration, Module 8														12 Oral Rehydration															
13 Perform vacuum extraction, Module 9														13 Vacuum Extraction															

114

Topic 4 Roles and Responsibilities of the LSS Trainer

Trainers, in meeting the learning objectives of this topic, will be able to

- 1 describe the role and tasks of the LSS trainer
- 2 describe steps in implementation of LSS training
- 3 develop a training schedule

Role and Responsibilities of the LSS Trainer

As we have already seen, the trainer must play many roles in addition to being a professional midwife and care provider. She must be a friend, teacher, counselor, coach, supporter, and encourager. She must also be an active learner. Review the role of the midwife in LSS Module 1 **Introduction to Maternal Mortality**

The trainer must prepare for her task by reviewing her own skills so that she is competent and confident in teaching LSS. During the TOT, each trainer conducts and masters all of the life-saving skills and learning activities for LSS midwives. With her co-trainers, she chooses areas of responsibility she feels best suited and qualified to carry out.

Some planning must be done in advance (see Step 1) of the training including decisions about **why** (goals of training), **when** (training dates), **where** (training location), **with whom** (trainers), and **for whom** (trainees) the training will take place. **Resources** (money, supplies, materials) and **needs** (training site assessment) must also be considered. Certain **preparations** (schedules, food, lodging, teaching aids) must be made in time to ensure a smoothly run course.

As you plan, keep in mind that the trainees are adults who *want to learn* new skills and information relevant to their job. Since you will find out specifically what they need to learn by conducting written and clinical assessments after they arrive at the training site, some of the planning must take place after the training course begins. This allows you to modify the course according to the trainees' interests, experiences, needs, and capabilities.

The TOT is conducted using the same competency based approach as LSS. This helps the trainers learn the method of teaching/learning. The trainers review (or learn) LSS as they prepare for and guide the learning of their co-trainers. The trainers practice LSS and practice teaching LSS at the same time.

LSS TRAINER TASKS

- Perform LSS with competency and confidence
- Plan, prepare, and implement Life-Saving Skills training activities
- Assess learning needs of the trainee midwife using written tests and clinical skill evaluations
- Teach competency based LSS using the adult learning and participatory approach
- Practice effective communication skills in teaching and learning situations
- Evaluate LSS performance using the checklists and discuss competence with the trainee
- Provide supervision and support to the trainee midwife during training
- Maintain a register of trained LSS midwives and reports of training activities

Materials And Equipment

The *Life-Saving Skills Manual for Midwives* includes goals and objectives for each topic, course content, case studies, review questions and checklists. The trainers are responsible for having additional reference books available and knowing where others can be obtained if needed. Many times books can be borrowed from a medical, nursing, or midwifery school library. The trainer should make sure there is one complete LSS manual on each clinical unit (labor, antenatal, postpartum) to be used as a reference during training.

The LSS Midwife may need to receive equipment to *supplement* what she has available so that she will be able to perform all the skills she has learned. Equipment needed for each procedure is listed at the beginning of each skill. The modules or skills you choose to teach will determine what equipment is needed. In many cases hospitals or maternity homes will already have most of the equipment. In order to keep the training program at a reasonable cost, it is important to do an inventory of what is available before dispensing equipment. The inventory for midwives is usually done at the beginning of a course. See the registration and inventory form beginning on page 96. The trainer will need to review, compare or check each midwife's inventory with the master list of equipment and put together and dispense to the midwife the equipment she will need in order to perform LSS.

Training Schedule (Timetable) and Timing of Classes

The schedule for a training course should be made after all necessary information is available, including the following

Course Content - The *Life-Saving Skills Manual for Midwives* covers the most common causes of maternal and newborn mortality and morbidity. Needs assessments and other data give the decision makers information to help them decide which of these topics should be covered in the training (The decision regarding priority topics was made before training was organized). Information gathered from midwife trainees is also critical when deciding priority skills or even steps in a skill for each midwife. For example, one midwife may not have performed an episiotomy for over a year, another may have performed many episiotomies but never used a needle holder, and a third midwife in a class may be very competent in episiotomy repair. Each of these three midwives will need to focus on different steps in the skill and, in fact, the third midwife may be able to help the first two midwives. Some midwife trainees may feel a need to have additional time for practice beyond the two week training. When planning the length of the training, consider the experience, knowledge, and performance of each midwife. Using all of this information, you can proceed to plan the classes and other activities. **Lesson Plans**, beginning on page 180, are guides that include suggestions for teaching each module in the LSS manual.

Length of the Training Course - Although 2 weeks is planned for each midwife trainee, allow flexibility according to the individual trainee's needs. It is usually advisable to have at least a one week break after each two week training. This gives time for the LSS trainers to catch up on clinical tasks and provides a space for trainees who need additional time. Our experience has shown that between two and five percent of trainees will need extra time to master skills, either due to a lack of clinical opportunity or because the trainee needs additional time to acquire competence in a particular skill.

Other Considerations - The way you organize the training schedule will be affected by many things, such as how long trainees can be away from their work sites, how much clinical experience is available in the hospital used for training, how many skills are taught, and so on. Think about how to best use the hours of each day. Plan the schedule according to the hours when people usually wake up, work, eat meals, rest, pray, and so on. Plan the clinical experiences according to the times antenatal, postpartum and other clinics are held. The LSS trainers usually have other job responsibilities and these will affect the schedule, too.

LSS Training Schedules (sample) - The training schedule is used as a guide. All clinical opportunities are taken which means that class discussions are interrupted. The schedule is rearranged to accommodate clinical experiences. Sometimes the on-call team (with or without a trainer) can respond to the clinical experience and call the entire class when a delivery or other experience is ready. Again, flexibility is very important. The trainees who are on-call may need assistance to catch up on class discussions. On the following pages are **two examples** of a LSS training schedule. Look carefully at these LSS training schedules. They may help you decide when and how to cover LSS activities in your own LSS training.

- LSS Program A on pages 116 and 117 includes *all of the skills* in the LSS Manual *except* some topics in Module 10 **Other Emergencies**
- LSS Program B, on pages 118 and 119, Adult CPR in Module 6 **Resuscitation**, all of Module 9 **Vacuum Extraction**, and all of the topics Module 10 **Other Emergencies** *were not taught*

Explanation of Terms for training schedules on pages 116 to 119

- **Opening** - Since this is a continuing education training and many training courses are run, an official opening is not usually necessary. It is time consuming and increases the budget. All the LSS trainers try to be present for the first morning of each new training. Introductions and a warm welcome are extended to all trainees. The timetable is usually reviewed to make sure trainees understand, and their questions are answered. It is important to have one timetable posted where any schedule changes are made. Everyone should make a habit of referring to this timetable for up to date information.
- **Pretest** - This refers to a written test that provides trainers and trainees with baseline information about each trainee's knowledge at the beginning of training. Clinical testing (assessment) done during each clinical opportunity is like a clinical pretest. The first performance by each trainee can be considered the baseline.
- **Break , Lunch** - There are usually two breaks a day as well as lunch. When clinical opportunities present, trainees may be asked to take a "quick" break and then relieve each other. Lunch or breaks may not always be at the same time for all trainees.
- **Homework** - Daily assignments are given. If there are no clinical opportunities, the trainees work on these in the classroom either in groups or individually. When modules are assigned, it is expected that the trainee will

write answers to all review questions, complete the case studies, and read the skills checklists. All trainees are expected to study and practice skills as they feel the need.

- **On-call** - Trainees are grouped into teams, two midwife trainees make one team. Depending on the number of clinical opportunities, one or two teams may be on-call at a time. Usually each team works independently. Members of a team take turns with one conducting the skill and one helping. The helper makes sure that the skill is conducted according to the skills checklist. On-call is from 0800 in the morning until 0800 the next day, or there may be 12 hour shifts of 0800 (8 AM) to 2000 (8 PM) and 2000 (8 PM) to 0800 (8 AM).
- **Rounds** - The on-call team(s) make morning postpartum rounds on the women they delivered.
- **Rounds Report** - The on-call team(s) use a Life-Saving Skills rounds report form to record information and then report their findings in class. A sample form is located on page 290.
- **Review** - The assigned group gives a summary of the previous day's activities including "how did the day go?" (a short evaluation discussion). They also review major points. This is a good time for any clarification of the previous days' discussions.
- **The day before training begins** (usually a Sunday) a number of tasks and activities can be completed. The following is suggested for all training programs.

Participants arrive
Welcome
Fill out registration form
Receive training timetable
Receive *Life-saving Skills Manual for Midwives*
Take orientation tour
Participant assignment to teams of two for being on-call
Read homework assignment, do review questions

SAMPLE A, PAGE 1

LSS PROGRAM A TIMETABLE LIFE-SAVING SKILLS

TIME	DAY 1 MONDAY	DAY 2 TUESDAY	DAY 3 WEDNESDAY	DAY 4 THURSDAY	DAY 5 FRIDAY	DAY 6 SATURDAY
8:00 AM	Welcome Introductions Overview of Maternal Mortality Video Why Did Mrs. X Die? OR Case Study Discussion Registration Pretest LSS Definition and Overview	Review Maternal on Vacuum Extraction Episiotomy and Laceration Repair Seminar	Review Episiotomy and Laceration Repair Prevention and Treatment of Hemorrhage. Active Management of Third Stage Manual Removal of Placenta Bimanual Compression of Uterus Manual Removal of Clots and Products of Conception	Review Prevention and Treatment of Hemorrhage Use of Partograph for Labor Management	Review Use of the Partograph More on the Partograph	Review Labor and Delivery Problems Infection Prevention
10:30 AM	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK
11:00 AM	Introduction to the Problem Solving Method Measuring Pelvic Size Vacuum Extraction Seminar Video on Vacuum Extraction	Suturing Practice	Continue	Continue Second Stage Review	Continue Labor and Delivery Problems	Continue
2:00 PM	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM MIDWIVES 1 2 ON-CALL 8:00 PM TO 8:00 AM MIDWIVES 3 4 ON-CALL	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM MIDWIVES 5 6 ON-CALL 8:00 PM TO 8:00 AM MIDWIVES 7 8 ON-CALL	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM MIDWIVES 1 2 ON-CALL 8:00 PM TO 8:00 AM MIDWIVES 3 4 ON-CALL	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM MIDWIFE 5 6 ON-CALL 8:00 PM TO 8:00 AM MIDWIVES 7 8 ON-CALL	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM MIDWIVES 1 2 ON-CALL 8:00 PM TO 8:00 AM MIDWIVES 3 4 ON-CALL	CLINICAL ASSIGNMENT 8:00 AM TO 8:00 PM MIDWIVES 5 6 ON-CALL 8:00 PM TO 8:00 AM MIDWIVES 7 8 ON-CALL
	HOMEWORK Study Module 4 on Episiotomy and Laceration Repair Study Module 9 on Vacuum Extraction	HOMEWORK Study Module 5 on Prevention and Treatment of Hemorrhage	HOMEWORK Study Module 3 on Monitoring Labor Progress	HOMEWORK Review Module 3 on Partograph Study Module 10 on Labor and Delivery Problems	HOMEWORK Study Module 7 on Infection Prevention	HOMEWORK Review All Modules for the Week (3 4 5 7 9 10)

SAMPLE A, PAGE 2

**LSS PROGRAM A TIME TABLE
LIFE-SAVING SKILLS**

TIME	DAY 7 SUNDAY	DAY 8 MONDAY	DAY 9 TUESDAY	DAY 10 WEDNESDAY	DAY 11 THURSDAY	DAY 12 FRIDAY
8 AM		Review Infection Prevention Quality Antenatal Care: Use of the Antenatal Risk Assessment Tool in Prevention and Treatment of Anemia and Pregnancy Induced Hypertension	Review Quality Antenatal Care Intravenous Infusion Fluid Management Recognition and Treatment of Sepsis Premature Rupture of Membranes Puerperal Fevers Incomplete and Septic Abortions	Review Recognition and Treatment of Sepsis Cardio Pulmonary Resuscitation and Heimlich Maneuver	Review CPR Cardio-Pulmonary Resuscitation continued	General Review
10 30 AM		BREAK	BREAK	BREAK	BREAK	CLOSING
11 00 AM		Practice Tool at Antenatal Clinic	Continue	Continue	Continue	Review POST TEST
2 00 PM	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
	CLINICAL ASSIGNMENT 8 00 AM TO 8 00 PM MIDWIVES 1 2 ON-CALL 8 00 PM TO 8 00 AM MIDWIVES 3 4 ON-CALL	CLINICAL ASSIGNMENT 8 00 AM TO 8 00 PM MIDWIVES 5 6 ON-CALL 8 00 PM TO 8 00 AM MIDWIVES 7 8 ON CALL	CLINICAL ASSIGNMENT 8 00 AM TO 8 00 PM MIDWIVES 1 2 ON CALL 8 00 PM TO 8 00 AM MIDWIVES 3 4 ON CALL	CLINICAL ASSIGNMENT 8 00 AM TO 8 00 PM MIDWIVES 5 6 ON-CALL 8:00 PM TO 8 00 AM MIDWIVES 7 8 ON-CALL	POST TEST CLINICAL ASSIGNMENT 8 00 AM TO 8:00 PM MIDWIVES 1 2 ON-CALL 8 00 PM TO 8 00 AM MIDWIVES 3 4 ON-CALL	OPTIONAL CLINICAL ASSIGNMENT 8 00 AM TO 8 00 PM MIDWIVES 5 6 ON-CALL 8 00 PM TO 8 00 AM MIDWIVES 7 8 ON-CALL
	HOMEWORK Study Module 2 on Quality Antenatal Care	HOMEWORK Study Modules 7 & 8 on Hydration and Management of Sepsis	HOMEWORK Study Module 6 Resuscitation Cardio Pulmonary and Heimlich Maneuver	HOMEWORK Review Module 6 on Resuscitation	HOMEWORK General Review	

122

SAMPLE B PAGE 1

LSS PROGRAM B TIMETABLE LIFE-SAVING SKILLS

TIME	MONDAY DAY 1	TUESDAY DAY 2	WEDNESDAY DAY 3	THURSDAY DAY 4	FRIDAY DAY 5	SATURDAY DAY 6	SUN DAY 7
0700		ROUNDS	ROUNDS	ROUNDS	ROUNDS	ROUNDS	
0800	OPENING WELCOME	ROUNDS REPORT	ROUNDS REPORT	ROUND REPORT	ROUND REPORT	ROUND REPORT	
0815	INTROS	REVIEW	REVIEW	REVIEW	REVIEW	REVIEW	
0825	PRETEST	MODULE 4 EPISIOTOMY DEMONSTRATION and RETURN DEMONSTRATION	MODULE 5 HEMORRHAGE CASE STUDIES	MODULE 3 PARTOGRAPH DEMONSTRATION	MODULE 5 HEMORRHAGE REVIEW QUESTIONS	MODULE 7 SEPSIS GUEST LECTURE SEPSIS REVIEW QUESTIONS	ON CALL AS NEEDED
1000	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1015	MODULE 1 LSS MATERNAL MORTALITY SKILLS CHECKLISTS PROBLEM SOLVING	MODULE 4/5 DEMONSTRATION SECOND AND THIRD STAGE	MODULE 2 ANTENATAL DEMO FETAL GROWTH PRE ECLAMPSIA, ANEMIA	MONITORING LABOR USING THE PARTOGRAPH	CLINICAL MID-TRAINING EVALUATION	SEPSIS CASE STUDIES	ON CALL AS NEEDED
1200	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
1330	MODULE 4 EPISIOTOMY REVIEW QUESTIONS	CLINICAL PRACTICE EPISIOTOMY	CLINICAL PRACTICE ANTENATAL EPISIOTOMY	CLINICAL PRACTICE ANTENATAL EPISIOTOMY PARTOGRAPH	CLINICAL, PRACTICE	PREVENT INFECTION DEMO IN LABOR UNIT	ON CALL AS NEEDED
1500	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1515 HOMEWORK	MODULE 5 HEMORRHAGE MODULE 4 EPISIOTOMY	HEMORRHAGE CASE STUDY MODULE 2 ANTENATAL	MODULE 3 MONITORING LABOR PROGRESS	MODULE 5 HEMORRHAGE	MODULE 7 SEPSIS INDIVIDUAL REVIEW OF CHECKLISTS	TRAINERS MEETING REVIEW MATERIAL COVERED	ON CALL AS NEEDED
1800	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE	
ON CALL FROM 0800-0800	TEAM 1 4	TEAM 2 3	TEAM 3 2	TEAM 4 1	TEAM 1 4	TEAM 2 3	

SAMPLE B PAGE 2

**LSS PROGRAM B TIMETABLE
LIFE-SAVING SKILLS**

TIME	MONDAY DAY 8	TUESDAY DAY 9	WEDNESDAY DAY 10	THURSDAY - DAY 11	FRIDAY - DAY 12	SATURDAY DAY 13	SUNDAY
0700	ROUNDS	ROUNDS	ROUNDS	ROUNDS	ROUNDS		
0800	ROUNDS REPORT	ROUNDS REPORT	ROUNDS REPORT	ROUNDS REPORT	ROUNDS REPORT	ON CALL AS NEEDED	
0810	REVIEW	REVIEW	REVIEW	REVIEW	REVIEW		
0815	CLINICAL	MODULE 6 INFANT RESUSCITATION NEWBORN CARE DEMO	MODULE 8 HYDRATION REVIEW QUESTIONS	POST TEST	CLINICAL	"	
1000	BREAK	BREAK	BREAK	BREAK	BREAK		
1015	CLINICAL	MODULE 6 CASE STUDY	HYDRATION CASE STUDY	CLINICAL	CLINICAL		
1200	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH		
1330	CLINICAL	CLINICAL	HYDRATION DEMO AND CLINICAL	CLINICAL	CLINICAL		
1500	BREAK	BREAK	BREAK	BREAK	BREAK		
1515 HOMEWORK	MODULE 6 RESUSCITATION CASE STUDY	MODULE 8 HYDRATION REVIEW QUESTIONS AND CASE STUDY	REVIEW ALL INFORMATION REVIEW CHECKLISTS	CLINICAL	POST TEST REVIEW FINAL EVALUATION		
1800	CLOSE	CLOSE	CLOSE	CLOSE	CLOSING		
ON CALL FROM 0800 TO 0800	TEAM 3 2	TEAM 4 1	TEAM 1 4	TEAM 2 3	AS NEEDED	AS NEEDED	

Points to think about when making your LSS Timetable

Keep in mind that the schedule needs to be flexible. Do not be afraid to change your plans. Think about the following questions before you make your schedule.

Which time of day is best for what?

Early morning hours are usually best for discussions on new topics. The afternoon, when trainees may be sleepy, may be a good time for more active projects like case studies and homework preparation.

At the beginning of the training course or near the end?

Note in the attached training schedules that skills which require a great deal of clinical practice, or are not often available clinically, are taught in the first few days of the program so participants will have the theory and practice skills before seeing clients. Therefore vacuum extraction, episiotomy repair, administration of local anesthesia, and treatment of hemorrhage *must be* taught early in the training program.

Guest lecturers?

Life-saving skills training was *developed by midwives for midwives*. Obstetricians, referral physicians, and experienced midwives with a specialty in one of the topics may provide assistance in skills such as infant resuscitation, vacuum extraction, and so forth. It is important that the guest lecturers be briefed in the problem solving learning methodology to ensure consistency in learning experiences.

Forms? Training activities need to be documented. You may choose to design your own training timetable. The **blank timetables** (page 288 to 289) and **training report forms** (page 283), and **other forms** (pages 177 to 178) may be adapted or copied. There are other blank forms at the back of this manual that you may find useful when conducting training. Select or develop forms that will help you keep records regarding every aspect of your training so that you can tell others what you are doing.

LEARNING ACTIVITY Write LSS Training schedule

Write your training schedule. Use the blank forms samples in the lesson plans and forms section on pages 288 to 289.

Topic 5 Trainers' Work Plan

Trainers, in meeting the learning objectives of this topic, will be able to

- 1 identify and accept responsibilities for tasks in LSS training
- 2 develop a plan for carrying out LSS training tasks

Task Assignments

The LSS trainers (training team) will carry out most of the training activities. During the TOT, responsibility must be assigned for each portion of the training. One member of the training team should be in charge of tasks related to each activity listed on the training schedule. It helps if one person is in charge of similar activities. For example, one person can be in charge of the labor and delivery activities. This person would make sure everything is ready for partograph, episiotomy, active management of third stage, hemorrhage and so forth. The person responsible does not have to do all of the teaching for labor and delivery, but will make sure that someone does carry out each of the scheduled activities. This person will also make sure that labor and delivery staff are prepared, equipped, and informed about the training activities. Many times the LSS midwife trainer in charge of labor and delivery chooses to be responsible for these activities.

As previously mentioned, the training team will need the help of others to carry out the training activities. You may invite other health professionals as guest lecturers or as supervisors for the clinical experience. The clinical midwife supervisors are the most important people that you will choose to help you in your training effort. Trainees must practice. The training team can not be on-call twenty four hours a day. Clinical midwives who have the interest, LSS competence, ability, time, and willingness to teach are ideal. Involve these midwives in the development of the LSS training schedule. The better they understand what LSS is trying to accomplish and how it is organized, the better they will be at training.

Organizing and implementing LSS training begins as soon as the LSS coordinator is identified. The coordinator, usually chosen before or during the site preparation activities (Step Three on page 50), assigns responsibility for the activities and then follows up to make sure they are completed. She ensures that all planned preparation activities are carried out. The training team leader is responsible for the many administrative and management issues as they arise at the training site. The coordinator and team leader work with the institution's key personnel to address these issues. As a group, the LSS training team supports and assists the team leader for their site. This person will assume responsibility for LSS training.

She will make sure the LSS training tasks are carried out as agreed by the training team. The team leader conducts training team meetings, makes sure trainers are free to teach, teaches LSS, and other tasks to ensure that the training is a success.

A sample LSS training task list is found on the following page. Adjust the list according to the particular program. Trainers should choose tasks during the TOT. It is important to have most of the tasks completed ahead of time. The training team leader monitors the preparations. Check off items, or at least refer to the training task list, when preparing for each training. The responsibility for tasks may change from time to time. Rotate responsibilities so that several people become competent to perform each task making it easier to deal with vacations and other absences. Flexibility in running a training program ensures a satisfied training team.

LEARNING ACTIVITY Plan Tasks for LSS Training

Read and discuss the sample training tasks found on the following two pages. Then revise the LSS training task list for your LSS training. Remember to make sure that all of the information on your time schedule is part of your training task list. Fill in the blanks.

LSS TRAINING TASK LIST (sample)

TASK	TRAINER	DATE TO BE DONE	DONE	OTHER
PREPARATION				
1 Prepare staff in Labor/delivery Unit, Antenatal Clinic/Unit, Postpartum Unit, Surgery (theater), Newborn Care Unit	<i>GNI</i>	4/4/98		
Ask for assistance	<i>GNI</i>	4/4/98		
Ensure sufficient supplies	<i>MOO</i>	4/4/98		
Ensure high quality care provided to role model partograph, infection prevention, referral system, protocols	<i>MUJ</i>	1/3/98		
2 Trainers' organizing meeting	<i>ITN</i>	4/4/98		
Training equipment ready	<i>MOO</i>	18/3/98		
Handouts prepared	<i>MUJ</i>	7/3/98		
• Timetable	↓	4/4/98		
• Written tests	↓	7/3/98		
• LSS Clinical Guide (Checklists)	↓	4/4/98		
• Partographs for practice	↓	4/4/98		
• Final evaluation form	↓	7/3/98		
• Registration Form	↓	7/3/98		
• Inventory Form	↓	7/3/98		
• Name Tags	↓	1/3/98		
• Incident Report Forms	↓	7/3/98		
• LSS Manuals	↓	4/4/98		
• LSS Equipment Kits	<i>TSS</i>	7/3/98		
• Certificates	↓	7/3/98		
3 Accommodation and Meals Arranged	<i>GNI</i>	7/3/98		

TASK	TRAINER	DATE TO BE COMPLETED	DONE	OTHER
CONDUCT LSS TRAINING				
1 Welcome trainees as they arrive Registration Timetable Assignments Handouts	MOO	15/5/98		
2 Orient to accommodations/facility	MUJ	25/5/98		
3 Written Tests	TTE	25/5/98		
4 Practice equipment care and distribution	MUJ	25/5/98		
5 Clinical Assessments	ALL	"		
6 Mid and Final Evaluations from Trainees	IWE	"		
7 Wrap up with trainees	ITN	"		
8 Closing	ALL	"		
9 Write Training Report	MUJ	"		
10 LSS Training Staff Meetings	GNI	"		
MODULE RESPONSIBILITIES		4/4/98		
1 Module 1	GNI	"		
2 Module 2	MOO	"		
3 Module 3	MUJ	"		
4 Module 4	TTE	"		
5 Module 5	IWE			
6 Module 6	ITN	"		
7 Module 7	GNI	"		
8 Module 8	MOO	"		
9 Module 9	MUJ	"		
10 Module 10	TTE	"		

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN:	LSS TRAINING FOR MIDWIVES	125
	Goal, Objectives, Common Terms	126
	Introduction	127
	• Topic 1: Learn Life-Saving Skills	128
	<i>Life-Saving Skills Manual for Midwives</i>	128
	Using the Skills Checklists to Learn Skills	130
	Guidelines for Care and Referral	132
	• Topic 2: Community Outreach	134
	• Topic 3: Management of the Work Place	136
	Records and Reports	136
	Antenatal, Labor, Delivery and After Delivery Records	137
	Learning Activity: Create a Record	137
	Sample Pregnancy Records	138
	Referral Form	142
	Sample Forms: Referral, Outcome of Referral	143
	Incident Report Form	145
	Learning Activity: Complete Incident Form	145
	Supplies, Equipment and Medicines	150
	List of Supplies, Equipment and Medicines by Skill	151
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP SEVEN: LIFE-SAVING SKILLS TRAINING FOR MIDWIVES

Once the trainers and the facility are ready, training can begin with the training site staff as the first group. Training all the midwives at the hospital strengthens the training site as a model facility and enables all the midwife on staff to be competent clinical instructors.

Life-Saving Skills (LSS) training helps midwives to review, revise, and update their midwifery skills and develop confident competence in performing life-saving skills. Because learning takes place in many ways and on many levels, several methods are used to help trainees achieve the LSS objectives. Ways to use the *Life-Saving Skills Manual for Midwives*, skills checklists, and guidelines to aid learning are described. Since community resources are vital to the midwife's ability to offer timely referral of problems and emergencies, working with the community is discussed. Good management practices in the health center or clinic are outlined and sample forms explained.

Goal

Life-Saving Skills training will help the midwife review, revise, and update her midwifery skills. LSS training will assist the midwife develop competence and confidence in performing life-saving skills.

Objectives

At the end of LSS training, the LSS midwife will be able to

- 1 describe and competently demonstrate the problem solving method of providing care and timely referral for women during pregnancy according to the objectives found in Modules 1 through 10 of *Life-Saving Skills Manual for Midwives*
- 2 identify ways to work with the community to ensure that resources are available to help her provide care and timely referral
- 3 demonstrate management methods for her place of work including record keeping

Common Terms Used in LSS Programs

Competent - able, capable, sufficient, adequate A competent midwife is able to adequately perform all the steps in a skill

Confident - certain, assured, sure, unafraid, positive A confident midwife believes she can perform all of the steps in a skill well enough to teach others

Perform - accomplish, act, do A midwife can do a skill

Introduction

In all training, the major task of trainers is to assist trainees acquire knowledge and skills. The training schedule is designed to be flexible to take advantage of clinical opportunities that may arise. Trainees remain on-call 24 hours a day for the same reason. Most LSS training courses are two weeks long with a one week break for trainers between each cycle to allow time for routine clinical and administrative duties, evaluation of the training, and preparation for the next class.

LSS trainers, together with the LSS training site staff (described in Step Two on page 39), help practicing midwives acquire LSS knowledge and skills. The program is designed in a way that allows LSS to be taught *wherever and whenever opportunities exist*. These may be in the labor ward, the delivery room, antenatal clinic, the theater (operating room), newborn care unit, or postpartum unit. Some topics, such as working with the community to prevent maternal deaths, are learned through discussion or role plays in the classroom or during postpartum home visits. Others, such as management of the workplace, are learned as trainees work in a well managed facility (modeling) as well as through reading and discussions.

