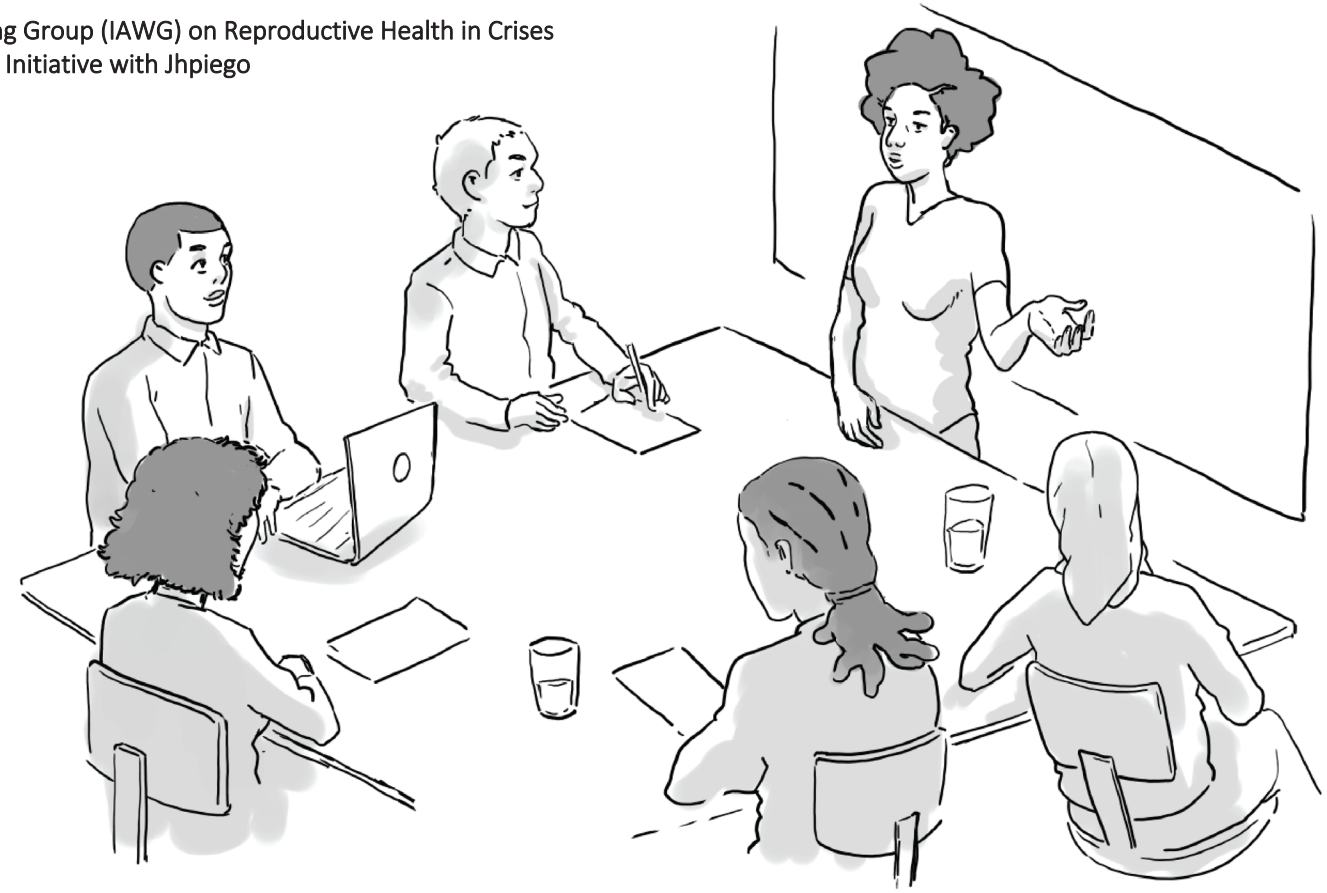
BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE IN CRISIS SETTINGS: SELECT SIGNAL FUNCTIONS

PARTICIPANT WORKBOOK

Clinical Outreach Refresher Training Module for Health Care Providers Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises
Training Partnership Initiative with Jhpiego



ACKNOWLEDGEMENTS

These training materials were developed in 2017 through an ongoing collaboration among the membership of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises through the efforts of the Training Partnership Initiative. The project was made possible thanks to generous funding provided by USAID's Office of Foreign Disaster Assistance (OFDA). UNFPA, the Helping Mothers Survive Secretariat based at Jhpiego, the Women's Refugee Commission, and Laerdal Global Health have been of invaluable support to the production of this module. Tomo Watanabe contributed substantially to drafting the training module content. Kristen Harker, Dr. Wilma Doedens, and Dr. Nguyen Toan Tran also contributed technical input. The IAWG Training Partnership Initiative is grateful to the Juba College of Nursing and Midwifery and Save the Children for piloting this module in South Sudan and for their inputs to the materials.

In 2020, funding from the Netherlands Ministry of Foreign Affairs allowed for this module to be updated to align with the 2018 revised *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*. The 2020 revision was led by Sheena Currie with review and technical inputs provided by Dr. Blami Dao and Alemnesh Reta. Alison Greer provided a review and edits. The training materials were designed by Mikhail Hardy and Chelsea Ricker. IAWG is immensely grateful for their contributions.

Content for this training is based on World Health Organization guidelines and the *Inter-Agency Field Manual*. Various materials have been adapted with permission from Helping Mothers Survive modules:

Pre-eclampsia and eclampsia 2016 (hms.jhpiego.org/pre-eclampsia_eclampsia)
Post-partum hemorrhage 2017 (hms.jhpiego.org/bleeding-after-birth-complete)

Content from Helping Babies Survive has also been adapted, and videos from Global Health Media, Medical Aid Films, and White Ribbon Alliance incorporated into this module.

LIST OF ABBREVIATIONS

AMTSL	Active management of the third stage of labor
BEmONC	Basic emergency obstetric and newborn care
BP	Blood pressure
EmONC	Emergency obstetric and newborn care
IARH	Inter-Agency Emergency Reproductive Health (Kits)
IAWG	Inter-Agency Working Group (on Reproductive Health in Crises)
IM	Intramuscular
IP	Infection prevention
IU	International units
IV	Intravenous
MCG	Microgram
MGSO4	Magnesium sulphate
MISP	Minimum Initial Service Package (for Sexual and Reproductive Health)
NASG	Non-pneumatic anti-shock garment
NS	Normal saline
ORS	Oral rehydration solution
OSCEs	Objective structured clinical examinations
PPE	Personal protective equipment
PPH	Postpartum hemorrhage
PROM	Premature rupture of membranes
RAM	Rapid assessment and management
RL	Ringer's lactate
RMC	Respectful maternity care
S-CORT	Sexual and reproductive health clinical outreach refresher training
TBA	Traditional birth attendant
TXA	Tranexamic acid
UBT	Uterine balloon tamponade
WHO	World Health Organization
WRA	White Ribbon Alliance

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INTRODUCTION

THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health is a priority set of lifesaving activities to be implemented at the onset of every emergency. The 2018 MISP for Sexual and Reproductive Health has six objectives and another priority activity:

1. Ensure the health sector/cluster identifies an organization and a sexual and reproductive health coordinator to lead and coordinate the implementation for the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive sexual and reproductive health services, integrated into primary health care as soon as possible.

Other priority: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Neglecting the MISP for Sexual and Reproductive Health in crisis settings has serious consequences: preventable maternal and newborn deaths; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV.

Nurses, midwives, and physicians working in emergencies provide the sexual and reproductive health services needed to achieve the objectives of the MISP. IAWG has designed a series of short clinical outreach refresher trainings (S-CORTs) in order to reinforce previously acquired knowledge and skills of health care staff tasked with providing these priority services. *Basic Emergency Obstetric and Newborn Care in Crisis Settings*, Select Signal Functions is one of these modules. Please visit www.iawg.net/scorts to access all training materials in the series and more information on their use.

