

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



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

TABLE OF CONTENTS

INTRODUCTION	3
HOW TO USE THIS WORKBOOK	5
UNIT 1: COURSE OVERVIEW	6
UNIT 2: WHAT IS EMERGENCY OBSTETRIC AND NEWBORN CARE (EMONC) AND WHY IS IT NEEDED?	7
UNIT 3: RESPECTFUL MATERNAL AND NEWBORN CARE IN EMERGENCIES	12
UNIT 4: RAPID ASSESSMENT AND MANAGEMENT	13
UNIT 5: PREVENTION AND MANAGEMENT OF POSTPARTUM HEMORRHAGE	14
UNIT 6: MANUAL REMOVAL OF THE PLACENTA	17
UNIT 7: TRANSPORT AND REFERRAL	18
UNIT 8: PREVENTION AND MANAGEMENT OF PERIPARTUM INFECTION	20
UNIT 9: PREVENTION AND MANAGEMENT OF SEVERE PRE-ECLAMPSIA AND ECLAMPSIA ..	22
UNIT 10: ESSENTIAL NEWBORN CARE AND NEWBORN RESUSCITATION	28
UNIT 11: NEXT STEPS AND CLOSING	31

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: www.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.



MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

iawg.net/IAFM

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

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



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



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



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

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



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 these 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: unfpa.org/procurement

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.

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 36.8° 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	Yes	No
1. Tell the woman (and her support person) what is going to be done, listen to her, and respond attentively to her questions and concerns.		
2. Provide continual emotional support and reassurance, as feasible.		
3. Put on personal protective barriers.		
4. Wash hands thoroughly and put on sterile surgical gloves.		
5. Clean vulva and perineum with antiseptic solution.		
6. 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.		
7. 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.		
8. Maintain compression until bleeding is controlled and the uterus contracts.		
9. Remove gloves and wash hands thoroughly with soap and water and dry with a clean, dry hand-towel or air dry.		
10. Monitor vaginal bleeding, take the woman's vital signs, and make sure that the uterus is firmly contracted.		

Checklist for Uterine Balloon Tamponade (Some of the following steps/tasks should be performed simultaneously)					
Step/Task	Cases				
GETTING READY					
1. Prepare the necessary equipment					
2. Tell the woman what is going to be done, listen to her, and respond attentively to her questions and concerns					
3. Provide continual emotional support and reassurance, as feasible					
4. Start IV of normal saline or Ringer's lactate with oxytocin (20 iu in 500 mL)					
5. Give ampicillin 2 grams IV					
6. Put on personal protective barriers					
7. Wash hands and forearms thoroughly with soap and water and dry					
8. Put sterile surgical gloves on both hands					
9. Prepare uterine balloon tamponade on a clean surface: open the condom and place the inner end of a Foley catheter inside the condom					
10. Using a suture or cord ties, securely tie the condom to the catheter					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
UTERINE BALLOON TAMPONADE					
1. Clean the vulva and perineal area and place a clean/sterile drape beneath the woman's buttocks					
2. Ensure that the bladder is empty; catheterize if necessary					
3. 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					

4. 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)					
5. Infuse 250 mL of fluid into the condom until bleeding stops (or 250–500 mL with model)					
6. Tie or clamp the end of the catheter					
7. Wash hands thoroughly with soap and water and dry					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
POST-PROCEDURE TASKS					
1. Continue to monitor vaginal bleeding, vital signs, and urinary output					
2. Keep the oxytocin infusion running for at least 4 hours after insertion of the uterine balloon tamponade					
3. Complete patient records with details of the procedure and any drugs given, noting the time when the uterine balloon tamponade was inserted					
4. Ensure arrangements for referral to higher-level facilities where surgical capacity is available					
5. 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).

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.