The LSS training site staff strengthens the LSS program by supporting all midwives working at the facility. The LSS site staff develop competence as "LSS clinical instructors", thus allowing the training staff a little more flexibility with their individual work schedules.

LSS trainers are given support through intensive monitoring of the first class they teach and then monitoring and meetings every couple of months. Continuing education is discussed in Step 10 beginning on page 168.

Topic 1. Learn Life-Saving Skills

Life-Saving Skills Manual for Midwives

The *Life-Saving Skills Manual for Midwives* (LSS manual) is the basic document for LSS training. Analysis of information collected in the training needs assessment (described in Step Two on page 33), will help in identifying specific training needs. The advisory committee will help to select priority topics.

The LSS manual includes procedures and information that allow trainers to prepare **midwives** through a continuing education program. The LSS manual can also be used to prepare both **trainers and the staff of referral sites**. The manual and the training process ensure that trainees learn knowledge and skills they must have to provide pregnancy related emergency care. The LSS manual is also used by LSS trainers for their own continuing education and is a reference for **midwifery tutors**.

Following is a brief description of each of the 10 modules that make up the LSS Manual.

- Module 1** **Introduction to Maternal Mortality** includes a discussion of maternal mortality, an introduction to the problem solving method for giving maternity care, and an overview of teaching and implementation of LSS.
- Module 2** **Quality Antenatal Care** focuses on fundal height growth monitoring, prevention and treatment of anemia, and identification and management of pregnancy induced hypertension.
- Module 3** **Monitoring Labor Progress** includes history taking, physical examination, use of the partograph, and practice in monitoring progress of labor. There is also a review of normal second and third stage with a skills checklist.
- Module 4** **Episiotomies and Repair of Lacerations** contains prevention of lacerations during delivery, performing episiotomies, and repair of both episiotomies and lacerations.
- Module 5** **Prevention and Treatment of Hemorrhage** guides the midwife through active management of third stage, manual removal of the placenta, bimanual compression of the uterus, and digital evacuation.

- Module 6** **Resuscitation** provides skills in infant and adult cardiopulmonary resuscitation along with the Heimlich Maneuver
- Module 7** **Prevention and Management of Sepsis** includes chorioamnionitis, postpartum infection, postabortion infection, newborn sepsis, and infection prevention methods
- Module 8** **Hydration and Rehydration** directs prevention and management of shock and oral rehydration. Skills in intravenous, intraperitoneal, and rectal fluid therapy are also included
- Module 9** **Vacuum Extraction** includes indications, preparation to use, procedure, and care after use of the disposable and nondisposable vacuum extractors
- Module 10** **Other Emergencies** covers other labor and delivery problems such as shoulder dystocia and breech. Postabortion care with manual vacuum aspiration, symphysiotomy, oxytocin infusion, and how to assist at cesarean section are also included. After this module there is an LSS formulary and an LSS manual index

LSS -- A Clinical Practice Guide

The *Clinical Practice Guide* is a companion handbook to the LSS manual. It is to be used for monitoring LSS training as well as a guide for follow-up visits. It can also be used by LSS midwives for review and reference. The handbook includes the same skills checklists that are in the LSS manual. In the back of the handbook are summary forms for use during support and follow-up visits.

Using the Skills Checklist to Learn Skills

Step by step skill observation and observer feedback are the keys to assessing competence in skill performance. **LSS competence is gained with 100% correct performance of each step in a skill.** There is a skills checklist for each procedure taught in LSS. Each checklist describes the essential steps for one specific procedure. Midwife trainees are encouraged to use the checklist as a guide and evaluation tool. They use it when helping each other perform procedures in the step by step manner. They watch each other perform skills while following the steps on the checklist and each trainee continues practicing until she achieves LSS competency.

The trainer, using the appropriate skills checklist, is responsible for providing immediate feedback to the midwife trainee. She asks the trainee how she feels about her performance. She encourages questions and discussion of the experience. The trainer praises satisfactory steps and offers suggestions for areas needing improvement. Plans are made for the trainee's next opportunity for clinical practice. When both the trainer and trainee are satisfied with the competency and confidence of the trainee, the trainer signs off on that particular skill. Checklists are reviewed at regular intervals by both the trainee and trainer in order to make sure there are sufficient learning opportunities.

Record each skill practice. The trainee writes the date she is practicing the skill at the top of the first empty column. After she performs the skill, she reads each step again. She puts a "✓" if she did the step satisfactorily, or an "X" if she needs more practice or improvement. She writes comments in the space provided at the end of the skills checklist. She may write how she actually feels about the skill or her performance. The trainer observing the performance records her observations and writes information after the trainee completes filling out the checklist.

Look at the following sample checklist. There are four columns for the trainer and trainee to use. Sometimes both the trainer and trainee make checks for the same skill practice. They both make their checks in the same square. Other times the trainer may just write comments or discuss the steps with the trainee. Use as many copies of each skills checklist as are needed to reach confidence and competence. This sample is the first page of the checklist for **Active Management of Third Stage**. Both the trainer and trainee recorded for the first clinical opportunity. See that while most of the steps were satisfactory, some of the steps were not satisfactory. The trainee will need more practice at the first clinical opportunity.

Skills Checklist for Active Management of Third Stage

This checklist has two purposes

- 1 The midwife should use it as a guide for checking her own skills
- 2 The supervisor uses it when evaluating how well the midwife performs

After observing/performing write a rating ✓ = satisfactory OR X = needs improvement

Add any other comments in the comments section below

	Date 21/8	Date 22/8	Date 23/8	Date 24/8
When you actively manage the third stage prepare oxytocic in syringe before second stage, ensure empty bladder, place mother in semi-sitting or squatting position	✓✓	✓	✓	✓
1 Ask assistant to give oxytocic with delivery of anterior shoulder or give as soon as possible	×✓	✓	✓	✓
2 Dry and cover the baby Clamp and cut cord	✓✓	✓	✓	✓
3 Ask assistant, if available, to put the baby to breast	××	✓	✓	✓
4 The side of one hand is placed against lower half of the uterus just above the symphysis pubis	××	✓	×	✓
5 The other hand pulls with firm, steady tension on the cord with uterine contraction	✓✓	✓	✓	✓
6 Deliver placenta slowly, support with both hands Deliver membranes gently with a turning motion	×✓	×	×	✓
7 Rub the uterus until hard	✓✓	✓	✓	✓
8 Expel blood and clots	✓✓	✓	✓	✓
9 LOOK at the placenta and membranes to see that they are complete	✓✓	✓	✓	✓
10 Record information	✓✓	✓	✓	✓
11 Store oxytocic in a cool place out of the sun to preserve the potency of the medication	✓✓	✓	✓	✓

Comments 21/8 Needs practice supporting the uterus, was pushing too hard
 22/8 Feels more confident, is getting the idea of all the steps 23/8 Needs a little reminder in delivering the placenta slowly 24/8 Well done Signed Bty

Guidelines for Care and Referral

Guidelines are written instructions of actions to take for problems and findings which are identified. Guidelines help ensure consistency of care. They are used to guide the LSS midwife in providing care and in deciding whether to refer a client. Samples of antenatal, partograph and postpartum guidelines can be found on pages 264 to 270. These sample guidelines *must be reviewed and adjusted* to your local situation. Discussions about guidelines occur during the planning process in Step One on page 11. Decisions about guidelines are usually made during the training site preparation in Step Three on page 50. During LSS training, for example, when working with case studies or providing actual clinical care, the trainer should encourage trainees to use the guidelines as an aid in making decisions. After training, when the LSS midwife is working alone, she can consult the guidelines before deciding on the best action(s) to take.

Even though the guidelines outline exactly what care/action to provide in many situations, at times LSS midwives will find themselves facing conditions that are not covered. Therefore, it is essential that LSS midwives always use the problem solving method to assure that they have the best information on which to base decisions and client care.

How to Use the Guidelines

The problem solving method is taught in Module 1 **Introduction to Maternal Mortality**, beginning on page 122. In the problem solving method the midwife uses her findings from **ASK and LISTEN** and **LOOK and FEEL** to **IDENTIFY the PROBLEM** in order to **TAKE APPROPRIATE ACTION**. Specific steps are outlined for the midwife to take to find out what is wrong with a mother, and to decide how best to care for her. The guidelines provide a quick reference and help the midwife make her decision regarding appropriate action.

For example A pregnant woman comes to you saying that she is leaking water since early morning. It is now early evening. She has no signs of labor. What will you do for her? You will **ASK and LISTEN** and **LOOK and FEEL** according to the information in Module 7 **Prevention and Management of Sepsis**, page 76. When you **IDENTIFY the PROBLEM**, or potential problem (infection), look in the antenatal guidelines in the patient column for *mother*, on page 264. Then look in the problems column for *infection*. In the column labeled findings, it says, "Ruptured membranes for 6 hours or longer without signs of active labor." That is exactly this woman's condition. Under actions, it says, "Give broad spectrum antibiotic one dose by mouth and REFER." This information guides you in deciding the action you should take.

Another example A woman who is 32 weeks' pregnant and has been bleeding for about 4 hours comes to you. What do you do? You will **ASK and LISTEN** and **LOOK and FEEL** according to the information in Module 5 **Prevention and Treatment of Hemorrhage**, page 56. When you **IDENTIFY the PROBLEM**, or possible problem of bleeding after 28 weeks, look in the guidelines for *mother, bleeding after 28 weeks*. On page 266 under findings, it says, "Bleeding, more than 28 weeks gestation." That is this woman's condition. Under actions, it says "Monitor BP, pulse, and fetal heart rate. REFER. While waiting for transport hydrate (intravenous if possible), keep warm, shock care if shock signs, pain medication and reassure." The guidelines help you decide how best to care for the woman.

These examples give an idea of the way to use the guidelines. They help the midwife to provide consistent care for an emergency or a problem. Guidelines ensure that a woman receives safe and appropriate care including referral.

Topic 2 Community Outreach

A referral system is an important aid to saving lives. It can only succeed when there is transport, money, and family agreement. As she practices skills during training, there is always a step in which the midwife explains to the family or client what she is going to do. In the same way, when a problem needing referral is identified, she gives an explanation to the family so that they can first agree on the referral, and then prepare money and transportation in order to help their family member get to the best possible medical care.

It is good to help families *prepare for an emergency before one happens*. During the training, you can help midwife trainees consider how they can best do this. Although they can advise individual clients to put a little money away for transportation or purchase of necessary care or supplies, the best way to ensure timely referral is to work with the community so it understands the benefit of developing a community response for emergency cases. Together the people can solve any general transport problems and make plans for timely transfer of emergencies whenever they occur.

For example, in one village the people offered a transport owner/driver free accommodations in their relatively isolated town. Since he slept there each night, the town had transport available for night time emergencies.

Midwives can serve as team leaders to get emergency systems organized and operating. As a respected member of the community who cares for women and sees the effects of hemorrhage, convulsion, infection, and shock, a midwife is in a good position to help the people recognize these problems and learn that they can be solved. Communities can improve they and how other communities have solved these same problems. Midwives can encourage communities to make their own plans, well suited to the situation and resources.

If a woman enters pregnancy and labor in good health, there is a decreased chance (risk) of problems in pregnancy and need for blood transfusions. The community can contribute to the improved health of its girls and women by *encouraging adequate food intake*, doing away with food taboos which prevent women from getting foods they need, *encouraging antenatal care*, and *urging early referral to hospitals* and other resources when needed. To accomplish this in most communities, everyone needs to have the same information.

Midwives must not only teach the pregnant women, but also men and other family members. Working with the community for action is discussed in Module 1 **Introduction to Maternal Mortality**, page 19

When the midwife completes LSS training and returns to her work site, it is very important for her to explain to the people in her community what she has learned and how the community can help prevent death and sickness during pregnancy and childbirth. As a trainer, you must help the midwife trainee think about how she will do this. A trainee might decide, for example, to develop a monthly health meeting in order to give community members (men and women) an opportunity to discuss problems and information about saving lives. The following are examples of the types of information that might be shared and discussed at these meetings

Community Information for Saving Lives (sample)

Danger Signs of Pregnancy

Any bleeding
Headaches with visual problems
Swelling of face or hands
Abdominal pain
Decrease in baby movement

Pregnancy Advice

Nutrition enough food (and specific foods)
Anemia prevention
Rest and sleep
Avoid ill people
Avoid medicines
Take medicines given by midwife or doctor
Avoid strong fumes or smoke or chemicals
Emergency transportation plan

Danger Signs After Delivery

Too much bleeding
Fever
Abdominal pain
Foul odor of discharge
Convulsions

After Delivery Advice

Good Nutrition
Enough Fluids
Plenty of Rest
Breast feed baby at least every 2-3 hours
Family Planning

Blood Supply

Family Members
"Walking Blood Bank"

Emergency Transportation

Cost
Vehicle
Plan

Prevent Anemia

Girls
Women of Childbearing Age

Topic 3 Management of the Work Place

Management is part of the daily routine in every clinic or hospital. The performance of daily activities requires that people, time, equipment, materials, and drugs are organized to carry out the work. In order to carry out her work, the LSS midwife must have support (equipment, drugs, time, space, reports, records, and money) and a well organized system of work. A good system ensures that the midwife's activities are reported to the appropriate persons and the needs of the midwife are met so she can do her work.

Records and Reports

Records are the information kept on the work of the unit, on the health conditions being seen, and on individual clients, as well as information about staff, equipment, and supplies. Usually records are written information kept in notebooks, folders, or client cards/charts. Records are the midwife's memory.

Records are important in documenting health statistics such as births, deaths, diseases and problems. A record of her activities helps the LSS midwife and her supervisor (1) learn what is happening, (2) make decisions, and (3) assess progress towards goals. Records should be accurate (true), accessible (available when needed), and useful (contain information that can be used).

Reporting forms differ from country to country. On the following pages, you will find sample forms. These forms will help the midwife fill out her report to those who come for follow-up and support visits, and follow the progress of her clients. Compare the sample forms with your own reporting forms. Make any changes that may be needed in order to record and report LSS information.

Reports are the information communicated to the supervisor, the Ministry of Health and others. They are an important management tool. They can help a doctor understand the problem of a woman the midwife has referred. Information in reports can influence future actions by decision makers. The report may be oral or written. It may be statistics, such as numbers of births and deaths, or it may be the vital signs, problem, and a treatment given to a client. Most countries have standard maternal and child health reports which must be filled out monthly. The midwife will use her records to find the information for these reports.

Trainers can influence the recording and reporting habits of trainees by modeling good practice in these tasks, and by encouraging them to critique their own and fellow trainees' work when they use the antepartum assessment form, the partograph, and other forms

Antenatal, Labor, Delivery and After Delivery Records

A combination or individual record may be kept in your clinic. If you do not have a standard record form, you can use the information suggested on the next pages and make columns in a book or on a paper. The information needed to fill each column should be available in the client records. The antepartum assessment form is discussed in **Module 2 Quality Antenatal Care** on pages 2 13 to 2 19. The antenatal record should include information that allows the midwife to follow the progress of each woman during her pregnancy and to easily review outcomes and problems. The partograph is discussed in **Module 3 Monitoring Labor Progress** on pages 3 31 to 3 35. The partograph includes information that allows the midwife to follow the progress of each woman during her labor and to identify problems needing action by the midwife.

LEARNING ACTIVITY Create a Record

Assign two groups to create a record. One group will create a record using the antepartum assessment form and one group will create a record using the partograph.

Each group will appoint a spokesperson to present their record to the other group. The presentation should include *why* each column is included, *how* they expect the information will be used, and *who* will use it.

After the presentations and discussion, the following sample records can be compared to the newly created ones.

**CODE INFORMATION
FOR PREGNANCY RECORDS ON PRECEDING PAGES**

CODE A**MATERNAL COMPLICATION**

- 1 PLACENTA ABRUPTIO
- 2 PLACENTA PREVIA
- 3 UTERINE RUPTURE
- 4 PRE-ECLAMPSIA
- 5 ECLAMPSIA
- 6 MALPRESENTATION
- 7 MULTIPLE GESTATION
- 8 PREMATURE RUPTURE OF
MEMBRANES
- 9 PREMATURE LABOR
- 10 PROLONGED LABOR
- 11 CEPHALOPELVIC
DISPROPORTION
- 12 DIABETES
- 13 RH SENSITIZATION
- 14 SEPSIS
- 15 OTHER INFECTION
- 16 ANEMIA
- 17 FETAL DISTRESS
- 18 FETAL DEATH
- 19 MISCARRIAGE/ABORTION
- 20 POSTPARTUM HEMORRHAGE
- 21 LACERATION
- 22 RETAINED PLACENTA
- 23 UTERINE ATONY
- 24 INVERTED UTERUS
- 25 OTHER

CODE B**REFERRED FROM WHOM**

- 1 TRADITIONAL BIRTH ATTENDANT
- 2 FAMILY
- 3 MIDWIFE
- 4 PHYSICIAN
- 5 OTHER

CODE C**METHOD OF DELIVERY**

- 1 SPONTANEOUS DELIVERY
- 2 VACUUM EXTRACTION
- 3 FORCEPS
- 4 C/S

CODE D**NEWBORN COMPLICATION**

- 1 APGAR LESS THAN 6 AT 5 MINUTES
- 2 STILLBORN/PERINATAL DEATH
- 3 PREMATURITY (LESS THAN 37 WEEKS)
- 4 LOW BIRTH WEIGHT (LESS THAN 2500 GM
AT 37 WEEKS OR GREATER)
- 5 SEPSIS
- 6 CONGENITAL ABNORMALITY
- 7 RH INCOMPATIBILITY
- 8 OTHER

Referral Form

When the midwife cares for pregnant women and babies in the community, there will be times when she identifies an emergency or problem she is unable to handle. She will want to take or send a woman to the hospital or maternity clinic for special care. This will be much easier to do if she has already developed a good relationship with the staff at the referral unit.

Trainers can help hospital staff understand that it is important to have a good relationship with midwives working in the communities. Midwives will be more willing to send women with problems to the hospital when they feel their work is supported. The people in the community will be more willing to agree to a referral if the midwife can tell them about the people they will meet at the hospital.

The referral form is a way for the midwife to tell the people receiving the referral about the woman. On the front of the form, the midwife provides written communication about what happened and what she did to help the woman. This information is very useful for the midwives and doctors at the referral site. It allows them to quickly learn about the woman's problem and to see what has been done for her. After the client has received the necessary care, the form is returned to the midwife. This helps the midwife find out what happened to her client and what follow-up care she needs to provide. This information helps everyone to provide good, continuing care.

The sample referral form on the following pages uses information from an LSS midwife. As you can see, the information on the front of the form explains about the condition, problem, action taken, and reason for referral. The name, age, gravida, para, last menstrual period, due date, and weeks of gestation of the client are very important. The name and signature of the midwife are also important. On the back of the form there is space for information regarding the outcome of the referral. The form may be sent back to the midwife with the client, her family, or any other way convenient for the referral site.

Sample Referral Form, (Front)

Clinic <i>Wanikande</i>	REFERRAL FORM	Date <i>2 May, 1997</i>
Client name <i>Mrs HO</i>	Age <i>21</i>	
Gravida <i>2</i> Para <i>1</i> Abortion <i>0</i>	Last Menstrual Period <i>6 Aug 1996</i>	
Due Date <i>13 May 1997</i>	Weeks Gestation When Seen <i>38+</i>	
<p>What was the condition of the woman when she came to you? <i>Mrs HO was carried to me on a litter, she was cold and wet to touch, clothing was soaked with blood. She was very afraid and the family was crying B/P 90/44, P 112, no abdominal contractions felt, FHT 100 and strong She said that her bag of waters broke and blood started coming</i></p>		
<p>What was the problem? <i>Shock, vaginal bleeding maybe because of placenta previa.</i></p>		
<p>What did you do? <i>Explained to family that she must go to hospital, sent for transport, laid her with her feet a little above rest of her body (shock position), started intravenous infusion of D5%/W 1000 cc running 100 cc/hour, covered Mrs HO to keep her warm and tried to reassure her that she will be fine Monitored B/P, P, and FHT every 30 minutes</i></p>		
<p>What is the reason for referral? <i>Shock and bleeding, I can not manage the case</i></p>		
Name and Signature of Midwife <i>N Etukudo, RN, RM N Etukudo</i>		
<p>Reminder for Midwife</p> <ol style="list-style-type: none"> 1 Go with the mother if at all possible 2 Explain reason for referral to family, remind them to have money, ask them to come with you 3 Take all forms/records written referral, antenatal, pantograph, delivery, etc 4 Take medicines, instruments, equipment that you may need during travel to hospital 		

Sample Referral Form (Back)

Outcome of the Referral

Client Name Mrs H O Date 20 May 1997

Condition on Arrival *Arrived at the labor unit in blood soaked clothing and in shock Five family members and midwife were with her FHT 100 and strong, intravenous infusion has infiltrated with 200 cc remaining*

Care Given *Doctor notified, Blood drawn for typing and cross match, Intravenous infusion of Normal Saline started and running as fast as possible Cesarean section performed with live infant, APGAR 7 at 5 minutes*

Outcome *Mother and baby doing well, although blood loss of mother appeared to be 1000 cc Hemoglobin 8 grams following 1000 cc blood transfusion*

Follow-up Care *Daily visits for 1 week for wound care and routine postpartum care Then visit weekly for 6 weeks Ensure enough iron, folic acid Repeat hemoglobin in 6 weeks*

Name of Doctor Dr J Rofyat Final Diagnosis Partial placenta previa
Hospital City Hospital at the Crossroads

Incident Report Form A Life-Saving Action Report

At the end of LSS Training, each midwife is asked to complete one form for each incident requiring use of Life-Saving Skills. Once the form is filled out, it is sent to the LSS training site. This information serves as qualitative and quantitative data on how LSS has helped the midwife.

LEARNING ACTIVITY Complete Incident Form

Use this information and the form on the following pages to complete the incident report on this case.

Mrs. Btsue, 17 years old, in her first pregnancy, attended antenatal clinic regularly at your health center. You are a trained LSS Midwife. She had signs of pre-eclampsia during her pregnancy. You had referred her to the hospital where she was advised that she should deliver at the hospital.

She delivered in the village, helped by her mother. Mrs. Btsue bled much after delivery. She had a convulsion. Four hours after delivery, the family carried Mrs. Btsue to you at the health center. Upon arrival, the baby girl was very cold and weak. Mrs. Btsue was also cold and weak. Her pulse was difficult to feel and count. There is much blood (more than 500 cc) with clots on her clothing.

Ask your assistant to feel and rub the uterus, cover her and put her in shock position while you quickly start an intravenous infusion. You advise the grandmother to hold the baby close to her own body, cover the baby, including her head, and try to keep her warm. You ask the grandmother if the placenta has delivered. The grandmother says, "Yes, the placenta came out right after the baby was delivered."

As soon as you have the IV started, you feel the uterus. The uterus is soft and then hard. The bladder feels empty. You ask your assistant to continue to rub the uterus while you explain to Mrs. Btsue and her family what you are going to do.

You LOOK to see where the bleeding is coming from. There are no lacerations and the placenta is delivered. You see a small piece of membranes in the cervix. After carefully removing this piece of membranes and giving oxytocin, the uterus becomes hard. The bleeding is less than before.

The baby is more active, warm and acts hungry. The baby sucks the breast and Mrs. Btsue is smiling. Her blood pressure is 90/50, pulse 96 and the uterus is contracted. She is taking some warm tea. You go with her and the family to the hospital.

PAGE ONE		LIFE-SAVING SKILLS	
INCIDENT REPORTING FORM, A Life-Saving Action Report			
LSS TRAINER NAME		TODAY'S DATE	
Which training did you attend?		Training Date	
1 Complete the following client information			
a Client initials			
b Age			
c Parity			
d Last menstrual period (LNMP)			
e Due Date (EDD)			
f Weeks gestation when seen			
2 What was the emergency/problem treated?			
3 What was the condition of the woman when she came to you (include blood pressure pulse, estimated blood loss, edema, other important information)			
4 What did you do and in what order did you do them?			

PAGE TWO

LIFE-SAVING SKILLS

INCIDENT REPORTING FORM, A Life-Saving Action Report

5 What was the response of the woman? (Did she get better, stay the same, die?)

6 What follow-up care did she receive at your maternity, clinic, hospital or other place?

7 How confident and competent did you feel to handle this emergency/problem?

8 What additional skills or knowledge would have helped you to feel more confident and competent?

Please add as many pages of paper as necessary to fully describe your care of this woman

152

ANSWERS FOR THE ABOVE LEARNING ACTIVITY

PAGE ONE	LIFE-SAVING SKILLS
INCIDENT REPORTING FORM, A Life-Saving Action Report	
LSS TRAINER NAME S Sue	TODAY'S DATE 20 May 1997
Which training did you attend? Number 55	Training Date 21 Aug 1993
1 Complete the following client information	
a Client initials Mrs B	
b Age 17 years	
c Parity 1	
d Last menstrual period (LNMP) Mother did not bring her antenatal record	
e Due Date (EDD) Mother says she was due yesterday, she did not bring her antenatal record	
f Weeks gestation when seen Term	
2 What was the emergency/problem treated? Baby born 4 hours before arrival and close to shock, Mother shock and postpartum hemorrhage due to small piece of membranes in the cervix	
3 What was the condition of the woman when she came to you (include blood pressure, pulse, estimated blood loss, edema, other important information)? Shock, difficult to feel the pulse, did not take time for the blood pressure, estimated blood loss 500 cc	
4 What did you do and in what order did you do them?	
Asked assistant to FEEL and rub uterus while I	
1 Gave shock care shock position and warm	
2 Started intravenous infusion	
3 Asked grandmother to hold baby and keep warm	
4 Felt uterus TO MAKE SURE IT WAS HARD and bladder EMPTY	
5 Asked assistant to continue to rub uterus	
6 Looked to see where bleeding was coming from	
7 Removed membranes in cervix	
8 Gave oxytocin	
9 Felt uterus, it was harder than before	
10 Looked at bleeding, it was less than before	
11 Put baby to baby to breast, took blood pressure and pulse, gave warm tea	
Went with the mother and her family to the hospital	

PAGE TWO**LIFE-SAVING SKILLS****INCIDENT REPORTING FORM, A Life-Saving Action Report****5 What was the response of the woman? (Did she get better, stay the same, die?)**

Got better after removing membranes from the cervix

6 What follow-up care did she receive at your maternity, clinic, hospital or other place?

No information given but would expect at the hospital anemia screening, pre-eclampsia follow-up, and family planning counselling

7 How confident and competent did you feel to handle this emergency/problem?

I felt a little afraid, but remembered exactly what to do just like I did during my LSS training I did read, Module 5 about postpartum hemorrhage again

8 What additional skills or knowledge would have helped you to feel more confident and competent?

A refresher course is always a good idea, but I can not think of something specific

Please add as many pages of paper as necessary to fully describe your care of this woman

Supplies, Equipment and Medicines

The midwife must keep enough supplies, equipment, and medicines to be able to help the women who come to her. *Expendable* equipment is equipment that is used up within a short time such as matches, cotton wool, urine testing supplies, and disposable syringes. *Non-expendable* equipment is equipment that lasts for a long time and needs care and maintenance such as hemostats, scissors, weighing scales, stethoscope and books. In order to have both expendable and non-expendable equipment, the midwife must order, store, use and maintain it.

The midwife may be issued supplies, equipment, and sometimes even medicines following LSS training. These become part of her workplace inventory. She is responsible for them the same as other items she already has in her place of work. They are not her personal property. On pages 151 and 152, you will find a list of supplies, equipment and medicine according to each skill that the midwife needs to perform life-saving skills. Using the information on the inventory form that was filled out the first day of LSS training, the trainers must identify what to provide each midwife so that she will have what she needs to perform the skills learned during LSS training.