UNIVERSAL ACCESS: ENSURING SERVICES THAT ARE FREE OF STIGMA AND DISCRIMINATION

Words matter when describing and caring for individuals who need access to health care information and services and, in particular, the services presented in the S-CORT series. Language can have a significant impact on sexual and reproductive health and wellbeing as well as access to related information and services. At times, the terminology used in guidance, programs, and policies can be discriminating, stigmatizing, and dehumanizing. Conscious of the tensions that can arise when trying to use inclusive and appropriate language and, at the same time, be concise and efficient, especially in publications, the language used in the S-CORT series was guided by the following considerations:

- **On gender**. Throughout the S-CORT series, the terms "women," "girls," and, at times, the gender-neutral "person," "people," "client," "patient," or "individual" refer to those who use the services presented in the S-CORT. However, the authors recognize and emphasize that:
  - Not only cis-gendered women (women who identify as women and were assigned the female sex at birth) can get pregnant and have rights to quality health care, to be treated with dignity and respect, and to be protected from stigma, discrimination, and violence in all settings. Persons who are trans men/transmasculine, intersex, non-binary, and gender non-conforming can experience pregnancy and face unique barriers to accessing sexual and reproductive health information and services. The S-CORT language strives to reflect this diversity whenever possible but for ease of reference and use, "women" or "women and girls" may be often applied.
  - Sexual violence "survivors" can be women, men, trans, intersex, non-binary, gender non-conforming individuals, and individuals of all ages.
- **On age**.[1] Adolescents—girls, boys, trans, intersex, non-binary, and gender non-conforming—have unique sexual and reproductive health needs and should not be discriminated against in terms of access to information, services, care, and support. Equally important are the sexual and reproductive health needs of older persons. The S-CORT language strives to reflect this age diversity whenever possible, but for ease of reference and use, it often does not use age-specific terminology.
- **On disability.** The sexual and reproductive health needs of persons living with disabilities have been widely neglected. They should not be discriminated against regarding access to sexual and reproductive health information, services, care, and

1. For updated resources and support for organizations supporting adolescents, see the updated IAWG Adolescent *Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings*: 2020 Edition, available at: iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition.

support. While for ease of reference and use disability-specific terminology is not always applied, the S-CORTS were developed using universal design principles to ensure accessibility of these materials. Facilitators and organizations are encouraged to take into consideration the accessibility needs of persons living with disabilities in the communities they serve and in particular the interpretation, mobility, and other accessibility needs of participants in these trainings.

- **On diversity**. All individuals, no matter how diverse their personal, social, cultural, and economic background, have a right to access sexual and reproductive health information, services, care, and support free from stigma, discrimination, and violence. Images and language in this guide have been designed with diversity in mind, however, the S-CORT language is not always able to reflect the rich diversity of individuals who access sexual and reproductive health information, services, care, and support.

S-CORT participants should keep these inclusive considerations of gender, age, disability, and diversity in mind when attending these trainings to further universal access to sexual and reproductive health information, services, care, and support.

WHAT CAN HEALTH STAFF DO?

The use of inclusive, appropriate, and respectful language is a cornerstone of reducing harm and suffering. All terminology requires contextualization to the local language and socio-cultural environment as well as a pragmatic approach, but one that should not sacrifice the promotion and use of stigma-free and all-gender-age-disability-diversity inclusive language. To help mainstream such language, health staff should consider the following principles to guide the way they speak, write, and communicate among themselves and with and about the persons accessing sexual and reproductive health information and services. These principles can help health staff prioritize the use of terminology that adheres to their professional mandate: caring for all people.

- **Engage and ask people and respect their preferences**. As terminology requires adaptation in local languages and cultures, each linguistic and professional community should be engaged in discussing and contextualizing diversity-inclusive terms so that they are acceptable in the circumstances they are to be used. For example, avoid assuming the person's gender ("Miss" or "Mister") and ask instead: "Hello and welcome. My name is B and I am your provider today. Could you please tell me how I should address you?".
- **Use stigma-free, respectful, and accurate language**. Avoid using judgmental terms that are not person-centered. Favor the use of humane and constructive language that promotes respect, dignity, understanding, and positive outlooks (for example, prefer "survivor of sexual violence" to "victim").
- **Prioritize the individual**. It is recommended to place individuals at the center, and their characteristics or medical conditions second in the description (i.e. persons living with disability or persons living with HIV). Therefore, the use of person-centered language should be preferred to describe what people have, their characteristics, or the circumstances in which they live, which should not define who they are and how health staff treat them.
- **Cultivate self-awareness**. Professionals working with persons from diverse backgrounds should be conscious of the language they use as it can convey powerful images and meanings. They should develop cultural humility and self-reflection, be mindful, and refrain from repeating negative terms that discriminate, devalue, and perpetuate harmful stereotypes and power imbalances. They should also encourage colleagues, friends, and their community to do so. Values clarification workshops for health (and non-health) staff working with people with diverse backgrounds and characteristics could be transformative in clarifying values and changing attitudes to improve interactions.

OBJECTIVE

The objective of the training is to refresh health care providers' lifesaving knowledge and skills in selected common pregnancy-related complications, including prevention and management post-partum hemorrhage, prevention and management severe pre-eclampsia and eclampsia, and prevention and management of maternal sepsis, as well as essential newborn care and newborn resuscitation.

TRAINING OVERVIEW

This training module is designed for clinical service providers including midwives, nurses, general practice physicians, obstetricians/gynecologists, and others who are currently attending or will attend births in the acute phase of an emergency response. The training is rooted in evidence and competency-based approaches. Both knowledge and skills will be assessed to determine the competency of participants in key clinical topics. Participants are required to complete a multiple-choice knowledge pre-test and post-test with a passing mark of 80%. Skills will be assessed during practice sessions. Infection prevention practices and respectful maternal and newborn care are integrated across topics and considered essential components of clinical practice.

HOW TO USE THIS WORKBOOK

This workbook is designed to serve as a learning tool during the training session and as a reference guide and job aid for your clinical work post-training. In addition to offering you a centralized location to keep your notes and plans for providing basic emergency obstetric and newborn care in crisis settings, it also provides contextual information, skills checklists, and recommendations for additional resources. You can access this participant workbook in addition to the presentations, facilitator's guidance, and links to supplemental resources on the IAWG website at www.iawg.net/scorts.

SUPPLEMENTARY MATERIALS FOR THIS TRAINING

In addition to the materials included in this workbook, you may receive the following job-aids and materials from your workshop facilitator, or you can download them at any time from the IAWG website at www.iawg.net/scorts.

- *MISP Checklist*
- *The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
- *Respectful care: A tool for Healthcare workers*. White Ribbon Alliance. Available: www.youtube.com/watch?v=aStnrRu_VrQ&t=30s
- *Bleeding After Birth*. Global Health Media. Available: globalhealthmedia.org/portfolio-items/bleeding-after-birth/?portfolioCats=191%2C94%2C13%2C23%2C65
- *Severe Pre-Eclampsia*. Global Health Media. Available: globalhealthmedia.org/portfolio-items/severe-pre-eclampsia/?portfolioCats=191%2C94%2C13%2C23%2C65
- *Helping Babies Breathe at Birth*. Global Health Media. Available: globalhealthmedia.org/portfolio-items/helping-babies-breathe-at-birth/?portfolioCats=191%2C94%2C13%2C23%2C65
- **Optional**: *How to Use the Uterine Balloon Tamponade*. Medical Aid Films. Available: www.youtube.com/watch?v=0ycliSjvcF4
- **Optional**: *Inserting an IV*. Global Health Media. Available: globalhealthmedia.org/portfolio-items/inserting-an-iv-2/?portfolioCats=191%2C94%2C13%2C23%2C65
- **Optional**: *Using an Anti-Shock Garment*. Global Health Media. Available: globalhealthmedia.org/portfolio-items/using-an-anti-shock-garment/?portfolioCats=191%2C94%2C13%2C23%2C65
- **Optional**: *Taking a Blood Pressure*. Global Health Media. Available: globalhealthmedia.org/portfolio-items/taking-a-blood-pressure/?portfolioCats=191%2C94%2C13%2C23%2C65

FEEDBACK ON THE TRAINING MATERIALS

The IAWG Training Partnership Initiative is interested in hearing from you. Please send any questions or feedback to info.iawg@wrcommission.org regarding the training materials and their use in your context.

UNIT 1 COURSE OVERVIEW

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

- Introduce each other and facilitators.
- Reflect on their expectations of the training.
- Explain the objectives of the training.
- Agree on the ground rules/norms of the training.
- Describe training materials and key teaching and learning approaches, including guided reading /self-study and assessment of training.

NOTES:

MY EXPECTATIONS FOR THIS TRAINING

TOPICS I WANT TO REVISIT

UNIT 2 WHAT IS EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC) AND WHY IS IT NEEDED?

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

- Explain the principles of preventing excess maternal and newborn mortality and morbidity in humanitarian settings.
- Discuss how basic emergency obstetric and newborn care (BEmONC) supports the implementation of the MISP for Sexual and Reproductive Health in an emergency.

The most common life-threatening obstetric complications are severe bleeding, infection, severe pre-eclampsia/eclampsia, complications of abortion, and obstructed labor. There are separate clinical refresher training modules devoted to obstructed labor and postabortion care. This module focuses on the skills related to managing severe bleeding, infection, and eclampsia.

