Quality Assurance Package for Midwives

TOOLKIT FOR PRACTICING PROFESSIONAL MIDWIVES

Introduction to the Manual

This publication is made possible with the generous support of the American People through the United States Agency for International Development (USAID). The contents of this publication are the sole responsibility of the Department of Health (DOH) and do not necessarily reflect the views of USAID or the United States Government.

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MESSAGE

The overall objective of *Kalusugan Pangkalahatan (KP)* or Universal Health Care is to achieve better health outcomes, make the health system more responsive, and reduce the inequities in health created by the widening gap between the rich and the poor. *KP* envisions Filipinos who are healthy, free from disease and infirmity through wider and more equitable access to quality health services. It is committed to provide an adequate number of health care professionals capable of meeting every Filipino's health needs and to offer them essential medicines, services and technologies of assured quality, availability and safety.

Nationally, less than half of our births are delivered in health facilities, and only 6 out of 10 births are delivered by skilled providers. 40% of maternal deaths can be prevented by ensuring access of mothers to skilled birth attendants and basic emergency obstetric and neonatal care in facilities.

KP acknowledges the potential of harnessing the underutilized contribution of private practice midwives in expanding access to Maternal Neonatal Child Health and Nutrition (MNCHN) services for women, infants and children. At the same time, the Department of Health (DOH) recognizes the significant role that midwives play in attaining optimal maternal and child health in the country through its MNCHN strategy.

Every community needs to have its own professional midwife to provide knowledge on safe pregnancy, childbirth, and care of mothers and babies after birth, as well as to deliver quality services. Midwives are among the frontline health professionals available at the grassroots providing those services on a daily basis that are crucial to improving and sustaining family health nationwide. In the public sector, midwives have a critical role as team leader of the Community Health Team and as member of the Basic Emergency Obstetric and Neonatal Care (BEmONC) at the Rural Health Units and birthing facilities.

The DOH places high priority on good quality care in both public and private practice of midwifery. In an effort to ensure good quality standards among all midwives, the DOH, together with the Private Sector Mobilization for Family Health Phase 2 (PRISM2) Project, developed a **"Quality Assurance Package for Midwives: A Toolkit for Practicing Midwives."** This toolkit is a quality standard reference material as well as a continuing quality improvement and monitoring tool designed for both public and private practicing midwives.

The DOH enjoins all practicing midwives in both public and private sectors to read, understand, conduct the activities and apply the precepts in this toolkit in the performance of their daily tasks. The DOH will do its best to provide the technical support, and where applicable, leverage resources to ensure delivery of optimum quality health care at all levels and at all times.

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ACKNOWLEDGEMENTS

The provision of **Maternal, Neonatal and Child Health and Nutrition (MNCHN)** services is a regular part of the basic services in government and private health institutions. In order to ensure program sustainability and maintain quality standards in providing these services, the Department of Health (DOH) in collaboration with the USAID/PRISM2 Project developed this Quality Assurance Package, a toolkit for practicing professional midwives in both the public and private sector. It aims to set the standards of quality and ensure continuing quality improvement in the provision of MNCHN services throughout the country.

We are grateful to all who contributed to the preparation, development, field-testing and finalization of this package.

The development and printing of this manual was made possible through funds provided by the United States Agency for International Development (USAID) through PRISM2/Chemonics International.

INTRODUCTION

RATIONALE

As the year for attaining the Millennium Development Goals (MDG) approaches, it has become apparent that achieving MDG 4 and MDG 5 targets remains a huge challenge for the country. The latest Maternal Mortality Ratio (MMR) of 162 per 100,000 live births and Infant Mortality Rate (IMR) of 25 per 1,000 live births are far from the target MMR of 52 and IMR of 19 by year 2015.

In order to facilitate the achievement of the MDGs, the Department of Health issued Administrative Order No. 2008-0029 on September 9, 2008, entitled "Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality." Among others, it seeks to increase the number of deliveries attended by skilled birth attendants and decrease the number of deliveries occurring at home by promoting deliveries at adequately-equipped birthing facilities with trained birth attendants.

At the forefront of the country's health care delivery system, and key to achieving national health goals and programs, are the estimated 20,000 professional midwives mostly employed by the government. Midwives are the most numerous community-based, first-contact, skilled birth attendants. They can play a key role in reducing maternal and neonatal deaths, since the two most significant factors contributing to maternal deaths in the country are deliveries by unskilled birth attendants and deliveries occurring at home.

This Quality Assurance Package for Midwives: A Toolkit for Practicing Professional Midwives was developed to ensure that midwives in both public and private practice adhere to quality standards in their provision of Maternal, Neonatal and Child Health and Nutrition services, either in government birthing facilities or in private clinics. It aims to provide continuing quality improvement by setting

standards of quality care, and providing an opportunity for midwives to conduct their own technical self-assessment, followed by technical monitoring and assistance by their supervisors.

This set of standards and tools are designed to be used both by midwives themselves and their supervisors who may come from their own midwife associations, from the DOH-Centers of Health Development, or from Local Government Units (LGUs) such as the Provincial Health Offices and the City Health Offices.

BACKGROUND

The Department of Health – Health Human Resources Development Bureau in its efforts to ensure that service providers at the grassroots level continuously provide quality services in the community, began developing a clinical care protocol that was intended for use by public sector practicing midwives. At the same time, a USAID-funded private sector project, the Private Sector Mobilization for Family Health (PRISM1) was also developing and using a quality measurement tool designed to objectively monitor the quality of services provided by private midwives under the project.

In July 2008, DOH-HHRDB and PRISM1 started working together with the aim of developing standard materials that can be used by both public and private midwives. After months and a series of consultative meetings, working drafts, testing the materials, the package was finally developed in June 2009, and updated in July 2010 and finally in April 2011. However, the materials still have room for improvement and will undoubtedly continue to undergo changes as new technologies addressing maternal and child health issues emerge.

DESCRIPTION

The Quality Assurance Package for Midwives: A Toolkit for Practicing Professional Midwives consists of five distinct toolkits contained in four separate manuals designed to be used by midwives and their supervisors.

For midwives, the four materials are:

1. Clinical Care Manual for Midwives,
2. Clinic Operation Standards Manual,
3. Monitoring Tool for Practicing Midwives: Midwife Portion, and the
4. A Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives.

For the midwives' supervisors and/or technical assistance providers, five useful materials are:

1. Clinical Care Manual for Midwives,
2. Clinic Operation Standards Manual,
3. Monitoring Tool for Practicing Midwives: Midwife Portion,
4. Monitoring Tool for Practicing Midwives: Supervisor Portion, and the
5. A Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives.

Needless to say, supervisors should also be aware of the standards of quality midwifery practice as contained in the materials in order for them to conduct proper technical monitoring. Results of the monitoring will then determine how supervisors can guide midwives and provide the appropriate technical assistance.

For simplicity, the **Quality Assurance Package** has been divided into four manuals.

Section 1 is the **Clinical Care Manual for Midwives**. This manual provides the standards of care in the professional conduct of practicing midwives. It consists of two parts.

Part 1, entitled "Management," includes guidelines in the management of the different phases of pregnancy and delivery – from prenatal care, care during labor and childbirth, care during the postpartum period and newborn care.

Part 2 on "Special Procedures" contains information and a review of some basic and special procedures that **previously trained** midwives are expected to perform. These procedures should be performed ONLY by midwives who have been formally trained to perform them, and only when indicated. **This manual in itself is NOT sufficient to allow any midwife to perform the procedures without the proper training.**

Section 2, the **Clinic Operation Standards Manual**, helps guide midwives on how to operate and manage a birthing home. It consists of two parts: Standard Operating Procedures and Standard Clinic Forms.

The standard operating procedures provides guidelines for the professional midwife as she performs various clinic tasks such as outpatient consultations, admissions, infection prevention practices, referral systems, waste management and clinical recording.

The second part contains the different forms that will be used by the midwife in recording patient data. These include forms for family planning, prenatal consultation, recording of labor monitoring results, birthing plan, postpartum records, newborn case records and others. There is a detailed explanation of how these forms must be filled up and when to use which form for a particular type of patient.

Section 3, the **Monitoring Tool for Practicing Midwives** allows midwives to review their own practices, make improvements, and seek outside assistance for resolving issues. This quality improvement tool has two parts: the midwife portion and the supervisor portion.

The midwife portion (Section 3A) of the tool has two components: the self-assessment portion which determines the midwife's perspective of the level of quality of MCH/FP services she provides, and the action plan that addresses the things that need to be improved as identified in the self-assessment portion.

The supervisor's portion (Section 3B), on the other hand, serves at least two purposes: 1) to validate the midwife's assessment of her own professional competence, quality of services and her facility; and 2) to determine the midwife's progress in improving the quality of FP-MCH services based on her validated numerical scores and the action plans developed during the midwife's self-assessment portion. With this toolkit, both midwife and supervisor have the opportunity to address deficiencies and mobilize resources toward improving the quality of services in the birthing home.

Section 4, **Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives,** is a user-friendly manual that provides step-by-step guidelines in organizing and

managing the Clinical Case Conference for Midwives as a continuing quality improvement activity. It is a technical meeting that serves as a venue for midwives to acquire professional updates from medical experts. The DOH Centers for Health Development, local government units' health offices, nongovernment organizations or even midwife associations may act as the organizing agency in conducting this activity.

INSTRUCTIONS TO USERS

This package serves both as a reference material and as a monitoring tool. As a reference material, practicing midwives can refer to the sections on clinical care and standard operating procedures when needed. Midwives can also refer to it when they want to review certain procedures or steps in performing certain tasks.

It also serves as a self-assessment tool that midwives can use to evaluate themselves and thereby use their own resources to improve the quality of services based on their own assessment. It can also be used as a supervisory monitoring tool to determine how technical supporters may provide assistance to ensure quality of services.

The different sections of this package can be used separately and individually. Depending on the need, a midwife may choose to use only a particular portion or section of the package. Each section includes more detailed instructions on its use.

ACRONYMS, ABBREVIATIONS AND TERMINOLOGY

AMTSL	Active Management of Third Stage of Labor
BEmOC	Basic Emergency Obstetrics Care
BEmONC	Basic Emergency Obstetrics and Newborn Care
BHS	Barangay Health Station
BTL	Bilateral tubal ligation
CBT	Competency-based training
CCC	Clinical Case Conference
CHD	Center for Health Development
CHO/MHO/PHO	City Health Office/Municipal Health Office/Provincial Health Office
CQI	continuing quality improvement
CVHWs	Community Volunteer Health Workers – these may include Barangay Health Workers (BHWs), Barangay Station Population Officers (BSPOs) or Barangay Nutrition Scholars (BNS), and other volunteer health workers
DOH	Department of Health
EDD	Expected Date of Delivery
ENC	Essential Newborn Care
FP	Family Planning
FHT	Fetal Heart Tones
HHRDB	Health Human Resources Development Bureau
HIV	Human Immunodeficiency Virus
IE	Internal Examination
IEC	Information, education and communication
IMAP	Integrated Midwives' Association Philippines, Inc.
IP	Infection Prevention
LGU	Local Government Unit
LGU-HO	LGU Health Officer i.e., Provincial or City or Municipal Health Officer
LSS	Life Savings Skills
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MFPI	Midwives Foundation of the Philippines, Inc.
ML/LA	Minilaparotomy under local anesthesia
MNCHN	Maternal, Neonatal and Child Health and Nutrition
MW	Midwife
MWA	midwives' association
NGO	non-government organization
NSV	No-scalpel vasectomy
Ob-Gyne	Obstetrics and Gynecology
OR	operating room
PHIC	Philippine Health Insurance Corporation
PLGPMI	Philippine League of Government and Private Midwives, Inc.
PPH	Post Partum Hemorrhage
POGS	Philippine Obstetrical and Gynecological Society
PPM	Private practicing midwife
PPS	Philippine Pediatric Society
RHU	Rural Health Units
SIAs	Strategic Intervention Areas
STI	Sexually Transmitted Infection
TOT	Training of Trainers
USAID	United States Agency for International Development
VS	Voluntary Sterilization