List of Supplies, Equipment, and Medicines by Skill

Module 1 Introduction to Maternal Mortality

Module 2 Quality Antenatal Care

Antenatal assessment form/graph
 Reflex hammer
 Blood pressure apparatus
 Adult weighing scales
 Hemoglobin testing equipment
 Urine testing equipment
 Centimeter tape
 Height measure or a wall marked
 Ferrous sulfate
 Folic acid
 Vitamin C
 Magnesium sulfate injection
 Valium injection

Module 3 Monitoring Labor Progress

Labor partograph
 Fetal stethoscope
 Thermometer
 Sterile gloves
 Bowl
 Antiseptic solution
 Sterile gloves
 Cotton or cloth squares
 BP apparatus
 Pulsometer or watch
 Urinary catheter
 Magnesium sulfate injection
 Valium injection

Module 4 Episiotomies and Repair of Lacerations,

Light source
 Soap and water
 Antiseptic solution
 Sterile gloves
 Needle holder or toothed clamp
 Sharp scissors
 Sponge forceps (ring forceps) 1 or 2
 Suture (absorbable chromic 2-0 or 3-0)
 Suture needle taper or round
 Thumb forceps (tissue forceps)
 Syringe size 10-20 cc is best
 Needle 1 ½ inch 22 gauge is ideal
 Gauze or cloth to keep area dry
 Local anesthesia

Module 5 Prevention and Treatment of Hemorrhage

ACTIVE MANAGEMENT OF THIRD STAGE

Regular delivery pack
 Syringe and needle
 Oxytocic injection

MANUAL REMOVAL OF THE PLACENTA

Sterile gloves
 Antiseptic lubricant
 Soap and water
 Regular delivery pack
 Analgesic or anesthesia
 Intravenous supplies and solutions
 Broad spectrum antibiotic
 Oxytocic injection

BIMANUAL COMPRESSION OF THE UTERUS

Sterile gloves
 Urinary catheter
 BP apparatus
 Time piece
 An assistant
 An emergency transport system
 Intravenous supplies and solutions
 Oxytocic injection
 Broad spectrum antibiotic

MANUAL REMOVAL OF CLOTS AND PRODUCTS OF CONCEPTION

Regular delivery pack
 Sterile gloves
 Vaginal speculum
 Broad spectrum antibiotic
 Oxytocic injection

Module 6 Resuscitation

INFANT RESUSCITATION

Suction catheter (DeLee)
 Suction bulb
 Clean dry cloth or gauze
 Place (such as a table)
 Clean dry cloths
 Oxygen, if available

ADULT RESUSCITATION

No equipment
 HEIMLICH MANEUVER
 No equipment

Module 7 Prevention and Management of Sepsis**POSTPARTUM OR POSTABORTION INFECTION**

Oxytocic
 Broad spectrum antibiotic
 Metronidazole
MASTITIS
 Antibiotic
BREAST ABSCESS Incision and drainage
 Analgesia/anesthesia
 Scalpel, size 11 blade if possible
 Soap and water or antiseptic
 Sterile gloves
 Artery forceps
 Gauze squares and bandage
 Container for waste

Antibiotic

OTHER INFECTIONS

Broad spectrum antibiotics
BABY OPHTHALMIA NEONATORUM
 Antibiotic eye ointment or eye drops
 Crystalline (aqueous) penicillin injection
 Salt water solution

BABY SEPTICEMIA

Ampicillin or crystalline penicillin injection
 Nasogastric tube for feeding baby unable to suck
POSTPARTUM TETANUS

Nasogastric tube for feeding baby unable to suck
 Diazepam or amobarbital sodium injection
 Crystalline penicillin injection
 Procaine penicillin with streptomycin injection

INFECTION PREVENTION

Decontamination solution
 Containers to soak instruments
 Cloths
 Utility gloves
 Time piece
 Soap and water
 Brush
 High level disinfection pot
 Heat source
 Transfer forceps

Module 8 Hydration and Rehydration**INTRAVENOUS INFUSION**

Adhesive tape/plaster
 Padded arm board
 Sterile intravenous tubing
 Clamp for intravenous tubing
 Intravenous fluid
 Antiseptic solution
 Cotton, gauze or cloth
 Sterile needle, 20 Gauge
 Rubber tourniquet
 Intravenous stand or nail in the wall
 Clean or sterile gloves

RECTAL FLUIDS

Enema can with tubing
 600 cc of fluid
 Cloth
 Soap and water
 Gloves
INTRAPERITONEAL INFUSION
 Intravenous fluid
 Giving set (1)
 Sterile needle (18 or 19 Gauge is best)
 Soap and water or antiseptic
 Adhesive tape
 Gauze pads
 Gloves

Module 9 Vacuum Extraction

Delivery Pack
 Vacuum Extractor

Module 10 Other Emergencies

LABOR AND DELIVERY PROBLEMS
 Delivery Pack
 An assistant
 An emergency transport system

POSTABORTION CARE

Vaginal speculum
 Uterine tenaculum
 Sponge (ring) forceps
 Magnifying glass
 Light source
 Swabs/gauze
 Antiseptic solution
 Gloves
 Strainer
 Clear container
 Manual vacuum aspiration kit
SYMPHYSIOTOMY
 Scalpel with No 20 blade
 Urinary catheter
 Sterile gloves
 Episiotomy equipment
 Delivery pack
 Vacuum extraction set
 Resuscitation equipment
 Light source
 Soap and water
 Two assistants
 Two reliable persons

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT:	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
	Orientation Workshop Schedule	155
	Learning Activity: Plan for Orientation Workshop	155
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN	CONTINUING EDUCATION	168

STEP EIGHT: ORIENTATION WORKSHOP FOR REFERRAL STAFF

As important as having consistency within the training facility is to the quality of training, it is equally critical to the quality of care to have *consistency at all levels of service provision*. The standardization of protocols, documentation methods (partograph), and knowledge in critical areas provided to midwives and others providing pregnancy care through the LSS training, with that of providers at all referral sites, is a necessary step.

An orientation workshop is conducted by the LSS training team for key staff of all referral sites within the program area to ensure the cooperation of all who will play a supportive role in making LSS a success. In some cases the workshop(s) includes the supervisor for the hospital stores, the community pharmacist, the supervisor of midwives, and other key persons. The workshop gives supervisors enough detail to enable them to identify ways they can support the program without having midwifery knowledge and skills.

All staff at a referral site, especially those involved in maternal care and their supervisors, are encouraged to participate in the orientation workshop. This orients them to the LSS program process, develops their support for the program, and ensures use of similar protocols and documentation. The topics usually include review of maternal mortality and morbidity (scope of the problem), overview of LSS, infant resuscitation (CPR), infection prevention, monitoring labor using the partograph, guidelines, and referral procedures for LSS midwives.

Each referral site has a list of all LSS midwives in its area. The staff receive information from the supervisory visits. They give feedback to the LSS midwife on outcomes and appropriateness of referrals. The site staff encourage the LSS midwife to participate in clinical updates at the facility. If possible, all of the equipment that LSS midwives have been trained to use is available at the referral site. This may help to upgrade the referral site and provides a familiar environment for clinical practice.

Rather than doing an orientation workshop at each referral site (in some cases there may only be one to three people at a site or health center), people from many referral sites in one area or district (this may be up to 40 people) might come to the same orientation workshop. In other areas, workshops may be held with doctors and midwives from the district hospitals and from all the community health centers in the project districts. The training is conducted by the LSS trainers with support from the OB/GYN consultants. Trainers use the LSS manual as reference for this workshop. The workshop gives the LSS trainer visibility in her teaching role.

Schedule: ORIENTATION WORKSHOP (sample)

TIME	DAY 1	DAY 2
8 AM	Maternal Mortality & Morbidity Overview of LSS	Problem Solving and Referral Procedures
9 AM	Monitoring Labor Using the Partograph	Antenatal Assessment of Problems in Pregnancy
12 NOON	LUNCH	LUNCH
1 PM	Infant Resuscitation Immediate Care at Birth Respiratory Resuscitation Cardiopulmonary Resuscitation	Infection Prevention Procedures
4 30 PM	Review and CLOSE	Review and CLOSE

LEARNING ACTIVITY Plan for the Orientation Workshop

Write a presentation about maternal mortality to present at the orientation workshop Use locally available information and Module 1

Write an overview of LSS, using the information in this manual, in *Life-Saving Skills Manual for Midwives* Module 1, and what you have learned. You may also interview other LSS trainers for additional information.

How will you receive evaluation from the participants of the orientation workshop?

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE:	SUPERVISION: FOLLOW-UP AND SUPPORT VISITS	157
	Time Frame for Follow-up and Support Visits	158
	Doing Follow-Up and Support Visits	161
	Identify Supervisors	161
	Observation Opportunities	162
	Knowledge and Skills Assessment	162
	Follow-up and Support Visit Plan	163
	Follow-up and Support Visit Summary	164
	Referral Feedback	165
	LSS Trainer and Supervisor Support	165
	Learning Activity: Use Follow-Up/Support Visit Form	167
STEP TEN	CONTINUING EDUCATION	168

STEP NINE: SUPERVISION FOLLOW-UP AND SUPPORT VISITS

What and how LSS midwives continue to learn after the completion of their LSS training is just as important as the original training. The follow-up and support they receive, and the people who provide it, can make a difference in the midwives' success or failure once they return to their place of work. The ideal support comes from

- An LSS midwife's community (those who have received care share information about services they received)
- Other LSS midwives (those who have been working longer and have more experience share what they have learned)
- LSS trainers and supervisors (those who taught the midwife)
- Referral site staff (those who receive referrals and provide clinical updates) ¹¹

LSS training must be supported by an ongoing system for follow-up and support visits. Training midwives and other pregnancy care providers without adequate follow-up has been shown repeatedly to have limited effect. These visits support both quality health care and midwives by

- Monitoring routine use of guidelines (protocols)
- Reinforcing midwife knowledge and skills
- Assuring safety of services given
- Helping maintain/improve confidence

The best way to tell if the LSS midwife is using the skills learned during LSS training is to watch the **performance** in the **place of work**. A supervisor, trainer, referral site midwife, or coworker can objectively determine whether the LSS midwife is performing LSS by observation using specific skills checklists. This is a shared responsibility of the LSS midwife and others to ensure clinical competency.

Time Frame for Follow-up and Support Visits

Follow-up and support is a long term commitment. The time frame should fit into the existing supervision schedule. The visits are usually conducted by the supervisor every three months for the first year following LSS training. (If a midwife's performance needs improvement, the visits may need to be more often or the midwife may need to return to the training center for additional skills practice.)

¹¹ Adapted from Werner D. Bower B (1982) Helping Health Workers Learn p 10-11

After the first year, the LSS midwife is encouraged to continue clinical updates with her referral site team. Look at the follow-up and support visit time frame below. Continued quarterly support visits, as recorded in the following time frame, are useful so the supervisor, trainer, referral site staff, and the LSS midwife can discuss clinical needs and performance. This information also helps LSS trainers evaluate the training they are doing, make necessary adjustments, and gather information for continuing education (see page 169).

The person responsible for follow-up and support (trainer or program coordinator) must keep a list of LSS trained midwives, date of completing LSS, and date and place of visits. The following sample may be used as a guide.

FOLLOW-UP AND SUPPORT VISIT TIME FRAME (sample)											
Name	Date of LSS Training	Month and Place of Visit									
		3*	6*	9*	12*	15	18*	21	24*	27	30*
<i>Aord</i>	<i>7/98</i>	<i>Oct</i>	<i>Jan99</i>	<i>Apr</i>	<i>July</i>	<i>Dec</i>	<i>Jan00</i>	<i>Apr</i>	<i>July</i>	<i>Dec</i>	<i>Jan01</i>

KEY * Work site visit by supervisor or trainer
LSS midwife goes to referral site for clinical update

When you visit, look at what the LSS midwife has actually done. This often gives you information about which skills you need to observe. The follow-up and support visit form on page 296, gives you an outline to follow. As you read it, you will see that there are many activities to do.

- ask the LSS midwife what she is doing,
- look at charts and records,
- observe actual care at the work site,
- discuss questions or problems,
- give general comments, and
- supply forms

Each visit consists of

- Interview
 - to assess the attitude and awareness of using LSS in the midwifery routine
 - to motivate, encourage, and support according to the situation
 - to assess whether LSS has been used in the care of maternity clients (focus on antenatal risk assessment, monitoring labor using the partograph, and postpartum follow-up)
 - to identify problems that may be preventing the use of LSS
- Record Review
 - to determine the extent and quality of use of partographs and antenatal risk assessment records
 - to assess whether the LSS midwife uses these tools as instructed during training
- Observation
 - to determine the possession, accessibility, storage, and condition of selected equipment (apron, gloves, artery forceps, bulb syringes, oxytocics)
 - to determine competency of selected skills using the skills checklist (infection prevention care of gloves, antenatal risk assessment, monitoring labor using the partograph, episiotomy, active management of third stage, and infant resuscitation) *Some of these skills may be observed during clinical updates at referral site*
- Communication with Referral Site Staff
 - to determine competency of referral skills (find out what cases have been referred, their management, and review referral form/client record)
 - to update referral site staff on results of supervisory visit

Doing Follow-up and Support Visits

Follow-up and support, sometimes called job performance evaluation, is an on-going process. Each time you make a visit, plan with the LSS midwife the things to be done before your next scheduled visit. These regular visits are encouraging to the LSS midwife, especially those in rural or isolated area who do not have the opportunity to see or talk with others. These visits reinforce the importance of the quality life saving care being given to women.

A Trainers Experience

In Uganda, follow-up visits were so important to LSS midwives. Many of the midwives were without transport or phones. Some even lived on an island with ferry transportation twice a week. The LSS trainer provided technical, material, and social support!

LSS Trainer, Uganda

Identify Supervisors

Try to use the present supervision system by training the designated supervisor(s) in LSS. If there is no identified supervisor, the LSS training team and the decision makers will need to discuss and identify a supervisor for their LSS midwives. It may be decided that LSS midwives within a certain area will meet every month and that the meeting site rotate among the midwives. The follow-up and support form should be used. Twice a year the midwives could make arrangements to spend two to three days at the referral site to update their clinical skills.

The supervisor should receive an LSS orientation and an overview of the LSS program's needs regarding follow-up information. An LSS trainer should accompany the supervisor on some visits. This may open communications between hospital personnel and nonhospital staff, because trainers are usually hospital staff who do not routinely provide pregnancy care and services outside of the hospital.

Observation Opportunities

Clinical skill observations at the LSS midwives' place of work are the ideal way to assess performance competency after training. However, the skills learned during LSS are not skills one can plan to observe. A supervisor may travel to a health center for a follow-up visit on a day when scheduled activities do not provide clients needing any of the skills learned in LSS. In order to avoid this problem and to make sure the time is spent efficiently, one might plan to be there on a day when antenatal or postpartum clinic is scheduled. This will allow for observation of the LSS midwife performing skills for a pregnant woman or a postpartum mother and baby.

Plan to spend a full day at one place of work. If this place of work is a hospital with a number of LSS midwives, the supervisor may be able to observe more than one LSS midwife during the day. At rural sites, a full day may be necessary to watch and work with just one LSS midwife. Allowing quality time during an evaluation visit continues the process of midwives learning from each other. This is especially important for the rural LSS midwife who lacks the opportunity of sharing with other midwives. The supervisory visit can also help provide a time to solve problems and share experiences. Refer to the follow-up and support visit form beginning on page 296 and the *Clinical Practice Guide*¹² for skills checklists and a place to write a summary of the visit.

Knowledge and Skills Assessment

Additional written and clinical testing after training gives the training staff and the LSS midwife information about her long term retention of knowledge and skills. These assessments may be carried out at three months, six months, one year and then annually after training. From this information, topics requiring additional training (continuing education) may be identified.

¹² A companion handbook to the LSS manual. It includes LSS skills checklists plus follow up and support visit summaries.

Follow-up and Support Visit Plan

Supervisors or LSS trainers visiting an LSS midwife should go prepared with a plan of activities. The plan might follow this outline:

- Ask whether she is having any problems. Help solve the problems.
- Review the previous month's activities. Find out what was accomplished. Note any problems. Discuss how to prevent the problems.
- Check the antenatal risk assessment and partograph records.
- Make clinical observations as available. Offer supportive feedback.
- Determine the possession, accessibility, storage, and condition for selected equipment.
- Make notes of performance and observations and follow-up plans in the follow-up and support visit form on page 296 and in the LSS midwives' *Clinical Practice Guide* (see sample of completed follow-up and support visit summary on the next page).
- Discuss your findings and follow-up plans with the LSS midwife. Make an agreed upon date to return for the next visit.
- Provide necessary forms.

FOLLOW-UP AND SUPPORT VISIT SUMMARY						
ANTENATAL CARE LAST MONTH				DELIVERIES LAST MONTH		
NEW	REVISIT	REFERRALS		Number	REFERRALS	
		Number	Reason		Number	Reason
3	15	1	B/P 160/100, epigastric pain, swelling of hands	5	0	
Number of TBA or home birth attendant (HBA) visits ? (Comments on the back)					5	
What was the most serious problem you saw last month? <i>Antenatal woman with PIH</i>						
What were the causes? <i>Pregnancy</i>						
What can you do to prevent the problem from happening again? <i>Not able to prevent but make sure women and families know the danger signs of pregnancy and come for help</i>						
Use information from Follow-up and Support form to indicate performance ✓ (satisfactory), X (needs improvement)						

	✓ or X	COMMENTS / PLANS
Infection prevention	✓	
Delivery equipment	✓	
Oxytocic	X	<i>Locked in cupboard, only in charge has key</i>
Postpartum visits	✓	
Family planning counseling	✓	<i>Three women accepted family planning</i>
Incident form review	---	<i>no cases</i>
Referral form review	✓	
Antenatal record review	✓	
Partograph review front	✓	
Partograph review back	✓	
Number of forms supplied • partograph <u>20</u> • antenatal <u>0</u> • referral <u>0</u> • incident report <u>0</u>		Supervisor <u>Kceb Anaid</u> Date <u>15 July 1998</u> Return Visit Date <u>15 October 1998</u>

Clinical Skills Checklist Summary see pages 100 to 102 in **A Clinical Practice Guide**

Referral Feedback

The referral site staff must provide support to the LSS midwife by giving feedback on the clients referred (see page 142 for referral form) This information can be shared with the training team and the supervisor This type of team supervision and support will help to sustain a program If those involved in the care of a woman are also involved in helping each other, changes can be made and quality of care can be maintained and improved The following questions can be part of the follow-up information

- Are the referrals appropriate and timely?
- Was the LSS midwife's care appropriate?
- Did the LSS midwife come with the client?
- Did the family come with the client?
- Were referral notes, partograph, and/or antepartum assessment form complete and easy to read?

LSS Trainer and Supervisor Support

LSS Trainers and Supervisors also need support LSS midwives and others providing LSS are not the only ones who need a support system

- Trainers and supervisors need to provide support, advice, and friendly criticism to each other A coworker is the very best person to make suggestions, congratulate on a job well done, make clinical observations, and give encouragement when one is tired
- Program leaders and decision makers need to recognize and respond to the efforts being made by everyone in the LSS program A sign of team work throughout the system is when a leader reads reports and keeps herself up to date on the activities of a program

- LSS midwives and other providers of pregnancy care need to provide suggestions and friendly criticism to their trainers, supervisors, and program leaders. For example, one trainer is very kind, respectful, and always makes the LSS midwife feel comfortable even when the trainer needs to explain that the midwife still needs more improvement in a certain skill. It is essential that the midwife give this feedback to the trainer. It is healthy for all of us to receive comments about our work, whether it is perceived as good, or needs improvement. This gives the trainer reinforcement of her work.
- Women and families receiving pregnancy care need to tell the LSS midwife, trainers, supervisors, and decision makers how the services provided help them or how they may make life more difficult. For example, one maternity clinic has a set clinic day for antenatal and it is impossible for one pregnant woman to attend because it is at 10 AM and she is teaching school at that time. Issues that make it difficult for someone to receive care must be made known so that decisions can be made to make the care offered available to everyone.

LEARNING ACTIVITY Use Follow-Up and Support Visit Form

Use the follow-up and support visit form on page 296 to conduct a job performance evaluation. In order to learn first hand about follow-up and support, you should practice interviewing each other using the form as a guide.

Then you will receive the name and address of a clinically practicing midwife to interview and observe. You will need to be able to explain to the midwife what you are doing and why.

When you are finished, return to the classroom and prepare a 15 minute report about "your midwife." Remember to include how the midwife felt about the process and how you felt about asking all of these questions.

LIFE-SAVING SKILLS TRAINING PROGRAM PROCESS

		Page
STEP ONE	LSS PROGRAM PLANNING	7
STEP TWO	TRAINING NEEDS ASSESSMENT	25
STEP THREE	TRAINING SITE PREPARATION	45
STEP FOUR	PREPARE FOR TRAINING	60
STEP FIVE	TRAINING FOR TRAINERS -- CLINICAL	65
STEP SIX	TRAINING FOR TRAINERS -- TEACHING	69
STEP SEVEN	LSS TRAINING FOR MIDWIVES	125
STEP EIGHT	ORIENTATION WORKSHOP FOR REFERRAL STAFF	153
STEP NINE	SUPERVISION FOLLOW-UP AND SUPPORT VISITS	157
STEP TEN:	CONTINUING EDUCATION	168
	Continuing Education Is Important	169
	Accomplishing Our Goal	172

STEP TEN: CONTINUING EDUCATION

Continuing education includes all of those learning activities that take place after an LSS midwife or other provider of pregnancy care has finished training. The main goal of continuing education is to prevent deterioration of skills and knowledge. Continuing education is the responsibility of each of us. Continuing education for LSS providers (midwives, health assistants, traditional birth attendants, home birth attendants, and so forth) continues the cycle of evaluation (meet needs, evaluate, identify needs, prepare to meet needs as described on page 22). Follow-up visits to LSS midwives are another step in continuing education to help ensure the sustainability of the LSS program. The obstetrician and referral physician should provide information on referrals they have received. When weaknesses or problems are identified from any of these sources, additional training or updates are provided. An effective way to sustain an LSS training effort is by offering continuing education for both trainers and midwives.

Continuing education can be offered at a workshop, an annual professional meeting, a district monthly meeting, or as self study. Encourage midwives to ask for assistance when they feel they need it. Encourage LSS midwives to work together, review together, and even evaluate each other (peer review). If an LSS midwife has not performed an episiotomy or has not removed a retained placenta within six to twelve months after training, she probably needs to come to the training site or her referral hospital and manage a few women in labor.

Continuing Education Is Important

Continuing education is important to LSS midwives for many reasons. Continuing education maintains, improves, and teaches midwives knowledge and skills.

Continuing education

- Improves job performance and quality of service
- Teaches new knowledge and skills
- Motivates midwives through an improved job performance
- Develops a commitment to training. For example, LSS midwives who receive LSS training teach their new skills to other midwives
- Develops teamwork through periodic contact with others in the profession

Continuing education is *learning that goes on and on* and follows the five basic principles of LSS training

- **Explain why** the midwives must learn the topic or skill. If a midwife does not understand the purpose of the skill, she may not make a real effort to learn. Explain the reason for using the skill and the practical advantages.
- **Give the opportunity to learn** in the best way for each person. Each midwife has different abilities and talents. Each learns in different ways and at different rates. For example, one midwife may have much experience with a skill and be competent performing it. This midwife should be allowed and encouraged to choose the learning opportunities she needs to update another skill.
- **Provide a step by step method of learning** so each midwife can begin at the step of the skill where she needs the update. As each person is successful with a particular step, she can move on to another. For example, LSS training provides skills checklists with each step written in the order of optimum performance. Each midwife can enter at the level appropriate for her.
- **Encourage repeat practice** until every step in the skill is performed competently and with confidence. For example, the trainees are encouraged to watch each other perform skills and to follow along with the skills checklist, reinforcing the steps by reading and observation. Each midwife practices each skill until she performs competently.
- **Provide feedback** during skill practice. The LSS training method supports encouragement to all trainees while they practice, explaining when they are doing well, and providing suggestions when they need to improve. It is essential to inform trainees when the steps are not performed correctly so they will know what they need to improve.

Once a continuing education need is identified, either by a supervisor, trainer, or midwife, an opportunity to learn must be provided. Midwives should always be looking for ways to increase and update their knowledge and skills.

LSS Training Program Experiences

Program # 1. Monthly newsletters to LSS midwives provide continuing education by updating knowledge and information through case studies for the midwives to read, complete, and return to the training center. Midwives are requested to write about one experience each month. The case studies are based on midwives' experiences providing learning for both the midwife with the experience and for other midwives. An annual week long continuing education meeting is held to provide clinical skills opportunities.

Program # 2 The continuing education process is based on information from the peer review system. Peer review consists of LSS trained midwives reviewing clinical practice and documentation, and comparing to the standards and protocols taught in LSS training. This supports LSS areas of focus. Continuing educators, selected from among the midwives trained in LSS and peer review, are trained in a five day workshop by the midwives association training team. The continuing educators are responsible for taking information from the peer review and developing continuing education sessions addressing gaps in knowledge and skills. This continuing education is offered at midwifery association chapter meetings every three months. This integrated system assures the quality of maternal health care and sustainability of the program.

Continuing education can be provided by

- Visits from supervisors and trainers
- Meetings with other health workers
- Books and other educational materials
- Local radio health programs
- Refresher courses and training programs
- Someone who has previously received a refresher or training course doing it on the job
- Teaching staff of the midwifery, nursing, or medical school
- Meetings among other programs

LSS Trainers and Supervisors also need learning opportunities LSS midwives are not the only ones who need a chance to learn new ideas. Everyone needs to practice skills, meet new people, start new projects, be introduced to new ideas, and always try out new and better ways to do work.

USE IT (skill) OR LOSE IT (skill)

The same methods can be used to learn as have been suggested for the LSS midwives. Sometimes programs are sponsored for short courses on teaching methods. Motivation for trainers can be readily obtained by having them spend more time with those who benefit from the training they provide and the people in the communities. Remind yourself about their daily needs, their problems, the fun and frustrations they experience in their own lives. This will give you the spirit to work with people toward the reduction of maternal mortality.

Accomplishing Our Goal

The main goal of LSS is to help prevent maternal mortality and morbidity by identifying and taking necessary action in problems of pregnancy, labor and delivery. In the *Life-Saving Skills Manual for Midwives*, Module 1 **Introduction to Maternal Mortality**, on page 1-12, we learn about causes of maternal morbidity and mortality. Once the causes are understood, action can be taken in the health facility and the community to improve services for the mothers and newborns of the future. LSS is one way to help the midwife gain skills to help prevent mothers and babies from dying.

Records kept at a midwife's work place document her activities. It is customary for the midwife to submit a monthly report of those activities to the authorities at headquarters. The information from each midwife is compiled and added together with information from all other reporting sites. This data is compiled so we will have a better picture of the causes of death and illness, number of clients receiving services, deaths, births, types of referrals, home visits made, and other activities. This information becomes the vital statistics of the country. The birth rate, the maternal mortality rate, and infant mortality rate are all figured from this information. Continuing education needs can also be identified from this information.

We must focus not only on numbers (it takes many years to see a change in the maternal mortality), but on how well LSS midwives are prepared to help prevent mothers and babies from dying. The follow-up, support, advice, evaluation, continuing education, and the people who provide these, can make the LSS midwife and her trainer a success or failure in meeting people's needs.