Up to 80% of maternal deaths are preventable and a lot of work is needed to bring the global maternal mortality ratio to <70 per 100,000 live births per the United Nations Sustainable Development Goals targets. Indirect causes of maternal deaths include HIV and malaria. Progress in reducing maternal and newborn mortality in humanitarian settings is hindered as systems break down. Monitoring and reporting on maternal and perinatal mortality in humanitarian settings is very important. Check how this is done in your area.

The MISP for Sexual and Reproductive Health is part of the Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings, which was revised in 2018. MISP Objective 4 is to prevent excess maternal and newborn morbidity and mortality. Activities under this objective include:

- Ensure availability, accessibility, acceptability, and utilization of labor and birth, essential newborn care, and emergency obstetric and newborn care (EmONC) services:
  - **At health facilities**: This includes skilled birth attendants and supplies for normal births, essential newborn care, and management of basic obstetric and newborn complications (basic EmONC).
  - **At referral hospitals**: This includes all the health facility activities plus skilled medical staff and supplies for management of comprehensive obstetric and newborn emergencies (comprehensive EmONC).
- Establish a referral system to facilitate transport and communication from the community to the health center, and between the health center and the hospital.
- Ensure availability of a package of supplies and commodities for clean delivery and newborn care, where access to a health facility is not possible.

NOTES:

MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

iawg.net/IAFM

OBJECTIVE 1: ENSURE THE HEALTH SECTOR/ CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP
- Reports back to the health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation
- In tandem with health/GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services
- Shares information about the availability of SRH services and commodities
- Ensures the community is aware of the availability and location of reproductive health services

OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

- Work with other clusters especially the protection or gender based violence sub-cluster to put in place preventative measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence
- Make clinical care and referral to other supportive services available for survivors of sexual violence
- Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

IARH Kit 3 IARH Kit 5 IARH Kit 8 IARH Kit 9

OBJECTIVE 6: PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE AS SOON AS POSSIBLE. WORK WITH THE HEALTH SECTOR/CLUSTER PARTNERS TO ADDRESS THE SIX HEALTH SYSTEM BUILDING BLOCKS:

- Service Delivery
- Health Workforce
- Health Information System
- Medical Commodities
- Financing
- Governance and Leadership

GOAL

PREVENT MORTALITY, MORBIDITY, AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

OBJECTIVE 3: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

IARH Kit 1 IARH Kit 3 IARH Kit 5 IARH Kit 12 Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception] at primary health care facilities to meet demand
- Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

IARH Kit 1 IARH Kit 3 IARH Kit 4

OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
  - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage
  - At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)
  - At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure the availability of life-saving, post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

IARH Kit 2 IARH Kit 6 IARH Kit 8 IARH Kit 9 IARH Kit 10 IARH Kit 11 IARH Kit 12

IARH Kit 8 **Other Priority**: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

The MISP forms the starting point for SRH programming and respectful quality of care must be ensured from the start. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. These services should be sustained and built upon as soon as possible (ideally 3-6 months) with comprehensive SRH services and supplies throughout protracted crises and recovery.

Fundamental principles for SRH programming in humanitarian settings

- Work in respectful partnership with people receiving care, providers, and local and international partners
- Ensure equality by meeting people's varied sexual and reproductive health needs and ensuring that services and supplies are affordable or free, accessible to all, and of high quality
- Provide comprehensive, evidence-based, and accessible information and choice about the supplies and services available
- Ensure effective and meaningful participation of concerned persons and person-centered care that recognizes patients' autonomous decision-making power and choice for services and commodities
- Ensure privacy and confidentiality for everyone and treat people with dignity and respect
- Promote equity, with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g. rural/urban), disability, race, color, language, religion, political or other opinion, national, ethnic or social origin, property, birth, or other characteristics
- Recognize and address gender and power dynamics in healthcare facilities to ensure that people do not experience coercion, discrimination, or violence/mistreatment/disrespect/abuse in receiving or providing health services
- Engage and mobilize the community, including often marginalized populations such as adolescents, in community outreach to inform the community about the availability and location of MISP services and commodities
- Monitor services and supplies, and share information and results with the aim of improving quality of care

Community Level/Health Post: Community Level/Health Post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a 3-month period. The kits contain mainly medicines and disposable items.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 1A	Male Condoms	Red
Kit 2	Clean Delivery (A and B)	Dark blue
Kit 3	Post-Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	Treatment of Sexually Transmitted Infections	Turquoise

Primary Health Care Facility Level (BEmONC): Primary Health Care Facility Level (BEmONC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order theses kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance – Midwifery Supplies (A and B)	Brown
Kit 8	Management of Complications of Miscarriage or Abortion	Yellow
Kit 9	Repair of Cervical and Vaginal Tears	Purple
Kit 10	Assisted Delivery with Vacuum Extraction	Grey

Referral Hospital Level (CEmONC): Referral Hospital Level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 11	Obstetric Surgery and Severe Obstetric Complications Kit (A and B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels. The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

**** The new kit structure will only be available late 2019***

LEVEL	COMPLEMENTS	ITEM
Coordination	All Kits	Kit 0 - Administration and Training
Community and Primary Health Care - BEmONC	Kit 1	Kit 1B - Female Condoms
	Kit 2A	Chlorhexidine gel
	Kit 2B	Misoprostol (also complements Kits 6B and 8)
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)
Health Center or Hospital Level - CEmONC	Kit 4	Kit 7A - Intrauterine Device (IUD)
	Kit 4	Kit 7B - Contraceptive Implant
	Kit 6A	Non-Pneumatic Anti-Shock Garment
	Kit 6B	Oxytocin
	Kit 8	Mifepristone
	Kit 10	Hand-held Vacuum Assisted Delivery system

Complementary commodities are a set of disposable and consumable items and/or kits that can be ordered in specific circumstances to complement existing IARH Kits:

- where providers are trained to use the special supply;
- where the supplies were accepted and used prior to the emergency;
- after the rapid first order of SRH supplies in protracted crises or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels); and,
- where the use of the supplies is allowed to the fullest extent of the national law.

Information on the IARH kits and assistance with ordering can be provided by UNFPA country offices, or the UNFPA Humanitarian Office in Geneva. The IARH Kits can be ordered from UNFPA PSB in Copenhagen through either a UNFPA country office or the UNFPA Humanitarian Office; you can also reach out to the SRH working group/sub-sector coordinator to facilitate coordinated procurement of the IARH Kits.

UNFPA Humanitarian Office

UNFPA
Attn: Humanitarian Office
Palais des Nations
Avenue de la paix 8-14
1211, Geneva 10, Switzerland
Email: Humanitarian-SRHsupplies@unfpa.org

UNFPA Procurement Services Branch

UNFPA Procurement Service Branch
Marmovej 51
2100 Copenhagen, Denmark
Email: procurement@unfpa.org
Website: unfpaprocurement.org

Before placing an order, discuss with the SRH coordination group and/or the UNFPA country office to determine what is already being ordered and if orders can be combined.

Source: Inter-Agency Working Group on Reproductive Health in Crises. "Quick Reference for the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)," 2018. iawg.net/resources/misp-reference.

SIGNAL FUNCTIONS OF EMONC

BASIC EMONC

COMPREHENSIVE EMONC

COVID-19 and EmONC

Continuing essential sexual and reproductive health services and programs is critical during the COVID-19 response. Ignoring health care for women and newborns risks and overburdened health system at a later date and consequently poorer health outcomes. Pregnant women are more likely to die from non-COVID-19 related causes.

Remember, in situations where COVID-19 is present: screening, detecting, and triaging all clients presenting for care remains a priority to reduce the risk of spread. Good infection prevention (e.g., handwashing for clients and providers and wearing masks), physical distancing, and other standard precautions are the foundation for all health services.

For regular updates on COVID-19 visit: www.who.int/emergencies/diseases/novel-coronavirus-2019

For more information about adaptations for EmONC and other MISP for Sexual and Reproductive Health services and programming, please see the *MISP Considerations Checklist for Implementation During COVID-19* and other resources available at www.iawg.net/covid-19.

WHAT LIFESAVING SUPPLIES DO YOU NEED FOR BEMONC?

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

- Discuss issues that contribute to the mistreatment of women and newborns.
- Share examples of mistreatment.
- Explain the concept of respectful maternity care as a core component of quality care.

NOTES:

Source: White Ribbon Alliance. "Respectful Maternity Care Charter: The Universal Rights of Women and Newborns," 2019. Available: www.whiteribbonalliance.org/rmcresources.

UNIT 4 RAPID ASSESSMENT AND MANAGEMENT

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

- Quickly identify and treat an obstetric emergency.
- Initiate treatment of shock.