CONTENTS GUIDE

Quality Assurance Package for Midwives

TOOLKIT FOR PRACTICING PROFESSIONAL MIDWIVES

SECTION 1

Clinical Care Manual for Midwives

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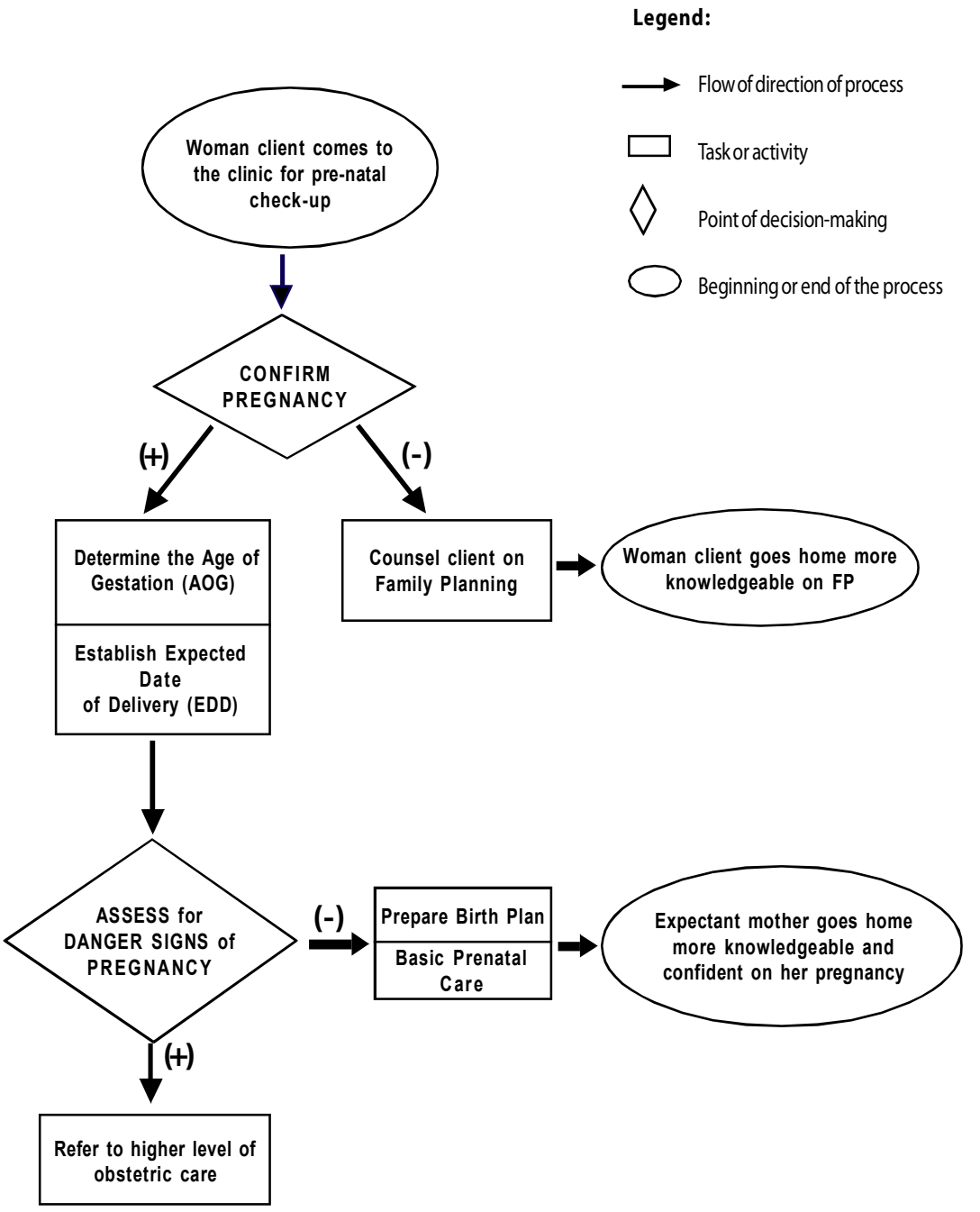
CONTENTS

Part 1
Management

PRENATAL CONSULTATIONS

The diagram below describes the flow of care for prenatal clients.



1. Detect and date the pregnancy

- Ask when the **first day of the woman's last normal menstrual period (LMP) was**.
- For a woman who usually has regular menstrual periods, if the menstrual period is delayed for a week or more she **may be** pregnant.
- Sometimes a woman may suspect she is pregnant because she has typical symptoms, including enlarged and tender breasts, nausea with occasional vomiting, the urge to urinate frequently, and unusual fatigue.
- A pregnancy test may be performed to confirm the pregnancy. If the result is negative but pregnancy is still suspected, repeat the test. The previous test might have been performed too early.
  - o Calculate gestational age by considering the **first day of the last menstrual period**. The **age of gestation** (AOG) is computed by counting the days from the first day of the last menstrual period to the time of consultation and dividing that number by seven to get the number of weeks.

Example:

A pregnant woman consulted you on 08 January 2007. The first day of her last normal menstrual period was on 06 August 2006. What is the AOG?

LMP= 06 August 2006
AOG= 22-23 weeks

Computation:

August	25 days (remaining)
September	30 days
October	31 days
November	30 days
December	31 days
January	8 days

155 ÷ 7 = **22 weeks and 1 day**

- o Establish the **expected date of delivery (EDD)** by:
  - Naegele's Rule based on the following formula:
    EDD = First day of the last menstrual period + 9 months + 7 days
    Or
    EDD = First day of the last menstrual period – 3 months + 7 days

In cases when the last menstrual period cannot be established reliably (i.e., woman is not sure, previously taking pills or DMPA, having abnormally short or long previous cycle), perform:

- **Bimanual examination** to determine uterine size within the first 12 weeks of the age of gestation.
- **Abdominal examination,** when the uterus can be palpated abdominally and the AOG may be determined by the symphysis-fundic measurement.

The figure below (Fig. 1) shows the estimated AOG based on the fundic height measurement.

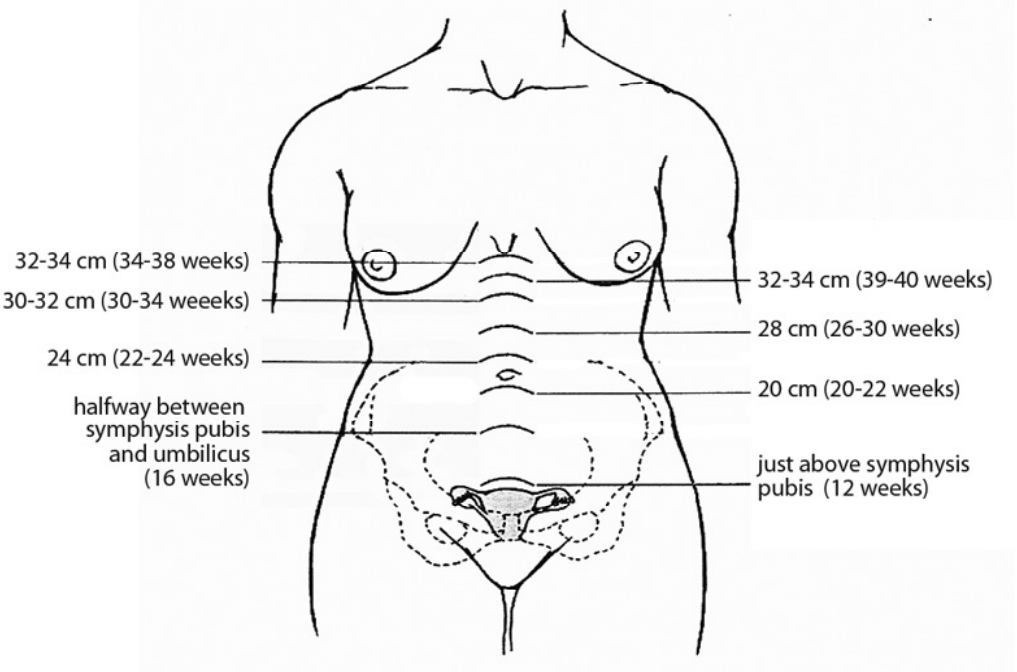


Figure 1. Normal Measurements of the Fundic Height Based on AOG

- **Ultrasound examination** which provides a reasonably accurate determination of the AOG if done before 24 weeks.

2. Do an "Immediate Assessment"

Observe or ask about the following danger signs of pregnancy. If any of them are present, the woman will have to be referred immediately to a higher level of service (e.g., obstetrician) and facility (e.g., hospital):

- Swelling of the legs, hands and/or face
- Severe headache, dizziness, blurring of vision
- Vaginal bleeding
- Foul vaginal discharge
- Watery vaginal discharge
- Pallor or anemia
- Fever and chills
- Vomiting

- Rapid or difficult breathing
- Severe abdominal pain
- Painful urination
- Convulsions
- Absence of or reduced fetal movements (fewer than 10 kicks in 12 hours in the second half of pregnancy)
- Hypertension or blood pressure of, or greater than, 140/90 mmHg.
- Abnormal laboratory results: urinalysis, CBC, blood sugar, Kahn-VDRL, etc.

3. Perform Basic Prenatal Care

After doing a "quick assessment" and once "danger signs" have been ruled out, basic prenatal care is undertaken as follows:

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
ASSESSMENT			
A. History			
1. Personal information			• This is to establish rapport with the woman and determine if she is within the "high-risk" category (e.g., below 18 years old; 34 years old and above). If she is, **refer** her to an Ob-Gyne or hospital. • The information will be used in the development of the "Birth Plan." • These are basic information necessary for recording, reporting, monitoring evaluation, and other studies.
Name	✓		
Age	✓		
Address	✓	✓	
Contact number	✓	✓	
Occupation /source of income	✓	✓	

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
2. Present Pregnancy			• This determines the status of the present pregnancy (i.e., age of gestation, the occurrence of discomforts in pregnancy and how she copes with these, the acceptability of the pregnancy and the occurrence of danger signs) which helps in formulating the birth plan and determines whether the woman would need a higher level of care.
LMP	✓	(May ask for LMP again, if in doubt)	
Age of gestation			
Expected date of delivery			
Any medical or obstetric problems experienced since the start of pregnancy (i.e., any of the danger signs)	✓	✓	
Possible pregnancy discomforts (e.g., nausea and vomiting, heartburn, constipation, edema)	✓	✓	
Whether pregnancy is planned or unplanned	✓	✓	
3. Medical History			• Some medical conditions may become worse during pregnancy. History of any of these illnesses puts the woman in the high-risk pregnancy category. • A pregnant woman with a history of any of these should be referred to a higher level of care (i.e., obstetrician, and/or hospital).
Ask about history of:			
• Hypertension	✓		
• Diabetes mellitus	✓		
• Rheumatic or other heart disease	✓		
• Convulsions	✓		
• Asthma	✓		
• Tuberculosis	✓		
• Psychiatric illness	✓		
• Congenital heart disease	✓		
• Thyroid disorders	✓		
• Polycystic ovary syndrome	✓		

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
4. Family History Ask if any family members have history of any of the following conditions: • Diabetes mellitus • Multiple pregnancy • Bleeding tendency • Mental disorder	 ✓ ✓ ✓ ✓		• A history of any of these conditions in immediate family members increases the risk of these conditions in the woman and her infant.
5. Social History • Substance/drug abuse • Alcohol intake or smoking • Civil status (i.e., married or unmarried) • Employment • Living conditions (e.g., environment)	 ✓ ✓ ✓ ✓ ✓		• Personal habits like intake of alcoholic beverages or smoking can cause congenital abnormalities and intrauterine growth retardation. • Unmarried women may need assistance to plan for the care of their infants. • Unemployment, poor housing condition and overcrowding increase the risk of communicable diseases, malnutrition, intrauterine growth retardation. • Couples who live in poor social conditions need special support and help. • If any of these is present, include initiatives in the birth plan to effect short and long term behavioral changes.

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
6. Obstetrical History			• Grand multiparity (5 or more pregnancies) puts the woman at high risk. Refer her to an OB and/or facility with higher level of care.
a. Ask:			
• how many pregnancies (gravidity) she may have had	✓		
• the number of previous pregnancies that reached viability (parity)	✓		• Miscarriages (3 or more successive during the first trimester) suggest a possible genetic abnormality in either the woman or her partner.
• the number of miscarriages or ectopic pregnancies	✓		• Mid-trimester miscarriages suggest an incompetent cervix. A previous ectopic pregnancy warns the midwife to ensure that the present pregnancy is intrauterine.
			• Multiple pregnancies tend to recur.
			• If any of these is present, educate the expectant mother on possible consequences of her current pregnancy and the referral network within the vicinity.