The evaluation of the LSS training -- before, during, and after -- can be thought of as a circle of activities (refer to page 22) This circle of activities provides continuing opportunities to learn Evaluation and learning go together When an LSS midwife or LSS trainer receives a visit from her supervisor, there will be evaluation and learning Meeting with other health workers to discuss clinical experiences provides peer evaluation and learning Self evaluation and learning can occur by reading books, references, newsletters, and other educational materials Formal refresher courses or self motivated apprenticeship opportunities using the LSS skills checklists, provide the LSS midwife a chance to see how well she performs and also give her a chance to review and learn the steps of skills This is all evaluation and continuing education as we learn from our successes and mistakes Evaluation is a **primary source** for identifying continuing education needs of LSS midwives *Continuing education (continued learning) is a key to reduction of maternal mortality*

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Table of Contents (Annotated) Lesson Plans and Forms

The following lesson plans and forms are listed in order of occurrence in the *Manual for Policy Makers and Trainers*

	Page
Lesson Plans for Life-Saving Skills	180
Module One Maternal Mortality and the Midwife	181
Module Two Quality Antenatal Care	187
Module Three Monitoring Labor Progress	192
Module Four Episiotomies and Repair of Lacerations	198
Module Five Prevention and Treatment of Hemorrhage	203
Module Six Resuscitation	214
Module Seven Prevention and Treatment of Sepsis	220
Module Eight Hydration and Rehydration	225
Module Nine Vacuum Extraction	230
Module Ten Other Emergencies	235
 Training Needs Assessment	 245
This tool is used for collecting baseline information on the situation, skills, and knowledge of midwives and also for collecting information on potential training sites Its use is described in Step Two	
Part I Baseline Information	245
Part II Statistics	246
Part III Clinical Skills	249
Part IV Midwife Knowledge	253
Part V Equipment, Supplies and Medicines	259
Part VI Hospital Training Site	261
 Guidelines (samples)	 264
The use of these sample guidelines is described in Steps One, Two, and Seven Each program should review, compare, and adjust existing guidelines, or develop new ones These sample guidelines may be serve as a reference in that process	
Antenatal Guidelines for the LSS Midwife	264
Partograph Guidelines for the LSS Midwife	268
Postpartum Guidelines for the LSS Midwife	269

	Page
LSS Training Site Supplies and Equipment List Order Form (suggested)	271
Equipment needed for training is listed. The list is discussed in Step Two. Modify it according to the local situation and topics to be included in the training. Then compare it with the equipment available at the training site to identify equipment that must be procured. Explanations are attached.	
Supplies and Equipment List for the LSS Midwife (suggested)	273
Once a basic equipment list has been created, it should be compared with data from the Training Needs Assessment, Part V to identify equipment and supplies LSS midwives will need at the end of their training. This form is discussed at the end of Step Two. Explanations are attached.	
LSS Participant Registration and Inventory Form	280
Each midwife trainee completes this form, either at her place of work before the workshop or when she arrives for the course. Its use is discussed in Step Six, Topic 2 Finding Out About the Midwife.	
Training Report Form	283
This form is used to keep track of trainees' clinical practice opportunities and their status in regard to competency in each skill. It is discussed in Step Six, Topic 3 Evaluating the Midwife.	
Weekly Evaluation Form (sample)	285
Both trainers and trainees use this form at the end of each week of training to assess the experience. The completed forms can be read and discussed by all concerned. Its use is described in Step Six, Topic 3 Evaluating the Midwife.	
Final Evaluation Form (sample)	286
Participants fill this form at the end of each training course. Trainers use the information to improve the course. It is described in Step Six, Topic 3 Evaluating the Midwife.	
Certificate of Attendance (sample design)	287
Each competent LSS midwife usually receives a certificate upon successful completion of the LSS training.	
LSS Training Schedule (blank form)	288
Trainers develop the schedule for the LSS training course as described in Step Six, Topic 4 Roles and Responsibilities of the LSS Trainer. These blank forms are for use in that process.	

	Page
Rounds Report Form	290
Trainees on the on-call team use this form to record information and then report their findings in class, see page 115	
LSS Training Task List	291
The team of trainers can use this form to plan who will take responsibility for each aspect of the course It is discussed in Step Six, Topic 5 Trainers' Work Plan	
Referral Form	292
At her place of work, the LSS midwife uses one side of the referral form to tell the staff at the referral site about the client she is sending The referral site staff records the outcome and follow-up care that is needed when the client returns to the LSS midwife Its use is described in Step Seven, Topic 3 Management of the Workplace	
Incident Report Form	294
Each time an LSS midwife uses life-saving skills, she is encouraged to complete one incident report This information serves as qualitative and quantitative data on how LSS has helped the midwives	
Follow-up and Support Visit Form	296
This form is used by trainers and supervisors during visits to LSS midwives It helps them to structure their visit and to record their observations, as well as discussing those observations with the LSS midwife	

Forms and Lists Included in the Text

Comparison of LSS Providers and Training Content - Introduction	4
LSS Program Process - Introduction	6
LSS Program Process Time Frame - Step One	8
List of Criteria for Advisory Committee Members - Step One	10
Memorandum of Understanding Checklist - Step One	15
List of Criteria to Identify Key Participants in Launch Meeting - Step One	17
General Outline of Program Budget Items - Step One	21
List of Possible Methods of Evaluation - Step One	24

	Page
List of Goals or Reasons for Conducting TNA- Step Two	27
Training Needs Assessment Budget Categories List - Step Two	29
Example of a List of Some Findings from a Survey - Step Two	34
Workshop Schedule for Training Site Preparation - Step Three	47
List of Trainer Tasks - Step Three	51
List of Selection Criteria - Step Three	52
Hospital Records Review - Step Three	55
Invitation Criteria - Step Four	62
Schedule for Training of Trainers (TOT) Teaching - Step Six	70
Skill Practice Chart - Step Six	88
Skills Checklists - Step Six	
Using Review Questions to Conduct a Discussion	90
Conducting a Case Study	91
Conducting a Demonstration	92
Clinical Learning Observation, Modeling, Coaching	93
LSS Registration and Inventory Form - Step Six	96
Training Report - LSS - Step Six	109
LSS Trainer Tasks - Step Six	111
LSS Timetables - Step Six	116
LSS Training Task List - Step Six	123
Pregnancy Records - Step Seven	138
Referral Form - Step Seven	143
Outcome of Referral - Step Seven	144
LSS Incident Reporting Form - Step Seven	146
List of Supplies, Equipment, and Medicines by Skill - Step Seven	151
Orientation Workshop Schedule - Step Eight	155
Follow-Up and Support Visit Summary - Step Nine	164

LESSON PLANS

Several methods and tools described in the lesson plans are used to help midwives learn life-saving skills. As you prepare to teach, keep in mind that the **essential learning experience is clinical practice** which provides the midwife with similar opportunities to those she will find in her own place of work.

It is a good idea for the trainer to write a lesson plan. This is a guide of what information you are going to teach, what method you will use, what equipment is needed, how to evaluate, and how much time will be available. The lesson plan helps the trainer get ready to teach. Remember that the lesson plan is a guide and may need to be changed or adapted depending on the experience and needs of the trainees.

On the following pages, you will find a sample lesson plan for each module. These lesson plans are written as a guide for the trainer. The lesson plans can be used as they are written, or the trainer can modify the lesson plan to make it more appropriate for the situation.

The lesson plan for each module is made up of four sections:

- *Learning Objectives* - These state what you expect the midwife to learn from the information in the module. These objectives are also stated at the beginning of each module.
- *Trainers Notes* - These are helpful teaching hints and suggestions based on prior teaching experiences of the material.
- *Teaching Session* - This outline will help you schedule your teaching time and suggest materials you may need to collect to teach the class.
- *Supplies and Equipment Issues* - This section provides helpful advice on where to obtain special supplies, videos or other equipment that you may need for teaching this lesson.

At the end of each lesson plan, you will find in **large and bold print** the *learning objectives* for that lesson. These pages can be used to make transparencies for use on an overhead projector. You may choose to write the objectives on a chalkboard or on newsprint. Or, ask the trainees to read the objectives in their module. Use whatever method suits your situation best but remember it is very important that everyone understands the objectives before teaching starts.

Remember that LSS *competency based training*, (1) states exactly what it is that midwives should learn, (2) provides instruction in critical knowledge, (3) helps midwives learn one thing well before going on to the next, and (4) requires each midwife to demonstrate competency. The goal of LSS training is to have confident, competent midwives who can practice advanced midwifery skills and save the lives of women and newborns.

Lesson Plan - Module One: Maternal Mortality and the Midwife

Learning Objectives (Also found in Module One, page 1 3)

The midwife caring for the mother and her newborn will be able to

- 1 Explain the meaning of maternal mortality, maternal morbidity and risk factors
- 2 List the major causes of death for women during pregnancy and childbirth in her place of work and worldwide
- 3 Describe the role she can play in reducing of maternal mortality at her place of work and in the community in which she lives
- 4 Describe how she will identify the cause(s) and the reason(s) women and newborns die in her community and her place of work, through interview and review of client records
- 5 Develop a plan for helping the people in her community learn how they can prevent illness (morbidity) and death (mortality) of women during pregnancy and childbirth

Trainer's Notes

Many of the trainees will come to this course having experienced maternal mortality in their own practice. Many are also unaware of the scope of the problem in their own country and worldwide. This introductory class will put the problem into focus. It will also start them thinking about ways in which they, their colleagues, and their communities can assume a shared responsibility for solving the problem of unnecessary deaths.

It is common for trainees to be very touched by the film *Why Did Mrs. X Die?* and cry. It is important to appreciate the terrible size of the problem, and then speak very positively of how these new emergency skills, plus community action, can bring about great change.

Introduction

To introduce the topic of maternal mortality and morbidity worldwide, see the introductory pages of module one. You will want to tap into the experience of the trainees and see what they know about the situation in their own areas. Sample questions you may wish to ask are

- What is the maternal mortality rate in our country? Our state/province? Our hospital/maternity home?
- What are the major causes of death in our area? What per cent of these deaths do you think are preventable?
- What are ways in which our communities can mobilize to help decrease maternal deaths?
- What are ways that I as a midwife can contribute to a decrease in maternal deaths?

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to the training and plenty of opportunity exists for studying practice both on models and clinically. Remind trainees to bring their modules with them to the clinical area. Reassure trainees that we are capable of learning our entire lives. They will have much practical experience to share with all at the training. We are all capable of continuing to learn until our death.

Teaching Session Maternal Mortality and the Midwife

Teaching Method/ Time	Content	Materials Needed	Evaluation
Group contributes (30 minutes)	<i>Evening before if possible</i> Registration Welcome Explain the schedule for the training emphasizing the importance of clinical practice (hours any holidays rounds, rounds report review postpartum visits breaks meals residential homework on call skills checklist) Tour Opening/launch of training	Registration forms, name tags, evaluation forms, schedule	
Group (15 minutes)	Warm up exercise for introductions - sponsors training staff trainees	Chalkboard chalk	
Individual work (30 minutes)	Written Pretest	Pretest forms	Compare the results pretest with post test
Discussion (30 minutes)	LSS Definition and Overview Read Objectives LSS Manual Overview (10 modules, index, table of contents, formulary notes skills checklists, review questions, case studies)	Handout LSS Objectives	
Video discussion (45 minutes)	Introduction Maternal Mortality Setting the scene either use a video such as <i>Why Did Mrs X Die?</i> , Debrief on the video or Conduct discussion of Maternal Mortality Worldwide and use the Case Study 1 - <i>Why Did this Woman Die</i> on page 1 17	Video machine TV monitor video extension cord and Module One	Knowledge displayed during discussion and Question and Answer periods
Trainer led discussion using page 1 20-1 21 questions and Case Study 3 page 1 30 (45 minutes)	Discussion of Maternal Mortality to include • Experience of the participant with maternal mortality including major causes of death for women and newborns she has noted in her workplace • meaning of maternal mortality, maternal morbidity, and risk factors • role midwives can play in reducing maternal mortality at her place of work and in the community in which she lives • how to identify cause(s) and reason(s) women and newborns die in her community and her place of work, through interviews and review of client records Develop a plan for helping people in her community learn how they can prevent illness (morbidity) and death (mortality) of women during pregnancy and childbirth	Overhead projector, transparencies	

Supply and Equipment Issues

There are several videos which you may wish to use to stimulate discussion and help trainees focus on the scope of the problem of maternal mortality and morbidity. Two of these are

- *Why Did Mrs. X Die?* 1990, 25 minutes, in PAL and NTSC format. English, French, Arabic. Cost \$36 US.
World Health Organization, Distribution and Sales
1211 Geneva 27, Switzerland. phone 41-22-791-2111 fax 41-22-791-0746

Note that the World Health Organization has a series of publications on Safe Motherhood, many of them free of charge. To obtain an up to date resource list of publications and to be placed on their mailing list for future publications, write to the WHO address above.

- *Vital Allies* - 18 minutes in PAL format and 28 minutes in NTSC, English only. Available free to developing countries and \$15 US to others. Write to
Family Health International, 588 Broadway Street, Suite 503
New York, New York 10012 USA. fax 212-941-5563, phone 212-941-5300

Remind participants that they will be learning skills that will save lives

MODULE ONE MATERNAL MORTALITY AND THE MIDWIFE

Learning Objectives

The midwife caring for the mother and her newborn will be able to:

- 1. Explain the meaning of maternal mortality, maternal morbidity, and risk factors.**
- 2. List the major causes of death for women during pregnancy and childbirth in her place of work and worldwide.**
- 3. Describe the role she can play in reducing of maternal mortality at her place of work and in the community in which she lives.**

- 4. Describe how she will identify the cause(s) and the reason(s) women and newborns die in her community and her place of work, through interviews and review of client records.**

- 5. Develop a plan for helping the people in her community learn how they can prevent illness (morbidity) and death (mortality) of women during pregnancy and childbirth.**

Maternal Mortality

“The death of a woman while pregnant or within forty-two days of termination of pregnancy, irrespective of the duration and site of pregnancy (uterine or extra-uterine), from any cause related to or made worse by the pregnancy or its management, but not from accidental or incidental causes”.

World Health Organization

Maternal Morbidity

Any symptom or condition resulting from or made worse by pregnancy. The quality of care often determines whether complications are effectively treated or continue on to death.

Lesson Plan - Module Two: Quality Antenatal Care

Learning Objectives (Also found in Module Two, page 2 1)

The midwife caring for mothers during the antenatal period will be able to

- 1 Take the medical history in a way that allows her to identify possible problems, especially anemia and pregnancy induced hypertension (preeclampsia) (**ASK and LISTEN**)
- 2 Identify anemia pregnancy induced hypertension and other problems in antenatal women by doing a physical examination, monitoring fundal height (uterine) growth testing reflexes, monitoring weight gain and vital signs, ordering laboratory tests, and other procedures (**LOOK and FEEL**)
- 3 Provide appropriate health information/advice, give treatments(s), and refer the woman to a doctor when appropriate (**IDENTIFY PROBLEMS/NEEDS and TAKE APPROPRIATE ACTION**)
- 4 Accurately record her findings on the Antepartum Assessment Form

Trainer's Notes

This class as outlined is quite long Notice how the group is doing They may need a break They may need more or less time than estimated The class may be broken up by need to move into the clinical area to use all clinical learning opportunities This lesson plan is just a guide to help the trainer organize this session Be flexible about how it is taught You may wish to break it into two You may try it as outlined above and modify it after seeing how tired the trainees are when absorbing new material

Our experience has been that quite a few trainees have not had the opportunity to use graphs (such as the antepartum assessment form) in many years If this is the case with your trainees, the class will take a long time and much individual assistance will be needed until graphing of the clinical data becomes mastered Have another trainer with you to help provide the individual attention If this session is very well taught, the upcoming class on the partograph will be much easier for participants

Although testing of reflexes tends to be new for many trainees, the skill is mastered without great difficulty How it goes will probably depend on how much of this material is completely new for trainees Keep in mind that times in the clinical area when you are not busy is an excellent time to pick out a case study and review it Your own experiences and case studies are also very important and make the training come alive for the trainees

Introduction

In talking about giving quality antenatal care, the trainees are likely to come with quite a bit of experience It might be helpful to start by asking them what are the barriers they encounter in practice to giving even better care You, the trainers, will learn practical information which will help you to keep the class realistic and focused Remember they are practicing midwives and may feel they should be very competent in this area It will take an open, supportive environment to help them to declare openly when they need assistance

Sample questions you might want to ask are

- What are the problems you encounter in giving antenatal care?
- Do you have space to examine and counsel clients where no one can over hear what is said?
- Are your records individualized with valuable information or so routine and short they don't really help in giving care?
- How do you set priorities about what to check or teach on days when your clinic is very busy and you can not do it all?

Summary

At the end of the lesson, it is important that you again allow time for questions Reassure trainees that today was an introduction to all of the skills and plenty of opportunity exists for practice both on each other and clinically

Teaching Session Quality Antenatal Care

Teaching Method/Time	Content	Materials Needed	Evaluation
Trainer led discussion (30 minutes)	Discuss how to identify antenatal risk, what can be done antenatally to decrease mortality (avoid/treat anemia and PIH) and use Review Questions, page 2 37-2 38	Module 2 , chalkboard, chalk	Correct responses to Review Questions
Demonstration of uterine growth monitoring reflex testing, and any other needed areas (60 minutes)	<ul style="list-style-type: none"> • ASK and LISTEN in a way that allows her to identify possible problems especially anemia (2 6) and pregnancy induced hypertension (2 10) fetal growth (2 4) • LOOK and FEEL to Identify anemia (2 7), pregnancy induced hypertension (2 10) and other problems in antenatal women, monitoring fundal height growth (2 4), testing reflexes (2 33) monitoring weight (2 16) and ordering laboratory tests • IDENTIFY PROBLEMS/NEEDS and TAKE APPROPRIATE ACTION according to findings and actions for anemia (2 7), pregnancy induced hypertension (2 11), fetal growth (2 5) 	Clients and antenatal equipment (2 3)	Ability of trainees to perform return demonstrations during clinical practice sessions
Case study (30 minutes)	Practice the problem solving steps using the Case Studies 2 and 3 (2 27 to 2 30)	Module 2	Accurate interpretation
Demonstrate and practice graphing on forms (90 minutes)	<ul style="list-style-type: none"> • Practice use of the antenatal risk assessment forms and discuss how to integrate into current records (2 13) • Accurately record her findings on the Antepartum Assessment Form using Case Study 1 (2 21 to 2 26) 	Antenatal case studies for practice on forms Multiple copies of antenatal assessment forms	Accurately complete forms

Supply and Equipment Issues

The equipment used for this class is usually not difficult to locate

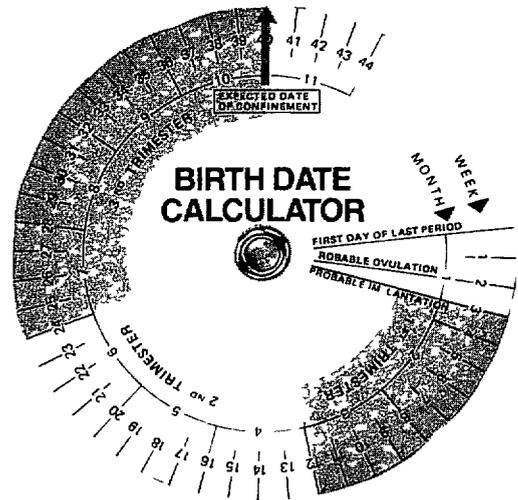
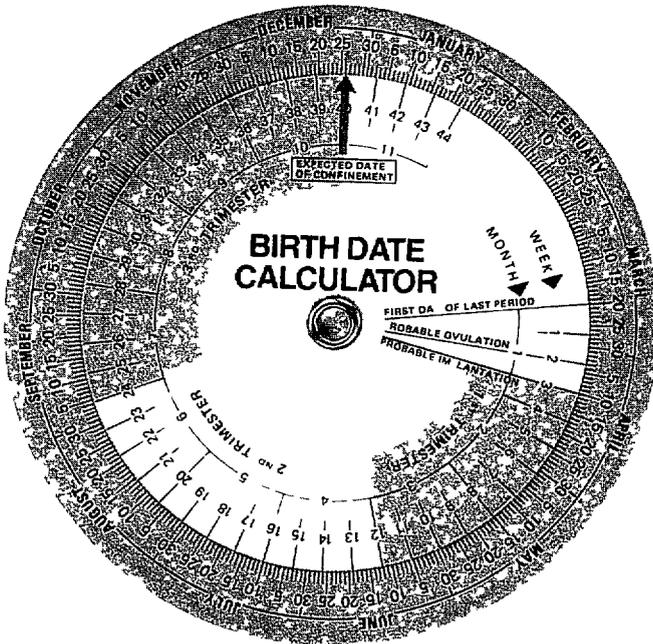
Measuring tapes with centimeters marked on one side and inches on the other can usually be located with sewing supplies in any market

Gestation wheels can be purchased or made from one model by photocopying the wheel and background on sturdy paper, cutting out the wheel, and pinning the two pieces together. A sample can be found at the bottom of this page which can be copied

Reflex hammers can be purchased from medical supply companies. You can also use the side of your hand, the tips of your fingers (short nails), or metal edge of a stethoscope

Antepartum assessment forms can be made locally. Clean copies for copying can be found in your module 2

Remind participants that these are skills that can save lives



MODULE TWO QUALITY ANTENATAL CARE

Learning Objectives

The midwife caring for mothers during the antenatal period will be able to:

- 1. Take the medical history in a way that allows her to identify possible problems, especially anemia and pregnancy induced hypertension (pre-eclampsia). (ASK and LISTEN).**

- 2. Identify anemia, pregnancy induced hypertension and other problems in antenatal women by doing a physical examination, monitoring fundal height (uterine) growth, testing reflexes, monitoring weight gain and vital signs, ordering laboratory tests, and other procedures. (LOOK and FEEL)**
- 3. Provide appropriate health information/advice, give treatment(s), and refer the woman to a doctor when appropriate. (IDENTIFY PROBLEMS / NEEDS and TAKE APPROPRIATE ACTION)**
- 4. Accurately record her findings on the Antepartum Assessment Form.**

Lesson Plan - Module Three Monitoring Labor Progress

Learning Objectives (Also found in Module Three page 3 1)

The midwife caring for women during labor and delivery should be able to

- 1 Admit a woman in labor, including
 - a Take the labor history (ASK and LISTEN)
 - b Do a general physical examination, an abdominal examination and a vaginal examination (LOOK and FEEL)
- 2 Write information from her findings (ASK, LISTEN, LOOK, FEEL) on the labor record including the partograph
- 3 Describe the latent and active phases of labor
- 4 Interpret a recorded partograph
- 5 IDENTIFY PROBLEMS/NEEDS of a woman and her baby during labor and TAKE NEEDED ACTION
- 6 Manage the labor of a woman during the second stage and record the findings
- 7 Record the outcome of delivery
- 8 Explain the importance of progress in labor for healthy outcomes of the mother and baby

Trainer's Notes

This class as outlined is quite long. Notice how the group is doing. They may need a break. They may need more or less time than estimated. The class may be broken up by need to move into the clinical area to use all clinical learning opportunities. This lesson plan is just a guide to help the trainer organize this session. Be flexible about how it is taught. You may wish to break it into two. You may try it as outlined above and modify it after seeing how tired the trainees are when absorbing new material.

Our experience has been that quite a few trainees have not had the opportunity to use graphs in many years. If this is the case with your trainees, the class will take a long time and much individual assistance will be needed until graphing of the clinical data becomes mastered. Have another trainer with you to help provide the individual attention. You may choose to teach half the partograph one day and practice filling out that portion and complete the second half of the lesson another day.

Keep in mind that times in the clinical area when you are not busy is an excellent time to pick out a case study and review it. Your own experiences and case studies are also very important and make the training come alive for the trainees.

One common mistake seen with health professionals new to use of the partograph is overuse of caesarean section. Although the midwife must notify the physician when the action line is crossed, this does not mean that surgery is the only answer. Remember that the action line indicates need for a complete re-evaluation of the status of the patient and determination that the pelvis is adequate, the baby is progressing in descent, the contractions are effective, the membranes have not been ruptured too long, the woman is well hydrated, etc. The important thing is that the mother is closely monitored by the physician/midwife team, the mother and baby are well, and that the labor is not being neglected. If all is normal, it is appropriate to observe the mother for another two hours (or augment labor if indicated).

Introduction

In discussing high quality intrapartum care, the trainees are likely to come with quite a bit of experience. It might be helpful to start by asking them what are the barriers they encounter in practice to giving even better care. You, the trainers, will learn practical information which will help you to keep the class realistic and focused. Remember, they are practicing midwives and may feel they should be

very competent in this area. It will take an open, supportive environment to help them to declare openly when they need assistance.

Sample questions you might want to ask are

- What are the problems you encounter in giving intrapartum care?
- Do you have space to examine and counsel clients in privacy?
- Are your antenatal records available when the woman comes for admission? Is the information individualized with valuable information or so routine and short they don't really help in giving care?
- What are the steps in admitting a patient? (History, physical, laboratory)
- How rapidly do you expect a woman to progress in latent phase? Active phase?
- What are some of the things that hinder labor progress?
- What are the interventions a midwife can use to assist good labor progress (hydration, frequent urination, ambulation, position change, etc.)?
- What are the advantages of using the partograph as a management tool?

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to all of the skills and plenty of opportunity exists for practice both on each other and clinically.

Teaching Session Monitoring Labor Progress

Teaching Method/Time	Content	Materials Needed	Evaluation
Trainer led discussion (30 minutes)	Use review questions to discuss admission of a woman in labor, including a Take the labor history (ASK and LISTEN) (3 6 to 3 9) b Do a general physical examination, an abdominal examination and a vaginal examination (LOOK and FEEL) (3 21)	Chalkboard, chalk or newsprint and markers	Correct responses to review questions
Demo and return (90 minutes)	Write information from her findings (ASK, LISTEN, LOOK, FEEL) on the partograph (3 31 to 3 49)	Large partograph, Module 3	Comparison of pretest and post test
	<ul style="list-style-type: none"> • Describe the latent and active phases of labor (3 2) • Practice writing information on partograph forms 	Multiple copies of partograph forms	Correct return demo
Case studies (80 minutes)	<ul style="list-style-type: none"> • Interpret a recorded partograph (3 50 to 3 58) • Use case studies (3 62 to 3 64) IDENTIFY PROBLEMS /NEEDS of a woman and her baby during labor and TAKE NEEDED ACTION 	Module 3	Ability to identify abnormal labor progress
Clinical practice sessions and On call	<ul style="list-style-type: none"> • Manage the labor of a woman and record the findings using the partograph (3 32 to 3 35) • Manage 2nd stage of labor and record the findings using the partograph (3 66 to 3 68) • Record the outcome of delivery (3 49) • Explain importance of progress in labor for healthy outcomes of the mother and baby (3 24) 	Intrapartum clients, partograph, equipment for monitoring labor (3 10) and 3rd stage (5 12)	Ability to manage labor and record findings

Supply and Equipment Issues

The equipment used in this lesson can be produced locally. Partograph forms can be printed locally. Clean copies for photocopying can be found in your module (3.59 to 3.60). It is important that forms are available in large quantity for practice. Teaching practice filling out the partograph in the classroom is necessary before practicing in the clinical area. Straight lines can be drawn on the forms with the use of rulers, a piece of cardboard, or other straight edge.

In some places large partograph form models have been made by painting the form onto a large chalkboard. It can then be used over and over. It can also be drawn on flipchart paper or cardboard and written on with colored chalk. This can be used only a few times. A large plasticized version of the partograph form can be purchased from the American College of Nurse-Midwives. See the front of the manual for mailing address.

Remind participants that these are skills that can save lives

Module Three

Monitoring Labor Progress

Learning Objectives:

The midwife caring for women during labor and delivery should be able to:

- 1. Admit a woman in labor, including:**
 - a. Take the labor history (ASK and LISTEN)**
 - b. Do a general physical examination, an abdominal examination and a vaginal examination (LOOK and FEEL)**

- 2. Write information from her findings (ASK, LISTEN, LOOK, FEEL) on the labor record including the partograph.**

- 3. Describe the latent and active phases of labor.**
- 4. Interpret a recorded partograph.**
- 5. IDENTIFY PROBLEMS/NEEDS of a woman and her baby during labor and TAKE NEEDED ACTION.**
- 6. Manage the labor of a woman during the second stage and record the findings.**
- 7. Record the outcome of delivery.**
- 8. Explain the importance of progress in labor for healthy outcomes of the mother and baby.**

Lesson Plan - Module Four Episiotomies and Repair of Lacerations

Learning Objectives (Also found in Module Four, page 4 1)

The midwife caring for mothers in labor and delivery will be able to

- 1 Name the two major types of episiotomies and explain how they differ
- 2 List signs and symptoms that indicate the need for an episiotomy
- 3 List signs and symptoms of vaginal and cervical lacerations
- 4 Perform a complete inspection of the cervix and vagina
- 5 Inject local anesthesia before doing an episiotomy
- 6 Cut and repair episiotomies
- 7 Repair a laceration
- 8 Explain to the mother the need for cutting an episiotomy performing a vaginal inspection, and/or repairing a laceration or episiotomy and obtain her consent

Trainer's Notes

This class as outlined is quite long. Notice how the group is doing. They may need a break. They may need more or less time than estimated. The class may be broken up by need to move into the clinical area to use all clinical learning opportunities. This lesson plan is just a guide to help the trainer organize this session. Be flexible about how it is taught. You may wish to break it into two. You may try it as outlined above and modify it after seeing how tired the trainees are when absorbing new material. How it goes will probably depend on how much of this material is completely new for trainees. Keep in mind that times in the clinical area when you are not busy is an excellent time to pick out a case study and review it. Your own experiences and case studies are also very important and make the training come alive for the trainees.

Introduction

In learning to cut and repair episiotomies and repair lacerations, midwives will likely have some background. They may have been allowed to cut episiotomies but not repair them, or they may have repaired them using out of date suturing techniques. Find out what the experience level of the group is before reviewing the content with them.