Your ability to provide appropriate care for a woman with an obstetric emergency will depend on the resources available at the facility where you are working. Rapid referral to a higher level of care may be needed. It is important to perform a rapid assessment of the woman at the first meeting to quickly identify conditions requiring referral. An initial rapid assessment upon arrival will help you decide whether you are able to treat her at the health center level, or if she needs immediate referral to a higher level of care.

Key Points:

- Speed is crucial when handling emergencies
- Work together as a team to start emergency care and initiate the transfer process
- Communicate clearly with each other and keep accurate records of all care given
- Know the resources at your facility
- Know the referral process and to where the woman can go for a higher level of care

POSSIBLE SIGNS OF OBSTETRIC EMERGENCY

SIGNS AND TREATMENT OF SHOCK

UNIT 5 PREVENTION AND MANAGEMENT OF POSTPARTUM HEMORRHAGE

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

- Demonstrate active management of the third stage of labor.
- Accurately identify normal and abnormal postpartum blood loss.
- Identify and manage the most common causes of postpartum hemorrhage following normal vaginal birth.
- Utilize supplies available, including those in the Inter-Agency Emergency Reproductive Health (IARH) Kits, to prevent and treat postpartum hemorrhage.
- Identify and appropriately refer women and newborns requiring a higher level of care.

NOTES:

WHAT RESOURCES DO I NEED TO PROVIDE AMTSL FOR PREGNANT PEOPLE IN MY CARE?

Active Management of The Third Stage of Labor (AMTSL) Skills Checklist	Yes	No
Following birth of the infant, provider checks for a second baby.		
Tells the woman what medication she is being given and why.		
Gives uterotonic medication within 1 minute of birth of the infant.		
Changes or takes off the first pair of gloves.		
Cuts the cord after 1-3 minutes.		
Explains to the woman what s/he is doing and applies counter-pressure while performing controlled cord traction.		
Performs controlled cord traction when the uterus is well contracted.		
Uses both hands to catch the placenta at the vulva.		
Gently turns the placenta while it is being delivered.		
Assesses fundal tone immediately following the delivery of the placenta and massages if soft.		
Inspects the placenta and membranes for completeness.		
Checks the woman's bleeding and vagina/perineum for tears.		
After explaining to the woman, gently checks perineum for any lacerations.		
Ensures the woman is clean and comfortable and the newborn is skin-to-skin; assists with breastfeeding.		

CASE STUDY: POSTPARTUM HEMORRHAGE

Farida is a 20-year-old para 1. She was brought to the health center by the local traditional birth attendant (TBA) because she has been bleeding heavily since childbirth at home 2 hours ago. The TBA reports that the birth of a full-term newborn was normal. Farida and the TBA report that the duration of labor was 12 hours. They also said the placenta was delivered spontaneously 20 minutes after the birth of the newborn, who was breastfeeding at the time.

ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, SCREENING PROCEDURES / LABORATORY TESTS)

1. What will you include in your initial assessment of Farida? Why?

_____
_____
_____

2. What particular aspects of Farida's physical examination will help you make a diagnosis or identify her problems/needs? Why?

_____
_____
_____

DIAGNOSIS (IDENTIFICATION OF PROBLEMS/NEEDS)

You have completed your rapid assessment of Farida. Your main findings include the following:

History

- The TBA says that she thinks the placenta and membranes were delivered without difficulty and were complete.

Physical examination

- Farida's temperature is 36.8º C, her pulse rate is 108 per minute, her blood pressure is 80/60, and her respirations are 24 per minute. She is pale and sweating. Her uterus is soft and does not contract with fundal massage. She has heavy, bright red vaginal bleeding. On inspection, there is no evidence of perineal, vaginal, or cervical tears.

3. Based on these findings, what is Farida's diagnosis (problem/need)? Why?

_____
_____
_____

CARE PROVISION (PLANNING AND INTERVENTION)

4. Based on your diagnosis (problem/need identification), what is your plan of care for Farida. Why?

_____
_____
_____

Bimanual Compression of The Uterus Checklist	Yes	No
Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.		
Provide continual emotional support and reassurance, as feasible.		
Put on personal protective barriers.		
Wash hands thoroughly and put on sterile surgical gloves.		
Clean vulva and perineum with antiseptic solution.		
Insert a hand into anterior vaginal fornix and form a fist with the back of the hand directed posteriorly and the knuckles in the anterior fornix; apply pressure against the anterior wall of the uterus.		
Place the other hand on the abdomen behind the uterus; press the hand deeply into the abdomen and apply pressure against the posterior wall of the uterus.		
Maintain compression until bleeding is controlled and the uterus contracts.		
Remove gloves and wash hands thoroughly with soap and water and dry with a clean, dry hand-towel or air dry.		
Monitor vaginal bleeding, take the woman's vital signs, and make sure that the uterus is firmly contracted.		
Inspects the placenta and membranes for completeness.		
Checks the woman's bleeding and vagina/perineum for tears.		
After explaining to the woman, gently checks perineum for any lacerations.		
Ensures the woman is clean and comfortable and the newborn is skin-to-skin; assists with breastfeeding.		

Checklist for Uterine Balloon Tamponade (Some of the following steps/tasks should be performed simultaneously)					
Step/Task	Cases				
GETTING READY					
Prepare the necessary equipment					
Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns					
Provide continual emotional support and reassurance, as feasible					
Start IV of normal saline or Ringer's lactate with oxytocin (20 iu in 500 mL)					
Give ampicillin 2 grams IV					
Put on personal protective barriers					
Wash hands and forearms thoroughly with soap and water and dry					
Put sterile surgical gloves on both hands					
Prepare uterine balloon tamponade on a clean surface: open the condom and place the inner end of a Foley catheter inside the condom					
Using a suture or cord ties, securely tie the condom to the catheter					
Ensures the woman is clean and comfortable and the newborn is skin-to-skin; assists with breastfeeding					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
UTERINE BALLOON TAMPONADE					
Clean the vulva and perineal area and place a clean/sterile drape beneath the woman's buttocks					
Ensure that the bladder is empty; catheterize if necessary					
Place the fingers of one hand into the vagina and identify the cervix; using clean technique, gently insert the catheter covered with the condom through the cervix until the condom has completely passed through the cervix					
Connects the outlet of the Foley catheter to the IV set which is connected to an infusion bag (large syringes can also be used to fill the condom)					
Infuse 250 mL of fluid into the condom until bleeding stops (or 250–500 mL with model)					
Tie or clamp the end of the catheter					
Wash hands thoroughly with soap and water and dry					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
Continue to monitor vaginal bleeding, vital signs, and urinary output					
Keep the oxytocin infusion running for at least 4 hours after insertion of the uterine balloon tamponade					
Complete patient records with details of the procedure and any drugs given, noting the time when the uterine balloon tamponade was inserted					
Ensure arrangements for referral to higher-level facilities where surgical capacity is available					
The uterine balloon tamponade can be left in utero for up to 24 hours. When deflating the condom (if patient is stable), deflate gradually by withdrawing 50 mL of fluid at a time via syringe, re-clamping to assess bleeding, etc. If the bleeding has stopped, the uterine balloon tamponade can be removed over a period of a few hours.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					

OPTIONAL SKILL: UTERINE BALLOON TAMPONADE. NOTES:

UNIT 6 MANUAL REMOVAL OF THE PLACENTA

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

- Recognize indications for manual removal of the placenta at multiple levels of care.
- Perform manual removal of the placenta.

Manual Removal of Placenta Skills Checklist	Completed? (Yes/No)
PREPARATION	
1. Explain the procedure to the woman and provide emotional support	
2. Insert an IV line with fluids rapidly infusing (with oxytocin if active bleeding)	
3. Assist the woman onto her back, ensure covered for privacy and warmth	
4. Give diazepam *5/10 mg IM/IV	
5. Give prophylactic antibiotics *Ampicillin 2g IV or IM and metronidazole 500 mg IV or 1 g by mouth, once (250 mg x 4)	
6. Clean the vulva and perineal area	
7. Ensure the bladder is empty; catheterize if necessary	
8. Wash hands and forearms well and put on sterile gloves (long if available)	
TECHNIQUE	
1. With one hand, hold the umbilical cord at the clamp; pull the cord gently until horizontal	
2. Insert the other hand into the vagina and follow the cord up into the uterus	
3. Drop the cord with the external hand and hold the fundus and provide counter-traction and prevent inversion	
4. Move fingers of the internal hand sideways to locate the edge of the placenta	
5. Keep fingers tightly together and use the edge of the hand to gradually make space between the placenta and uterine wall	
6. Proceed gradually until the entire placenta is detached from the uterine wall	
7. Withdraw the internal hand from the uterus gradually, bringing the placenta with it	
8. Use the internal hand to explore inside of the uterine cavity to ensure all placental tissue has been removed	
9. Examine the uterine surface of the placenta to ensure lobes and membranes are complete	
10. Safely dispose of materials and sharps, and clean and process instruments according to local infection prevention guidelines; wash and dry hands	
11. Continue to monitor bleeding, blood pressure, and pulse, and ensure that the uterus is well-contracted; complete the woman's records	

UNIT 7 TRANSPORT AND REFERRAL

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

- Safely stabilize and prepare a woman for transport after postpartum hemorrhage.
- Practice IV access and fluid administration.
- Practice use non-pneumatic anti-shock garment (optional).