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
b. Ask about: • Birth weight, gestational age and method of delivery of each previous infant as well as of perinatal deaths	✓		• Previous low birth weight infants or spontaneous preterm labors tend to recur. • Previous large infants (≥4 kg.) suggest maternal diabetes. If positive for this, refer to an Ob-Gyne, or back-up doctor or higher level of facility. • Previous Cesarean section may suggest a possible repeat Cesarean section *(refer all cases with history of previous CS).* • Previous perinatal deaths, still births, fetal deaths especially if no cause is known, may recur.
• Previous complications of pregnancy such as: Pre-eclampsia Prolonged labor Retained placenta Postpartum hemorrhage	✓		• These conditions can recur in the present pregnancy, therefore extra care and vigilance must be exercised by the midwife. *When in doubt, refer to Ob-Gyne or back-up doctor.*

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
7. Family Planning (FP) History/Plans Ask: • If she and her partner plan to have more children • The timing when she and her partner plan to have another child, if they plan to have more children • If she or her partner has used an FP method before • The reason for discontinuing an FP method previously used • If she or her partner plan to practice FP after delivery of this baby	✓ ✓ ✓ ✓ ✓		• Use this information to counsel on family planning based on the couple's reproductive need and their FP knowledge and experience. • FP counseling must include breastfeeding practice.
B. Physical Examination			
1. HEENT	✓	✓	• Any findings that are not within normal should be referred to a back-up doctor.
2. Heart and Lungs Auscultate: • Heart • Lungs	✓		• Presence of abnormal heart sounds such as murmurs, or breath sounds such as wheezes, rales should be referred to a back-up doctor or a higher level facility.
3. Abdomen Check: • For scars • Fundic height • Fetal heart tone/beats Perform:· Leopold's maneuver *(refer to "Part 2: Special Procedures" for review of Leopold's maneuver)*	✓	 ✓ ✓ ✓	• Scars may indicate previous surgical procedures such as Caesarean section. Refer to a back-up doctor if with previous surgery. • Getting the fundic height and the FHT are ways of assessing the status of the fetus inside the uterus. • Leopold's maneuver is a common and systematic way to determine the position of a fetus inside the woman's uterus, whether cephalic or breech presentation.

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
C. Laboratory Examination			
Determine: • Hemoglobin – measure on first visit. On subsequent visits, look for conjunctival and palmar pallor. Also, count number of breaths per minute. • Blood type • Urinalysis Ask about: • Episodes of fever or chills, pain or burning sensation	✓ ✓	 ✓	Baseline laboratory information of the woman is important to determine if she is anemic: • The normal hemoglobin cut-off level for a pregnant woman is 11g/dl. • Moderate Anemia - hemoglobin of 7-11g/dl, or palmar or conjunctival pallor plus heart rate of >100. • Severe Anemia - hemoglobin of <7 g/dl and/ or severe palmar and conjunctival pallor or any pallor with any of the following: • >30 breaths/minute • Gets tired easily • Breathlessness at rest • HR+>100 • Urinary tract infections (UTI), should be proven by culture and sensitivity and must always be treated in pregnant women. Refer to back-up Ob-Gyne if positive for UTI.

COMPONENTS	1st VISIT	SUBSEQUENT VISITS	SIGNIFICANCE
D. Schedule of Return Visit			
Discuss and set dates of next ante-natal visits	✓	✓	Routine antenatal care visits: • All pregnant women should have at least four routine antenatal visits. • First antenatal visit should be as early in pregnancy as possible before four months. Succeeding visits are at 6, 8, and 9 months gestation. • During the last visit, inform the woman to return if she does not deliver within 2 weeks after the expected date of delivery. Follow-up visits: If clients have problems such as: • Hypertension – return after 1 week if > 8 weeks pregnant. • Severe anemia – return after 2 weeks

4. Prepare a Birth Plan

A birth plan is prepared during the first antenatal visit, and is reviewed in succeeding visits. It should be modified if complications arise. This is discussed *in Section 2, Part 2: Clinic Operation Standards Manual/Clinic Forms.*

Next page is the Maternal Birth Plan form which is used to facilitate planning session with the expectant mother.

CLIENT NO.:_____ **Form 2B**

MATERNAL BIRTH PLAN

Please accomplish in duplicate during FIRST prenatal consultation.

NAME: _____ **AGE:** _____ **TEL. NO.:** _____

☐ **Yes**

ADDRESS: _____ **PhilHealth Member/Dependent:** ☐ **No**

1. Your **Midwife** will help you prepare a delivery plan. She will give you suggestions/ recommendations as to where to deliver best based on your health condition. It is recommended that you deliver in a facility, like in a birthing home with a skilled attendant.
2. You will keep this delivery plan with a copy attached to your maternal record.
3. This delivery plan will be reviewed and discussed with you every visit so it is important that you bring your copy every time you come.

1. Aside from the four (4) recommended prenatal visits, how many more visits would you want to have? ☐ 5 ☐ 6 ☐ 7 ☐ 8

   Routine visits:

   1st = before 4 months

   2nd= 6-7 months

   3rd= 8 months

   4th= 9 months

   Expected date of confinement _____

2. Do you intend to deliver in this health facility/clinic? ☐ Yes ☐ No

   If no, where do you intend to deliver? _____

3. What transportation will you take to get to the facility where you will deliver? ☐ Car ☐ Bus ☐ Jeep ☐ Tricycle ☐ Multicab ☐ Others specify _____

4. Will you have to pay for the transport to get to the health facility? ☐ Yes ☐ No

5. The cost of the delivery services including newborn screening (and newborn hearing screening) in this health facility/clinic is:

   Maternity Services Php _____

   Newborn Care Services Php _____

   - Newborn Screening Php _____
   - Newborn Hearing Screeening Php _____

   Cost to be covered by Philhealth

   Maternity Care Package Php _____

   Newborn Care Package Php _____

6. Who will go with you and support you during labor and delivery? **(Explain necessity)** _____

7. Who will help you take care of your home and children while you are here? **(Explain necessity)** _____

8. Do you intend to have more children? ☐ Yes ☐ No

9. How many more children do you intend to have? _____

10. Do you know of any family planning method? ☐ Yes ☐ No

11. Have you used any FP method before? **(Provide FP counseling at this point)** ☐ Yes ☐ No

5. Provide Immunization and Other Preventive Measures

TETANUS TOXOID (TT) IMMUNIZATION

Below is the schedule of TT immunization.

DOSAGE	GIVEN	PERIOD OF PROTECTION
1st dose	As early as possible during pregnancy	None
2nd dose	1 month after the 1st dose	3 years after the first dose
3rd dose	At least 6 months after the 2nd dose	5 years
4th dose	At least 1 year after the 3rd dose	10 years
5th dose	At least 1 year after the 4th dose	Lifetime

Provide TT vaccine as needed, based on the woman's immunization status.

Note: The DOH Field Health Service Information System (FHSIS) requires health care facilities to report on the number of mothers receiving TT vaccine. If the mother has complete immunization against tetanus, her babies will be protected at birth. The Child Protected at Birth is a quick assessment of the TT immunization status of the mother.

IRON/FOLATE

- Give iron 60 mg + folate 400 mcg to be taken by mouth once daily for three months starting on the last trimester.
- Provide health messages and counseling as follows:
  - Eat foods rich in Vitamin C as these help the body absorb iron.
  - Avoid tea, coffee and colas, as these inhibit iron absorption.
  - Possible side effects of iron/folate tablets include black stools, constipation, and nausea. Lessen side effects by:
    - Drinking more fluids (an additional 2-4 cups per day).
    - Eating more fruits and vegetables.
    - Getting adequate exercise such as walking.
    - Taking tablets with meals or at night.

VITAMIN A

- Care for women in areas endemic for Vitamin A deficiency must include micronutrient supplementation during pregnancy, as follows:
  - During the 1st-3rd trimesters – 10,000 IU per day orally; OR
  - During the 2nd and 3rd trimesters – 25,000 IU per week orally
- Advice the woman that she should not take more Vitamin A than prescribed.
- Advice the woman to increase dietary intake of locally available foods that are rich in Vitamin A such as yellow and orange fruits and vegetables (e.g., carrots, mangoes, pumpkin, squash) and dark, green, leafy vegetables.

6. Treat soil-transmitted helminthiasis

Women living in areas endemic for helminthiasis should receive the following information:

- Helminthiasis is transmitted through the skin from soil that contains hookworm larvae.
- Helminthiasis can cause anemia and protein deficiency.
- Some ways to avoid helminthiasis are as follows:
  - Always use footwear. Do not walk barefoot.
  - Dispose of feces carefully in a latrine pit.
  - Do not touch soil with bare hands, especially soil that is likely to contain feces.
  - Use good hygiene and infection prevention practices.
  - Always wash hands before eating and after using the toilet.

LABOR AND CHILDBIRTH

Steps in Managing a Woman in Labor and Delivery

1. Do an "Immediate Assessment" at the time of admission and during labor.
2. Assess the status of the pregnancy (i.e., of the woman and her fetus).
3. Determine the phase of labor.
4. Respectfully ask for the patient's informed consent for admission (clinic operations standard).
5. Monitor and manage the woman in labor.
6. Deliver the baby.
7. Deliver the placenta.
8. Monitor during the immediate postpartum period.

1. Do "Immediate Assessment"

a. Check the woman's condition:

- General condition
- Blood pressure
- Pulse rate
- Respiratory rate
- Temperature
- Observe for "danger signs"

The woman's condition is considered normal when she:

- Appears calm and relaxed between contractions and does not look pale. During contractions, her respiratory rate will increase and she will experience pain. However, she should not have

pain between contractions. When the cervix is fully dilated, the woman becomes restless, may vomit, and has the uncontrollable urge to bear down with contractions.

- Has an axillary temperature of 36-37°C.
- Has a pulse rate of 80-100 beats/minute.
- Has BP of 100/60 mmHg or above but less than 140/90.
- Does not have the following danger signs for which she will need to be referred to a hospital immediately.

SIGNS	POSSIBLE CONDITIONS
Vaginal bleeding of any amount (except for "show") since labor began	Placenta previa, Abruptio placentae
High blood pressure (≥ 140/90 mm Hg)	Pre-eclampsia
Temperature > 38°C	Infection
Low blood pressure with a systolic BP < 90 mm Hg	Hypotension, bleeding, dehydration
Severe pallor	Severe anemia, bleeding
Epigastric or abdominal pain	Impending eclampsia, preterm labor, ectopic pregnancy, internal bleeding probably caused by ruptured uterus, appendicitis
Severe headache	Pre-eclampsia, impending eclampsia
Blurred vision	Pre-eclampsia, impending eclampsia
Convulsions or unconsciousness	Eclampsia, seizure disorder, hyperglycemia or hypoglycemia and other metabolic disorders
Breathing difficulty	Pulmonary edema, congestive heart failure, bronchial asthma
Fetal heart rate <100 beats/min. or > 180 beats/min.	Fetal distress
Umbilical cord felt over the head or in the birth canal if the membranes are ruptured	Cord prolapsed
Bi-pedal edema with pallor, or hypertension	Kidney diseases

b. Check fetal condition

- Fetal heart rate
- Characteristics of the amniotic fluid, if membranes have ruptured

The fetal condition is considered normal when:

- Fetal heart rate **immediately after a contraction** is within 100-180 beats/min.
- If the membranes have ruptured, the amniotic fluid is clear

c. If the expectant mother exhibits any of the "danger signs," institute emergency measures or first aid prior to immediate referral and transport.

- General principles in managing emergencies:
  - o Follow the dictum in health care provision: DO NO HARM.
  - o Stay calm to be able to think logically and focus on the needs of the woman.
  - o Do not leave the woman unattended.
  - o Seek assistance from assistants and relatives to gather emergency equipment and supplies.
  - o Assess vital signs (i.e., blood pressure, pulse, and respiratory rate).
- Signs of conditions that warrant an emergency measure and immediate referral to Ob-Gyne or back-up doctor and/or higher health care facility are:

SIGNS	EMERGENCY MEASURES
Vaginal bleeding accompanied by signs of impending or frank shock like: • severe pallor • low blood pressure (systolic BP < 90 mm Hg) • pulse rate ≥ 110/min. • respiratory rate ≥ 30 breaths/min.	• Start IV infusion with either normal saline or lactated ringer's solution (i.e., D_5LRS) at a fast rate depending on the signs. Midwife is allowed to insert IV if he/she underwent training on IV therapy. • Turn woman onto her side to prevent aspiration if she vomits. • Elevate her legs to increase blood return to the heart. • Give oxygen at 6-8 L/min by mask or nasal cannula. • Transport immediately.
Breathing difficulty	• Prop up the woman on her left side. • Start an IV infusion of normal saline or lactated ringer's solution to keep an intravenous line open or to hydrate if needed. Midwife is allowed to insert IV if he/she underwent training on IV insertion. • Give 4-6L/min. of oxygen • Transport immediately.