NOTES:

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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 	

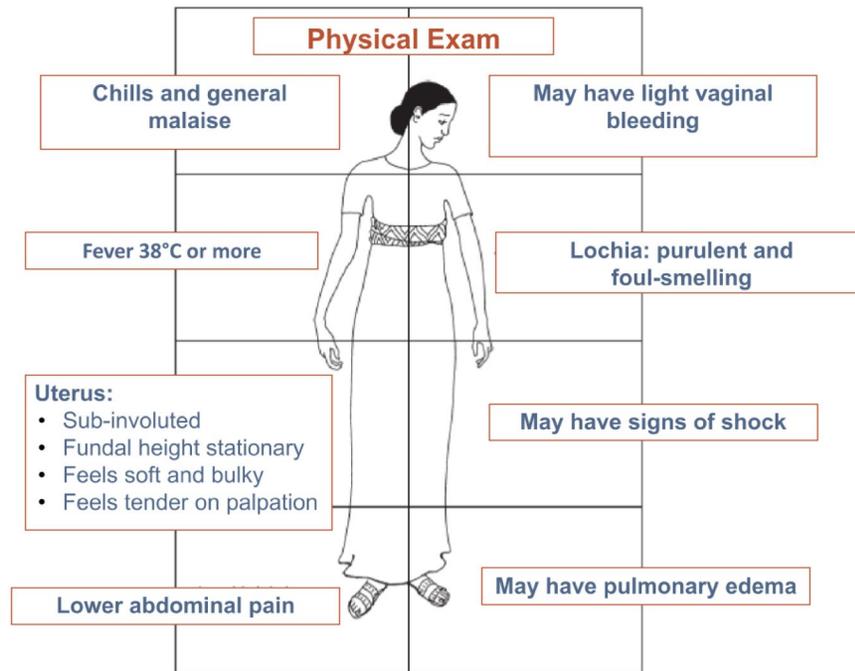
8	Complete referral record with: <ul style="list-style-type: none"> • Name of referring and referral facility • General information (name, age, address) • Obstetric history (parity, gestational age, complications in pregnancy) • Relevant past obstetric complications (e.g., previous cesarean section, 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	

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 INFECTION²



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

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 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 36.8° 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.

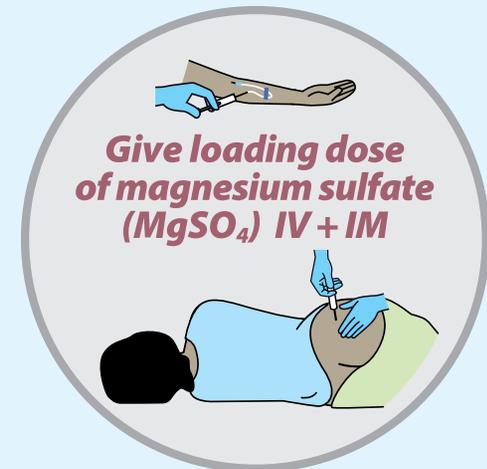
MgSO₄ Dosing and Monitoring Checklist

PREPARATION OF 4g 20% SOLUTION OF MAGNESIUM SULFATE (MgSO₄)

- 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% MgSO₄ is available, add 8 mL of MgSO₄ 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 MgSO₄. * vial containing (1 g/2 mL)

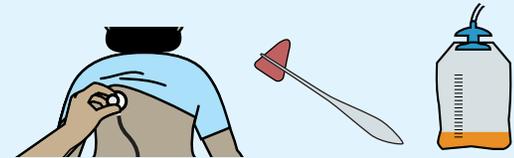
ADMINISTRATION OF LOADING DOSE OF MgSO₄

- Establish an IV line using normal saline or Ringer's lactate solution.
- Using a 20 mL syringe, draw 4 g of MgSO₄ 50% (8 mL)
- Add 12 mL sterile water or saline to the same syringe to make a 20% solution
- Give this 4g MgSO₄ 20% solution IV over 5 – 20 minutes.
-
- Using two 20 mL syringes, draw 5 g of MgSO₄ 50% (10 mL) in EACH syringe.
- Add 1 mL of 2% lignocaine to EACH of the two syringes.
- Inject 1st syringe by deep IM injection into one buttock (5g MgSO₄)
- Inject 2nd syringe by deep IM injection into the other buttock (5g MgSO₄)
-
- If convulsions recur** after 15 minutes, give 2 g of MgSO₄ 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 $\geq 30\text{ml/hour}$



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 MgSO_4 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