NOTES:

This unit provides a review of transport and referral for a woman who needs to move to a higher level of care during or after postpartum hemorrhage. Note that principles of transport and referral for other serious pregnancy-related complications or newborns requiring higher level care are the same.

REFERRAL CHECKLIST		
STEP	**ACTION**	**TICK WHEN DONE**
1	Provide appropriate clinical care to stabilize the woman and the newborn	
2	Explain to the woman (if she is conscious) and her family what is happening and that she or the newborn needs higher-level services	
3	Organize secure and reliable transportation for the woman/newborn	
4	Notify the referral site about the woman/newborn using a phone: • Explain her condition/diagnoses • Describe the care already provided • Give the estimated time of arrival	
5	Ensure that the woman/newborn is accompanied by a family member and/or a potential blood donor	
6	Assign a skilled care provider to attend the mother and/or the newborn during the transfer	
7	Prepare all essential supplies and materials needed during the transfer. This includes: • Supplies for clean and safe birth (if undelivered) • Emergency supplies (IV fluids, medicines e.g., oxytocin, magnesium sulphate) • Dry blankets and towels to keep the woman and the newborn warm • If transferring mother with newborn, practice skin-to-skin contact	
8	Complete referral record with: • Name of referring and referral facility • General information (name, age, address) • Obstetric history (parity, gestational age, complications in pregnancy) • Relevant past obstetric complications (e.g., previous cesarean section, postpartum hemorrhage) • The specific problem for which she is referred • Treatment initiated and the results of treatments • Name and signature of the provider • Give the referral record to the skilled care provider assigned to the transfer	
9	Record referral in the appropriate register	
10	Ensure that the assigned skilled provider obtains feedback from the referral center and ensures that the woman/newborn has a follow-up management plan	
11	Ensure that in the case of maternal or newborn death during referral, the assigned skilled provider reports and records details of mortality; this will help improve services	

IV Skills Checklist			
STEP	**INSERTION INTRAVENOUS (IV) FLUIDS CHECKLIST**	**YES**	**NO**
1	Explain the procedure to the woman and provide emotional support		
2	Gather all supplies • IV fluids and giving set • IV cannulae • tape • skin antiseptic and swab or cotton balls • tourniquet		
3	Wash hands with soap and water; wear clean gloves		
4	Open the package of sterile tubing and attach it to the fluids using sterile technique		
5	Hang the bag of solution up high enough to let it flow to the end of the tubing		
6	Tie the tube off at the end to prevent fluid waste		
7	Use a cloth or rubber tourniquet on the upper arm		
8	Identify a vein and clean the skin with available antiseptic		
9	Hold the vein steady between the first finger and thumb with one hand and carefully insert the needle into the vein with the other hand; look for blood in the needle hub; lay the needle almost flat and slide it the rest of the way into the vein.		
10	Remove tourniquet and attach the fluid tube to the needle		
11	Use tape to hold the needle in place		
12	Regulate the amount and speed of IV fluid flow depending on medical condition		
13	Dispose sharps safely and carefully; wash and dry hands		
14	Start an input/output chart to closely monitor fluid balance		

NOTES:

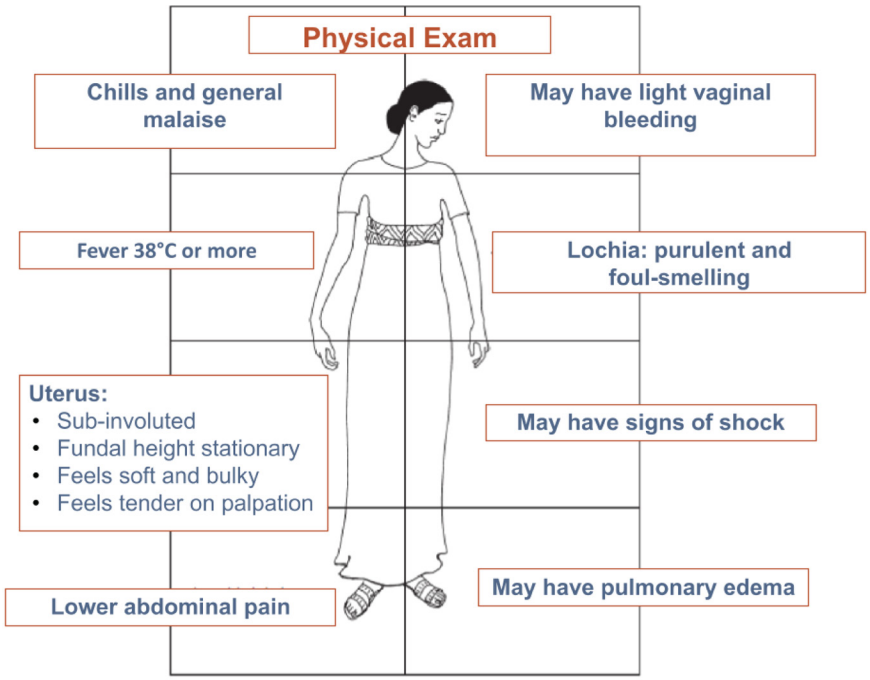
UNIT 8 PREVENTION AND MANAGEMENT OF PERIPARTUM INFECTION

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

- Review and apply prevention, assessment, diagnosis, treatment, and evaluation of peripartum infection.
- Identify and refer women to a higher level of care for severe infection (sepsis).

In crisis settings, there may be a lack of health supplies or infrastructure, and an increased workload. Staff working in the health sector may resort to taking shortcuts in procedures, which endanger the safety of both patients and staff. Therefore, it is essential that standard precautions are respected.

STANDARD PRECAUTIONS TO REDUCE RISK OF INFECTION[2]



CASE STUDY: FEVER AFTER CHILDBIRTH

Elizabeth is a 35-year-old para three. Elizabeth's husband has brought her to the health center today because she has had fever and chills for the past 24 hours. She gave birth to a full-term boy at home 72 hours ago. Her birth attendant was the local traditional birth attendant (TBA). Labor lasted two days and the TBA inserted herbs into Elizabeth's 's vagina to help speed up the childbirth. The newborn breathed spontaneously and appears healthy. The baby is with his older sister outside the facility.

ASSESSMENT (HISTORY, PHYSICAL EXAMINATION, SCREENING PROCEDURES/LABORATORY TESTS)

1. What will you include in your initial assessment of Elizabeth? Why?

_____

_____

_____

2. What particular aspects of Elizabeth's physical examination will help you make a diagnosis or identify her problems/needs? Why?

_____

_____

_____

DIAGNOSIS (IDENTIFICATION OF PROBLEMS/NEEDS)

You have completed your rapid assessment of Elizabeth. Your main findings include the following:

History

- Elizabeth admits that she has felt weak and lethargic, has abdominal pain, and has noticed a foul-smelling vaginal discharge. She does not have pain when she urinates and does not live in an area with malaria. She had a tetanus immunization and a booster 3 years ago. It is unknown whether her placenta was complete.

Physical examination

- Farida's temperature is 36.8º C, her pulse rate is 108 per minute, her blood pressure is 80/60, and her respirations are 24 per minute. She is pale and sweating. Her uterus is soft and does not contract with fundal massage. She has heavy, bright red vaginal bleeding. On inspection, there is no evidence of perineal, vaginal, or cervical tears.

2. World Health Organization. 2008. *Education material for teachers of midwifery: midwifery education modules. – 2nd ed.* Managing Puerperal Sepsis. Module 4. France.

3. Based on these findings, what is Elizabeth's diagnosis (problem/need)? Why?

CARE PROVISION (PLANNING AND INTERVENTION)

4. Based on your diagnosis (problem/need identification), what is your plan of care for Elizabeth? Why?

5. Based on these findings, what is your continuing plan of care for Elizabeth? Why?

NOTES:

UNIT 9 PREVENTION AND MANAGEMENT OF SEVERE PRE-ECLAMPSIA AND ECLAMPSIA

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

- Explain the classification of hypertensive disorders in pregnancy.
- Demonstrate ability to accurately measure and record blood pressure.
- Demonstrate ability to assess for severe pre-eclampsia and eclampsia in limited resource settings.
- Demonstrate ability to safely prepare and administer magnesium sulfate for intramuscular (IM) and IV administration.
- Discuss treatment protocols for anti-hypertensive medication administration.