SIGNS	EMERGENCY MEASURES
High blood pressure (BP $\geq$ 140/90) accompanied by convulsion	• Position woman on her left side to reduce risk of aspiration. • Protect woman from injuries but do not restrain. • Transport immediately.
Fetal heart rate < 100 beats/minute or > 180 beats/minute.	• Observe if persistent when taking after a contraction. • If sign is persistent and in the first stage of labor, give oxygen at 6-8 L/min. by mask or nasal cannula then transfer to a facility where Caesarean section can be performed. • If in the second stage of labor, give oxygen and deliver. Inform woman of the condition.
Umbilical cord lies in the birth canal below the fetal presenting part.	• If **cord is pulsating**, the woman is in the first stage of labor and delivery is not imminent: o Wearing high-level disinfectant or sterile gloves, insert a hand into the vagina and push the head upward to release the pressure on the cord and dislodge the head from the pelvis. o Place the other hand on the suprapubic area to keep the head dislodged from the pelvis. o When the head is dislodged from the pelvis, remove the hand in the vagina but keep the hand on the suprapubic area in place. o Transport the woman to the nearest facility where Caesarean section can be performed. • If cord is pulsating and the woman is in the second stage of labor when delivery is imminent, deliver the baby. Inform the woman of the problem. • If **cord not pulsating**, deliver the baby. Inform the woman of the possibility of fetal death.

2. Assess Status of Pregnancy

a. Confirm that woman is in labor by:

- Taking the history
  Suspect or anticipate labor if the woman has:
  - o Intermittent abdominal pain due to uterine contractions every 20 minutes with increasing frequency, duration, and intensity.
  - o Uterine contractions associated with blood-tinged, sticky vaginal discharge (bloody show).
  - o Watery vaginal discharge or sudden gush of water (indicating BOW rupture).

- Doing internal examination
  - o Cervical effacement occurs (There is thinning and shortening of the cervix).
  - o Cervix is dilated.

NOTE: <u>DO NOT</u> perform vaginal examination if the woman is bleeding and has a history of bleeding at any time after 7 months of pregnancy.

b. Check record. If there is no record:

- Determine if preterm by asking when delivery is expected or when her last menstrual period occurred.
- Review the birth plan
- Ask about:
  - o hemoglobin results
  - o TT immunization
  - o risk for STIs
- Ask about previous pregnancies, if any:
  - o Number of pregnancies
  - o type of delivery: normal spontaneous vaginal, Caesarean section, forceps, or vacuum extraction
  - o complications like postpartum hemorrhage, 3rd degree lacerations

c. Examine her abdomen for:

- Caesarean section scar
- Horizontal ridge across lower abdomen (sign of abnormal/prolonged labor)
- Contractions (frequency, duration, continuous contractions)
- Fetal lie and presentation
- Multiple fetuses
- Fetal movement

d. Refer to higher level of care (i.e., obstetrician or hospital) in case of danger signs and the following:

- Preterm labor
- Transverse lie and abnormal presentation (e.g., breech, shoulder, face)
- Multiple fetuses
- History in past pregnancies of:
  - o prolonged, difficult labor, including previous Caesarean section
  - o delivery other than normal, vaginal, spontaneous
  - o complications like postpartum hemorrhage and 3rd degree perineal lacerations

3. Determine stage and phase of labor

Symptoms and Signs	Stage of Labor	Phase
• Cervix not dilated	False labor /not in labor	
• Cervix dilated < 4 cm	First	Latent
• Cervix dilated 4-9 cm • Rate of dilatation at least 1 cm/hr • Fetal descent begins	First	Active
• Cervix fully dilated (10 cm) • Fetal descent continues • No urge to push	Second	Early (non-expulsive)
• Cervix fully dilated (10 cm) • Fetal head reaches pelvic floor • Woman has the urge to push • Perineum distending • Fetal head visible	Second	Late (expulsive)
• Delivery of the baby • Fundus gets firmer and rises in abdomen • Shape of the fundus changes • Cord lengthens • Small gush of blood from vagina	Third	

4. Monitor and Manage Labor

a. Supportive care during labor

Communication

- Explain all procedures, seek permission, and discuss findings with the woman.
- Keep her informed about the progress of labor.
- Praise, encourage, and reassure her that things are going well.
- Ensure and respect privacy during examinations and discussions.
- If known to be HIV positive or with previous or current sexually transmitted illnesses, find out what she has told her partner. Respect her wishes.

Cleanliness

- Encourage the woman to take a bath or shower or wash herself and genitals at the onset of labor.
- Wash the vulva and perineal areas before each examination.
- Wash hands with soap before and after each examination. Use clean gloves for vaginal examination.
- Ensure cleanliness of labor and birth areas.
- Clean up spills immediately.
- DO NOT re-use materials intended for single use.
- **DO NOT** give enema.

Mobility

- Encourage woman to walk around freely during the first stage of labor.
- Support the woman's choice of position (left lateral, squatting, kneeling, standing supported by a companion) for each stage of labor and delivery.

Urination

- Encourage the woman to empty her bladder frequently. Remind her every two hours.

Eating, drinking

- Encourage the woman to eat and drink as she wishes throughout labor.
- Nutritious liquid drinks are important, even in late labor.
- If the woman has visible severe wasting or tires during labor, make sure she eats and drinks.

Breathing technique

- Teach her to maintain her normal breathing.
- Encourage her to breathe out more slowly, making a sighing noise, and to relax with each breath.

- If she feels dizzy, unwell, is feeling pins-and-needles (tingling) in her face, hands and feet, encourage her to breathe more slowly.
- To prevent pushing at the end of the first stage, teach her to pant, to breathe with an open mouth, to take in two short breaths followed by a long breath out.
- During delivery of the head, ask her not to push but to breathe steadily or to pant.

Pain and discomfort relief

- Suggest change of position.
- Encourage as much mobility as may be comfortable for the woman.
- Encourage companion to:
  - massage the woman's back if she finds this helpful.
  - hold the woman's hand and sponge her face between contractions.
- Encourage her to use the breathing technique.
- Encourage a warm bath or shower, if available.

Birth companion

- Encourage support from the birth companion throughout labor.
- Describe to the birth companion what he or she should do:
  - Always be with the woman.
  - Provide support and encouragement.
  - Help her to breathe and relax.
  - Rub her back, wipe her brow with a wet cloth, do other supportive actions.
  - Give support using local practices which do not disturb labor or delivery.
  - Encourage woman to move around freely as she wishes and to adopt the position of her choice.
  - Encourage her to drink fluids and eat as she wishes.
  - Assist her to the toilet when needed.

- Ask the birth companion to call for help if:
  - The woman is bearing down with contractions.
  - There is vaginal bleeding.
  - She is suddenly in much more pain.
  - She loses consciousness or has fits.
  - There is any other concern.

- Tell the companion what he or she **should not do** and explain why:

  DO NOT encourage woman to push.
  DO NOT give advice other than that given by the health care provider.
  DO NOT keep woman in bed if she wants to move around.

b. Management during stages of labor

FIRST STAGE OF LABOR: LATENT PHASE OF LABOR (cervix dilated < 4 cm)

Monitor every hour:

- For danger signs
- Frequency, intensity, and duration of contractions
- Fetal heart rate (FHR)
  - o Normal if FHR is 100-180 beats/minute
  - o If FHR <100 or >180 beats/minute
    - Position woman on her left side and re-check after 30 minutes.

Fetal Heart Rate (FHR)	Condition of Fetus	Action needed
FHR returns to normal	BABY WELL	Monitor FHR every 15 minutes
FHR remains <100 or >180 beats/minute	BABY NOT WELL	Refer urgently to hospital while keeping the woman lying on her left side

- Record findings if contractions are $\geq$ 2 in 10 minutes, each lasting 20 seconds or more (indicates that the woman is in true labor).
- Record time of rupture of membranes and color of amniotic fluid.
- Give supportive care.
- **Never leave the woman alone.**

Monitor every four hours:

- Cervical dilatation:
  Unless indicated, **DO NOT** perform vaginal examination more frequently than every four hours.
- Vital signs:
  BP, temperature, pulse

ASSESS PROGRESS OF LABOR	TREAT AND ADVISE
• After four hours if: o no increase in contractions, and o membranes are not ruptured, and o no progress in cervical dilatation	• Discharge woman and advise her to return if: o pain/discomfort increases o vaginal bleeding occurs o membranes rupture

ASSESS PROGRESS OF LABOR	TREAT and ADVISE·
• After four hours if: o Contractions stronger and more frequent, ***but*** o No progress in cervical dilatation with or without membranes ruptured	• Refer woman to hospital urgently
• Cervical dilatation 4 cm or greater	• Plot in the partograph and manage as in **Active Labor** *(see Section 2 Part 2 for a review of the instructions on how to fill up the partograph)*
• If BOW has ruptured, check color of amniotic fluid and assess fetal condition	• If meconium-stained, refer to Ob-Gyne and pediatrician for proper management

FIRST STAGE OF LABOR: IN ACTIVE LABOR (cervix dilated 4 cm or more)

Monitor every 30 minutes:

- For emergency signs
- Frequency, intensity, duration of contractions
- Fetal heart rate
  - o Normal if FHR is 100-180 beats/minute
  - o If FHR <100 or >180 beats/minute
    - - Position woman on her left side and re-check after 30 minutes.

Fetal Heart Rate (FHR)	Condition of Fetus	Action needed
FHR remains <100 or >180	BABY NOT WELL	If early labor: Refer urgently to hospital while keeping the woman lying on her left side If late labor: o Call for help during delivery. o Monitor after every contraction. If FHR does not return to normal in 15 minutes, explain to the woman or her companion that the baby may not be well. o Prepare for newborn resuscitation.

Fetal Heart Rate (FHR)	Condition of Fetus	Action needed
FHR returns to normal	BABY WELL	Monitor FHR every 15 minutes.

- Cervix dilating and effacing (thinning)
- Descent of the baby's head during contractions
- Mood and behavior (distressed and anxious)

- Record findings regularly in Partograph.
- Give supportive care.
- Never leave the woman alone.

ASSESS PROGRESS OF LABOR	TREAT and ADVISE
• Partograph passes to the right of the ALERT LINE	• Reassess woman and consider criteria for referral. • Call back-up obstetrician. • Encourage woman to empty bladder. • Ensure adequate hydration but omit solid foods. • Encourage upright position and walking if woman wishes. • Monitor intensively. If no progress in two hours, refer immediately.
• Cervix dilated by 10 cm or bulging perineum.	• Manage as in **Second Stage of Labor.**

5. Deliver the Baby (Second Stage of Labor)

- **Watch out for danger signs, which include:**
  - o Hypertension
  - o Difficulty in breathing or cyanosis
  - o Hypotension (systolic BP < 90 mmHg)
  - o PR > 110/minute
  - o Vaginal bleeding > 100 ml
  - o Umbilical cord seen at the vulva
  - o Fetal heart rate < 100/minute or > 180/minute, persisting even after 30 minutes.
  - o Prolonged labor (no progression in descent of the head and delivery does not seem to be happening in two hours)
  - o Baby's shoulder stuck

Monitor every five minutes:

- For emergency (danger) signs.
- Frequency, intensity, duration of contractions.
- Fetal heart rate (normal is 100-180 beats/minute).

Fetal Heart Rate (FHR)	Condition of the Fetus	Action needed
If < 100 or >180 beats/ minute	BABY NOT WELL	• Call for help during delivery • Monitor after every contraction. If FHR does not return to normal in 15 minutes, explain to the woman or her companion that the baby may not be well· Prepare for newborn resuscitation
FHR returns to normal	BABY WELL	• Monitor FHR every 15 minutes

- Perineum thinning and bulging.
- Visible descent of the baby's head during contractions.
- Mood and behavior (distressed and anxious).

- Give supportive care as appropriate.
- Never leave the woman alone.