Sample questions you might want to ask are

- How many of you cut episiotomies in your clients?
- How many of you give local anesthesia before cutting the episiotomy?
- How many of you repair the episiotomy you have cut? How do you do it? What is your technique?
- How many of you have repaired more than 20 episiotomies this past year? More than 10? Less than 5?

This will help you to know the past experience and frequency with which this skill is practiced by the group. Keep your eye on those who have never or not recently practiced the skill. They may feel embarrassed or unconfident. You will want to monitor their progress carefully and give extra assistance as needed. Remember they are practicing midwives and may feel they should be very competent in this area. It will take an open, supportive environment to help them to declare openly when they need assistance.

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to all of the skills and plenty of opportunity exists for practice both on models and clinically. Remind trainees that they should bring their foam and instruments with them to clinical so that they can practice during quiet times.

Teaching Session Episiotomies and Repair of Lacerations

Teaching Method/Time	Content	Materials Needed	Evaluation
Group Discussion using review questions (4 33) (20 minutes)	<ul style="list-style-type: none"> •Define episiotomy (4 2) •Define two types of episiotomy (4 2) •Define laceration (4 2) •Discuss advantages and disadvantages of each for mother and infant (4 4 to 4 5) •Describe the signs and symptoms of how you know an episiotomy is needed (4 4), or that a laceration has already occurred (4 10) 	Module 4, chalkboard, chalk	Written responses to review questions Compare pretest and post test question
Discussion of routine vaginal inspection (10 minutes)	<ul style="list-style-type: none"> •Discuss the reasons for doing a thorough vaginal and cervical inspection on all women (with and without episiotomy) •Refer group to procedure outlines in the manual (4 11 to 4 12) 		
Demonstrate local infiltration of local anesthesia return demo (30 minutes)	Utilizing a square of sponge (foam rubber) demonstrate the technique to the participants the steps outlined on (4 6 to 4 8)	12 inch squares of sponge, needle and syringe (5 10 or 20 cc) for each person	Correct return demo of the skills in the classroom using the skills checklist
Demonstrate knot tying (30 minutes)	Demonstrate the steps of knot tying as outlined in the module (4 27 to 4 28)	Needle holder, curved needles, suture or thread, (may use expired suture for classroom practice)	Correct return demo of the skills in the classroom
Demonstrate mediolateral episiotomy repair return demo (60 minutes)	<ul style="list-style-type: none"> •Demonstrate how to repair a mediolateral episiotomy utilizing the step by step directions outlined in the module (4 13 to 4 19) •After completing the demonstration have individuals practice on their own foam (<i>More than one trainer will be needed to assist the trainees</i>) 	Sharp scissors thumb or tissue forceps sharp scissors, thumb or tissue forceps	Correct return demo of the skills in the classroom using the skills checklist
Clinical practice sessions and on call	Manage 2nd stage (3 66 to 3 68)		Correct return demo in the clinical areas using the skills checklist
	<ul style="list-style-type: none"> •Explain to the mother what you are doing, why, and obtain her consent •Demonstrate need for and cut, inspection, and repair a mediolateral episiotomy using the steps in the skills checklist (4 46 to 4 54) •Explain postpartum care to the mother •Evaluation of the episiotomy heals, oppose, and feels to the mother 	Equipment as listed (4 3)	Evaluation of episiotomy

Supply and Equipment Issues

Empty local anesthesia medicine bottles can be filled with water to simulate the experience without wasting local anesthesia (Make certain these bottles are boldly marked as having non-sterile water for classroom use only)

Knot tying can be done around a pencil bar on a bed frame, or any other stable slim object. Some trainees have difficulty seeing what they are trying to do and find it easier to start out with stout thread or yarn. Two strips of different colored yarn about 20 inches long can be knotted together and used to make a whole series of knots. The different colors allow the trainees to be clear about the order of motions needed.

It is expensive to use new suture in the classroom practice setting. However, inexpensive alternatives are not difficult. If you have expired suture, it may be used in the classroom for practice on sponge. You may also use strong thread, sometimes called coat thread, which can be put on a reusable curved needle. You might also try dental floss, hair dressing thread, or fine jewelry making thread.

Commercially made episiotomy repair models are extremely expensive, allow only one person to practice at a time, and break down quickly with heavy use. However, very inexpensive suturing models can be made from foam rubber such as that used in chair or sofa cushions. The foam can be cut in 12 inch squares with each midwife having her own practice foam. It is important that the trainer test out the quality of foam before purchasing a lot. Some foams appear durable, but the thread pulls through too easily and tears the sponge. Foam (sponge) comes in different grades and must be tested ahead. You may find this foam where furniture is made, upholstery shops, or sewing goods stores. For nice even edges, have the seller cut the foam for you in 10 to 12 inch squares. As the trainee continues to practice on her own foam, you are able to monitor her progress in spacing, placement, and tension of the suture and give feedback on progress.

Many trainers find it helpful to put all training supplies in a box several days before class so that all is in readiness. Make certain a second trainer is assigned to help with supervising trainees practicing. You may wish to divide the lesson and have two trainers teach parts.

Remind participants that these are skills that can save lives

Module Four

Episiotomies and Repair of Lacerations

Learning Objectives:

The midwife caring for mothers in labor and delivery will be able to:

- 1. Name the two major types of episiotomies and explain how they differ.**
- 2. List signs and symptoms that indicate the need for an episiotomy.**
- 3. List signs and symptoms of vaginal and cervical lacerations.**
- 4. Perform a complete inspection of the cervix and vagina.**

- 5. Inject local anesthesia before doing an episiotomy.**
- 6. Cut and repair episiotomies**
- 7. Repair a laceration.**
- 8. Explain to the mother the need for cutting an episiotomy, performing a vaginal inspection, and/or repairing a laceration or episiotomy, and obtain her consent.**

Lesson Plan - Module Five Prevention and Treatment of Hemorrhage

Learning Objectives (Also found in Module Five, page 5 3)

The midwife caring for women during labor and delivery will be able to

- 1 Ask questions regarding the woman's medical history, to determine her risk of hemorrhage (**ASK and LISTEN**)
- 2 Do abdominal and vaginal examinations to check for findings which alert her to the possibility of hemorrhage (**LOOK and FEEL**)
- 3 **IDENTIFY** problems/needs so she is able to take appropriate **ACTION**

Learning Objectives for Active Management of the Third Stage (Also found in Module Five, page 5 10)

- 1 Describe active management of the third stage
- 2 Deliver the placenta, using active management of the third stage
- 3 Explain the procedure(s) to the mother and others so they understand what is being done and why

Trainer's Notes

Worldwide hemorrhage remains the number one cause of maternal deaths. Hemorrhage also leaves women weak, susceptible to infection, and unable to enjoy and celebrate the birth of a child. Minimizing the loss of blood is one of the most important things a midwife can do. It is essential that each midwife practice the skills in this module until truly competent.

Introduction

Experienced midwives will come to the training with many good case studies for discussion as well as questions. In our experience active management of the third stage is one of the most intriguing and helpful skills for many of the midwives. If they are not used to putting traction on the cord, they may be quite fearful initially that they will pull the cord off. With practice as to proper amounts of traction confidence will grow. They will quickly be very impressed with the obvious clinical finding that women are indeed bleeding much less.

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to all of the skills and plenty of opportunity exists for practice both on the uterus models and clinically.

Learning Objectives for Manual Removal of the Placenta (Also found in Module Five page 5 18)

- 1 Define postpartum hemorrhage
- 2 Recognize signs and symptoms of the different causes of postpartum hemorrhage uterine atony (tired uterus), retained placenta, and vaginal and cervical lacerations
- 3 Record observations
- 4 Recognize the need for action and referral specific for the different causes
- 5 Manually remove a placenta
- 6 Explain to the mother and others the need for removal of a placenta and dangers of postpartum hemorrhage

Teaching Session Manual Removal of the Placenta

Teaching Method/Time	Content	Materials Needed	Evaluation
Discussion and review questions (60 minutes)	<p>Manual Removal of the Placenta</p> <p>1 Define postpartum hemorrhage (5 19)</p> <p>2 Use review questions on page 5 30 to discuss the signs and symptoms of the different causes of postpartum hemorrhage uterine atony (tired uterus), retained placenta, and vaginal and cervical lacerations</p>	Chalkboard, chalk, or newsprint Module 5	Compare the pretest and the post test Correct response to review questions
Case Study (60 minutes)	3 TAKE APPROPRIATE ACTION for shock uterine atony, retained placenta, laceration (5 22)	Case studies (5 66 to 5 72 and 5 79 to 5 80)	Ability to give good management plans to the case studies
Demonstration and return on models (30 minutes)	<p>4 Manually remove a placenta (5 23 to 5 29)</p> <p>5 Explain to the mother and others the need for removal of a placenta and dangers of postpartum hemorrhage (5 18)</p>	Soft pelvis, Placenta and membranes	Ability to demonstrate techniques on the models
Clinical practice and on call	Manually remove a placenta in theater (operating room) following c/section or when case presents in delivery room	Alert obstetricians, theater staff for access to clients	Satisfactory procedure using skills checklist (5 31 to 5 33)

Learning Objectives for Bimanual Compression of the Uterus (Also found in Module Five, page 5 34)

- 1 Define uterine atony and postpartum hemorrhage
- 2 Describe signs and symptoms of uterine atony
- 3 Describe signs and symptoms of postpartum hemorrhage
- 4 Record observations and actions
- 5 Identify the need for referral and refer
- 6 Perform bimanual compression
- 7 Explain to the mother and others the need for bimanual compression and the dangers of postpartum hemorrhage

Teaching Session Bimanual Compression of the Uterus

Teaching Method/Time	Content	Materials Needed	Evaluation
Group discussion and review questions (15 minutes)	<p>Bimanual Compression of the Uterus</p> <p>1 Define and describe signs and symptoms of uterine atony and postpartum hemorrhage (5 35)</p> <p>2 Describe signs and symptoms of uterine atony (5 36)</p>	Chalkboard, chalk or newsprint, Module 5	<p>Correct response to review questions</p> <p>Compare pretest and post test</p>
Case Study (45 minutes)	3 IDENTIFY THE PROBLEM, TAKE APPROPRIATE ACTION and refer (5 9)	Case study (5 73 to 5 78)	Correct responses
Demonstration and return in class and practice (30 minutes)	<p>4 Perform bimanual compression (5 37 to 5 40)</p> <p>5 Explain to the mother and others the need for bimanual compression and the dangers of postpartum hemorrhage (5 34)</p>	Cloth covered sponge rubber uterus model for bimanual compression	Return demo using skills checklist
Clinical experience and on call	Bimanual compression procedure	Equipment (5 37)	Satisfactory procedure according to skills checklist (5 44 to 5 48)

Learning Objectives for Manual Removal of Clots and Products of Conception (Also found in Module Five, page 5 49)

- 1 Define and recognize dilatation of the cervix.
- 2 Define and recognize postpartum or postabortion hemorrhage
- 3 Identify signs and symptoms of uterine atony, lacerations, and retained placenta, membranes or products of conception
- 4 Record observations and actions
- 5 Identify the need for referral and refer
- 6 Perform digital evacuation of the cervix
- 7 Explain to the woman and others the need for digital evacuation and the dangers of postpartum or postabortion hemorrhage

Teaching Session Manual Removal of Clots and Products of Conception

Teaching Method / Time	Content	Materials Needed	Evaluation
Trainer led group discussion using review questions (40 minutes)	<p>Use the review questions on page 5 57 to</p> <ol style="list-style-type: none"> 1 Define and recognize dilatation of the cervix (3 18 to 3 19) 2 Define and recognize postpartum or postabortion hemorrhage (5 50 to 5 51) 3 Review signs and symptoms of uterine atony, lacerations, and retained placenta, membranes, or products of conception (5 36) 4 Record observations and actions (5 55) 5 Identify the need for referral and refer (5 55) 	Module 3 and Module 5	Correct responses to review questions
Demonstration and return (30 minutes)	<ol style="list-style-type: none"> 6 Perform digital evacuation of the cervix (5 56) 7 Explain to the woman and others the need for digital evacuation and the dangers of postpartum or postabortion hemorrhage (5 49) 	Sponge rubber uterus model hollowed out and equipment (5 56)	Correct performance using the skills checklist
Clinical return demonstration and practice	<p>Following third stage</p> <ol style="list-style-type: none"> a Perform digital evacuation b Use the vaginal speculum for inspection 	Equipment (5 56)	Satisfactory performance using the skills checklist (5 58 to 5 61)

Supply and Equipment Issues

The equipment used in this lesson can be produced locally

Clinicians typically underestimate the amount of blood lost at all deliveries. To practice estimating blood loss a liter bottle covered with paper (so participants can not see how much is in the bottle) can be filled with varying amounts of colored water. This is then poured onto cloth and trainees are asked to estimate the amount of "blood lost". Half of a liter is postpartum hemorrhage. Red food dye is good for coloring the water. Other local dyes will work as well.

A model for bimanual compression of the uterus can be made from a large piece of foam rubber like that used to make the cushions used in many easy chairs. An outline of the large newly postpartum uterus is drawn on the foam rubber and then excess gradually trimmed away. The foam can then be covered with sturdy cloth to keep it clean and increase its life-span.

Likewise a foam rubber model can be used in demonstrating manual removal of the placenta and removal of products of conception. In this case the foam rubber is gradually hollowed out through a narrow section which becomes the cervix.

Remind participants that these are skills that can save lives

Module Five

Prevention and Treatment of Hemorrhage

Learning Objectives:

The midwife caring for women during labor and delivery will be able to:

- 1. Ask questions regarding the woman's medical history, to determine her risk of hemorrhage (ASK and LISTEN).**
- 2. Do abdominal and vaginal examinations to check for findings which alert her to the possibility of hemorrhage (LOOK and FEEL).**
- 3. IDENTIFY problems/needs so she is able to take appropriate ACTION.**

Active Management of the Third Stage

- 1. Describe active management of the third stage.**
- 2. Deliver the placenta, using active management of the third stage**
- 3. Explain the procedure(s) to the mother and others so they understand what is being done, and why.**

Manual Removal of the Placenta

- 1. Define postpartum hemorrhage.**
- 2. Recognize signs and symptoms of the different causes of postpartum hemorrhage: uterine atony (tired uterus), retained placenta, and vaginal and cervical lacerations.**
- 3. Record observations.**
- 4. Recognize the need for action and referral specific for the different causes.**
- 5. Manually remove a placenta.**
- 6. Explain to the mother and others the need for removal of a placenta and dangers of postpartum hemorrhage.**

Bimanual Compression of the Uterus

- 1. Define uterine atony and postpartum hemorrhage.**
- 2. Describe signs and symptoms of uterine atony.**
- 3. Describe signs and symptoms of postpartum hemorrhage.**
- 4. Record observations and actions.**
- 5. Identify the need for referral and refer.**
- 6. Perform bimanual compression.**
- 7. Explain to the mother and others the need for bimanual compression and the dangers of postpartum hemorrhage.**

Manual Removal of Clots and Products of Conception

- 1. Define and recognize dilatation of the cervix.**
- 2. Define and recognize postpartum or postabortion hemorrhage.**
- 3. Identify signs and symptoms of uterine atony, lacerations, and retained placenta, membranes, or products of conception.**
- 4. Record observations and actions.**
- 5. Identify the need for referral and refer.**
- 6. Perform digital evacuation of the cervix.**
- 7. Explain to the woman and others the need for digital evacuation and the dangers of postpartum or postabortion hemorrhage.**

Lesson Plan - Module Six Resuscitation

Learning Objectives (Also found in Module Six pages 6 1, 6 34, 6 52)

The midwife caring for the mother and baby will be able to perform infant resuscitation, adult resuscitation, and Heimlich Maneuver

Trainer's Notes

Many of the trainees may come to the training with experience with resuscitation of the infant. Many will likely have no experience with adult resuscitation and rarely with the Heimlich maneuver for choking. Many of the trainees may have learned infant resuscitation long ago, had little opportunity to practice under supervision, and use practices that are either dangerous or ineffective. It is important that plenty of opportunity be provided to talk out myths and misunderstandings regarding these topics. For some it is difficult to give up old and familiar practices. Some may become depressed or angry when they realize that lives could have been saved if only these skills had been known before.

It will be important to determine the recent experience and skill level. If may be necessary to go back and review anatomy and physiology in basic midwifery texts.

Introduction

If all of the group is experienced, some of these components may just be reviewed with much of the information drawn from the midwives themselves.

- Some questions to get started which may be helpful are
- How many of you resuscitate newborns in your practice?
- What are some of the techniques you have seen use in your practice or others which may not be helpful? (For example rapid bending of the infant, hold oxygen over the nose in non-breathing infant, dunking on cold water, rubbing with alcohol, etc.)
- How many of you use the APGAR score to determine the level of resuscitation required?
- How many of you record the one and five minute APGAR of newborns routinely?
- What is the APGAR of a stillborn?
- If an infant has a pulse of around 100 but is not breathing, what resuscitation would you do?
- If an infant has no pulse and is not breathing, what resuscitation would you do?
- What situations are most likely to require adult resuscitation?
- What are the things infants commonly choke on? Children? Adults?

Summary

This is a long class with lots of demonstrations and need for trainees to practice. You will need a second trainer to assist in helping trainees to practice on models. Depending on the size of your group, you may need to schedule smaller practice sessions so all get as much time as they need to practice on the models.

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to the new skills and plenty of opportunity exists for practice both on models and clinically. Remind trainees to bring their modules with them to the clinical area. Provide clinical opportunity for trainees to practice all of the resuscitation and newborn care techniques.

Learning Objectives for Infant Resuscitation (6 1)

- 1 Describe the care of the baby at birth
- 2 List the signs and symptoms of a baby that is having trouble living
- 3 Describe and demonstrate how to resuscitate a baby
- 4 List emergencies in the newborn that she must refer to the doctor

Teaching Sessions Infant Resuscitation

Teaching Method/Time	Content	Materials Needed	Evaluation
Trainer led discussion (45 minutes)	Discuss the care of the baby at birth (6 3 to 6 4) and emergencies in the newborn (6 18) which must be referred using the review questions on pages 6 21 to 6 22	Chalkboard, chalk, Module 6	Compare pretest and post test
Demonstration and return demonstration (90 minutes)	Describe and demonstrate care of newborn and how to resuscitate a baby (6 14)	Equipment (6 7), infant resuscitation model, disinfection solution to clean model	Skill in infant care and CPR return demonstrations with model using the skills checklists (6 30 to 6 33)
Case study	Identify the signs and symptoms of a baby that is having trouble living (6 6 to 6 13) using case studies on pages 6 23 to 6 29	Module 6 Case Studies	Correct responses
Clinical practice	Immediate care of newborn and infant resuscitation procedures	Equipment (6 7)	Satisfactory performance (6 30 to 6 33)

Learning Objectives for Adult Resuscitation (6 34)

- 1 Describe and demonstrate the actions she will take to help a person who is not breathing but does have a heart beat
- 2 List the signs and symptoms of a person who has no heart beat and is not breathing
- 3 Demonstrate the appropriate actions to save the life of a person who has no heart beat and is not breathing

Learning Objectives to Prevent Death by Choking -- Heimlich Maneuver (6 52)

- 1 List the signs and symptoms of a person who is choking
- 2 Describe and demonstrate the appropriate actions to take to help a person who is choking

Teaching Session Adult Resuscitation and Prevent Death by Choking -- Heimlich Maneuver

Teaching Method/Time	Content	Materials Needed	Evaluation
Trainer led discussion (20 minutes)	Use review questions (6 46 to 6 47) to discuss the adult resuscitation	Module 6	Correct responses
Demonstration return demonstration (90 minutes)	<ol style="list-style-type: none"> 1 Demonstrate and discuss actions to help a person who is not breathing but does have a heart beat (6 37 to 6 39) 2 Discuss the signs and symptoms of a person who has no heart beat and is not breathing 3 Demonstrate the appropriate actions to save the life of a person who has no heart beat and is not breathing (6 40 to 6 42) 	Adult resuscitation model cleaning solution such as alcohol or soapy water	Correct performance in doing return demonstration for adult CPR, and treatment for choking using the skills checklist
Trainer led discussion (15 minutes) Demonstration return demonstration (60 minutes)	<ol style="list-style-type: none"> 1 Define Heimlich Maneuver 2 Discuss the signs and symptoms of a person who is choking using the review questions on page 6 58 3 Describe and demonstrate the appropriate actions to take to help a person who is <ul style="list-style-type: none"> • <i>choking and is conscious</i> on page 6 54 to 6 55, and • <i>unconscious</i> on page 6 55 to 6 57 	Adult resuscitation model	

Supply and Equipment Issues

Commercially made infant and adult resuscitation models are very helpful and durable with excellent care. They are however very expensive. Local models however have been made using the trainers' creativity and initiative.

Appropriate models may be purchased by contacting your local teaching models company or

Anatomical Chart Co
8221 Kimball Avenue
Skokie, Illinois 60076-2956 USA fax 847-674-0211

NASCO
901 Janesville Avenue
Fort Atkinson, Wisconsin 53538-0901 USA phone 414-563-2446, fax 414-563-8296

Laerdal Medical Corp
167 Myers Corners Road
P O Box 1840
Wappingers Falls, NY 12590-8840 USA Phone 1-800-431-1055, fax 800-227-1143

Health Edco or Childbirth Graphics, A Division of WRS Group, Inc
P O Box 21270
Waco, TX 76702-1207 USA Phone 1-800-299-3366, fax 888-977-7653

Remind participants that these are skills that can save lives.

Module Six Resuscitation

Learning Objectives:

The midwife caring for the mother and baby will be able to perform:

Infant Resuscitation

- 1. Describe the care of the baby at birth.**
- 2. List the signs and symptoms of a baby that is having trouble living.**
- 3. Describe and demonstrate how to resuscitate a baby.**
- 4. List emergencies in the newborn that she must refer to the doctor.**

Adult Resuscitation

- 1. Describe and demonstrate the actions she will take to help a person who is not breathing but does have a heart beat.**
- 2. List the signs and symptoms of a person who has no heart beat and is not breathing.**
- 3. Demonstrate the appropriate actions to save the life of a person who has no heart beat and is not breathing.**

Prevent Death by Choking (Heimlich Maneuver)

- 1. List the signs and symptoms of a person who is choking.**
- 2. Describe and demonstrate the appropriate actions to take to help a person who is choking.**

Lesson Plan - Module Seven Prevention and Treatment of Sepsis

Learning Objectives (Also found in Module Seven, page 7 1)

The midwife caring for women and babies during and after pregnancy will be able to

- 1 Define sepsis in mother and baby
- 2 Take a history (**ASK and LISTEN**) and do a physical examination (**LOOK and FEEL**) according to signs and symptoms of mother and/or baby
- 3 Recognize signs and symptoms of chorioamnionitis postpartum infections and postpartum infections associated with lost pregnancy
- 4 Recognize signs and symptoms of sepsis and tetanus in the newborn and the mother
- 5 Take appropriate action to help the woman and/or baby live including preventive actions, giving treatment, and referring to a doctor when needed
- 6 Use universal precautions for infection protection at all times

Trainer's Notes

Though all of the trainees will be experienced in hand washing, gloving, and some aspects of equipment care, it is common for short cuts and carelessness to make standards of practice low. In this era of Hepatitis B, HIV/AIDS, and emerging infections resistant to current drugs, it is critical that we review these standards and keep our practice on a very high level. This is protection for the midwife, her staff of assistants and cleaners, clients, and the community.

Introduction

This class can be conducted in a number of interesting ways. After an introductory session on sepsis, how to recognize it and how to treat it, you may wish to go to the postpartum nursery, or gynecologic wards to review charts, identify signs and symptoms of infection, physically check the patient's progress, and review of adequacy of the treatment regime.

If that proves difficult or there are no patients with infections available, small groups can work on case studies.

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to the new skills and plenty of opportunity exists for practice in labor and delivery and on the wards. Remind trainees to bring their modules with them to clinical practice all the time. When labor and delivery is quiet, they should be urged to make infection rounds on the wards to identify problems and monitor patient progress seeing how they respond to the treatment regime.

Teaching Session Prevention and Treatment of Sepsis

Teaching Method/ Time	Content	Materials Needed	Evaluation
Trainer led discussion and use review questions on pages 7 47 to 7 51 questions one to twelve (30 minutes)	Define sepsis in mother and baby (7 4) Discuss a signs and symptoms of chorioamnionitis, postpartum infections, and postpartum infections associated with lost pregnancy b signs and symptoms of sepsis and tetanus in the newborn and the mother c take a history (ASK and LISTEN)	Chalkboard, chalk, Module 7	Compare pretest and post test
Demonstration and return demonstration (20 minutes)	Do a physical examination (LOOK and FEEL) (7 6 to 7 8) temperature, breasts uterus, lower abdomen, legs, kidneys genitalia	Alert antenatal and postpartum unit staff of client demonstration	Satisfactory performance (Use reference if needed) ¹³
Case studies on pages 7 52 to 7 59 (60 minutes)	IDENTIFY PROBLEMS AND TAKE APPROPRIATE ACTION to help the woman and/or baby live, including preventive actions, giving treatment and referring to a doctor when needed	Module 7 case study	Satisfactory responses in problem solving case study discussions
Discussion (10 minutes)	Use universal precautions for infection protection at all times use review questions 13 and 14 on page 7 51	Module 7	Correct responses
Demonstration and return demonstration (90 minutes)	Practice infection prevention in the classroom or clinical area a hand washing (7 26) b glove use (7 26) c infection prevention steps (7 28 to 7 29) d high-level disinfection of equipment (7 30) e care of gloves (7 35 to 7 41) f waste disposal (7 32)	Equipment gloves glove wrappers, bread bag or other glove substitute Soap and water for hand washing Decontamination cleaning, and high-level disinfection equipment Notify staff in antenatal, labor, delivery and postpartum units of class visits	Satisfactory performance in classroom and clinic area of infection prevention return demonstration using skills checklists (7 62 to 7 68)

¹³Beck D et al (1998) *Healthy Mother and Healthy Newborn Care* antenatal and postpartum examination checklists

Supply and Equipment Issues

Equipment for decontamination and high level disinfection need not be expensive. Plastic bowls and buckets found in markets worldwide are quite effective. Gloves and local glove wrappers (either paper or cloth) are used to demonstrate proper gloving and glove removal for decontamination. Where the supply of gloves is lacking or irregular glove substitutes (such as bread bags) should be demonstrated.

Refer to the module for the guidelines on disinfectants and procedure (Learning Aid 2 page 7 35, Learning Aid 3 page 7 42 and in Module 10 Learning Aid 4 page 10 60)

Remind participants that these are skills that can save lives

Module Seven

Prevention and Treatment of Sepsis

Learning Objectives:

The midwife caring for women and babies during and after pregnancy will be able to:

- 1. Define sepsis in mother and baby.**
- 2. Take a history (ASK and LISTEN) and do a physical examination (LOOK and FEEL) according to signs and symptoms of mother and/or baby.**
- 3. Recognize signs and symptoms of chorioamnionitis, postpartum infections, and postpartum infections associated with lost pregnancy.**

- 4. Recognize signs and symptoms of sepsis and tetanus in the newborn and the mother.**
- 5. Take appropriate action to help the woman and/or baby live, including preventive actions, giving treatment, and referring to a doctor when needed.**
- 6. Use universal precautions for infection protection at all times.**

Lesson Plan - Module Eight Hydration and Rehydration

Learning Objectives (Also found in Module Eight, page 8 1)

The midwife caring for mothers will be able to

- 1 Describe normal daily fluid needs
- 2 Define shock and dehydration
- 3 Identify common causes of shock and dehydration in mothers
- 4 Record observations of hydration status
- 5 Identify signs that indicate a need for referral
- 6 Identify the best intravenous solution to use in a specific emergency situation, and the amount to be given
- 7 List potential dangers of giving fluids intravenously (in the vein)
- 8 Describe and demonstrate how to give intravenous fluid
- 9 Describe and demonstrate how to give fluid in the rectum
- 10 Describe and demonstrate how to give intraperitoneal fluid

Trainer's Notes

Many of the trainees may come to the training with experience with starting intravenous solutions or making oral rehydration solution for dehydration. It will be important to determine the recent experience and skill level of trainees prior to giving a long class which may be too introductory for them.