NOTES:

Hypertension complicates 5 to 10% of all pregnancies and is associated with 14% of all maternal deaths. There is a spectrum of hypertensive disorders, which are often progressive and move quickly to severe disease. This session focuses on managing severe pre-eclampsia and eclampsia. Severe pre-eclampsia and eclampsia are considered to be life-threatening emergencies and will require referral from a health center to a higher level of care for ongoing therapy and treatment. Both are linked with serious complications.

Blood pressure is checked any time a pregnant/postpartum woman presents with a problem. Magnesium sulfate, the drug of choice (anti-convulsant) for treatment of severe pre-eclampsia and eclampsia, is available in IARH Kit 6.

ASSESSMENT FOR PRE-ECLAMPSIA AND ECLAMPSIA

All women past 20 weeks of pregnancy and all postpartum women should have their blood pressure measured when they present to the clinic for care. Pregnant women with pre-eclampsia or eclampsia will present with raised blood pressure, protein in urine, and may have other danger signs. In severe pre-eclampsia and eclampsia, the risks to the mother's health are sufficiently high to warrant the birth of the baby irrespective of its maturity. With eclampsia birth should take place within 12 hours of onset convulsions.

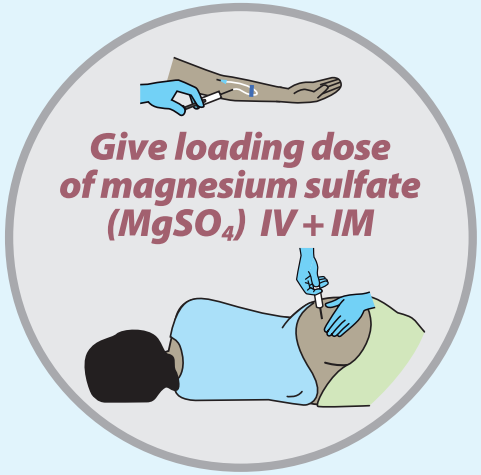
- For women with mild pre-eclampsia or gestational hypertension at term, induction of labor is recommended. In women with severe pre-eclampsia at term, a policy of early birth is recommended. Stabilize and assist the birth. If it is not safe to allow labor to progress for the mother and fetus in severe pre-eclampsia, then cesarean birth is recommended.
- For women with severe pre-eclampsia, a viable fetus, and between 34 and 36 (plus 6 days) weeks of gestation, a policy of expectant management may be recommended, provided that uncontrolled maternal hypertension, increasing maternal organ dysfunction, or fetal distress are absent and can be monitored.
- For women with severe pre-eclampsia, a viable fetus, and before 34 weeks of gestation, a policy of expectant management is recommended, provided that uncontrolled maternal hypertension, increasing maternal organ dysfunction, or fetal distress are absent and can be monitored.
- Induction of labor is recommended for women with severe pre-eclampsia at a gestational age when the fetus is not viable or unlikely to achieve viability within one or two weeks.

$MgSO_4$ Dosing and Monitoring Checklist

PREPARATION OF 4g 20% SOLUTION OF MAGNESIUM SULFATE ($MgSO_4$)

- ☐ Wash hands thoroughly with soap and water or use alcohol hand rub and air dry.
- ☐ Using a 20-mL syringe, draw 12 mL of sterile water for injection.If 50% $MgSO_4$. is available, add 8 mL of $MgSO_4$ 50% solution* to 12 mL of water for injection to make 20 mL of 20% solution (4 g per 20 mL). If the concentration is different, correctly mix 4 gm of $MgSO_4$. ** vial containing (1 g/2 mL)*

ADMINISTRATION OF LOADING DOSE OF $MgSO_4$



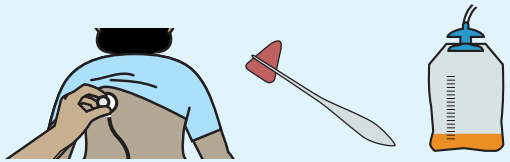
- ☐ Establish an IV line using normal saline or Ringer's lactate solution.
- ☐ Using a 20 mL syringe, draw 4 g of $MgSO_4$ 50% (8 mL)
- ☐ Add 12 mL sterile water or saline to the same syringe to make a 20% solution
- ☐ Give this 4g $MgSO_4$ 20% solution IV over 5 – 20 minutes.

- ☐ Using two 20 mL syringes, draw 5 g of $MgSO_4$ 50% (10 mL) in EACH syringe.
- ☐ Add 1mL of 2% lignocaine to EACH of the two syringes.
- ☐ Inject 1st syringe by deep IM injection into one buttock (5g $MgSO_4$)
- ☐ Inject 2nd syringe by deep IM injection into the other buttock (5g $MgSO_4$)

- ☐ **If convulsions recur** after 15 minutes, give 2 g of $MgSO_4$ 20% by IV over 5 minutes.

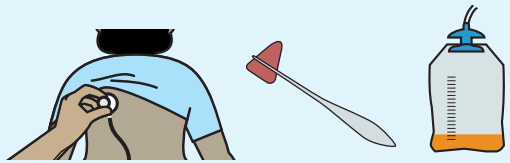
- ☐ To Decontaminate: Flush needle and syringe with 0.5% chlorine solution three times; then place in a puncture-proof container.
- ☐ Remove gloves and discard them in a leakproof container or plastic bag.
- ☐ Wash hands thoroughly with soap and water.

MONITORING FOR SIGNS OF TOXICITY



- ☐ Count respiration rate for 1 minute every hour. The rate should be ≥ 16.
- ☐ Patella reflexes should be present. Check every hour:
  - Place one hand under woman's knee and lift leg off bed.
  - Tap patellar tendon just below kneecap with a reflex hammer.
- ☐ Insert an indwelling urinary catheter and measure urinary output hourly. Output should be ≥ 30ml/hour

ADMINISTRATION OF MAINTENANCE DOSE OF $MgSO_4$



- ☐ Before repeating administration of $MgSO_4$, check that:
  - Respiratory rate is at least 16 per minute.
  - Patellar reflexes are present.
  - Urinary output is at least 30 mL per hour over 4 hours.
- ☐ Give 5 grams of MgSO4 50% solution, together with 1 mL of 2% lignocaine in the same syringe, by deep IM injection into alternate buttocks (every 4 hours).
- ☐ WITHHOLD or DELAY drug if:
  - Respiratory rate falls below 16 per minute.
  - Patellar reflexes are absent.
  - Urinary output has fallen below 30 mL per hour over the preceding 4 hours.
- ☐ In case of respiratory arrest:
  - **Shout for help!**
  - Assist ventilation with mask and bag.
  - Give calcium gluconate 1 g (10 mL of 10% solution) IV slowly.

January 2017

Helping Mothers Survive

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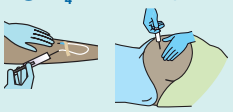
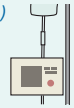
Helping Mothers and Babies Survive Pre-Eclampsia & Eclampsia Medication Table

Agent	Dose	Continuation	Max Dose	Comments
Magnesium Sulfate (MgSO4) Anticonvulsant Treatment for Women with Severe Pre-eclampsia or Eclampsia				
$MgSO_4$ *(Pritchard regimen)* 	4g 20% solution IV AND 10g 50% solution IM (5g in each buttock with lignocaine)	Repeat q 4 hours: 5g 50% solution IM in alternative buttocks with lignocaine	Continue for 24 hours after birth, or last convulsion – whichever occurs last.	If convulsions recur after 15 minutes, give 2g $MgSO_4$ 20% IV. Monitor for toxicity hourly. Withhold if any signs of toxicity.
$MgSO_4$ *(Zuspan regimen)* 	4 g 20% solution IV infusion over 5 – 20 minutes.	1 g/ hour IV infusion	Continue for 24 hours after birth, or last convulsion (whichever occurs last).	Monitor for toxicity hourly. Withhold if any signs of toxicity.
Antihypertensive Medications to Treat Severe Hypertension				
Hydralazine IV 	5 mg IV, slowly	Repeat q 5 min until target BP reached Repeat hourly as needed, or give 12.5 mg IM q 2 hours as needed	20 mg/ 24 hours	
Labetalol PO ⛀	200 mg PO	Repeat after 1 hour until target BP reached	1200 mg/ 24 hours	Do not give to women with congestive heart failure, hypovolemic shock, or asthma.
Labetalol IV 	10 mg IV	If inadequate response after 10 min, give 20 mg IV Can double dose to 40 mg, then 80 mg (wait 10-min between doses) until target BP is reached	300 mg, then switch to oral	Do not give to women with congestive heart failure, hypovolemic shock, or asthma.
Nifedipine immediate-release caps PO ⛀	5 – 10 mg PO	If inadequate response after 30 min, repeat dose until target BP is reached	30 mg	Consider other agents if BP not lowered within 90 min.
Alpha methyldopa PO ⛀	750 mg PO	Repeat after 3 hours until target BP is reached	3 g/ 24 hours	
Antenatal Corticosteroid Treatment for Preterm Birth				
Dexamethasone IM 	12 mg IM	Repeat after 24 hours. Give a single, repeat course if preterm birth does not occur 7 days, the woman is < 34 weeks, and the risk of preterm birth persists.	24 mg/24 hours	**Never give more than two courses.** Do NOT give if you cannot confirm the GA is < 34 weeks. Do NOT give if you think the woman may have an infection, or the preterm infant cannot receive adequate care if needed.