DELIVER THE BABY	TREAT and ADVICE, if required
• Ensure all delivery equipment and supplies, including newborn resuscitation equipment, are sterile and available, and place of delivery is clean and warm (25°C).	
• Ensure bladder is empty.	• If unable to pass urine and bladder is full, empty bladder by: o encouraging the woman to urinate o if unable to urinate, catheterize – wash hands – clean urethral area with antiseptic – put on clean gloves – spread labia – clean area again – insert catheter up to 4 cm – measure urine and record amount – remove catheter

DELIVER THE BABY	TREAT and ADVICE, if required
• Stay with the woman and offer her emotional and physical support. • Assist the woman into a comfortable position of her choice, as upright as possible.	• **DO NOT** let her lie flat on her back. • If the woman is distressed, provide relief by: o Encouraging her companion to: - massage the woman's back if she finds this helpful. - hold the woman's hand and sponge her face between contractions. o Teaching her to pay attention to her normal breathing and encouraging her to breathe out more slowly, making a sighing noise, and to relax with each breath. o Telling her not to push during delivery of the head but to breathe steadily or to pant.
• Allow her to push as she wishes with contractions	**DO NOT** urge her to push: • If after 30 minutes of spontaneous expulsive efforts, the perineum does not begin to thin and stretch with contractions. Do a vaginal examination to confirm full dilatation of the cervix. • If cervix is not fully dilated, await second stage. Place woman on her left side and discourage pushing.
• Wait until the baby's head is visible and perineum is distending.	• If second stage lasts for two hours or more without visible steady descent of the head, **refer** immediately to hospital**.** ***Use the partograph results or reading or trend to determine prolonged labor and therefore need for urgent referral.***
• Wash hands with clean water and soap. Put on gloves just before delivery.	• Use double gloves: one for delivering the baby and instituting immediate care of the newborn; remove the first gloves before cord clamping. ***Refer to "Immediate Newborn Care" on page 66.***

DELIVER THE BABY	TREAT and ADVICE, if required
• Ensure controlled delivery of the head: o Keep one hand gently on the head as it advances with contractions. o Support perineum with other hand and cover anus with pad held in position with side of hand during delivery o Leave the perineum visible (between thumb and first finger). o Ask the mother to breathe steadily and not to push during delivery of the head. o Encourage rapid breathing with mouth open.	• If expulsive efforts are potentially damaging,exert more pressure on perineum. • Discard soiled pad to prevent infection.
• Feel gently around baby's neck for the cord.	• If cord is present and loose, deliver the baby through the loop of the cord or slip the cord over the baby's head. • If cord is tight, clamp and cut cord, then unwind.
• Check if the face is clear of mucus and membranes.	• Gently wipe face clean with gauze or cloth, if necessary.
• Await spontaneous rotation of shoulders and delivery (within 1-2 minutes) • Apply gentle downward pressure to deliver top shoulder. • Lift baby up, towards the mother's abdomen to deliver lower shoulder.	• If there is delay in delivery of the shoulder: o Do not panic. Call for additional help. o Explain the problem to the woman and her companion. o Ask the woman to lie on her back while gripping her legs tightly flexed against her chest, with knees wide apart. Ask companion or additional helper to keep the legs in that position. o Ask an assistant to apply continuous pressure downward, with the palm of the hand on the abdomen directly above the pubic area, while maintaining continuous downward traction on the fetal head. o If not successful, **refer** immediately to hospital**.**

DELIVER THE BABY	TREAT and ADVICE, if required
• Place baby on mother's abdomen ensuring immediate skin-to-skin contact while drying the newborn for at least 30 seconds. **Refer to "Immediate Newborn Care" on page 66.** • Note time of delivery	• Dry the baby immediately at least 30 seconds without removing the vernix. • Place newborn on skin-to-skin contact with mother's abdomen. • Remove wet cloth and place dry blanket at baby's back and bonnet on its head to keep baby warm. • Wait for cord pulsations to stop before clamping and cutting the cord.
• Assess baby's need for ventilation or resuscitation. ***Refer to "Newborn Resuscitation" on page 70.*** **Situations requiring immediate management:** o No breathing or gasping (less than 20 breaths/minute) o Cyanosis (blueness) o Breathing difficulty (less than 20 breaths or more than 60 breaths per minute, chest in-drawing) o Newborn is limp or floppy and not actively crying.	• If newborn is floppy, limp, not breathing or severely distressed, clamp and cut the cord immediately. • Place the baby on a firm, warm surface for resuscitation if needed. • Care after successful resuscitation: o Prevent heat loss by placing the baby in skin-to-skin contact on the mother's chest and covering the baby's head and body. o Encourage the mother to breastfeed and assist in latching the baby onto the breast. o If baby is not sucking well, transfer mother and baby to a higher level of facility.

Observe standard infection prevention practices by following the procedures enumerated in Infection Prevention (page 35), and in Section 2 (Clinic Operation Standards Section).

6. Deliver the Placenta (Third Stage of Labor)

- **Identify danger signs which necessitate referral:**
  - o Placenta not delivered within 30 minutes
  - o Placenta delivered but incomplete
  - o Heavy bleeding

- The following are the steps for delivering the placenta:

NOTE: WHO recommends that "Active Management of Third Stage of Labor (AMTSL) should be practiced in all pregnancies because of overwhelming evidence proving that it reduces the risk of post-partum hemorrhage." *(Integrated Management of Pregnancy and Childbirth: A guide for midwives and doctors. pp. C-73 to C-75)* AMTSL is an effective measure to prevent PPH. AMTSL can be delivered wherever women give birth, including at home, by trained health care providers linked to essential supplies. AMTSL speeds delivery of the placenta by increasing uterine contractions and prevents PPH by averting uterine atony. The components of AMTSL are:

- Administration of a uterotonic agent within one minute after the baby is born
- After the cord is clamped, delivery of the placenta by controlled cord traction (gently pulling on the umbilical cord) with counter-traction on the fundus
- Fundal massage after delivery of the placenta

DELIVER THE PLACENTA	**TREAT and ADVICE IF REQUIRED**
AMTSL Protocol:	
• Within one minute of delivery of the baby, palpate the abdomen to exclude another baby. (If there are conditions that necessitate immediate attention on the newborn, ask an assistant to deliver the placenta as described.)	
• **Give the mother 10 IU Oxytocin IM as soon as it is determined that there is no other baby.**	
• Clamp cord (delayed clamping): o Wait until the cord ceases to pulsate or 2-3 minutes after the baby's birth, whichever comes first. o Tightly tie around the cord at 2 cm from the baby's abdomen and 3 cm from the first tie. o Cut between ties with sterile scissors.	

DELIVER THE PLACENTA	TREAT and ADVICE IF REQUIRED
• Await strong uterine contractions and deliver placenta by **controlled cord traction**. o Place side of one hand (usually left) above the symphysis pubis with palm facing towards the mother's umbilicus. This applies counter traction to the uterus during controlled cord traction. o If the placenta does not descend during 30-40 seconds of controlled cord traction, release both cord traction and counter traction on the abdomen and wait until the uterus is well contracted again. Then repeat controlled cord traction and counter traction. o As the placenta is coming out, catch in both hands to prevent tearing of the membranes. o If membranes do not slip out spontaneously, gently twist them into a rope and move them up and down to assist separation without tearing the membranes.	Observe for signs of placental separation: o Uterus changes shape from discoid to globoid o Sudden gush of blood o Lengthening of the cord **DO NOT** pull the umbilical cord. **DO NOT** squeeze or push the uterus to deliver the placenta.
• Apply fundal massage after delivery of the placenta.	
• Check if placenta and membranes are complete by holding the placenta in both hands in a cupped position with the rough surface facing upward and observing that there are no gaps or spaces in between the cotyledons that may indicate missing placental parts.	• **DO NOT** manually explore the uterus for retained placental fragments. • ***NOTE: NEVER "CLEAN" the uterus manually with your gloved hand or with OS (operating sponge) or with anything. This is not an acceptable practice for doctors or midwives or nurses.*** • If placenta is incomplete, refer to back-up obstetrician or hospital.

DELIVER THE PLACENTA	TREAT and ADVICE IF REQUIRED
	• If blood loss was about 250 ml but bleeding has stopped: o Plan to keep the woman in the facility. o Monitor every 30 minutes for four hours: - BP, pulse - vaginal bleeding - uterus, ensuring that it is well contracted o If monitoring not possible in the facility, **refer** to hospital**.**

7. Monitor Immediate Postpartum

- Check every five minutes if the uterus is well contracted and there is no heavy bleeding.
- Examine perineum, lower vagina and vulva for tears.
- Collect, estimate and record blood loss throughout the third stage and immediately afterwards.
- Clean the woman and the area beneath her. Put sanitary pad or folded clean cloth under her buttocks to collect blood, and help her change clothes.
- Monitor and assess maternal well-being up to six hours as follows (WHO recommendation):
  - o take the vital signs (blood pressure, pulse rate, temperature)
  - o watch out for vaginal bleeding (soaked pads every five minutes is a sign of heavy bleeding)
  - o check uterine firmness
    - Every 15 minutes for 2 hours
    - Then, every 30 minutes for 1 hour
    - Then, every hour for 3 hours
  - o monitor and assess newborn well-being
  - o continue breastfeeding initiation

What to do when problems occur:

A. Bleeding

- For heavy bleeding:
  - o Check placenta for completeness.
  - o Check for perineal or reproductive tract (i.e., cervix and vagina) laceration(s).
  - o Call for help.

- If uterus is soft and not contracted,
  - massage uterus to expel clots, if any, until it is hard.
  - give oxytocin 10 IU IM
  - start an IV line, add 20 IU of oxytocin to IV fluids and give at 60 drops/minute.
- Empty the bladder.

- If bleeding persists and uterus is soft:
  - Continue massaging uterus until it is hard.
  - Apply bimanual uterine or aortic compression.
  - Continue IV fluids with 20 IU oxytocin at 30 drops/minute.
- **Refer** the woman immediately to hospital**.**

B. Lacerations/tears

- If there is/are third degree tear/s (which means involving the rectum or anus) refer urgently to the hospital.
- For tears which are actively bleeding (moderate to profuse), apply pressure over the tear with a sterile pad or gauze and put legs together. **DO NOT** cross ankles. **Refer** immediately to the hospital**.**
- For first and second degree lacerations, repair the lacerations IF YOU ARE TRAINED to do so.

Infection Prevention During Deliveries

Consider every person potentially infectious (even the health staff, the mother, and the baby). Practice routine procedures that protect both health workers and patients from contact with infectious materials:

- Wash hands thoroughly before and after doing internal vaginal examination on the patient.
- Wash hands thoroughly before and after caring for a woman or newborn, before and after treatment procedures including cord cutting, and after handling of waste or potentially contaminated materials.
- Wear fresh sterile or high-level disinfected (HLD) gloves when performing delivery, cord cutting, or blood drawing.
- Wear clean heavy utility gloves when handling and cleaning instruments, handling contaminated wastes, cleaning blood and body fluid spills.
- During deliveries: wear gloves, cover any cuts, abrasions or broken skin with a waterproof bandage, wear a long apron made from plastic or other fluid resistant material and shoes, protect your eyes from splashes of blood.
- Safely dispose sharps immediately after use in a puncture-resistant container, properly labeled for the purpose, and kept nearby the bed.
- Never re-use, recap, or break needles after use.
- Do not re-use materials intended for single use.

- Dispose of bloody or contaminated items in leak-proof containers.
- Pour liquid waste down a drain or flushable toilet.
- Collect and keep clothing or sheets stained with blood or body fluids separate from other laundry.
- Make sure that instruments are processed according to standards.
- Ensure that all instruments, supplies and other materials to be used during delivery are properly sterilized and appropriately labeled as such before use.
- Thoroughly clean the delivery and labor rooms immediately after each delivery with disinfectants.
- Dispose all used materials accordingly.

POSTPARTUM CARE

1. Do "Immediate Assessment" for every postpartum care visits.

MOTHER'S CONDITION

Check the mother's condition:

- General appearance
- Blood pressure
- Pulse rate
- Temperature
- Observe for "danger signs"

The woman's condition is **considered normal** when:

- Her facial expression is alert and responsive yet calm.
- Her behavior is appropriate.
- Systolic BP is 90-140 mmHg and diastolic BP < 90 mmHg.
- Axillary temperature is < 38°C.
- Pulse rate < 110 beats/minute.
- She does not have any of the following danger signs.
  (If she exhibits any of the following, refer her to a hospital immediately.)

SIGNS	POSSIBLE CONDITIONS
Heavy vaginal bleeding (1 pad soaked/hour) or sudden increase in vaginal bleeding	Retained placental fragments
High blood pressure (≥ 140/90 mm Hg)	Postpartum pre-eclampsia; chronic hypertension
Temperature > 38°C	Infection

SIGNS	POSSIBLE CONDITIONS
Low blood pressure with a systolic BP < 90 mm Hg	Hypotension, check for bleeding, dehydration
Severe pallor	Severe anemia
Epigastric or abdominal pain	Impending eclampsia, internal bleeding probably caused by ruptured uterus
Severe headache/blurred vision	Pre-eclampsia, impending eclampsia
Convulsions or unconscious	Eclampsia, seizure disorder, metabolic conditions such as those related to diabetes or other illnesses
Breathing difficulty	Pulmonary edema, congestive heart failure, bronchial asthma
Foul smelling vaginal discharge either from uterus or laceration	Infection
Pain in calf with or without swelling	Thrombosis
Inappropriate behavior	Post partum depression or other psychological/psychiatric conditions

BABY'S CONDITION

Check the newborn's condition:

- Respiration
- Color
- Cord stump
- Breastfeeding

The newborn's condition is normal when:

- The respiratory rate is within 20-60 breaths/minute.
- There is no gasping of breath.
- There is no grunting on expiration.
- There is no chest in-drawing.
- The baby's lips, tongue, and nailbeds are pink and not pale.
- There is no cyanosis except for, at times, the feet and hands.
- The cord stump is not bleeding or reddish.
- The baby is breastfeeding well (sucks well and feeds at least five times a day).
- There are no danger signs for which the baby should be immediately referred to a higher level of care (pediatrician or hospital).