Introduction

If all of the group is experienced, these components may just be review with much of the information drawn from the midwives themselves.

Some questions which may be helpful are

- How many of you have started intravenous fluids? Made oral rehydration solution (ORS)?
- How many times have you performed these skills in the past six months?
- What problems have you encountered in performing these skills?
- Have you ever given fluids by way of the peritoneum or rectum? Describe what the situation was and how you dealt with it.

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to the new skills and plenty of opportunity exists for practice both on models and clinically. Remind trainees to bring their modules with them to the clinical area. Provide clinical opportunity for trainees to practice making ORS and for starting intravenous fluids if they are not already skilled.

Teaching Session Hydration and Rehydration

Teaching Method/Time	Content	Materials Needed	Evaluation
Trainer led discussion using review questions (8 22 to 8 24) (30 minutes)	Discuss a normal daily fluid needs (8 1 to 8 2) b shock and dehydration (8 3) c common causes of shock and dehydration in mothers (8 4) d observations of hydration status (8 4 to 8 5) e potential dangers of giving fluids in the vein (8 12)	Module 8, chalkboard, chalk	Compare pretest and post test Correct responses demonstrated in review question discussions
Case Study (60 minutes)	IDENTIFY PROBLEMS/NEEDS AND TAKE APPROPRIATE ACTION a Identify signs that indicate a need rehydration and for referral (8 5) b Identify the best intravenous solution to use in a specific emergency situation, and the amount to be given (8 17 to 8 18)	Module 8, case study (8 25 to 8 28)	Satisfactory responses in the problem solving steps
Discussion/ demonstration and return demonstration (30 minutes)	Describe and demonstrate how to a make your own oral rehydration fluids (8 19 to 8 20) b how to give intravenous fluid (8 7 to 8 11) c how to give fluid in the rectum (8 13 to 8 14) d how to give intraperitoneal fluid (8 15 to 8 16)	• Oral rehydration equipment (8 19 and 8 20) • IV equipment (8 7) • Intrapertoneal equipment (8 15) • Rectal infusion equipment (8 13)	Correct demonstration using the skills checklist (8 29 to 8 35)
Clinical practice and on call	For clinical practice participants can practice giving oral rehydration and starting infusions on each other or in the clinical site	Equipment on page 8 7	Satisfactory performance using the skills checklists
Optional demonstration on a model (30 minutes)	Giving infusions by rectum and intraperitoneal are rare clinical experiences and will be discussed and practiced only in the classroom, according to need	Optional enema tubing and can	Correct performance using the skills checklists
Optional Discussion (30 minutes)	Convulsion care (8 21)	Module 8	Satisfactory responses during discussion

Supply and Equipment Issues

Remember that though in the module there are specific recommendations regarding what type of fluids are preferable for intravenous and intraperitoneal use. In a serious emergency use whatever fluids are available. Oral rehydration solution (ORS) should be made with the cleanest water available. Fluids given by rectum need be only clean, not sterile.

Remind participants that these are skills that can save lives

Module Eight Hydration and Rehydration

Learning Objectives:

The midwife caring for mothers will be able to:

- 1. Describe normal daily fluid needs.**
- 2. Define shock and dehydration.**
- 3. Identify common causes of shock and dehydration in mothers.**
- 4. Record observations of hydration status.**

- 5. Identify signs that indicate a need for referral.**
- 6. Identify the best intravenous solution to use in a specific emergency situation, and the amount to be given.**
- 7. List potential dangers of giving fluids intravenously (in the vein).**
- 8. Describe and demonstrate how to give intravenous fluid.**
- 9. Describe and demonstrate how to give fluid in the rectum.**
- 10. Describe and demonstrate how to give intraperitoneal fluid.**

Lesson Plan - Module Nine Vacuum Extraction

Learning Objectives (Also found in Module 9, page 9 1)

The midwife caring for a mother during delivery will be able to

- 1 List indications for using the vacuum extractor
- 2 Prepare the vacuum extractor for use
- 3 Explain to the mother and others the need for vacuum extraction
- 4 List situations in which vacuum extractions should not be used
- 5 Describe potential dangers for mother and baby when the vacuum extractor is used
- 6 Explain the procedure for performing vacuum extraction
- 7 Use the vacuum extractor to help a mother deliver her baby
- 8 Demonstrate good care and cleaning of the vacuum extractor

Trainer's Notes

The midwives may have various types of vacuum extractors available to them in their own practice or hospitals. If more than one type is in use, try to have them available for practice. Participants often find this content completely new and enjoy this class very much. They should be assured that the equipment will be available in the delivery unit as well for them to practice their skills prior to clinical practice.

Introduction

In learning about vacuum extraction midwives may have knowledge of only forceps and some will have familiarity with both. Find out the level of experience of the group.

Sample questions you might want to ask are

- How many of you have performed vacuum extraction in your own practice?
- How many total do you think you have performed?
- For those of you who have not had direct experience, have you ever seen it done?
- What type of extractor(s) have you used?

Summary

At the end of the lesson it is important that you again allow time for questions. Reassure trainees that today was an introduction to the new skills and plenty of opportunity exists for practice both on models and clinically. Remind trainees to bring their modules with them to the clinical area and the vacuum extractor and baby doll model will be made available for their practice in quiet times.

Teaching Session Vacuum Extraction

Teaching Method/Time	Content	Materials Needed	Evaluation
Group Discussion and Review Questions (20 minutes)	<ul style="list-style-type: none"> List indications and conditions for using the vacuum extractor (9 4) List situations in which vacuum extractions should not be used (9 5) Explain the procedure for performing vacuum extraction (9 6) Discuss how to inform the mother and others of the need for vacuum extraction and what to expect (9 6) 	Review Questions (9 18 to 9 19), chalkboard, chalk	<p>Compare pretest and post test</p> <p>Correct responses in discussion and review questions</p>
Demonstration and return demonstration (60 minutes)	<p>Demonstrate</p> <ul style="list-style-type: none"> how to prepare the vacuum extractor for use (9 11 to 9 15) application and removal of cup Have participants practice in pairs raising the pressure to safe delivery levels utilizing scalp cup on each other's arms vacuum extractor delivery using doll and pelvis model (9 6 to 9 10) 	Module 9, Equipment (9 6), Delivery doll model, Bony pelvis model	Correct performance using skills checklist (9 20 to 9 22)
Trainer led demonstration (15 minutes)	<p>Demonstrate care and cleaning of the vacuum extractor (9 17)</p> <p>Refer to the infection prevention steps (7 28 to 7 30)</p>	Module 7 and 9, Vacuum extractor, Infection prevention equipment	Correct demonstration using the skills checklist (9 21 to 9 22 and 7 62 to 7 64)
Optional video (23 minutes), Discussion (10 minutes)	Show video tape on vacuum extraction Ask for impressions and questions after showing	Video machine with TV monitor, tape compatible with PAL or NTSC, extension cord	
Clinical practice and on call	Use the vacuum extractor to help a mother deliver her baby	Alert delivery unit staff (doctors and midwives) to need of clients	Satisfactory performance using skills checklist
	Optional Have participants practice during births of appropriate candidates		

Supply and Equipment Issues

A video of how to use the non-electric, hand held vacuum pumps with flexible plastic cups (CMI, Mityvac or Silastic) available in NTSC or PAL format cost \$20 00 USD lasts 23 minutes, English only can to obtained from

Columbia Medical and Surgical Inc
PO Box 5877
Bend Oregon 97708-5877 USA phone 503-388-0347, fax 503-382-2978

Many programs will have bony pelvis and infant doll models in their schools of midwifery, medicine, or nursing If you do not have these models you may be able to borrow them locally For those wishing to purchase these models or others several sources are

Anatomical Chart Company
8221 Kimball Avenue
Skokie, Illinois 60076-2956 USA
fax 847-674-0211

Health EDCO or Childbirth Graphics
WRS Group, Inc
PO Box 21207
Waco, Texas 76702-1207 USA
fax 817-751-0221

NASCO Health Care Educational Materials
901 Janesville Avenue
Fort Atkinson, Wisconsin 53538-0901 USA
fax 414-563-8296

Remind participants that these are skills that can save lives

Vacuum Extraction

Learning Objectives:

The midwife caring for a mother during delivery will be able to:

- 1. List indications for using the vacuum extractor.**
- 2. Prepare the vacuum extractor for use.**
- 3. Explain to the mother and others the need for vacuum extraction.**
- 4. List situations in which vacuum extractions should not be used.**

- 5. Describe potential dangers for mother and baby when the vacuum extractor is used.**

- 6. Explain the procedure for performing vacuum extraction.**

- 7. Use the vacuum extractor to help a mother deliver her baby.**

- 8. Demonstrate good care and cleaning of the vacuum extractor.**

Lesson Plan - Module Ten Other Emergencies

Learning Objectives - Labor and Delivery Problems (found on page 236), **Postabortion Care** (found on page 237), and **Symphysiostomy** (found on page 239)

Trainer's Notes

This module is a combination of three distinct topics - labor and delivery problems, postabortion care, and symphysisiotomy. They are taught separately. The topic of **labor and delivery problems** is covered in all basic midwifery education programs. However, as clinicians gain experience many questions arise. Other clinicians may have not had the opportunity to handle such cases for some time. Thus a refresher using models and the opportunity to sit with other experienced clinicians to share bits of wisdom is very valuable. It is helpful to keep the pelvic and baby models in the clinical areas so that trainees can practice hand maneuvers when labor and delivery is quiet.

Keep in mind that times in the clinical area when you are not busy is an excellent time to pick out a case study and review it. Your own experiences and case studies are also very important and make the training come alive for the trainees.

The second area, **postabortion care** including the use of the Manual Vacuum Aspirator may be quite new for many midwives. Midwives who are not experienced in doing pelvic examinations in early pregnancy or speculum examinations will need more time to master these skills. This material may be offered in a training of its own, or integrated into a complete Life-Saving Skills training program.

The third section of this module deals with **symphysisiotomy**. This is a life-saving procedure and continues to have great merit in parts of the world where access to safe cesarean section is not possible. Where needed, midwives trained in the procedure have proven to be highly competent. In teaching this section, it is important to have a trainer well experienced in this less common technique. The number of complications seen with this technique is directly related to the experience of the clinician.

Introduction

In talking about giving quality intrapartum and postabortion care, the trainees are likely to come with quite a bit of experience. It might be helpful to start by asking them what are the barriers they encounter in practice to giving even better care. You, the trainers, will learn practical information which will help you to keep the class realistic and focused.

Summary

At the end of the lesson, it is important that you again allow time for questions. Reassure trainees that today was an introduction to all of the skills and plenty of opportunity exists for practice both on each other and clinically.

Learning Objectives - Labor and Delivery Problems (Also found in Module Ten page 10 2)

The midwife caring for a mother in labor and delivery will be able to

- 1 Identify abnormal positions or presentations, including occiput posterior position, face presentation breech presentation transverse lie presentation, incomplete rotation of the shoulders and multiple pregnancy
- 2 Describe the management of each abnormal position or presentation
- 3 Describe and outline the action that must be taken for uterine inertia (tired uterus) and umbilical cord prolapse

Teaching Session Labor and Delivery Problems

Teaching Method/Time	Content	Materials Needed	Evaluation
Use review questions for group discussion (60 minutes)	Identify and discuss management of labor and delivery problems	Module 10 review questions (10 24 to 10 25) Chalkboard chalk	Compare pretest and post test
Demonstration and return demonstration (60 minutes)	Describe and demonstrate the management of a Umbilical cord prolapse (10 7 to 10 9) b Uterine inertia (10 10 to 10 11) c Occiput posterior position (10 4 to 10 6) d Shoulder dystocia (10 12 to 10 15) e Breech presentation (10 16 to 10 19)	Models pelvis, fetus, and placenta	Ability to perform correctly with models using the skills checklists in the classroom setting
Clinical practice and on call	Labor and delivery problems are not common clinical experiences trainees are encouraged to be "on call" for these problems --even to observe Class is always interrupted for these experiences Individuals practice as needed on models	Alert labor and delivery staff to the need for clients with labor and delivery problems	Satisfactory performance using skills checklists
Optional Discussion and demonstration (30 minutes)	Discuss and demonstrate oxytocin infusion procedure	Module 10 (10 21 to 10 23)	Satisfactory performance
Optional Discussion (15 minutes)	Assist at emergency blood transfusion	Module 10 (10 95 to 10 96)	Satisfactory response
Optional Discuss and demonstrate (60 minutes)	First assist at Cesarean Section • Preparation of mother (10 97) • Preparation of equipment in operating room or theater (10 98 to 10 99) • Procedure to assist (10 99 to 10 101) • Postoperative care of mother (10 101)	Equipment 10 98	Satisfactory return demonstration

Learning Objectives - Postabortion Care (Also found in Module Ten, page 10 43)

The midwife caring for a mother in labor and delivery will be able to

- 1 Identify possible problems with incomplete abortion and hemorrhage from the medical history (ASK and LISTEN) and vaginal examination (LOOK and FEEL)
- 2 Identify problems/needs of a woman with incomplete abortion and take appropriate ACTION including appropriate referral
- 3 Explain to the woman and her family the need for using the Manual Vacuum Aspiration (MVA) in incomplete abortion care, and the dangers of hemorrhage and infection
- 4 Perform the step-by-step procedure and safely use the MVA for incomplete abortion
- 5 Record progress of vital signs during the MVA procedure, type and amount of fluids given, estimated blood loss, products of conception, and medication given
- 6 Describe how she will do postabortion follow-up and family planning counseling
- 7 Demonstrate infection prevention practices that reduce disease transmission to clients, family, midwives, and other health care staff, including cleaners

Teaching Session Postabortion Care

Teaching Method/Time	Content	Materials Needed	Evaluation
Group discussion (60 minutes)	Review <ul style="list-style-type: none"> • normal anatomy and physiology of reproductive system • find the cause of bleeding (5 3) • digital evacuation skill (5 56) • intra-abdominal bleeding (5 62) • infection associated with abortion (7 9) • infection prevention practices that reduce disease transmission to clients, family, midwives, and others health care staff, including cleaners (7 25 to 7 33) 	Midwifery text, Module 5 and 7	Correct responses to questions
Group discussion (60 minutes)	Discuss <ol style="list-style-type: none"> a Medical history (ASK and LISTEN) and vaginal examination (LOOK and FEEL) to identify incomplete abortion and hemorrhage (10 10 45 to 10 46) b IDENTIFY PROBLEMS/NEEDS of a woman with incomplete abortion and TAKE APPROPRIATE ACTION, including appropriate referral (10 47) 	Module 10 review questions 10 69 to 10 71	Correct responses to review questions
Role play, demonstration and return demonstration (90 minutes) Individual practice in classroom	<i>Preparation</i> including <ul style="list-style-type: none"> • explain to the woman and her family the need for using the Manual Vacuum Aspiration (MVA) in incomplete abortion care, and the dangers of hemorrhage and infection • prevent infection • MVA instruments ready • management of pain • vaginal examination • prepare the woman(10 48 to 10 51) 	Role play script for explanation MVA Instrument Kit (10 60)	Correct procedure on return role play and demonstration according to skills checklist (10 72 to 10 73)

Teaching Session Postabortion Care (continued)

Teaching Method/Time	Content	Materials Needed	Evaluation
Clinical demonstration and return demonstration (60 minutes)	Perform the step-by-step procedure and safely use the MVA for incomplete abortion (10 52 to 10 56)	MVA Kit, Equipment and Supplies (10 60 to 10 61)	Satisfactory return demo using the skills checklists (10 73 to 10 75)
Clinical demonstration and return demonstration (30 minutes) Role play for practicing postabortion family planning (60 minutes)	Monitoring the woman's recovery including postabortion family planning (10 57 to 10 58) Record progress of vital signs during the MVA procedure, type and amount of fluids given, estimated blood loss, products of conception, and medication given (10 56)	B/P apparatus, anemia testing procedure, records, family planning materials	Satisfactory performance using the skills checklists (10 74 to 10 75)
Clinical practice	Perform the procedure and safely use the MVA for incomplete abortion, monitor record	Equipment (10 60 to 10 61)	Satisfactory performance, skills checklists (10 73 to 10 75)
Demonstration and return demonstration (60 minutes)	Care of MVA Equipment (10 64 to 10 65 and 7 25)	Equipment and infection prevention equipment	Correct demo care / infection prevention
Optional Discussion and demonstration (60 minutes)	<ul style="list-style-type: none"> • High-level disinfection of instruments • Preparing dilute chlorine solutions • Chemicals for sterilizing MVA instruments 	Module 10 (10 61 to 10 63)	Correct responses to questions Correct return demonstration
Optional Demonstration / Discussion (60 minutes)	Management of MVA equipment problems and complications	Module 10 (10 66 to 10 67)	Correct return demonstration
Optional Demonstration / Discussion (60 minutes)	How to administer paracervical block (10 68 to 10 69)	MVA Equipment, 10 to 20 ml syringe 3 5 cm 22/25 gauge needle, anesthetic	Satisfactory demo in clinical area

Learning Objectives - Symphysiotomy (Also found in Module Ten, 10 76)

The midwife caring for a mother in labor and delivery will be able to

- 1 List and recognize the indications for doing a symphysiotomy
- 2 Demonstrate how to position the mother for a symphysiotomy
- 3 Explain to the mother and others the need for symphysiotomy
- 4 List the contraindications of a symphysiotomy
- 5 Explain the dangers for the mother when doing a symphysiotomy
- 6 Describe the procedure for symphysiotomy
- 7 Do a symphysiotomy to help a mother deliver her baby
- 8 Give postpartum care to a woman after symphysiotomy

Teaching Session Symphysiotomy

Teaching Method/Time	Content	Materials Needed	Evaluation
Group discussion using the review questions (45 minutes)	Discuss <ul style="list-style-type: none"> • indications and need for doing a symphysiotomy (10 80 to 10 81) • contraindications and dangers for the mother when doing a symphysiotomy (10 82) • describe the procedure for symphysiotomy (10 83 to 10 87) 	Module 10 review questions (10 89 to 10 91)	Correct responses to review questions
Demonstration and return demonstration (45 minutes)	Demonstrate how to position the mother for a symphysiotomy	Module 10 (10 88)	Correct return demonstration
Review using model (30 minutes)	<ul style="list-style-type: none"> • Measurement of diagonal conjugate • Normal cephalopelvic proportion • Cephalopelvic disproportion • Normal female pelvis 	Module 10 (10 77 to 10 79), model of baby, pelvis, and placenta	Satisfactory responses
Case study (20 minutes)	Read and discuss a <i>midwife's experience</i> on page 10 77 <ul style="list-style-type: none"> • what were the indications for doing a symphysiotomy? • who assisted with the position? • what additional management was given? 	Module 10	Satisfactory responses to questions
Demonstration and return demonstration on model (60 minutes)	<ul style="list-style-type: none"> • perform a symphysiotomy to help a mother deliver her baby (10 83 to 10 87) • postpartum care to a woman after symphysiotomy (10 87) 	Pelvic model, scalpel and scapel blade, sterile urinary catheter, gloves	Satisfactory response using skills checklist (10 92 to 10 94)
Clinic practice and on call	A symphysiotomy is a rare clinical experience. It is an emergency, surgical, life-saving procedure when done by a skilled and experienced midwife or doctor. Update your skills on a model--be ready.	Equipment (10 83)	Individual practice using skills checklist for review

Supply and Equipment Issues

Supplies and equipment commonly found in labor and delivery rooms are needed for the class segments on labor and delivery problems, and symphysiotomy. Manual Vacuum Aspiration equipment can be obtained from medical supply companies or from IPAS, Carrboro, North Carolina, USA.

Remind participants that these are skills that can save lives

Module Ten Other Emergencies

Learning Objectives:

The midwife caring for a mother in labor and delivery will be able to:

Labor and Delivery Problems

- 1. Identify abnormal positions or presentations, including occiput posterior position, face presentation, breech presentation, transverse lie presentation, incomplete rotation of the shoulders and multiple pregnancy.**
- 2. Describe the management of each abnormal position or presentation.**
- 3. Describe and outline the action that must be taken for uterine inertia (tired uterus) and umbilical cord prolapse.**

Postabortion Care

- 1. Identify possible problems with incomplete abortion and hemorrhage from the medical history (ASK and LISTEN) and vaginal examination (LOOK and FEEL).**
- 2. Identify problems/needs of a woman with incomplete abortion and take appropriate ACTION, including appropriate referral.**
- 3. Explain to the woman and her family the need for using the Manual Vacuum Aspiration (MVA) incomplete abortion care, and the dangers of hemorrhage and infection.**
- 4. Perform the step-by-step procedure and safely use the MVA for incomplete abortion.**

- 5. Record progress of vital signs during the MVA procedure, type and amount of fluids given, estimated blood loss, products of conception, and medication given.**
- 6. Describe how she will do post abortion follow-up and family planning counseling.**
- 7. Demonstrate infection prevention practices that reduce disease transmission to clients, family, midwives, and other health care staff, including cleaners.**

Symphysiotomy

- 1. List and recognize the indications for doing a symphysiotomy.**
- 2. Demonstrate how to position the mother for a symphysiotomy.**
- 3. Explain to the mother and others the need for and the dangers of a symphysiotomy.**
- 4. List the contraindications of a symphysiotomy.**
- 5. Describe the procedure for symphysiotomy.**
- 6. Do a symphysiotomy to help a mother deliver her baby.**
- 7. Give postpartum care to a woman after symphysiotomy.**

TRAINING NEEDS ASSESSMENT FORM ¹⁴

TRAINING NEEDS ASSESSMENT PART I - BASELINE INFORMATION

INTERVIEWER NUMBER _____ QUESTIONNAIRE NUMBER _____ DATE OF INTERVIEW _____

1 NAME _____ 2 AGE _____
 3 HOME ADDRESS _____
 4 EDUCATIONAL BACKGROUND _____
 5 HOW LONG WILL YOU STAY AT THE WORK SITE YOU ARE NOW _____ (YEARS)
 6 DISTRICT _____ 7 VILLAGE _____
 8 NAME AND ADDRESS OF FACILITY _____

9 NAME AND ADDRESS OF SECOND JOB (IF HAVE ONE) _____

10 POSITION OF PERSON BEING INTERVIEWED (CIRCLE ONE)
 Midwife (a) Physician (b) Other _____ (c)

11 TYPE OF FACILITY (CIRCLE ONE)
 Regional Hospital (a) District Hospital (b) Clinic with Beds (c)
 Clinic without beds (d) Clinic (e) Village Maternity Home (f)
 Private Maternity Home (g) Midwifery Practice (h)

12 (ANSWER ONLY IF RESPONSIBLE FOR SUPERVISING A MIDWIFE)
 A HOW MANY MIDWIVES DO YOU SUPERVISE (Give names and location)

B HOW MANY MIDWIVES CAN VISIT YOU TRAVELING UP TO 2 HOURS TO REACH YOU?
 (Give names and location)

¹⁴ Adapted from Beck, D Annas Y (1995) Training Needs Assessment

250

TRAINING NEEDS ASSESSMENT PART II - STATISTIC

1 Number of Patients Seen For Per Month Last Year (if worked less than 1 year state number months)

	Per Month	Last Year (if worked less than 1 year state number months)
A Antenatal New		
B Antenatal Revisit		
C Deliveries		
D Postpartum		
E Family Planning		
F Child Care		
G General Health Services		
H Postabortion Care		

2 Number of Referrals Per Month Last Year (if worked less than 1 year state number months)

	Per Month	Last Year (if worked less than 1 year state number months)
A ANTENATAL		
1 From Midwife to Hospital		
2 From Midwife to Clinic		
3 From Midwife to Midwife (answer only if midwife)		
B LABOR AND DELIVERY		
1 From Midwife to Hospital		
2 From Midwife to Clinic		
3 From Midwife to Midwife (answer only if midwife)		
C POST PARTUM		
1 From Midwife to Hospital		
2 From Midwife to Clinic		
3 From Midwife to Midwife (answer only if midwife)		
D NEONATAL		
1 From Midwife to Hospital		
2 From Midwife to Clinic		
3 From Midwife to Midwife (answer only if midwife)		

3 Referrals in last year	Number Referred	Reason for Referral
A ANTENATAL		
B LABOR AND DELIVERY		
C POSTPARTUM		
D NEONATAL		

4 Referral Site	Name of the Nearest Referral Center	Distance to Referral Center
A Hospital		
B Clinic		
5 Methods of Transportation (Circle most used method)	How much time to referral center by	Cost to referral center
A Car		
B Bus		
C Motorbike		
D Boat		
E Horse		
F Walking		
G Other		

- 6 Approximately what percentage of the time does a patient refuse to go to a referral center because they can not pay the cost of transport? (Probe the answer such as "up to 10%, up to 25%, or more)

TRAINING NEEDS ASSESSMENT PART III - CLINICAL SKILLS, (page 1)

Instructions

- 1 First ask the person you are interviewing if they were **TRAINED** to perform the clinical skills in the list Please make a check mark in the **TRAINED** column if they answer "yes"
- 2 Next ask the person you are interviewing if they **USE** the clinical skills in the list during their daily work Please make a check mark in the "USE" column if they answer "yes"
- 3 Next ask the person you are interviewing if they **WANT/NEED TRAINING** or **REFRESHER** in the clinical skills in the list Please make a check mark in the "WANT TRAINING/REFRESHER" column

CLINICAL SKILL		TRAINED	USE	WANT TRAINING/ REFRESHER
1	Perform Antenatal Risk Screening			
	Includes Antenatal Review of			
	a Medical History			
	b Surgical History			
	c Obstetric History			
	d Menstrual History			
	e Blood Pressure Checks			
	f Measures Uterus			
	g Fetal Heart Rate Checks			
	h Weight Gain Checks			
2	Uses Universal Precautions			
	a Wear Protective Clothing			
	1) gloves			
	2) apron			
	3) eye covering			
	4) feet covering			

CLINICAL SKILLS, (page 2), continued

CLINICAL SKILL	TRAINED	USE	WANT TRAINING/ REFRESHER
b Care with Sharp Objects			
c Avoid Contact with Body Fluids			
d Equipment			
1) decontaminate in Chlorine Solution 10 min			
2) clean in soap and water			
3) disinfect or sterilize			
e Clean Rooms and Furniture with Disinfection Solution			
f Proper Disposal of Waste (Burn or bury placenta needles)			
3 Do Counseling For			
a Antenatal Care			
b Anemia			
c Sexually Transmitted Diseases (STD) Prevention Human Immunodeficiency Virus (HIV) Reproductive Tract Infections (RTI)			
d Sexually Transmitted Diseases treatment			
e Nutrition			
f Breast-feeding			
g Family Planning			
1) When counsel on Family Planning			
a) Antenatal			
b) Postpartum			
c) Postabortion			
2) Counsel on Family Planning Methods (List methods available)			
4 Provide Family Planning Method (List methods available)			

CLINICAL SKILLS, (page 3), continued

	CLINICAL SKILL	TRAINED	USE	WANT TRAINING/ REFRESHER
5	Infection			
	a. Check for and diagnose infections of			
	1) Sexually Transmitted Diseases (STD)			
	2) Human Immunodeficiency Virus (HIV)			
	3) Breast			
	4) Uterus			
	5) Bladder/Kidney			
	6) Ophthalmia Neonatorum			
	7) Neonatal Septicemia			
	8) Tetanus			
	b. Give Antibiotics for Infection			
	1) Pills			
	2) Injection -intramuscular (IM)			
	3) Injection - intravenous (IV)			
6	Perform Reflex Testing			
7	Perform Testing to Check Kidney Tenderness (CVA)			
8	Fluid Replacement			
	a. Start Intravenous infusion			
	b. Give Rectal Infusion			
	c. Give Intrapertoneal Infusion			
9	Check Hemoglobin			
	a. If doing so method used			
10	Perform Speculum Exam			
11	Perform Bimanual Exam			
12	Gynecological Procedures			
	a. Perform Menstrual Regulation			
	b. Perform Manual Vacuum Aspiration			
	c. Perform Dilatation and Curettage			

CLINICAL SKILLS, (page 4) continued

CLINICAL SKILL	TRAINED	USE	WANT TRAINING/ REFRESHER
13 Labor and Delivery			
a Use Partograph to Manage Labor			
b Perform External Version			
c Perform Internal Version			
d Perform Vacuum Extraction or Low Forceps			
e Perform Symphysiotomy			
f Cut an Episiotomy			
g Give Local Anesthesia for Suturing			
h1 Examine for			
1) Lacerations of the Vagina/Perineum			
2) Lacerations of the Cervix			
3) Completeness of the Placenta			
i Suture/Repair			
1) Episiotomy			
2) Cervical Laceration			
3) Vaginal Laceration			
4) 3rd and 4th Degree Lacerations			
k Bimanual Compression of Uterus			
1) External			
2) Internal			
l Manually Remove Placenta			
m Give Oxytocic			
1) Intramuscular			
2) Intravenous			
14 Resuscitation			
a Mother			
b Infant			
15 Cesarean Section a Set up for Cesarean Section			
b First Assist at Cesarean Section			
16 Perform Circumcision a Female			
b Male			

TRAINING NEEDS ASSESSMENT PART IV- PROVIDER KNOWLEDGE, (page 1)

The following questions were designed to assess the skill level of the provider interviewed. Please ask the question listed and check off responses mentioned. Note that not all of the actions listed would be correct in the situation described in the question. Wrong answers will be scored appropriately. If other reactions besides the ones listed are mentioned, please specify them under "other".