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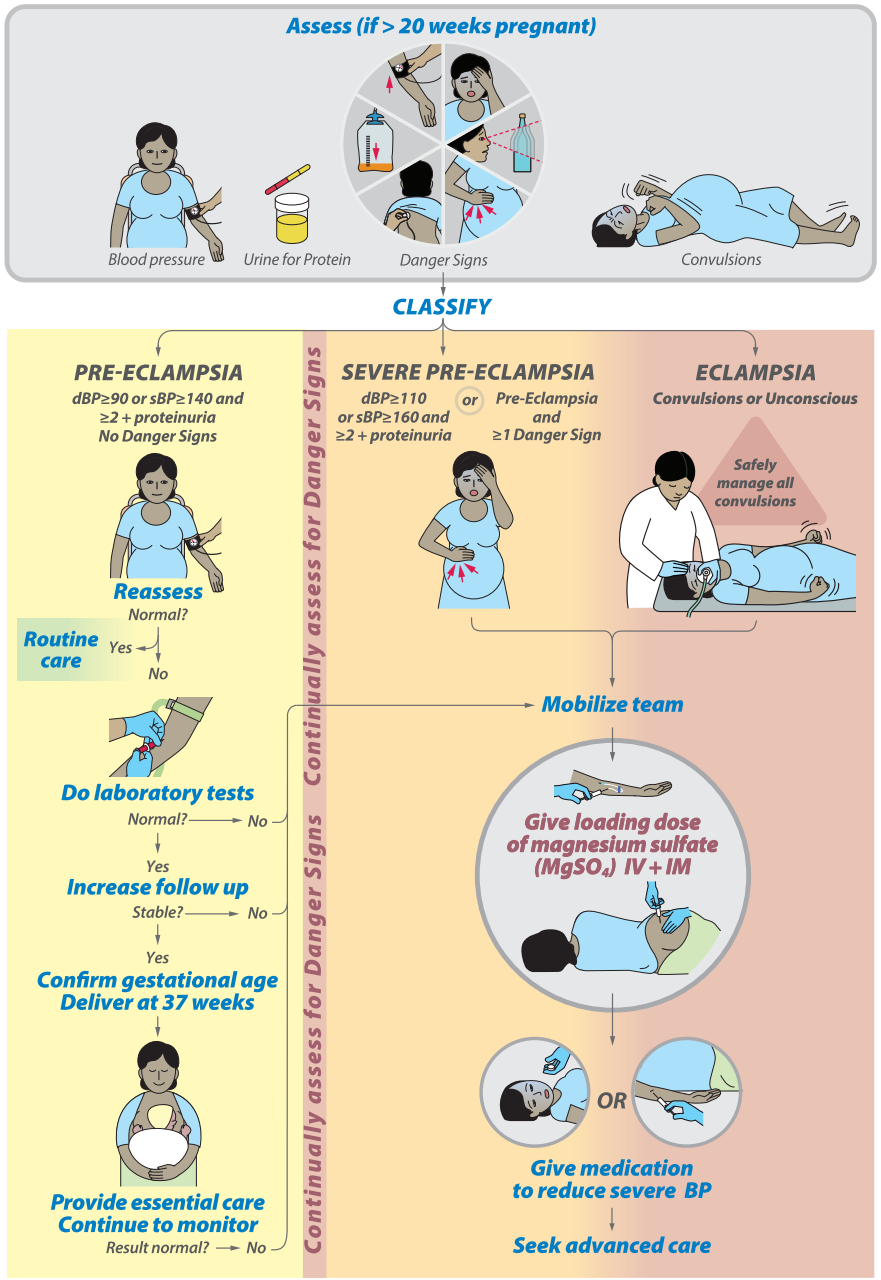
Helping Mothers and Babies Survive