DANGER SIGNS:

- Breathing difficulty (abnormal respiration, chest in-drawing, grunting, gasping, not breathing)
- Convulsions, spasms, arching of the back
- Cyanosis (bluish color on the face, lips, body except foot or hands)
- Pallor
- Fever
- Jaundice (yellowish)
- Not feeding well
- Diarrhea with signs of dehydration (sunken fontanels)
- Persistent vomiting or abdominal distention
- Pus or redness of the umbilical stump
- Swollen limbs or joints

After the immediate assessment, postpartum care visits are performed as outlined below.

Note: The recommended schedule for postpartum visits is:
1st visit = within 24 hours after delivery (home visit by midwife)
2nd visit = within 7 days postpartum (home visit by midwife)
3rd visit = at 6 weeks postpartum (clinic visit by patient)

COMPONENTS OF MATERNAL POST-PARTUM CARE	INITIAL	SUBSEQUENT VISITS
ASSESSMENT		
Ongoing assessment of mother	Up to 6 hours after birth, while at the birthing facility	
HISTORY		
Personal Information	✓	
Daily habits and lifestyle	✓	
Present pregnancy and childbirth	✓	
Present postpartum period	✓	✓
Obstetric history	✓	
Contraception history/plans	✓	✓
Medical history	✓	
Interim history	✓	✓
PHYSICAL EXAMINATION		
General well-being	✓	✓
Vital signs	✓	✓
Breasts	✓	✓
Abdomen	✓	✓
Legs	✓	✓
Genitals	✓	✓

COMPONENTS OF MATERNAL POST-PARTUM CARE	INITIAL	SUBSEQUENT VISITS
CARE PROVISION		
On-going supportive care	Up to discharge from facility	
Breastfeeding and breast care	✓	Reinforce key messages
Family planning	✓	Reinforce key messages
Nutritional support	✓	Reinforce key messages
Self-care and other healthy practices • Hygiene • Rest and activity • Sexual relations and safer sex • Newborn care	✓	Reinforce key messages
Immunizations and other preventive measures for the mother • Tetanus toxoid immunizations • Iron/folate • Intermittent preventive treatment for malaria (in endemic areas) • Vitamin A supplementation	✓	Reinforce key messages
Early and exclusive breastfeeding	✓	Reinforce key messages

2. On-going Assessment and Supportive Care

- Within six hours after delivery, the woman and the newborn should be assessed and given supportive care as recommended.
- Remember to keep mother and newborn together.
  - o Avoid separating mother and newborn even when individually assessing and caring for them.
  - o Place the baby in skin-to-skin contact immediately upon delivery and assist the mother in breastfeeding her newborn immediately.
  - o Keep mother and baby together day and night.
  - o Encourage the mother to participate in examining and caring for the baby.
- Respectfully encourage the mother to ambulate as early as possible whenever she can.

- Assess the mother and newborn during the first six hours after delivery as follows:

	Mother	**Newborn**
Every hour	Firmness of the uterus (massage or give oxytocin if soft) Amount of vaginal bleeding Palpate the bladder (if palpable, ask her to urinate) Vital signs and pain assessment	Vital signs especially temperature
Every two hours	Blood pressure, pulse rate	Attachment & breastfeeding Cry, activity and color
Once	Temperature	Urine output/diaper change
Whenever breastfeeding	Newborn correctly latched on to the mother's breast Baby suckles well	Breastfeeding positioning

The following are the elements of providing supportive care during the first six hours after delivery and recommendations for implementing them.

ELEMENTS	**RECOMMENDATIONS**
• Attentiveness and communication	• Attend to the woman at least every hour, and look for non-verbal cues of her needs and preferences. • Give verbal encouragement. • Provide information and reassurance about her condition and the well-being of her newborn. • Encourage her to ask questions and express her feelings. • Tell her companion to remain with her.
• Mother-baby bonding	• Ensure non-separation of the mother and newborn from the delivery area until transfer to a private room/ward. • Maintain skin-to-skin contact between mother and newborn as much as possible. • Encourage the mother to hold and explore her newborn freely.

ELEMENTS	RECOMMENDATIONS
• Mother-baby bonding	• Encourage the mother and her family to cuddle and talk to the newborn as much as they wish. • Build the mother's confidence in being able to care for her newborn through verbal and non-verbal messages of encouragement and praise. • Encourage early and exclusive breastfeeding.
• Comfort	• Ensure that the beddings are clean and blankets are enough to keep warm • Maintain a calm environment conducive to rest to facilitate bonding and start of breastfeeding.
• Nutrition	• Encourage the woman to eat and drink as she desires. • Encourage the woman to breastfeed on demand and exclusively as early as possible after birth.
• Elimination	• Encourage the woman to pass urine when the urge is felt or when the bladder is palpable. • Encourage sufficient fluids and food to facilitate easy bowel movement and prevent constipation.
• Hygiene/infection prevention	• Replace soiled and wet clothing and beddings. • Keep soiled and wet linen in a bucket, plastic bag, or other container prior to washing, separate from the clean ones. • Keep clean pads and cloths to cover the perineum.
• Parenting support	• Observe the parents' actions and behaviors; use this information to guide individual health messages and counseling on basic care provision. • Provide information and reassurance of the newborn's well-being. • Encourage the couple to ask questions and express their feelings. • Help build their confidence through verbal and nonverbal messages of praise and encouragement, as appropriate. • Provide scientific information on responsible parenting such as on family planning and family health.

3. History

(Some of these have already been taken previously and need not be repeated if records exist.)
If this is the first encounter or visit after delivery, take a complete history that includes:

- Personal information
- Daily habits and lifestyle
- Present pregnancy and labor/childbirth
- Present postpartum period
- Obstetric history
- Contraceptive history/plans
- Medical history
- Interim history

If this is a return visit, the interim history and history of the present postpartum period will suffice.

The following are questions asked to obtain necessary information about the woman and her newborn with recommended actions, as appropriate. These are most important if the mother delivered at home or while in transit or in other facility.

3.1 Personal Information

QUESTIONS	ACTIONS
• What is the woman's name?	• Use the information to identify the woman. • Use this opportunity to establish rapport. • If baby died (stillbirth or neonatal death): o Provide help with the grieving process: - Allow the parents to see and hold the baby after death, if this is appropriate. Avoid separating the parents and the baby too soon (before they indicate that they are ready) as this can delay the grieving process. - Encourage the parents to name the baby, if appropriate. - If appropriate and if the parents desire, give them some mementos of the baby, such as a lock of hair or a palm print to help with the grieving process.

QUESTIONS	ACTIONS
	• Assist with final arrangements: o Encourage locally-accepted burial practices o Assist parents and refer them to appropriate authorities if there is a need to conduct medical procedures (such as autopsies). o Help the family as much as possible with all paperwork necessary to register the baby's birth and death. Arrange to see the family a few weeks after the death to answer questions and provide any necessary support to the grieving process. Link the family to those who can render support such as those provided by a religious person or a community support group, if the family desires.
• What is her age (her date of birth)	• If age is 18 or below: o Ensure that she has a support system in place. o Use kind, direct, honest, and matter-of-fact communication. o Avoid treating her like a child. o Treat her with respect, fostering self-esteem, and building trust so that she can feel safe in addressing any issue when caring for herself and her newborn. o Ensure confidentiality and privacy during visits. Answer any questions she has, and encourage her to ask questions. o Encourage her to bring a companion of choice whenever she visits. Respect her right to make decisions about her care and that of her newborn. If complications arise, ensure that she understands the situation and allow her time to make important decisions. o If examinations or procedures are required, explain the procedure, get her consent, and tell her what to expect. Listen to her concerns, and answer her questions before proceeding.

QUESTIONS	ACTIONS
• What is her address and contact number, if any?	• Use the information to be able to do home follow-up visits, when necessary, and gain insights on her living conditions.
• What is her educational attainment and occupation? What is the family's source of income?	• Use information to provide individualized counseling and recommendations for care.

3.2 Daily habits and lifestyle

QUESTIONS	ACTIONS
• Does she work outside the home? • Is her daily workload strenuous (i.e., how far does she walk, does she carry heavy loads or engage in physical labor)? • Does she get adequate sleep/rest? • Is her dietary intake adequate (i.e., what does she eat on a typical day)? • Is she currently breastfeeding?	• Use this information to: o Determine if there is a balance between the physical demands of the woman's daily life and her dietary intake. o Guide appropriate nutritional recommendations.
• Does she smoke, drink alcohol, or use any other potentially harmful substances?	• Use information as a guide to formulate appropriate messages on health practices and educate her to bring about positive behavioral changes.
• With whom does she live (husband, partner, children, other household members)?	• Use information to determine availability of a family support system, or need for one.

The following questions, which will help determine existence of violence against the woman, are sensitive. The service provider must explain to the woman that these questions are given to all clients and any information she provides will be kept confidential.

QUESTIONS	ACTIONS
• Has anyone kept her from seeing family or friends, not allowed her to leave the house, threatened her life, or restricted her freedom? • Has she ever been injured, hit, or forced to have sex by someone? • Is she frightened of anyone?	• If the woman answered YES to any of the questions: o Validate her experience. o Acknowledge the abuse and tell her that it is not her fault, that this should not be happening, and that no one deserves to be hit or abused in any way. o Help the woman feel that there are available systems to support her. Link her to appropriate local sources of support (e.g., faith-based organizations, women's desk in police precincts). o Help her feel empowered by encouraging and sharing information with her.

3.3 Present or current pregnancy and labor/childbirth

QUESTIONS	ACTIONS
• When was the birth or when did she give birth?	• Use this information to guide further assessment and care provision. The clinical significance of this information and the care the woman requires vary depending on how much time has elapsed since the birth of her newborn.
• Where did the birth take place, and who attended this (e.g., doctor, midwife, traditional birth attendant)? • If delivered in a health facility, what did the labor/childbirth care include (e.g., drugs and medications, counseling)? • If at home and not attended by a skilled service provider, was basic newborn care provided (e.g., eye infection prophylaxis, Vitamin A administration)?	• Use information to guide further care. If delivered at home without a skilled birth attendant, be alert for signs of conditions or complications that may not have been adequately addressed during labor and childbirth.

QUESTIONS	ACTIONS
• Were there complications during labor and delivery (e.g., vaginal bleeding during labor and delivery, hypertension, convulsions, prolonged labor, fetal distress, perineal tears/ lacerations, retained placenta or placental fragments, and fever)? • If there was a complication, how was this managed?	• Provide appropriate follow-up with attention to possible consequences of complications (e.g., anemia for vaginal bleeding, chronic hypertension), as appropriate. • If with complications, refer the patient to an Ob-Gyne or a hospital/appropriate specialty clinics.
• Were there any newborn complications during this childbirth?	• If there were complications, emphasize the importance of practicing good newborn care and early detection of possible problems.

3.4 Present postpartum period

QUESTIONS	ACTIONS
• Has she had heavy vaginal bleeding during this postpartum period?	***Normal variations:*** • Day 1 postpartum Amount of bleeding is similar to normal menses, clots smaller than a lemon may be passed • Day 2-6 postpartum Lochia (normal discharge from the uterus after delivery) with no bleeding o If the woman has frank, heavy bleeding, a steady slow trickle of blood, intermittent gushes of blood, or blood clots as big as a lemon, refer immediately. o If the woman no longer has abnormal bleeding but had heavy bleeding during this postpartum, manage anemia.

QUESTIONS	ACTIONS
• What is the color of her lochia?	***Normal variations:*** • Day 2-4 postpartum Red lochia (lochia rubra), dark or brownish discharge with fleshy odor. Woman changes pads/cloth every 2-4 hours • Day 5-14 postpartum Discharge contains less blood and is pinkish-brown (lochia serosa) with a musty, stale odor • Week 3 or 4 postpartum White lochia (lochia alba) Discharge becomes creamy white to yellowish o Lochia may continue for up to six weeks postpartum o An increase in discharge may be noted as the woman becomes more active • If lochia is foul-smelling, especially when accompanied by fever, refer immediately.· If color and amount of lochia are not within normal range for time frame, this can be due to sub-involution of the uterus. Treat with uterotonic drugs such as Ergometrine 2 mg orally 3x daily (if not hypertensive). Determine her blood pressure first before giving Ergometrine. o If accompanied by fever or if woman is hypertensive, refer immediately.
• Has she had problems with bowel and bladder function since childbirth, such as: o Incontinence? o Leakage of urine or feces to the vagina? o Burning sensation when urinating? o Inability to urinate when there is an urge? o Constipation?	• **Refer** to higher level of care like an obstetrician or hospital.