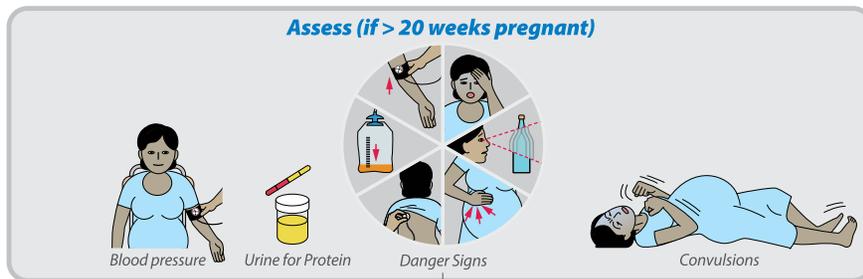
Helping Mothers and Babies Survive *Pre-Eclampsia & Eclampsia* Medication Table

Agent	Dose	Continuation	Max Dose	Comments
Magnesium Sulfate (MgSO₄) Anticonvulsant Treatment for Women with Severe Pre-eclampsia or Eclampsia				
MgSO₄ (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.
MgSO₄ (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.

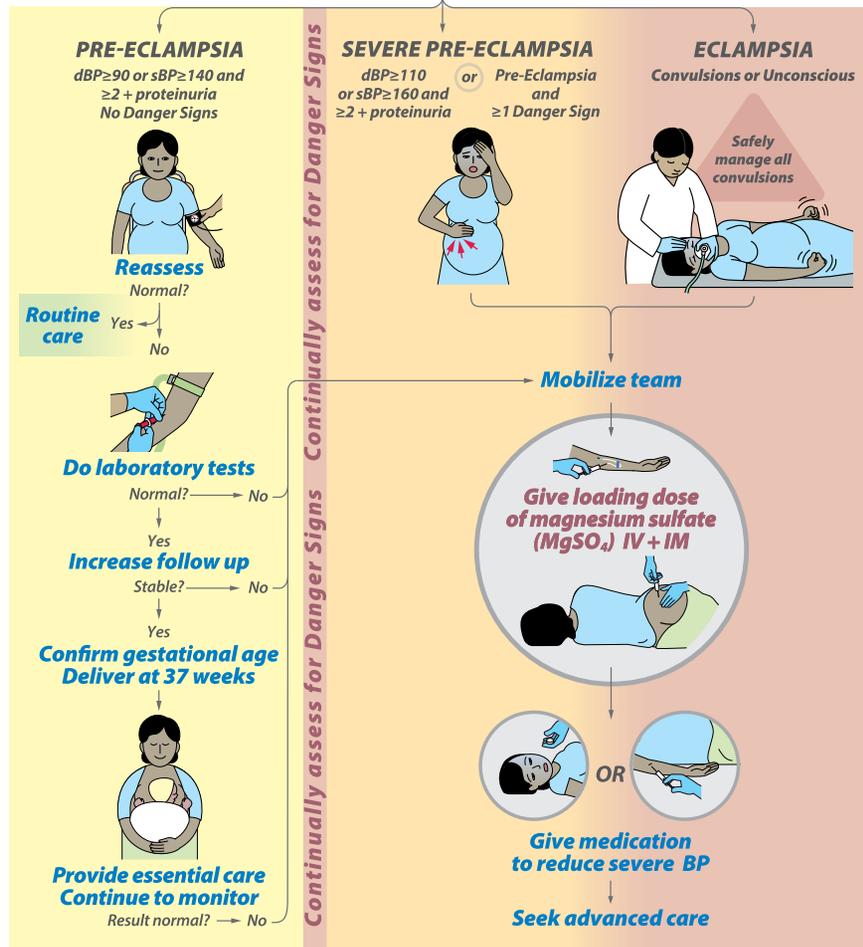
August 2018

Helping Mothers and Babies Survive Pre-Eclampsia & Eclampsia

ACTION PLAN 1

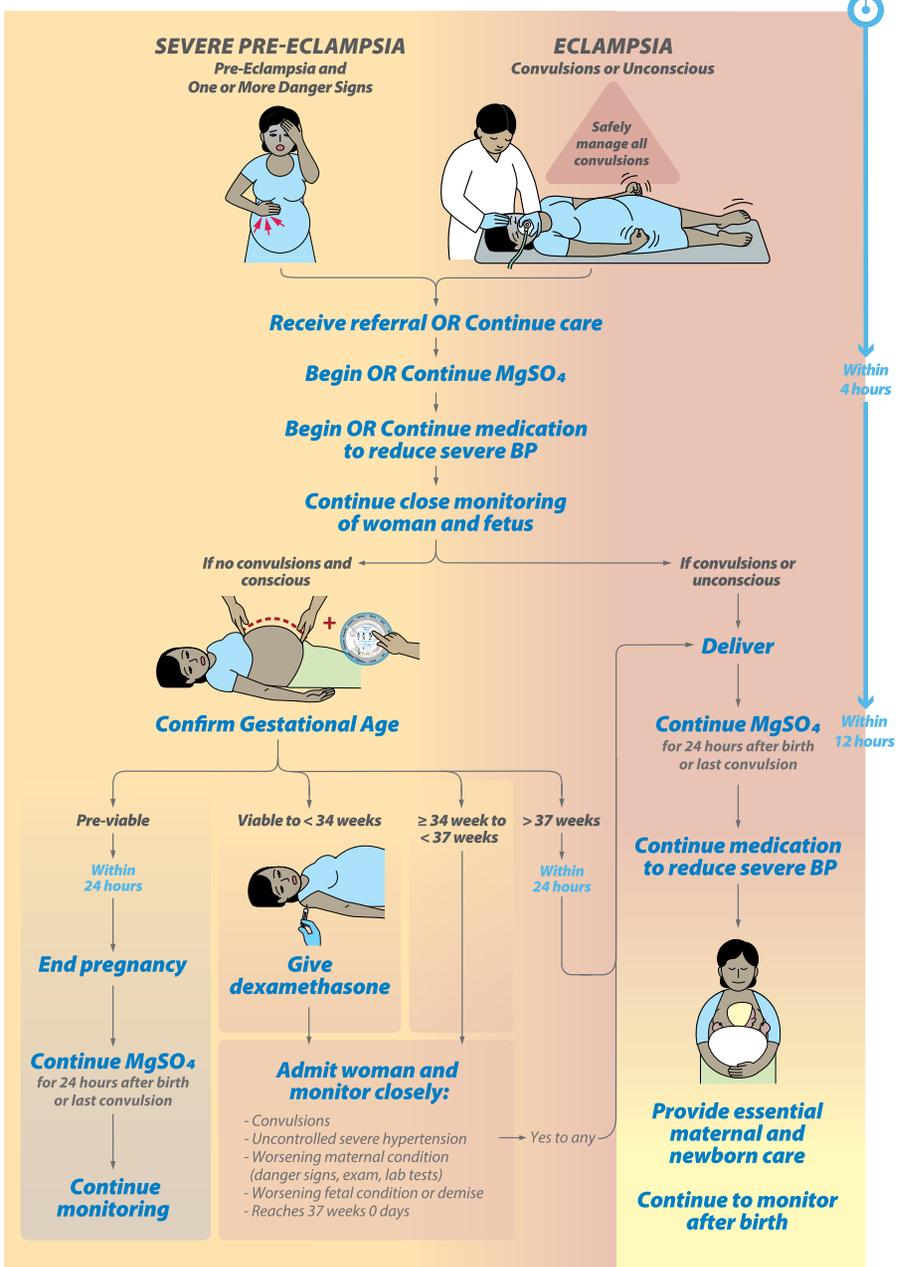


CLASSIFY



Helping Mothers and Babies Survive Pre-Eclampsia & Eclampsia

ACTION PLAN 2 - ADVANCED CARE



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. <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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	

ACTION PLAN FOR AFTER THE BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE TRAINING⁵

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.

Suggested citation:

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and Jhpiego. Clinical Management of Sexual Violence Survivors in Crisis Settings: A Training Course for Health Care Providers. New York: 2021.

© 2021 Inter-Agency Working Group (IAWG) on Reproductive Health in Crises

Jhpiego
1615 Thames St. #200
Baltimore, MD 21231
www.jhpiego.org

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises
Training Partnership Initiative
Women's Refugee Commission
15 West 37th Street, New York, NY 10018
info.iawg@wrcommission.org
www.iawg.net



Inter-Agency Working Group on
Reproductive Health in Crises