Pre-Eclampsia & Eclampsia

ACTION PLAN 1

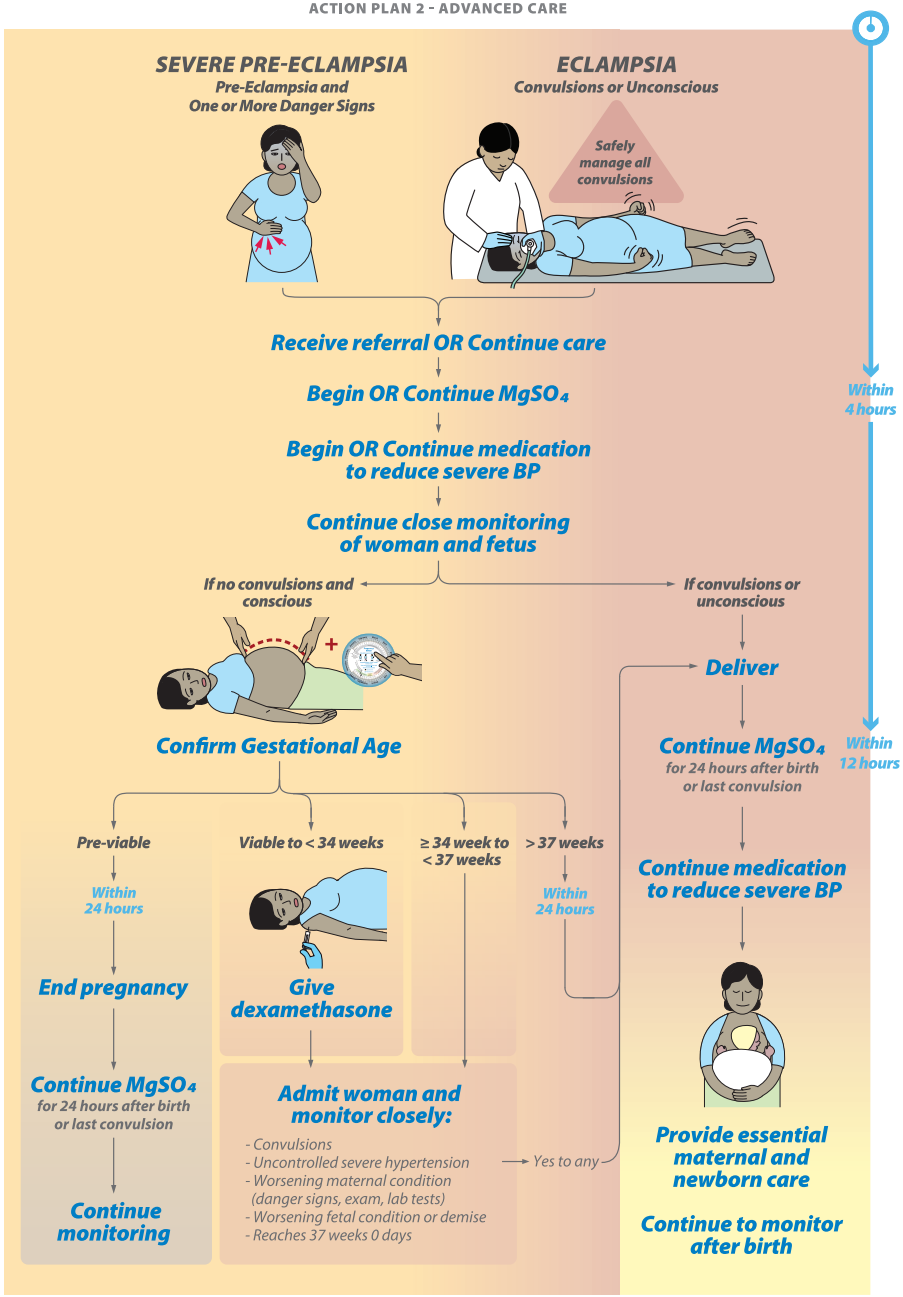


January 2017

Helping Mothers and Babies Survive

Pre-Eclampsia & Eclampsia

ACTION PLAN 2 - ADVANCED CARE



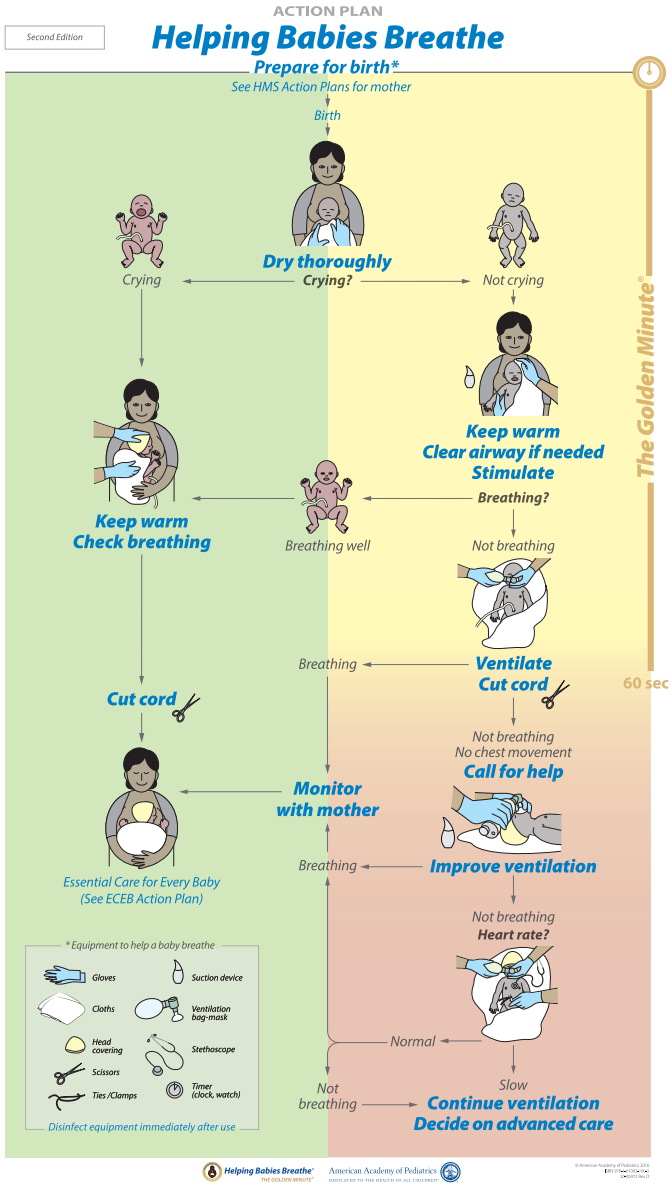
Magnesium Sulfate
TREATMENT OF SEVERE PRE-ECLAMPSIA
1.
2.
3.
4.
5.
6.
DURING A CONVULSION
1.
2.
3.
4.
5.
AFTER A CONVULSION
1.
2.

NOTES:

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

- Discuss the main causes of newborn deaths and challenges for newborn care in humanitarian settings.
- Explain essential newborn care.
- Perform newborn resuscitation using a bag and mask.

NOTES:



Source: American Academy of Pediatrics, and Helping Babies Breathe. "Prepare for Birth: Action Plan," 2016. Available: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/helping-babies-survive/Pages/Helping-Babies-Breathe-Edition.aspx.

Checklist for Newborn Resuscitation (Many of the following steps/tasks should be performed simultaneously)[3]				
Step/Task		Remarks	Yes	No
GETTING READY (Prepare for a birth)				
1. Ensure that the area for newborn resuscitation is prepared and that a mucus extractor, self-inflating bag, correct-sized masks for ventilation, and pediatric stethoscope are clean and ready to use for every birth. Provider should have washed hands and put on sterile gloves, and checked bag and mask.				
2. Tell the woman (and her support person) what is going to be done and encourage them to ask questions.				
3. Provide continual emotional support and reassurance, as feasible.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY?	**INITIALS**	**DATE**		
IMMEDIATE NEWBORN CARE				
1. When a baby is born, place immediately on mother's abdomen and dry the baby quickly and thoroughly with a dry cloth. Note the time of birth.				
2. Assess the baby's crying and breathing efforts. If crying or breathing normally, continue with routine care. If not crying or breathing normally, go to "Initial Resuscitation Step #1."				
3. Remove the wet cloth and place baby skin-to-skin on the mother's chest, covering with a warm, dry cloth. Cover the head with a cap or cloth.				
4. Clamp and cut cord within 1-3 minutes or after pulsations have ceased.				
5. Continue to observe the baby's breathing/crying as you proceed with the other steps of the birth.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY?	**INITIALS**	**DATE**		
INITIAL RESUSCITATION STEPS (If the baby does not cry or not breathing normally)				
1. Dry the baby quickly and thoroughly. Remove the wet cloth.				
2. Clear the airway if needed; position the head and suction mouth and nose only if secretions seen. (Do not suction mouth and nose routinely.)				
3. Stimulate breathing by rubbing the back 2-3 times.				
4. If the baby cries or breathes normally, place the baby skin-to-skin on mother's chest, covering with a warm, dry cloth. Cover head with cap or cloth.				
5. If the baby does not breathe after stimulation, quickly clamp and cut the cord, place the baby on a clean, dry surface in the resuscitation area/ beside the mother, and cover with a hat and dry cloth, leaving the chest exposed.				
6. Proceed with ventilation using a bag and mask within one minute after birth.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY?	**INITIALS**	**DATE**		

3. Adapted from Jhpiego. 2015. *Emergency Obstetric Care for Midwives and Doctors* course. Updated and aligned with *Helping Babies Breathe 2.0.*

Checklist for Newborn Resuscitation (Many of the following steps/tasks should be performed simultaneously)				
Step/Task		Remarks	Yes	No
RESUSCITATION USING BAG AND MASK				
1. Position the baby's head in a slightly extended position to open the airway.				
2. Place the mask on the baby's face so that it covers the chin, mouth, and nose. Form a seal between the mask and face and begin ventilation.				
3. Ensure that the chest is rising with each ventilation. Ventilate at a rate of 40 breaths/minute for 1 minute.				
4. If the baby cries or starts breathing, keep the baby warm skin-to-skin, and continue with essential newborn care.				
5. If the baby is still not breathing, call for help and improve ventilation. • Head – reposition, reapply mask • Mouth – clear secretions, open mouth slightly • Bag – squeeze harder and continue ventilation				
6. If not breathing well, palpate the umbilical cord or listen to the heart rate with a stethoscope. • If the heart rate is more than 100, continue ventilation. • If the baby is breathing spontaneously and there is no in-drawing of the chest and no grunting, put the baby in skin-to-skin contact with the mother. • Monitor with the mother.				
7. If breathing is less than 30 breaths per minute, heart rate is less than 100 beats per minute, or severe chest in-drawing is present, continue ventilating (with oxygen if available) and arrange for immediate referral for advanced care.				
8. If the baby does not breathe spontaneously and has no detectable heart rate after 10 minutes of ventilation, resuscitation should be stopped.				
9. If the baby has a heart rate below 60 beats per minute and no spontaneous breathing after 20 minutes of ventilation, resuscitation should be stopped.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY?	**INITIALS**	**DATE**		
POST-PROCEDURE TASKS				
1. Wipe the equipment with clean gauze soaked in chlorine solution 0.5%. Then clean and process.				
2. Wash hands thoroughly.				
3. Ensure that the mother is aware of the outcome of the resuscitation and provide support as necessary.				
4. Record pertinent information on the mother's/newborn's record.				
SKILL/ACTIVITY PERFORMED SATISFACTORILY?	**INITIALS**	**DATE**		

UNIT 11 NEXT STEPS AND CLOSING

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

- Complete a knowledge assessment.
- Discuss options for ongoing skills practice and post-training activities (such as peer to peer, clinical drills, mentorship).
- Explain training resources and job aids.
- Develop a simple action plan for improving facility readiness for BEmONC.
- Explain how the training met their expectations and course objectives.

NOTES:

ACTION PLAN FOR AFTER THE BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE TRAINING[5]

Select a few priority areas to focus on. Gaps or challenges are identified if something is NOT seen or practiced, or if essential supplies are missing.

GAP or CHALLENGE to be Addressed	Actions	Person Responsible	Timeline	Resources / Support Needed	IARH Kits/ Supplies to be Ordered

5. Helping Mothers Survive. "Pre-Eclampsia & Eclampsia OSCE 1: Administering the Loading Dose of MgSO4," October 2018.

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