(SAY) I am going to ask you to describe what would you do if a woman came to this health station with certain conditions

- 1 (SAY) When a woman comes to the health station at 28 weeks gestation with heavy vaginal bleeding, what conditions or signs do you look for? (Check any answers mentioned)

LOOK FOR	MENTIONED	
	Yes	No
a Presentation of fetus		
b Signs of labor		
c Tenderness (palpate)		
d Signs of shock		
e Signs of anemia		
f Whether blood is clotting		
g Amount of external bleeding		
h Other (specify)		

PROVIDER KNOWLEDGE, (page 2), continued

- 2 (SAY) When a woman comes to the health station at 28 weeks gestation with heavy vaginal bleeding, what do you do? (Check any answer mentioned)

ACTION	MENTIONED	
	Yes	No
a Perform a vaginal examination		
b Refer to a doctor or hospital		
c Take blood for grouping, cross matching, hemoglobin		
d Organize donors for blood supply		
e Check vital signs		
f Set up intravenous infusion		
g Other (specify)		

- 3 (SAY) When a woman complains of malaise 48 hours after delivery, what do you ask her? (Check any answers mentioned)

ASK ABOUT HER	MENTIONED	
	Yes	No
a Abdominal pain		
b Chills		
c A feeling of extreme body warmth		
d Foul odor or discharge		
e Back pain or trouble voiding		
f Pain in the calf of her legs or thighs		
g Pain in breast		
h Other (specify)		

PROVIDER KNOWLEDGE, (page 3), continued

- 4 (SAY) When a woman complains of malaise 48 hours after delivery, what do you do? (Check any answers mentioned)

ACTION	MENTIONED	
	Yes	No
a Palpate abdomen		
b Examine lochia		
c Examine perineum		
d Examine breast		
e Refer to a physician		
f Give stat ampicillin 1 g IM before referral		
g Put up IV fluids (normal saline)		
h For pain relief, administer simple analgesic		
l Administer oxytocin		
j Keep the woman well-hydrated		
k Consider prophylactic treatment of malaria in endemic areas		
l Other		

- 5 (SAY) When a woman complains of malaise 48 hours after delivery, what do you do for follow up?

ACTION	MENTIONED	
	Yes	No
a Monitor the woman daily to exclude worsening signs of infection		
b If no improvement in condition after 48 hours, refer		
c Others		

PROVIDER KNOWLEDGE, (page 4), continued

6 (SAY) When a pregnant woman for an antenatal visit at 32 weeks gestation and complains to you of having swollen hands and increasing headaches, what do you do? (Check any answers mentioned)

ACTION	MENTIONED	
	Yes	No
a Take the woman's blood pressure		
b Check the woman's urine for proteinuria		
c Do reflex testing		
d Other (specify)		

7 (SAY) When a pregnant woman for an antenatal visit at 32 weeks gestation and complains to you of having swollen hands and feet and increasing headaches, what do you do if the woman has signs of eclampsia? (Check any answers mentioned)

ACTION	MENTIONED	
	Yes	No
a Give the woman aspirin		
b Keep the woman quiet and away from activity		
c Prepare a tongue blade for emergency seizure		
d Administer hypertensive		
e Administer anticonvulsant		
f Transport the woman to the nearest hospital/doctor		
g Tell her to return in 24 hours		
h Other (specify)		

PROVIDER KNOWLEDGE, (page 5), continued

- 8 (SAY) When you are caring for a woman in labor, how do you recognize that her labor is not proceeding normally? (Check any answers mentioned)

SIGNS	MENTIONED	
	Yes	No
a The latent phase (early labor) lasts longer than 8 hours		
b The first stage of labor exceeds 12 hours		
c The second stage of labor is longer than 2 hours		
d Other (specify)		

- 9 (SAY) A woman you have just delivered passes more than 500 mls of blood from the genital tract shortly after delivery What action would you take? (Check any answers mentioned)

ACTION	MENTIONED	
	Yes	No
a Call for help		
b Massage the fundus		
c Give ergometrine IM or IV		
d Empty the woman's bladder		
e Examine the woman for lacerations of the perineum, vagina and cervix		
f Start IV fluids		
g Take blood for grouping and cross-matching		
h Other (specify)		

PROVIDER KNOWLEDGE, (page 6), continued

- 10 (SAY) When a woman you have just delivered passes more than 500 mls of blood from the genital tract shortly after delivery and has not yet been able to deliver the placenta, what action do you take? (Check any answers mentioned)

ACTION	MENTIONED	
	Yes	No
a Controlled cord traction		
b Give oxytocin		
c Manually remove placenta		
d Watch for signs of shock		
e Other (specify)		

- 11 (SAY) When a woman you have just delivered passes more than 500 mls of blood from the genital tract shortly after delivery and bleeding does not stop, what actions do you take? (Check if the answer is mentioned)

ACTION	MENTIONED	
	Yes	No
a Remove to the hospital immediately		
b Other (specify)		

TRAINING NEEDS ASSESSMENT PART V - EQUIPMENT, SUPPLIES, MEDICINES (page 1)

Please ask if the equipment and supplies listed are available. If yes, please mark the appropriate box and ask if it is in working condition, and whether it needs repair or replacement. If the equipment or supplies are not available, please mark "no".

IS THE FOLLOWING	AVAILABLE		WORKING		IN NEED OF REPAIR OR REPLACEMENT	
	Yes	No	Yes	No	Yes	No
1 HEMOSTAT/ARTERY FORCEPS						
2A. SCISSORS FOR CORD						
2B SCISSORS FOR EPISIOTOMY						
3 FETAL STETHESCOPE PINARD OTHER						
4 BLOOD PRESSURE APPARATUS						
5 ADULT STETOSCOPE						
6 SUCKER SUCTION BULB OR DELEE						
7 URINARY URETHRAL CATHETER						
8 RECTAL TUBE						
9 PROTECTIVE APRON						
10 SURGICAL GLOVES						
11 HEAVY GLOVES FOR CLEANING						
12 TOWEL FOR CLEAN DELIVERY OR DRY BABY						
13 SYRINGES AND NEEDLES						
14 INSTRUMENT TRAY WITH COVER						
15 KIDNEY OR PLACENTA BASIN						
16 REFLEX OR PERCUSSION HAMMER						
17 MEASURING TAPE						
18 VAGINAL SPECULUM						
19 SUTURE WHAT KIND?						
20 SUTURE NEEDLES						
21 NEEDLE HOLDER						
22 TISSUE/THUMB FORCEPS WITHOUT TEETH						
23 SUTURE SCISSORS						
24 SPONGE HOLDING FORCEPS WITHOUT TEETH						

EQUIPMENT, SUPPLIES, MEDICINES, (page 2) continued

IS THE FOLLOWING	AVAILABLE		WORKING		IN NEED OF REPAIR OR REPLACEMENT	
	Yes	No	Yes	No	Yes	No
25 ORAL AIRWAY ADULT INFANT						
26 URINE TESTING KIT						
27 TOWELS OR DRAPES FOR SUTURING						
28 BABY WEIGHT SCALE						
29 ADULT WEIGHT SCALE						
30 HEIGHT MEASURE						
31 HEMOGLOBIN MEASURE WHAT KIND?						
32 INTRAVENOUS FLUIDS/GIVING SETS						
33 OXYTOCICS						
34 ANTIBIOTICS						
35 STERILIZATION EQUIPMENT WHAT KIND? STEAMER BOILER AUTOCLAVE						
OTHER						
AMBU BAG RESUSCITATOR						
ANTISEPTIC						
BOOTS OR FEET COVERING						
COTTON WOOL						
EYE PROTECTION						
LIGHT SOURCE						
MACKINTOSH (PLASTIC COVERING)						
METAL BOWLS						
ORAL REHYDRATION FLUID						
OXYGEN TANK WITH REGULATOR						
TIME PIECE						
VACUUM EXTRACTOR						
MANUAL VACUUM ASPIRATION KIT						

TRAINING NEEDS ASSESSMENT: PART VI - HOSPITAL TRAINING SITE, (page 1)

FOR HOSPITALS THAT ARE POSSIBLE TRAINING SITES ONLY

1 Organogram of hospital - names and positions of administrative and MCH staff
(write on separate sheet)

2 Schools using hospital as training site in MCH?

a Names of schools

School #1 _____

School #2 _____

School #3 _____

School #4 _____

b Percent of time students use	School #1	School #2	School #3	School #4
1) Antenatal Clinic				
2) Postpartum Clinic / Ward				
3) Labor and Delivery Ward				

3 Clinic Space

	Antenatal	Labor	Delivery
Number of Rooms			
Airflow (none, average, excellent)			
Windows (none, average, excellent)			
Lighting for Procedures (yes, no)			
Running Water (yes, no)			
Cleanliness (poor, average, excellent)			
Space for Privacy (yes, no)			

HOSPITAL TRAINING SITE, (page 2) continued

- 4 Number of Midwives on Labor and Delivery Ward during
- a Day Shift _____
 - b Evening Shift _____
 - c Night Shift _____
- 5 Number of Midwives in Antenatal Clinic per shift _____
- 6 Number of Midwives in Postpartum Clinic per shift _____
- 7 Copies available of
- a Antenatal form (yes/no) _____
 - b Partograph form (yes/no) _____
 - c Delivery record (yes/no) _____
 - d Well-Baby card/record (yes/no) _____
 - e Document to take home after delivery (yes/no) _____
- 8 If LSS training site opened at hospital is there
- a Lodging for students near to hospital _____
 - b Catering for student meals available _____
 - c Space for classroom near Labor Ward _____
 - d On-call sleep room available for student/teacher _____
 - e Training equipment/models/materials available (yes/no)
 - 1) Delivery model and placenta _____
 - 2) Bony pelvis _____
 - 3) Infant resuscitation model _____
 - 4) Adult resuscitation model _____
 - 5) Teaching Charts/posters _____
 - 6) Books _____
 - 7) Films/Videos/slides _____
 - 8) Video Machine (list system PAL, VHS, Other) _____
 - f Clinical Equipment (yes/no)
 - 1) Number of delivery packs _____
 - 2) Suture needle _____
 - 3) Suture (type, size) _____
 - 4) Needle Holders _____
 - 5) Tissue Forceps _____
 - 6) Suture Scissors _____
 - 7) Vacuum Extractors (type/number) _____

HOSPITAL TRAINING SITE, (page 3) continued

9 Identified Hospital Equipment/Supply Needs?

10 Training Needs Expressed by Staff and Administrators?

GUIDELINES: Antenatal Guidelines for the LSS Midwife (Sample)

DANGER SIGNS IN PREGNANCY (Ask at each visit) Any Bleeding Headache Visual Problems Swelling of Face/Hands Abdominal (Epigastric) Pain Baby does not move as much as usual			
PATIENT	PROBLEMS	FINDINGS	ACTIONS
MOTHER	CPD	Height 145 cm or less	REFER
	MALARIA	In malaria dense area's	Give prophylaxis Chloroquine 250 mgm once a week beginning at 3 months until 6 weeks postpartum
	ANEMIA	Normal Screening	1 Check hemoglobin at first visit and every three months 2 Look for signs of anemia pale conjunctiva, pale nails, extreme tiredness
		Hemoglobin 11 Gram or above	1 Iron (ferrous sulfate) 320 mg (60 mg elemental iron) plus 2 Folic acid 250 mcg daily Give iron and folic acid for 90 days minimum during pregnancy and 40 days postpartum
		Hemoglobin 8 1 to 10 9 Gram	Treat for anemia 1 Iron 320 mg three times a day for one month 2 Counsel ON foods for iron, folic acid and vitamin C 3 Retest in one month a If no change test for parasites, REFER b If improving Continue iron 3 times a day for 2 months Retest at the end of two months, Treat according to protocols
	Hemoglobin 8 Gram or below	REFER	

PATIENT	PROBLEMS	FINDINGS	ACTIONS
MOTHER	PRE-ECLAMPSIA	Normal screening	Take blood pressure at each visit
		Blood pressure 140/90 or above	1 Ask mother about symptoms of pre-eclampsia headache, visual changes, abdominal (epigastric) pain 2 Check urine for protein 3 Check reflexes 4 Hydrate 5 Have mother rest for 20 minutes lying on her left side 6 Recheck blood pressure 7 If B/P still 140/90 with normal reflexes and urine, put on bed to rest for 12 hours If not improved, REFER
		Blood pressure 140/90 AND any one of the following headache, blurred vision, edema, protein in urine, hyperreflexia or history of convulsions	1 Give Diazepam 10 mg IM 2 REFER
	TETANUS	Normal prophylaxis	Give Tetanus (WHO SCHEDULE) TT-1 Give at first contact or as early as possible in pregnancy TT-2 Give at least four weeks after TT-1 TT-3 Give at least 6 months after TT-2 or during subsequent pregnancy TT-4 Give at least one year after TT-3 or during subsequent pregnancy TT-5 Give at least one year after TT-4 or during subsequent pregnancy

PATIENT	PROBLEMS	FINDINGS	ACTIONS
MOTHER	INFECTION	Ruptured membranes for 6 hours or longer without signs of active labor	1 Give broad spectrum antibiotic one dose by mouth 2 REFER
		Temperature 39° C or above without signs of malaria	1 Give broad spectrum antibiotic one dose by mouth 2 Hydrate 3 Cool compresses 4 REFER
		Temperature 39° C or above with signs of malaria	1 Treat for malaria 2 Hydrate 3 Cool compresses 4 REFER, if no improvement in six hours
		Any inguinal swelling, perineal sores or vaginal discharge with odor	REFER
	BLEEDING UP TO 28 WEEKS GESTATION	1 Cervix closed (with uterine pain and history of passing products of conception)	1 Oxytocin 2 Hydrate 3 Observe BP, pulse and bleeding for 24 hours 4 REFER if fever or bleeding continues
	Careful speculum exam shows	2 Cervix open (with uterine pain, severe bleeding, and products of conception not passed)	1 Remove clots and products of conception at cervix 2 REFER 3 While waiting for transport a Take BP, Pulse b Hydrate c Broad spectrum antibiotic d Shock care if shock signs e Pain medication and reassure
	BLEEDING AFTER 28 WEEKS	1 Bleeding 2 More than 28 weeks gestation	1 Monitor BP, pulse and fetal heart rate 2 REFER 3 While waiting for transport a Hydrate (intravenous is possible) b Keep warm c Shock care if shock signs d Pain medication and reassure

PATIENT	PROBLEMS	FINDINGS	ACTIONS
BABY	Fundal height too large or too small for gestation	If 2 cm above or below expected size or if above or below expected size by fingerbreaths	1 Recheck in one week 2 If still above or below expected size one week later - REFER
		If <i>more</i> than 2 cm above or below expected size OR if <i>much</i> above or below expected size by fingerbreaths	REFER
	Decreased baby movement	Fetal heart rate normal	1 Hydrate mother (at least 2-3 glasses of water) 2 Have mother rest on left side for 20 minutes 3 Recheck babies movement 4 If not improved - REFER
		No fetal heart rate	REFER
	Abnormal fetal heart rate	Fetal heart rate below 120 or above 160	1 Hydrate mother (at least 2-3 glasses of water) 2 Have mother rest on left side for 20 minutes 3 Recheck babies heart rate 4 If not improved - REFER
	Abnormal position	Baby is not vertex and mother is near term or going into labor	REFER for delivery to Hospital
	Baby not descended near term	If mother primigravida OR multigravida with big baby	REFER for delivery to Hospital

GUIDELINES- Partograph Guidelines for the LSS Midwife (Sample)

TOPIC	FINDINGS	ACTION NO DOCTOR ON SITE	ACTION WITH DOCTOR AT SITE
BABY'S HEART BEAT	Above 160, below 120, or sudden change	Hydrate, position change and count baby heart after each contraction for three contractions If not normal, REFER	Same action, Count every 5 minutes Call doctor, Check contractions, if oxytocin running decrease flow
LIQUOR	Meconium or bloody	REFER	Call doctor
MEMBRANES	Rupture without contractions	Check for prolapse of cord/manage REFER	Check for prolapse/manage Call doctor
	Rupture for 6 hours or more with contractions	REFER unless delivery about to start Give broadspectrum antibiotic	Give broad spectrum antibiotic Call doctor unless delivery about to start
CERVIX DILATATION	1-3 CMS more than 8 hours	Hydrate and REFER	Hydrate and Call doctor
	Crosses alert line	Hydrate and REFER	Call doctor and hydrate
	Reaches action line	Mother should be with doctor already	Call doctor for action
DESCENT OF BABY	5/5 and 3 CMS or more	REFER	Call doctor
MOTHER	Temperature 39° or more	Sponge, hydrate and REFER	Hydrate, call doctor, Check fetal heart every 15 minutes until normal temperature
	Pulse below 60 or above 90	Hydrate and REFER	Hydrate, call doctor, monitor fetal heart every 15 minutes until pulse normal
	B/P 140/90 or more	Diazepam 20 mg, REFER with mother on left side	Stop oxytocin infusion if running Call doctor, Reposition mother to left side

GUIDELINES: Postpartum Guidelines for the LSS Midwife (Sample)

PATIENT	PROBLEMS	FINDINGS	ACTIONS
MOTHER	BLEEDING	Prevention -- limit blood loss	<ol style="list-style-type: none"> 1 Give oxytocic with anterior shoulder of baby or as soon as possible 2 Dry and cover baby, clamp cord and put baby to breast 3 Deliver placenta 4 Rub up a uterine contraction 5 Expell any blood clots 6 Make sure bladder is empty 7 Examine placenta and membranes
	Heavier than monthly period OR Fresh, bright red blood OR Continuous bleeding of a small amount OR Uterus feels hard but is getting larger	Placenta or membranes in uterus (RETAINED PLACENTA OR MEMBRANES)	<ol style="list-style-type: none"> 1 Rub up uterine contraction 2 Empty bladder if full 3 Remove placenta/membranes 4 Give repeat oxytocic 5 Rub up contraction 6 Expell clots 7 Hydrate, put baby to breast 8 REFER if still bleeding
		Placenta out and complete (UTERINE ATONY)	<ol style="list-style-type: none"> 1 Rub up uterine contraction 2 Express clots 3 Give repeat oxytocic 4 Empty bladder if full 5 Hydrate, put baby to breast 6 REFER If uterus still not contracted 7 External Bimanual Compression during referral or 20 minutes 8 Repeat oxytocin, again 9 Continue hydration 10 Continue compression if still bleeding 11 Make sure family prepared to accompany to doctor

PATIENT	PROBLEMS	FINDINGS	ACTIONS
MOTHER	BLEEDING , continued	Placenta is out AND uterus is well contracted	<ol style="list-style-type: none"> 1 LOOK for laceration in the birth canal and the cervix 2 Repair if skill to do so OR apply continuous pressure using your gloved hand or with sponge forceps according to LSS procedure 3 Hydrate and REFER
	INFECTION	Temperature of 39° or above	<ol style="list-style-type: none"> 1 Give a single dose of 2cc or 600,000 units of Procaine Penicillin and 0.5 Gram of streptomycin IM 2 Hydrate 3 Cool compresses 4 Give Paracetamol to lower fever 5 REFER, If vaginal discharge with odor, keep in a semi-sitting position to facilitate drainage
		Urinary tract infection or upper respiratory infection	<ol style="list-style-type: none"> 1 Give broad spectrum antibiotic TID for 10 days 2 Hydrate 3 Treat fever 4 REFER if fever not reduced in 24 hours
BABY	ANY ABNORMAL FINDINGS	<ul style="list-style-type: none"> • Irregular breathing by 12 hours after delivery • Poor feeding or sucking • Weak, limp, cannot wake up • Cold to touch and weak • Unusual cry • Fever or signs of infection • Jaundice in 24-36 hours • Extreme irritability • Stiffness or convulsions • Persistent vomiting • No stool by third day 	<ol style="list-style-type: none"> 1 REFER if possible 2 Keep the baby warm 3 Give expressed breast milk if the baby cannot suck 4 Encourage the mother and family to hold the baby 5 Explain to the mother and family the problem and what they can expect to happen at the referral site

EQUIPMENT LISTS ¹⁵

The training needs assessment (TNA) identifies the available items at both the LSS Training Site and the midwives places of work. The following pages provide a suggested list of items used during LSS training and by the LSS midwife. By now the decision has been made as to what topics are being taught during LSS, mark those items needed to teach. Using the information from the TNA read the list and mark those available. Now you can make a mark those needed to be ordered. *The form is written to help you put together your order.* During LSS Training, each midwife is requested to complete an individual inventory of her actual working site. This information is used to provide each midwife with the additional things necessary for her to perform LSS.

LSS Training Site Supplies and Equipment List Order Form (suggested)						
TYPE	QUANTITY			COST		
	NEEDED	AVAILABLE	ORDER	PER UNIT	TOTAL	
a Video, Why did Mrs X Die?						
b Video, Birthing Positions						
c Mannikin Infant CPR						
Adult CPR						
d Pelvis/fetus set						
Boney Pelvis						
Fetal Model						
Placenta/Cord Model						
Cloth Pelvic Model						
e Episiotomy Practice Set						
Repair Model						
Suture/Thread						
Suture needles						
Needle holder						
Tissue forceps						
Suture scissors						
f Cervical Dilatation Model						
g Pelvic Station Chart						

¹⁵ See detailed explanation of equipment list and 1996 United States Dollars costs on pages 275 to 279

276

LSS Training Site Supplies and Equipment List Order Form (suggested)						
TYPE	QUANTITY			COST		
	NEEDED	AVAILABLE	ORDER	PER UNIT	TOTAL	
h Muscles of Pelvic Floor Laminated Poster						
i Episiotomy Repair Poster						
j Partograph, laminated						
k Partograph Forms						
l Antenatal Risk Assessment Form, Laminated						
m Antenatal Risk Assessment Forms						
n Antenatal Forms						
o Marking Pens						
p Vacuum Extractor						

LSS Midwife Supplies and Equipment List (suggested)						
TYPE	QUANTITY			COST		
	NEEDED	AVAILABLE	ORDER	PER UNIT	TOTAL	
<i>Life-Saving Skills Manual for Midwives</i>						
Midwifery Reference Textbook						
1 Hemostat/artery forceps						
2 Cord/episiotomy scissors						
3 Fetal scope						
4 Blood pressure machine						
5 Stethoscope						
6 Bulb mucus syringe						
7 Urinary catheters						
8 Rectal tubes						
9 Delivery apron						
10 Surgical latex gloves						
11 Cleaning gloves						
12a Surgical towels						
12b Lap sponges						
13a Injection syringes						
13b Needles						
14 Stainless steel containers with lids						
15 Kidney shaped/placenta basin						
16 Reflex hammer						
17 Tape measure						
OTHER SUPPLIES AND INSTRUMENTS/EQUIPMENT DEPENDING ON NEEDS						
18a Vaginal speculum, small						
18b Vaginal speculum, med						
19 Suture, absorbable						
20 Suture needles						

LSS Midwife Supplies and Equipment List (suggested)						
TYPE	QUANTITY			COST		
	NEEDED	AVAILABLE	ORDER	PER UNIT	TOTAL	
21 Needle holders						
22 Tissue/thumb forceps						
23 Suture scissors						
24 Sponge holding forceps						
25 Airway, adult & infant						
26 Urine testing set						
27 Towels						
28 Baby Weight Scale						
29 Adult Weight Scale						
OTHER SUPPLIES AND INSTRUMENTS/EQUIPMENT DEPENDING ON NEEDS						
30 Height Measure						
31 Hemoglobin Measure						
32a Intravenous Fluids						
32b Intravenous Giving Sets						
33 Oxytocics						
34 Antibiotics						
35 Sterilization Equipment						
36 Vacuum Extractor						
37 Manual Vacuum Aspiration (MVA) Kit						
38 Uterine Tenaculum for MVA						
39 Magnifying Glass for MVA						
40 Strainer for MVA						
41 Scalpel with No 20 blade						

Explanation of Equipment and Supplies

If teaching models and surgical instrument supplies are not readily available in your country, some suggested suppliers, order numbers and up to date catalogs are available at the American College of Nurse Midwives (ACNM) (Fax: 202-728-9896, or Phone 202-728-9881) Feel free to contact the LSS Coordinator for information USD = United States Dollars

FOR ONE LSS TRAINING SITE

- a **1- VIDEO, WHY DID MRS X DIE?**, available from WHO, Safe Motherhood Program VCR SYSTEM IDENTIFIED AT NEEDS ASSESSMENT
- b **1- VIDEO, ALTERNATE BIRTHING POSITIONS**, VCR SYSTEM IDENTIFIED AT NEEDS ASSESSMENT USD 200
- c **1- INFANT CPR MANIKIN** USD 245 Replacement airway system (lungs) 24 for 36 USD
Replacement face inserts, 10 for 19 50 USD
Or
1 - Infant CPR Trainer, "Baby Anne" with foreign body airway obstruction feature, head tilt/chin lift movable jaw, realistic chest compliance during compression, chest rises with sufficient air inflation USD 79 95 Replacement airways 24 for 10 USD, Foreign Body Objects 10 for 3 USD, jaw 4 00 USD, mask connector 3 USD
- 1- ADULT FAMILY CPR TRAINER** 45 USD but not very sturdy **VIDEO "PASS CPR"** 29 95 USD
Another option is a full sized adult basic torso with ventilation (breathing) and compression (heart) system USD 395
- d The following four items must all fit (correct size) together, so that if the fetal model not available, then look elsewhere for the entire set of boney pelvis, fetal model, placenta/cord model and cloth pelvis
- | | |
|-------------------------------|--|
| 1- BONEY PELVIS | a pelvic model which has correctly proportioned average inlet and outlet of the dimensions of an adult female and a moveable coccyx, for use with below fetal model USD 41 |
| 1- FETAL MODEL | a soft fetus (baby) with hard land marked head USD 42 50 |
| 1- PLACENTA/CORD MODEL | for the above fetal model, has amniotic and chorionic membranes USD 33 95 |
| 1- CLOTH PELVIC MODEL | is a soft pelvis for above fetal model USD 54 95 |
- e **Episiotomy Practice** for trainee to use for practice during training, sometimes some of the equipment can be borrowed from hospital supplies or midwifery school
- 1- EPISIOTOMY REPAIR MODEL** for each trainee, using sponge (foam) cushions, purchase locally, identify availability on needs assessment
- 4 ROLLS/SPOOLS THREAD** of heavy cotton thread purchased wherever available
- 2 packets of 2-0 (sometimes written as 00) chromic catgut suture** for each trainee (so if 60 midwives to be trained, 120 packets of suture is needed, 1 box usually has 100 packets, so 2 boxes would be ordered) USD 87 for one box of 100 packets
- 2 per trainee stainless steel reusable round body (atraumatic) ½ circle size 7 suture needles** (so if 60 midwives to be trained, 120 needles to be ordered)

1 CORD/EPISIOTOMY SCISSORS, BLUNT/BLUNT, this is abbreviated B/B, to make an episiotomy and cut the cord (**must be very good stainless surgical steel**) These scissors are blunt on both blades to prevent accidental injury 6 3/4" Mayo Straight Scissors, straight USD 33 45

1 for each trainee MAYO HAGAR NEEDLE HOLDERS 7 inches used for holding the needle when suturing or sewing a wound USD 41 80

1 for each trainee TISSUE OR THUMB FORCEPS WITHOUT TEETH 6 inches serrated used for holding tissue while suturing USD 3 30