QUESTIONS	ACTIONS
• What are her feelings about the baby and about her ability to take care of him or her?	• Use the information to counsel her on mother-baby bonding and relationship.
• Does she feel that breastfeeding is going well?	• If NO, explore causes of breastfeeding inadequacy (e.g., breast pain, ineffective positioning or attachment).

3.5 Obstetric history

QUESTIONS	ACTIONS
• How many pregnancies has she had including this one? How many of these pregnancies completed seven or more months of gestation when delivered? How many were premature deliveries? How many abortions has she had, if any? How many living children does she have at present? (This is the obstetrical score.)	• Use the information for individualized health messages and counseling.
• Has she experienced complications in her previous pregnancies?	• Be alert for possible abnormalities (e.g., recurrence of hypertension) and use the information for individualized health messages and counseling.
• If this is not her first child, what was her experience with breastfeeding then?	• If she had problems breastfeeding previous babies, explore the reason(s) and provide scientific information to assist her to succeed with breastfeeding this time. • For a primigravid, we should ask about breastfeeding preparedness and plans for her newborn once delivered. This should also include non-separation or rooming-in practices.
• If this is not the woman's first childbirth, has she had postpartum depression or psychosis during a previous postpartum period?	• Be alert for the possibility of recurrence. Refer for signs of recurrence.

3.6 Contraceptive history and plans

QUESTIONS	ACTIONS
• Does she plan to have more children? How many more? • When does she plan to get pregnant again? • Has she used a family planning method before? • Does she plan to use a family planning method?	• Use the information for family planning counseling. • Provide scientific family planning counseling, as appropriate.

3.7 Medical history

QUESTIONS	ACTIONS
• Does the woman have allergies?	• If she answered YES, avoid exposure to any known allergens.
• Assess her risk for sexually-transmitted infections by asking the following questions: o How is her relationship with her husband? Is there reason to suspect that her partner may not be faithful? o Has she or her partner been previously treated for sexually transmitted diseases? o Has she experienced having the following? – Unusual discharge from her vagina? – Itching or sores in or around her vagina? – Pain or burning sensation when urinating?	• If she answered YES to any of the questions, advise her to practice safe sex by using condoms. • If symptoms are present, **refer**.

QUESTIONS	ACTIONS
• Has she been diagnosed with hepatitis (with reactive Hepatitis B surface antigen), tuberculosis, heart disease, kidney disease, diabetes, goiter, history of receiving RhoGAM for Rh incompatibility or any other serious chronic disease?	• If she answered YES and the problem is unresolved, **refer**.
• Has she had previous hospitalization or surgeries? If yes, for what?	• If the condition is unresolved or has the potential to complicate the postpartum period, **refer**.
• Has she had a complete series of five TT immunizations?	• If NO, proceed according to the recommended TT immunization schedule.

3.8 Interim history

QUESTIONS	ACTIONS
• Does she have medical, obstetric, social, or personal concerns? • Has she had any problems (or significant changes) since the last visit?	• Consider change(s) in the plan of care appropriate to her concerns.
• Has there been a change in the woman's personal information since the last visit? • Has there been a change in her daily habits or lifestyle (increase in workload, decrease in rest or sleep or dietary intake, etc.) since the last visit? • Has there been a change in her medical history since the last visit?	• Determine changes in the plan of care.

QUESTIONS	ACTIONS
• Has she been unable to carry out any part of the plan of care (e.g., taking of medications as prescribed, following dietary recommendations)?	• Assess further the reason for non-compliance. • Consider changing the plan or counseling for compliance.

4. Physical Examination

After completing the history, perform a physical examination. Be sure to record all findings in the woman's chart. Do a complete physical examination, as prescribed below, for all consultation visits.

4.1 Assessment of General Well-being

ELEMENT	NORMAL	ACTION
Gait and movements	• The woman walks without a limp. • Her gait and movements are steady and moderately paced.	• If findings are not within normal range, ask these follow-up questions: o Has she been without food for a prolonged period? o Has she been taking drugs/ medications, herbs, etc? o Does she have an injury? • If YES to any of the above questions, consider the findings when planning for care. • If NO to all of the above questions, **refer** for further assessment of the problem.
Facial expression	• Her facial expression is alert and responsive, yet calm.	
Behavior	• Her behavior is appropriate.	
General cleanliness	• The woman is generally clean (e.g., no visible dirt and odor).	• If the woman appears unclean, consider individualized messages and counseling on self care. • If she has a bad odor, investigate for possible infections.

ELEMENT	NORMAL	ACTION
Skin	• The skin is free from lesions and bruises.	• If there are lesions and bruises on the woman's skin that are probably a result of physical abuse, refer for further support and management regarding violence against women. • If there are lesions and bruises on the woman's skin and violence is not suspected, refer for further evaluation and management.
Conjunctiva	• The conjunctiva is pink (not white or pale pink) in color.	• If pale conjunctiva, o Check for abnormal bleeding during delivery and postpartum period. o Request for a hemoglobin determination: – If < 7 gm/dl, **refer.** – If 7-11 gm/dl with no active bleeding, advise doubling intake of iron, i.e., 1 tablet 2x daily for 3 months.

4.2 Vital Signs Measurement

- Have the woman remain seated or lying down and relax for a few minutes before taking her vital signs.
- While taking her temperature, measure her blood pressure and pulse rate.
- For abnormalities, refer to a higher level of care (i.e., physician, obstetrician, or hospital).
- The following are the normal findings:
  - o Blood pressure
    - Systolic BP is 90-140 mmHg
    - Diastolic BP is less than 90 mmHg
  - o Temperature is lower than 38°C
  - o Pulse is less than 110 beats/minute

4.3 Breast Examination

- Help the woman prepare for further examination.
- Explain to her the significance and process of the breast examination.
- Bring her to a room where privacy and confidentiality are guaranteed.
- Explain to her that she can bring her companion inside the room.
- If the examiner is a male health care provider, request somebody to accompany the woman in the room.
- Respectfully ask the woman to uncover her body from the waist up. Have the woman lie comfortably on her back.
- Start by visually inspecting the overall appearance of the woman's breasts, such as contours, skin, and nipples; note abnormalities.
- Gently palpate the breasts; note abnormalities.

ELEMENT	NORMAL	ACTION
Breast inspection	• Contours are regular with no dimpling or visible lumps. • Skin is smooth with no puckering, no areas of scaliness, thickening, or redness; and no lesions, sores, or rashes. ***Normal variations:*** o If she is breastfeeding, breasts may look "lumpy" or irregular depending on emptying of milk ducts/ lobes. o Breasts may be larger (and more tender) than usual. Veins may be larger and darker, more visible beneath the skin. o Areolas may be larger and darker than usual, with tiny bumps on them.	• If findings are not within normal, **refer**.

ELEMENT	NORMAL	ACTION
Breast palpation	• Soft and non-tender. • No localized areas that are red or feel hot or are extremely tender. **Normal variations:** • If breastfeeding, breasts may feel lumpy or irregular depending on emptying of milk ducts/lobes. • On Days 2 to 4 after child birth, breasts may become swollen, hard or tense. This usually resolves within 24 to 48 hours.	• Explain to the woman that breast engorgement is normal when the milk starts to come in around 2-3 days after birth. Explain that although it may be painful, it should get better with time. • Advise the woman to use the following method to empty the breasts: o Use warm water or a hot compress 5-10 minutes before feeding and gently massage the breast to allow milk to flow more easily. o Express a small amount of milk before feeding to soften the breast and make it easier for the baby to latch on. o Feed the baby as frequent as every 2 hours. o Let the baby suckle on each breast. o Change her position each time the baby nurses so that all ducts will be emptied. • Advise the woman to: o Apply cool compresses between feeds. o Take paracetamol 500 mg 30 minutes before breastfeeding as needed, if non-pharmaceutical treatments do not provide relief. If a bad odor is present, investigate for possible infections. o Wear a well-fitting support bra. o Avoid wearing a tight bra, which can press on a duct and cause it to block. • Advise the woman to return for care if the pain or discomfort persists or if the breasts become red, warm, more painful, or if she develops fever and chills. **Refer** to higher level of care if the problem persists or worsens.

ELEMENT	NORMAL	ACTION
	Nipples • There is no abnormal nipple discharge. o Only colostrum (on Day 1 or 2 postpartum) or milk is coming from the nipples. o No pus is coming from the nipples. • No cracks, fissures, or other lesions • Nipples are not inverted. **Normal variations:** o Nipples may be taut and shiny when breasts become engorged (on Days 2 to 4 postpartum).	o Nipples may be sore. • If pus is coming from the nipples, **refer** to higher level of care. • If nipples are cracked, fissured or sore: o Advise woman as follows: - Be sure that the baby is well attached when feeding and that the baby's mouth encircles the whole areola. - Start feeding on the side that is less sore. - If cracking is severe on one nipple, feed only from the other breast for 1-2 days until cracking is healed. Regularly express milk from affected breast. - If both nipples are sore and severely cracked, feed baby with expressed breastmilk. Regularly express breastmilk to ensure continuous production of milk. - When removing the baby from the breast, break the suction gently by pulling on the baby's chin or corner of the mouth. - Rub breastmilk on the nipple and areola after each feed, and allow it to dry. - Apply pure lanolin to the nipples between feeds. - Wash breasts only once per day, do not use soap or alcohol on the breasts. - If non-pharmacologic treatments do not provide relief, paracetamol 500 mg may be taken 30 minutes before breastfeeding, as needed. - Wear a supportive bra that is not tight. o Advise woman to return for care if the pain or discomfort persists or worsens. • **Refer** for conditions that persist or worsen.

4.4 Abdominal Examination

- Always ensure privacy and confidentiality at all times when examining the woman's body.
- Respectfully ask the woman to uncover her abdomen.
- Have her lie on her back with her knees slightly bent.

ELEMENT	NORMAL	ACTION
Surface of the abdomen	• There is no incision from a recent uterine surgery (e.g., Caesarean section, surgery for ruptured uterus).	• If there is an incision from recent surgery, advise the woman to see her surgeon for follow-up.
Palpation of the uterus for involution	• The uterus feels firm. • The uterus is not tender. • Fundal height decreases about 1 cm per day for the next 9-10 days postpartum. o Immediately after completion of the 3rd stage of labor, the uterus may be at the level or slightly above the umbilicus. o At 24 hours after birth, the uterus is usually one finger's breadth below the umbilicus. o On the 6th day postpartum, the uterus is approximately midway between the umbilicus and the symphysis pubis. o At 6 weeks postpartum, the uterus is no longer palpable abdominally. ***Normal variation:*** o Involution may be slower in women who are multiparous or following multiple gestation, polyhydramnios (having an excess of amniotic fluid), the birth of a large baby, or infection. o Although the rate of involution may vary in different women, the uterine size should progressively decrease.	• If the uterus is very tender, **refer** the woman to a higher level of care. o If the uterus has enlarged or has not decreased in size since the last visit, give a uterotonic such as Ergometrine (if she is not hypertensive) 2 mg by mouth 3x a day for 5 days. Determine her blood pressure first before giving Ergometrine.

ELEMENT	NORMAL	ACTION
Palpation of the abdomen to check the bladder	• Bladder is not palpable. o Woman is able to urinate when the urge is felt.	• If the woman is unable to urinate, drain the bladder with a catheter under strict aseptic/antiseptic procedure. • If she is still unable to urinate when the urge is felt, **refer** to higher level of care.

4.5 Leg Examination

ELEMENT	NORMAL	ACTION
Calves	• No pain in the calf when foot is dorsiflexed or flexed upwards.	• If calf pain is felt (and deep vein thrombosis or blood clots cannot be ruled out), **refer.**

4.6 External General Examination

- If it has not yet been done, explain to the woman the procedure for performing genital or vaginal examination.

ELEMENT	NORMAL	ACTION
Overall appearance (vaginal opening, skin, and labia)	• Nothing is protruding from the vagina. • There is no urine or stool coming from the vagina. • There is no swelling. • There is no incision (sutures) from tears, or episiotomy. • The general skin is free from sores, ulcers, warts, nits, or lice. • The labia are soft and not painful.	• If findings are not within normal, **refer**.