1 for each trainee SUTURE SCISSORS (operating room scissors, straight 6 ½ inch sharp/blunt) used for cutting suture so one blade is sharp and one blade is blunt, this is abbreviated S/B The scissors can be curved or straight They should be straight for our purposes USD 5 87

- f **1- CERVICAL DILATATION MODEL** used to teach effacement and dilatation of the cervix during partograph training USD 12 95 They can be locally made from wood, pattern in LSS Module 3
- g **1- PELVIC STATION Chart**, used to teach descent of baby in labor, on the back has internal exam and positions for labor USD 12 95
- h **1- LAMINATED POSTER MUSCLES OF THE PELVIC FLOOR** shows the stretching and changes in the pelvic floor during birth process USD 12 95
- I **1- LAMINATED POSTER EPISIOTOMY REPAIR** 12 95 USD
- J **1- LAMINATED PARTOGRAPH AND MARKING PENS, 55 USD**, need to check at ACNM Has been made locally on chalk blackboards
- k **4 - Partograph forms**, to practice plotting partograph
- l **1 - LAMINATED Antenatal Risk Assessment Form**, 2 pages 100 USD, check at ACNM
- m **4 - Antenatal Risk Assessment Forms**, to practice plotting information
- n **4 - Antenatal Forms**, to practice using local antenatal forms
- o **1 Set of Marking Pens** for use with laminated partograph and antenatal risk assessment forms
- p **1-Vacuum Extractor** The type will depend on the country and the decisions they make

Other 1 - Pregnancy calculator per trainee , includes general info about fetal and pregnancy development for each week gestation USD 2 75

Training Reference *A Book for Midwives* - A Manual for Traditional Birth Attendants and Community midwives by Susan Klein, (1995), can be purchased from The Hesperian Foundation

Training Reference *Where Women Have No Doctor* - A health guide for women by Burns, Lovich, Maxwell, and Shapiro, (1997), can be purchased from The Hesperian Foundation

Training Reference *Healthy Mother Healthy Newborn Care* and accompanying ***A Guide for Caregivers*** by Beck Buffington, and McDermott, (1998), a basic LSS book with postpartum outreach and community integration emphasis, can be purchased from the American College of Nurse-Midwives

SUPPLIES AND EQUIPMENT FOR LSS MIDWIFE (suggested)

1 - *Life-Saving Skills Manual for Midwives*, 3rd edition and accompanying *A Clinical Practice Guide* by Marshall and Buffington, (1998) for each LSS midwife can be purchased from the American College of Nurse-Midwives

1 - A Reference Midwives Textbook Midwifery by Varney, or Myles Textbook for Midwives available in *paperback* from AMREF or TALC, or other midwifery text as applicable to country

SUPPLIES AND EQUIPMENT FOR EACH MIDWIFE TRAINED issued according to need as identified on each midwife's inventory Usually issued at the completion of training

- 1 **2 - HEMOSTATS/ARTERY FORCEPS** or called hemostatic forceps, 7-8 INCHES stainless steel used to clamp the umbilical cord before cutting it, this may be a lower quality of stainless steel USD 9 95
- 2 **1 - CORD/EPISIOTOMY SCISSORS, BLUNT/BLUNT**, this is abbreviated B/B, to make an episiotomy and cut the cord (**must be very good stainless surgical steel**) These scissors are blunt on both blades to prevent accidental injury 6 3/4" Mayo Dissecting Scissors, straight USD 33 45
- 3 **1 - FETAL SCOPE** is used to listen to the baby's heart beat before delivery One type is trumpet shaped made from wood, metal or plastic/rubber called a Pinard (USD 10 -25) one has two flexible tubes (one for each ear of the midwife)connected to a small trumpet shaped metal dome called binaural (USD 50-75) and one is battery or electric run called a Doppler (USD 500+)
- 4 **1 - BLOOD PRESSURE MACHINE** is used for taking the blood pressure USD 59 85 If these are too cheap, they fall apart
- 5 **1 - STETHOSCOPE** to use for listening to the blood pressure USD 4 25
- 6 **2 - BULB OR EAR SYRINGES, 2 OZ, RED RUBBER** (note, the blue 3 oz is not as useful for our purpose) for sucking mucus out of the baby's nose and mouth USD 2 85
- 7 **2 - URINARY (urethral) CATHETERS, STRAIGHT, RUBBER, SIZE 14 FRENCH** for urinary catheterization USD 0 85 -2 50
- 8 **2 - RECTAL TUBES, STRAIGHT RUBBER CATHETER, SIZE 18 FRENCH** for rectal infusion USD 0 85
- 9 **1 - HEAVY COTTON/CANVAS APRON** 1 for USD 3 00 These are washable and autoclavable OR a heavy plastic/rubber apron
- 10 **12 - PAIR STERILE SURGICAL LATEX GLOVES, SIZE 6 ½** for deliveries Sterile pairs, size 6 ½ for USD 6 00 for 12 pair
- 11 **1 - PAIR HEAVY RUBBER not sterile CLEANING GLOVES** Utility Medium Living Glove at 1 pair = USD 2 30
- 12 **6 - SURGICAL TOWELS or LAP SPONGES or COTTON BLANKETS, REUSABLE** for providing a clean delivery area and drying the baby

- 13 **100 - DISPOSABLE 3 CC SYRINGES WITH 25 GAUGE NEEDLE 1 ½ INCHES LONG** for giving injections
- 14 **2 - STAINLESS STEEL CONTAINERS WITH LID, 12 INCHES X 7 INCHES, 2 INCHES DEEP TO KEEP EQUIPMENT** USD 31 95 each utility tray with cover
- 15 **1 - Kidney shaped basin** for placenta Polypropylene 12 oz emesis basin USD 2
- 16 **1 - Reflex hammer, Percussion Hammer** for checking reflexes USD 1 55
- 17 **1 - Tape measure** for measuring fetal growth and mother's height Tape Measure 1/4" wide to 60" long on other side 150 cm USD 6 55

OTHER INSTRUMENTS/EQUIPMENT DEPENDING ON COUNTRY NEEDS

- 18 a **1 - SMALL VAGINAL SPECULUM, USD 9 35** Graves small vaginal speculum
- 18 b **1 - MEDIUM VAGINAL SPECULUM, USD 10 25** Graves medium vaginal speculum
- 19 **20 - packets of 2-0 (sometimes written as 00) chromic catgut suture** This has taper needle CT-1 attached for USD 87 for 100 packets
- 20 **12 - stainless steel reusable round body (atraumatic) ½ circle size 7 suture needles** USD 9 70 for 12 needles
- 21 **1 - MAYO HAGAR NEEDLE HOLDERS 7 inches** used for holding the needle when suturing or sewing a wound 41 80 USD
- 22 **1 - TISSUE OR THUMB FORCEPS WITHOUT TEETH** used for holding tissue while suturing USD 2 95 - 3 30
- 23 **1 - PAIR SUTURE SCISSORS** used for cutting suture so one blade is sharp and one blade is blunt, this is abbreviated S/B The scissors can be purchased curved or straight They should be straight for our purposes for 5 87 USD
- 24 **1 - SMOOTH SPONGE HOLDING FORCEPS, 9 ½ - 10 inches** used to hold the cervix for examination, **(must be very good stainless surgical steel and very important that smooth jaws)** USD 42 50 Forester straight smooth jaws sponge forceps
- 25a **1 - ADULT ORAL AIRWAY** for resuscitation 10/pk USD 3 35
- 25b **1 - INFANT ORAL AIRWAY** USD 0 50

- 26 **1 - URINE TESTING SET, DETERMINE AT NEEDS ASSESSMENT**
- A Urstik Reagent Strips dip in urine and read test for protein and glucose USD 25 for 100 strips in one bottle so that is just for 100 tests
- OR**
- B 2 Test Tubes, 1 Test Tube Holder, 1 Spirt Burner, 1 Dropper Bottle with Acetic Acid 15 USD per kit
- OR**
- C Other local set or use laboratory
- 27 **4 - Towels or Drapes for Suturing, 430X500 mm (17-20 inches), 1 USD each**
- 28 **Baby Weight Scale Spring hanging scale, 8 USD**
- 29 **Adult Weight Scale, low use, less then 100 adults to weigh per month = 50 USD**
High volume above 100 adults to weigh per month = 400 USD
- 30 **Height Measure painted on the wall, attached to scale**
- 31 **Hemoglobin Measure Hemoglobinometer (60 USD), Sahli (50 USD)**
- 32 **Intravenous fluids (1000 ml bag 3 55 USD) and giving sets (2 95 USD)**
- 33 **Oxytocics, box of 10 doses for 1 USD**
- 34 **Antibiotics, depends on the type**
- 35 **Sterilization equipment steamer local (20 USD), boiler (20 USD), autoclave (pressure cooker type 60 USD)**
- Others **Ambu Baby Resuscitator for a delivery room USD 141 33**
- Equipment as identified in Module 10 Other Emergencies**
- **For Incomplete Abortion Care**
Uterine Tenaculum, Schroeder Braun, straight (45 30 USD)
Magnifying Glass, hi-quality optical lense, 4" (7 50 USD)
Strainer, stainless steel, (5 00 USD)
Manual Vacuum Aspiration Kit
 - **For Symphysiotomy**
Scalpel with Number 20 blade or
Disposable 13 60 USD for 20 scalpels with blade attached

LSS PARTICIPANT REGISTRATION AND INVENTORY FORM, Page 1

TRAINING CENTER NAME _____ TRAINING GROUP NUMBER _____

1 NAME _____ 2 AGE _____ (YEARS) 3 MARRIED/SINGLE _____

4 MAILING ADDRESS _____

5 EDUCATION BASIC SCHOOL _____ (NUMBER OF YEARS)
NURSING _____ (NUMBER OF YEARS)
MIDWIFERY _____ (NUMBER OF YEARS)

OTHER FORMAL TRAINING _____

6 NAME OF PLACE OF WORK _____

7 ADDRESS AND DIRECTIONS TO PLACE OF WORK _____

8 WHAT IS YOUR WORK POSITION _____

9 HOW LONG HAVE YOU WORKED AT THE PLACE YOU ARE NOW? _____

10 HOW FAR OR HOW LONG DOES IT TAKE TO GO TO YOUR CLOSEST REFERRAL SITE?

11 HOW MANY DELIVERIES DO YOU ATTEND EACH MONTH? _____

12 APPROXIMATELY HOW MANY EPISIOTOMIES DO YOU DO IN ONE MONTH? _____

13 DO YOU USE THE PARTOGRAPH? _____

14 SINCE YOU COMPLETED MIDWIFERY TRAINING, HAVE YOU EVER

A MANUALLY REMOVED A PLACENTA? _____ HOW OFTEN AND WHEN? _____

B USED BIMANUAL COMPRESSION? _____ HOW OFTEN AND WHEN? _____

C STARTED AN INTRAVENOUS INFUSION? _____ HOW OFTEN AND WHEN? _____

D USED A VACUUM EXTRACTOR? _____ HOW OFTEN AND WHEN? _____

E GIVEN LOCAL ANESTHESIA? _____ HOW OFTEN AND WHEN? _____

F PERFORMED INFANT RESUSCITATION? _____ HOW OFTEN AND WHEN? _____

LSS PARTICIPANT REGISTRATION AND INVENTORY FORM, Page 2

15 Below is a list of equipment and supplies, please A) put a ✓ (tick) after each item that you have in the second column, and B) if you have the item, put the number (in working condition and not broken) you have in the third column

COLUMN ONE	COLUMN 2	COLUMN 3
ITEM	✓ (TICK) IF YOU HAVE THE ITEM	IF YES, WRITE THE NUMBER YOU HAVE
1 HEMOSTAT/ARTERY FORCEPS		
2A SCISSORS FOR CORD		
2B SCISSORS FOR EPISIOTOMY		
3 FETAL STETHESCOPE PINARD OTHER		
4 BLOOD PRESSURE APPARATUS		
5 ADULT STETHOSCOPE		
6 SUCKER SUCTION BULB, OR DELEE		
7 URINARY URETHRAL CATHETER		
8 RECTAL TUBE		
9 PROTECTIVE APRON		
10 SURGICAL GLOVES		
11 HEAVY GLOVES FOR CLEANING		
12 TOWEL FOR CLEAN DELIVERY OR DRY BABY		
13 SYRINGES AND NEEDLES		
14 INSTRUMENT TRAY WITH COVER		
15 KIDNEY OR PLACENTA BASIN		
16 REFLEX OR PERCUSSION HAMMER		
17 MEASURING TAPE		
18 VAGINAL SPECULUM		
19 SUTURE, what kind?		
20 SUTURE NEEDLES		
21 NEEDLE HOLDER		
22 TISSUE/THUMB FORCEPS, without teeth		
23 SUTURE SCISSORS		
24 SPONGE HOLDING FORCEPS WITHOUT TEETH		
25 ORAL AIRWAY ADULT, INFANT		

LSS PARTICIPANT REGISTRATION AND INVENTORY FORM, Page 3

COLUMN ONE	COLUMN 2	COLUMN 3
ITEM	✓ (TICK) IF YOU HAVE THE ITEM	IF YES, WRITE THE NUMBER YOU HAVE
26 URINE TESTING KIT		
27 TOWELS OR DRAPES FOR SUTURING		
28 BABY WEIGHT SCALE		
29 ADULT WEIGHT SCALE		
30 HEIGHT MEASURE		
31 HEMOGLOBIN MEASURE, what kind		
32 INTRAVENOUS FLUIDS AND GIVING SETS		
33 OXYTOCICS, what kind		
34 ANTIBIOTICS, what kind		
35 STERILIZATION EQUIPMENT, what kind? Steamer, boiler or autoclave (pressure cooker)		

**LIFE SAVING SKILLS -TRAINING REPORT
BEFORE TRAINING INFORMATION**

TRAINING REPORT, PAGE 1

PARTICIPANT NAME	A G E	JOB		CLINICAL EXPERIENCE						
		POSITION	LOCATION	1	2	3	4	5	6	

KEY CLINICAL EXPERIENCE

- 1 = number of deliveries each month
- 2 = number of episiotomies each month
- 3 = uses partograph, mark yes or no
- 4 = have you ever manually removed a placenta, mark yes or no
- 5 = have you ever performed bimanual compression, mark yes or no
- 6 = have you ever started an intravenous infusion, mark yes or no

OTHER COMMENTS

2/1/00

TRAINING REPORT, PAGE 2 LIFE-SAVING SKILLS - TRAINING REPORT

NAME	OPPORTUNITIES FOR CLINICAL PRACTICE													CLINICAL COMPETENCY DEMONSTRATED													EXAM	
	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9	10	11	12	13	PRE	POST

Write number of CLINICAL OPPORTUNITIES	Write ✓ = competent, ✖ = needs additional practice
1 Conduct a quality antenatal examination, Module 2	1 Antenatal anemia, toxemia, fetal growth monitoring
2 Monitoring labor progress using the partograph, Module 3	2 Labor Progress history, exam, use partograph
3 Conduct a normal delivery, Module 3	3 Episiotomy / Lacerations, Inspection, Repair
4 Perform and repair episiotomy, Module 4	4 Active Management of Third Stage
5 Active management of third stage of labor, Module 5	5 Manual Removal of Placenta
6 Manual removal of a placenta, Module 5	6 Bimanual Compression of the Uterus
7 Newborn resuscitation at birth, Module 6	7 Infant Resuscitation
8 Perform infection prevention steps, Module 7	8 Infection Prevention Care
9 Provide postabortion care, Module 7	9 Postabortion Care
10 Conduct sepsis evaluation, Module 7	10 Incision and Drainage of Breast Abscess
11 Perform intravenous infusion, Module 8	11 Intravenous Infusion
12. Administer oral rehydration, Module 8	12 Oral Rehydration
13 Vacuum Extraction, Module 9	13 Vacuum Extraction

10/1/20

LSS WEEKLY EVALUATION FORM

1 Do you find the class and clinical areas satisfactory for your learning? Yes/No
Please explain

2 Are the boarding arrangements satisfactory? Yes/No
Comments

3 The trainer's methods of teaching are satisfactory Yes/No
Comment on methods and/or individual trainers if necessary

4 The topics covered are relevant to your work Yes/No
Comments

5 The trainers and trainees are interacting well together Yes/No
Please explain

6 Are there topics, skills or information not on the LSS schedule that you would like to cover during training? Please explain

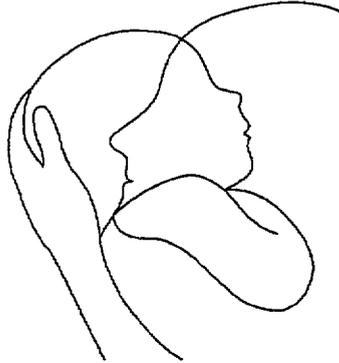
Please you the back of this form for any other comments

LSS FINAL EVALUATION FORM

PLEASE EVALUATE THE FOLLOWING STATEMENTS FEEL FREE TO COMMENT BELOW AND USE THE BACK FOR ADDITIONAL WRITING SPACE	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
1 For the work I do the LSS training was appropriate					
2 Material covered related to my experiences and possible solutions were dealt with in the LSS training					
3 Training facilities and arrangements were satisfactory					
4 The LSS Trainers were knowledgeable and skilled					
5 The LSS Trainers were fair and friendly					
6 The LSS Trainers communicated clearly and simply					
7 Teaching Aids were useful					

COMMENTS

Certificate of Attendance (Sample)



CERTIFICATE OF ATTENDANCE

This is to certify that

Llahsram Teragram
is a Life-Saving Skills Midwife

in the Life-Saving Skills Program

through a Safe Motherhood Project Funded by The Funder

held in *Somewhere City*, 30 July 1998

Jointly organized by

**THE AMERICAN COLLEGE OF NURSE-MIDWIVES
THE HOSPITAL STAFF, THE MIDWIVES ASSOCIATION, AND THE
MINISTRY OF HEALTH**

American College of Nurse Midwives

The Hospital

signature
[Name, Trainer, Project Director]

signature
[Title, Name, Position]

WEEK ONE							
LIFE SAVING SKILLS FOR MIDWIVES TRAINING SCHEDULE, PAGE 1							
TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUN
0700	-						
0800							
0815							
0825							
1000	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1015							
1200	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
1330							
1500	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1515 HOMEWORK							
1800	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE	
ON CALL= 0800 - 0800	TEAMS	TEAMS	TEAMS	TEAMS	TEAMS	TEAMS	

WEEK TWO		LIFE SAVING SKILLS FOR MIDWIVES TRAINING SCHEDULE, PAGE 2					
TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUN
0700							
0800							
0810							
0815							
1000	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1015							
1200	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	
1330							
1500	BREAK	BREAK	BREAK	BREAK	BREAK	BREAK	
1515 HOMEWORK							
1800	CLOSE	CLOSE	CLOSE	CLOSE	CLOSE		
ON CALL= 0800 TO 0800	TEAMS	TEAMS	TEAMS	TEAMS	TEAMS		

ROUNDS REPORT FORM

PROCESS	MOTHER - 1	MOTHER - 2	MOTHER -3	MOTHER -4
DATE + TIME				
BIRTH INFORMATION	BIRTH INFO	BIRTH INFO	BIRTH INFO	BIRTH INFO
1 NAME				
2 G/P/AB				
3 DELIVERY DATE/TIME, METHOD				
4 PERINEUM CONDITION,ANESTHESIA				
5 BLOOD LOSS				
6 BABY - SEX, APGAR,POSITION				
7 PROBLEMS?				
POSTPARTUM ROUNDS	POSTPARTUM	POSTPARTUM	POSTPARTUM	POSTPARTUM
MOTHER 1 FEVER?				
2 BREASTS				
3 UTERUS				
4 LOCHIA				
5 PERINEUM				
PROBLEMS?				
BABY 1 EYES				
2 OBSERVE SUCKING				
3 CORD				
4 URINATION/STOOL				
PROBLEMS?				

502

REFERRAL FORM

Clinic			Date
Client name		Age	
Gravida	Para	Abortion	Last Menstrual Period
Due Date		Weeks Gestation When Seen	
What was the condition of the woman when she came to you?			
What was the problem?			
What did you do?			
What is the reason for referral?			
Name and Signature of Midwife			
Reminder for Midwife 1 Go with the mother if at all possible 2 Explain reason for referral to family, remind them to have money, ask them to come with you 3 Take all forms/records written referral, antenatal, partograph, delivery, etc 4 Take medicines, instruments, equipment that you may need during travel to hospital			

Outcome of the Referral (Back)

Client Name _____ **Date** _____

Condition on Arrival

Care Given

Outcome

Follow-up Care

Name of Doctor _____ **Final Diagnosis** _____

Hospital _____

PAGE ONE	LIFE-SAVING SKILLS
INCIDENT REPORTING FORM	
LSS TRAINER NAME	TODAY'S DATE
Which training did you attend?	Training Date
1 Complete the following client information	
a Client initials	
b Age	
c Parity	
d Last menstrual period	
e Due Date	
f Weeks gestation when seen	
2 What was the emergency/problem treated?	
3 What was the condition of the woman when she came to you (include blood pressure, pulse, estimated blood loss, edema, other important information)	
4 What did you do?	

PAGE TWO

LIFE-SAVING SKILLS

INCIDENT REPORTING FORM

5 What was the response of the woman? (Did she get better, stay the same, die?)

6 What follow-up care did she receive?

7 How confident and competent did you feel to handle this emergency/problem?

8 What additional skills or knowledge would have helped you to feel more confident and competent?

FOLLOW UP SUPPORT VISIT FORM ¹⁶

Name of Person Being Visited				Date			
Name of Trainer or Supervisor				Training Number			
Training Dates				Training Center			
District				Clinic			
ANTENATAL CARE LAST MONTH				DELIVERIES LAST MONTH			
NEW	REVISIT	REFERRALS		Number	REFERRALS		
		Number	Reason		Number	Reason	
AREAS BEING EVALUATED							
1 COMMUNITY INTEGRATION				Number Home Birth Attendants (TBA) Visited		Total Number Home Birth Attendants in Midwife Community	
1 1 Has met with Home Birth Attendant in her village (for this question fill in number)							
				YES		NO	
1 2 Has met with community leaders after training							
1 3 Has explained/asked leaders for support							
1 4 Number of times midwife attended delivery or provided postpartum examination for Home Birth Attendant (check yes for only one answer below)							
a 1 - 2							
b 3 - 4							
c 5 - 8							
d 9 - 12							
e Over 12							
2 INFECTION PREVENTION							
2 1 Uses heavy cleaning gloves for cleaning instruments							
2 3 Apron							
a Uses when attending deliveries							
b Easily available							
c Clean							

¹⁶ Adapted from Beck, D et al (1995) Peer Review Visit Form p 1-6

		YES	NO
Decontamination solution			
a	Prepares solution correctly		
b	Changes solution according to guidelines		
c	Uses solution to clean		
	1) Delivery area		
	2) Instruments		
	3) Linens and supplies		
2 4	Uses infection prevention steps appropriately		
3	LABOR AND DELIVERY		
3 1	Uses partograph for each labor and delivery		
3 2	Instruments and gloves ready for delivery		
3 3	Oxytocic available and stored in a cool place		
3 4	Suction bulb or DeLee suction available		
4	POSTPARTUM		
4 1	Conducts home visits		
	a On mothers she delivers		
	b On mothers delivered by Home Birth Attendant		
4 2	Counsels and gives (if necessary) iron folate pills (40) to all mothers visited		
4 3	Family planning		
	a Gives counseling to all mothers visited		
	b Assists all mothers visited to make decision on FP by 6 weeks postpartum		
5	FORMS		
5 1	Incident Reporting Form (in last 6 months)		
	a Filled out for each major complication		
	b Filled out correctly		
5 2	Referral Form (in last 6 months)		
	a Filled out for each referral		
	b Filled out correctly		

COMMENTS

6 ANTENATAL RECORD REVIEW

Review up to 4 antenatal records for the last 4 mothers who delivered

Yes = ✓

No = 0

Chart Number	Number of Patient Visits	Fetal Heart Rate Checked	Fundal Height Measured Each Visit	BP Checked Each Visit	Hemoglobin Tested Per Protocol	Iron Folate Pills Given Per Protocol	Urine Tested Per Protocol	Asks Danger Signs Each Visit
1								
2								
3								
4								

7 LABOR RECORD - PARTOGRAPH

Was the following information recorded CORRECTLY for the last 4 mothers who delivered Yes = ✓ No = 0

Partograph Number	Blood Pressure	Amniotic Fluid	Dilatation	Descent	Contractions	Fetal Heart Rate	Fluids Given	Urination
1								
2								
3								
4								
Case Study								

8 LABOR RECORD - PARTOGRAPH

Was the following information recorded using the time schedule stated in LSS? Yes = ✓ No = 0

Partograph Number	Vaginal Exam	Fetal Heart Rate	Contractions	Urination	Fluids Given	Referral if Needed
1						
2						
3						
4						
Case Study						

9 LABOR RECORD - (BACK PAGE)

Was the following information recorded ? Yes = ✓ No = 0

Partograph Number	Placenta Noted as Complete	Oxytocin Given	APGAR Score Given	Complications Stated
1				
2				
3				
4				
Case Study				

10 POSTPARTUM CARE RECORD

Review records of up to 4 mothers who have recently completed their 40 days postpartum Yes = ✓ No = 0

Chart Number	Number of Postpartum Visits	Mother Exam Each Visit	Baby Exam Each Visit	Family Planning Started	Iron Given	Complications Noted
1						
2						
3						
4						

FOR ANY "NO" ANSWERS ON THE PREVIOUS PAGES (SECTIONS 1 - 10), PLEASE EXPLAIN

FORMS NEEDED	YES	NO	NUMBER GIVEN
Antenatal Record			
Labor Record Partograph			
Referral Form			
Incident Reporting Form			
Postpartum Record			

SKILLS CHECKLIST - DISCUSSED OR OBSERVED	YES	NO	COMMENT
Antenatal Assesment and Treatment			
Monitoring Labor Progress on Admission			
Monitor Labor Progress			
Episiotomy and Laceration Repair			
Active Management of Third Stage			
Manual Removal of Placenta			
Bimanual Compression of the Uterus			
Inspection with Vaginal Speculum			
Digital Evacuation			
Infant Resuscitation			
Adult Resuscitation			
Hemlich Maneuver			
Incision and Drainage of Breast Abscess			
Infection Prevention			
Care of Surgical Gloves			
Starting an Intravenous Fluid in a Peripheral Vein			
Giving Fluids in the Rectum			
Giving Fluids into the Peritoneal Cavity			
Using a Vacuum Extractor			
Persistent Occiput Posterior Position			

	YES	NO	COMMENT
Umbilical Cord Prolapse			
Uterine Inertia (Tired Uterus)			
Shoulder Dystocia			
Breech Management			
Manual Vacuum Aspiration			
Postabortion Care Monitor and Counsel			
Symphiotomy			

AREAS OF EXCELLENCE

AREAS NEEDING IMPROVEMENT

AREAS IMPROVED SINCE LAST VISIT

COMMENTS/SUGGESTIONS

SIGNATURE OF PERSON BEING VISITED _____

NEXT VISIT PLANNED ON _____

COPY OF INFORMATION (1) Original filled out and kept by Supervisor/Trainer
 (2) Record of information in *Clinical Practice Guide*

FOLLOW-UP AND SUPPORT VISIT SUMMARY ¹⁷						
ANTENATAL CARE LAST MONTH				DELIVERIES LAST MONTH		
NEW	REVISIT	REFERRALS		NUMBER	REFERRALS	
		NUMBER	REASON		NUMBER	REASON

What was done last month? (Use the back for additional comments)

Number of TBA or home birth attendant (HBA) visits ?
What was the most serious problem you saw last month?
What were the causes?
What can you do to prevent the problem from happening again?

Use information from Follow-up and Support Form to indicate in the second column ✓ (satisfactory) or X (needs improvement), in the third column PLANS.

Infection prevention		
Delivery equipment		
Oxytocic		
Postpartum visits		
Family planning counseling		
Incident form review		
Referral form review		
Antenatal record review		
Partograph review front		
Partograph review back		
Number of forms supplied • partograph _____ • antenatal _____ • referral _____ • incident report _____	Supervisor _____ Date _____ Return Date _____	
Clinical Skills Checklist Summary see page 95 in the <i>Clinical Practice Guide</i>		

¹⁷ See A *Clinical Practice Guide* for additional summary forms