ELEMENT	NORMAL	ACTION
Lochia (color and amount)	• Day 1 postpartum bright red blood • Days 2-4 postpartum o Red lochia (lochia rubra), dark or brownish discharge with fleshy odor o Woman changes pads/cloth every 2-4 hours • Days 5-14 postpartum o Discharge contains less blood and is pinkish brown (lochia serosa) with a musty, stale odor • Week 3 or 4 postpartum o White lochia (lochia alba) o Discharge becomes creamy white to yellowish • Lochia may continue for up to 6 weeks postpartum	• If lochia is foul-smelling especially when accompanied by fever, **refer** immediately. • If color and amount of lochia are not within normal range for time frame, this can be due to sub-involution of the uterus. Treat with uterotonic drugs such as Ergometrine 2 mg orally 3x daily (if not hypertensive) until stopped. Determine her blood pressure first before giving Ergometrine. • If accompanied by fever or if woman is hypertensive, **refer** immediately.
Vaginal bleeding	• Day 1 postpartum: amount of bleeding is similar to heavy menses. • Day 2 to 6 weeks postpartum o Lochia with no bleeding. This may be accompanied by blood clots smaller than a lemon.	• If the woman presently has frank heavy bleeding, a steady trickle of blood from the vagina is noted, inter-mittent gushes of blood, or blood clots larger than lemons, **refer** to higher level of care.
Perineum	• No localized pain, tenderness, persistent swelling. • There is no urine or feces leaking from the vaginal opening. • There is no incision or sutures from tears, or episiotomy. **Normal variations:** o Bruising, swelling, and discomfort may last up to Day 3 or 4 postpartum. o Healing may be slower if there was prolonged pushing during labor, an episiotomy or tear, or trauma during childbirth.	• If perineum is severely tender, **refer**. • If there are tears or incision, advise hygiene to prevent infection. • If there is incontinence or leakage of urine or feces into the vagina, **refer**.

Postpartum Care Provision

1. Breastfeeding and Breast Care

Based on the woman's breastfeeding history and any other relevant findings or discussion, individualize the key messages below.

Breastfeeding Guidelines

- The woman should breastfeed her baby **exclusively** for the first six months of life. This means that the baby should not be given anything else to drink (i.e., no water, juice, milk formula or any other drink) and eat (e.g., rice, cereals) during this time. The baby should receive only breastmilk at this time.
- The baby should be breastfed whenever he or she wants, day and night (**on demand**), which should be about every 2-3 hours (8-12 times in 24 hours).
- To ensure that the baby is getting enough to eat, the woman should note how often the baby urinates (at least six times per day during the first 2-7 days after birth indicates adequate intake).

Additional Advice

- The breastfeeding woman needs adequate rest and sleep. Because the baby wakes during the night for feeding, the woman may become tired during the day. It would help to rest or take naps during the day, whenever the baby is sleeping.
- The breastfeeding woman needs **extra fluid and food intake**. She should drink at least one glass of fluids every time the baby breastfeeds or she expresses her breastmilk. She should also eat the equivalent of one extra meal per day.

Breast Care

- To prevent engorgement, breastfeed at least every 2-3 hours on demand (including during the night) and use both breasts at each feeding. If breastfeeding is not possible, the woman is advised to express every 2-3 hours. This also ensures that there is continuous production of milk.
- Wear a cotton bra or breast binder that is supportive but not tight and constrictive.
- Keep the nipples clean and dry.
- Wash nipples with a clean cloth and warm water only, no soap. Wash no more than once daily.
- After breastfeeding or washing the nipples, leave some breastmilk on the nipples and allow them to dry by exposing them to air.

2. Family Planning

Many postpartum women do not want any more children or want to delay their next pregnancy for at least two years. Unfortunately, many women leave obstetric services without receiving FP counseling or methods. The following are guidelines on initiating FP counseling during the postpartum period.

- Introduce the concepts of birth spacing and family planning.
  - o Intervals of at least three years between births have health benefits for both the woman and the baby.
  - o Well planned family size results in better socio-economic development for the family.
- Discuss the woman's previous experience with and beliefs about contraception, as well as her preferences.
- Based on the woman's knowledge and experience in family planning, individualize the following key messages:
  - o Women who do not breastfeed can become pregnant again very quickly. On average, women who do not breastfeed will begin:
    - Ovulating by 4 weeks after delivery.
    - Menstruating by 6 to 8 weeks after delivery.
- Women who breastfeed **exclusively** may be protected from becoming pregnant for up to six months. Breastfeeding can inhibit ovulation. The Lactational Amenorrhea Method (LAM) provides effective contraception for a breastfeeding woman if she is fully or nearly fully breastfeeding, her menses have not yet returned, and she is less than 6 months postpartum. When all three criteria are present, LAM provides more than 98 percent protection from pregnancy. If any of the criteria change, another family planning method should be started if the woman does not want to get pregnant.
- The following table summarizes appropriate family planning methods for postpartum women. The time for starting these methods depends on the woman's breastfeeding status.

METHOD OPTIONS FOR WOMEN WHO PLAN TO BREASTFEED
Source: Family Planning: A Global Handbook for Providers, 2007. Appendix D. Medical Eligibility Criteria for Contraceptive Use. p. 325

Can be used immediately postnatal	• Lactational Amenorrhea Method (LAM) • Condom • Female sterilization • IUD
Delay 6 weeks	• Progestin-only pills • Progestin-only injectables
Delay 6 months	• Fertility awareness methods • Combined oral contraceptives

METHOD OPTIONS FOR WOMEN WHO CANNOT BREASTFEED *Source: Family Planning: A Global Handbook for Providers, 2007. Appendix D. Medical Eligibility Criteria for Contraceptive Use. p. 325*	
Can be used **immediately** postnatal	• Condom • Progestin-only pills • Progestin-only injectables • Female sterilization • IUD
Delay 3 weeks (earliest start at Day 21)	• Combined oral contraceptives

Remember
- Encourage full breastfeeding for all postpartum women.
- Do not discontinue breastfeeding to begin use of a family planning method.
- Family planning methods used by breastfeeding women should not adversely affect breastfeeding or the health of the baby.
- Family planning methods used must be compatible with the practice of full breastfeeding.

3. Nutritional Support

Based on the woman's dietary history, the resources available to the woman and her family, and other relevant findings and discussion, individualize the following key messages.

All women should eat a balanced diet including a wide variety of foods consisting of:
- Beans and nuts
- Starchy foods (e.g., potatoes, cassava, maize, cereals, rice)
- Animal products (e.g., meat, milk, eggs, fish, yoghurt, cheese), fruits and vegetables

Eat a variety of foods each day, including foods rich in:
- Iron: red meat, liver, eggs, peanuts, lentils, dark green leafy vegetables, and shellfish.

Substances that inhibit iron absorption, such as coffee or tea and calcium supplements, should be avoided or taken two hours after meals.
- Vitamin A: liver, milk products, eggs, sweet potatoes, pumpkin, carrots, and papaya
- Calcium: milk, dark green leafy vegetables, shrimp, dried fish, beans, lentils
- Magnesium: cereal, dark green leafy vegetables, seafood, nuts
- Vitamin C: oranges or other citrus fruits, tomatoes

Women who are breastfeeding should also:

- Eat at least two additional servings of staple food per day to supply the 300-500 extra calories needed.
- Eat at least three additional servings of calcium-rich foods to supply the extra 1200 mg of calcium needed.
- Drink at least eight glasses of fluid each day; and drink a cup of fluids each time she breastfeeds.
- Include a variety of fluids such as water, milk and juice.
- Eat smaller, more frequent meals if unable to consume larger amounts of food during regular meals.
- Avoid alcohol and tobacco. These decrease milk production.
- Try to decrease amount of heavy work and increase rest time.

4. Hygienic Practices/ Prevention of Infection

In addition to practicing good general hygiene, the postpartum woman should be advised as follows:

- During the postpartum period, the woman may be more susceptible to infection and should be especially careful to practice good genital hygiene, including the following:
  - Keep the vulvar and vaginal area as clean and dry as possible.
  - Wash hands before and after washing the genitals.
  - Use a clean cloth to wash and another to dry the genital area.
  - Wash the genital area with soap and water after using the toilet.
  - Wash/wipe genitals from front to back, starting with the vulva and ending with the anus not the other way around as this would potentially bring infection or infectious organisms from anus to vulva.
  - Change perineal pads or cloths at least six times per day during the first week, and at least twice per day thereafter. Cloths may be reused after they are washed, boiled and sun-dried between uses.
  - Wear cotton underpants and comfortable, loose-fitting clothing. Avoid nylon underpants and pantyhose.
  - It is perfectly safe for postpartum mothers to take baths regularly.
- Avoid douching, having sex, and inserting tampons or anything in the vagina for at least two weeks after birth or until:
  - There is no longer any lochia serosa, and
  - The lochia alba has diminished.

5. Rest and Activity

Based on the woman's history and other relevant findings, individualize the following key messages:

- During the postpartum period, a woman needs plenty of rest to facilitate healing after birth. Adequate rest will help the postpartum woman regain her strength and recover more quickly.

- A breastfeeding woman needs even more time to rest. Because she is breastfeeding, and her sleep at night will be interrupted, advise her to have periodic rest periods during the day when the newborn is sleeping.
- Many women should be able to resume all activities by 4 or 5 weeks. She should get back into her usual routine gradually, paying attention to her body for signs that she may be stressing herself or may need more rest.

6. Sexual Relations and Safer Sex

Based on the woman's history and other relevant findings, individualize the following key messages:

- A woman should avoid having sexual intercourse for at least two weeks after birth, until:
  - o There is no longer any lochia serosa, and
  - o The lochia alba has diminished.
- After that, the woman can decide when she is ready to resume sexual activity. Healing of episiotomy or tears and type or amount of lochia may influence her level of comfort with intercourse. Intercourse should be avoided, however, if she experiences:
  - o Vaginal bleeding
  - o Perineal pain
- A woman is more susceptible to sexually transmitted infections (e.g., HIV, syphilis, gonorrhea, or chlamydia) during the postpartum period while the reproductive tract is still healing and returning to its pre-pregnancy condition.
- If she experiences any abnormality such as vaginal bleeding, perineal pain, etc. during intercourse, or foul vaginal discharge, immediately refer her to an Ob-Gyne or a doctor of choice.

7. Immunization and Other Preventive Measures

Tetanus Toxoid Immunization

Below is the schedule of tetanus toxoid (TT) immunization.

Dosage	Given	Period of Protection
1st dose	As early as possible during pregnancy	None
2nd dose	1 month after the 1st dose	3 years after the first dose
3rd dose	At least 6 months after the 2nd dose	5 years
4th dose	At least 1 year after the 3rd dose	10 years
5th dose	At least 1 year after the 4th dose	lifetime

Provide TT vaccination as needed based on the woman's immunization status.

Iron/Folate

- Give 60 mg iron and 400 mcg folate to be taken by mouth once daily for three months.
- Provide health messages and counseling as follows:
  - Eat foods rich in Vitamin C as these help the body absorb iron.
  - Avoid tea, coffee, and colas, as these inhibit iron absorption.
  - Possible side effects of iron and folate tablets include black stools, constipation, and nausea. Lessen side effects by:

- Drinking more fluids (an additional 2-4 cups per day)
- Eating more fruits and vegetables
- Getting adequate exercise such as walking
- Taking tablets with meals or at night

Area-Specific Preventive Measures (for areas endemic for the conditions)

- **Malaria**

  Women living in malaria-endemic areas should receive the following information:
  - Malaria is a parasitic infection that can cause severe anemia, renal failure, pulmonary edema, and high fever.
  - Malaria is transmitted through a mosquito bite. Some ways to avoid mosquitoes are as follows:
    - Sleep every night under an insecticide-treated net.
    - Get rid of standing water, thick foliage, and other potential mosquito-breeding areas around the house.
    - Cover arms and legs around twilight and sunrise.
    - Use a mosquito repellant, if available.
  - Emphasize importance of taking iron-folate tablets as malaria causes anemia.
  - If signs of malaria develop (i.e., fever, joint pains, headaches, anorexia), immediately seek medical consultation.
  - It is very important to get all of the recommended doses of intermittent preventive treatment.
    - Single dose of three tablets of sulfadoxine 500 mg - pyrimethamine 25 mg monthly

- **Soil-transmitted helminthiasis infestation**

  Women living in areas endemic for soil-transmitted helminthiasis should receive the following information:
  - Helminthiasis is transmitted through the skin from soil that contains larvae.
  - Helminthiasis can cause anemia and protein deficiency.
  - Some ways to avoid helminthiasis are as follows:
    - Always use footwear. Do not walk barefoot.

- Dispose of feces carefully in a latrine pit.
- Do not touch soil with bare hands, especially soil that is likely to contain feces.

o Always wash hands thoroughly before eating and after using the toilet.
o Use good hygiene and infection prevention practices.

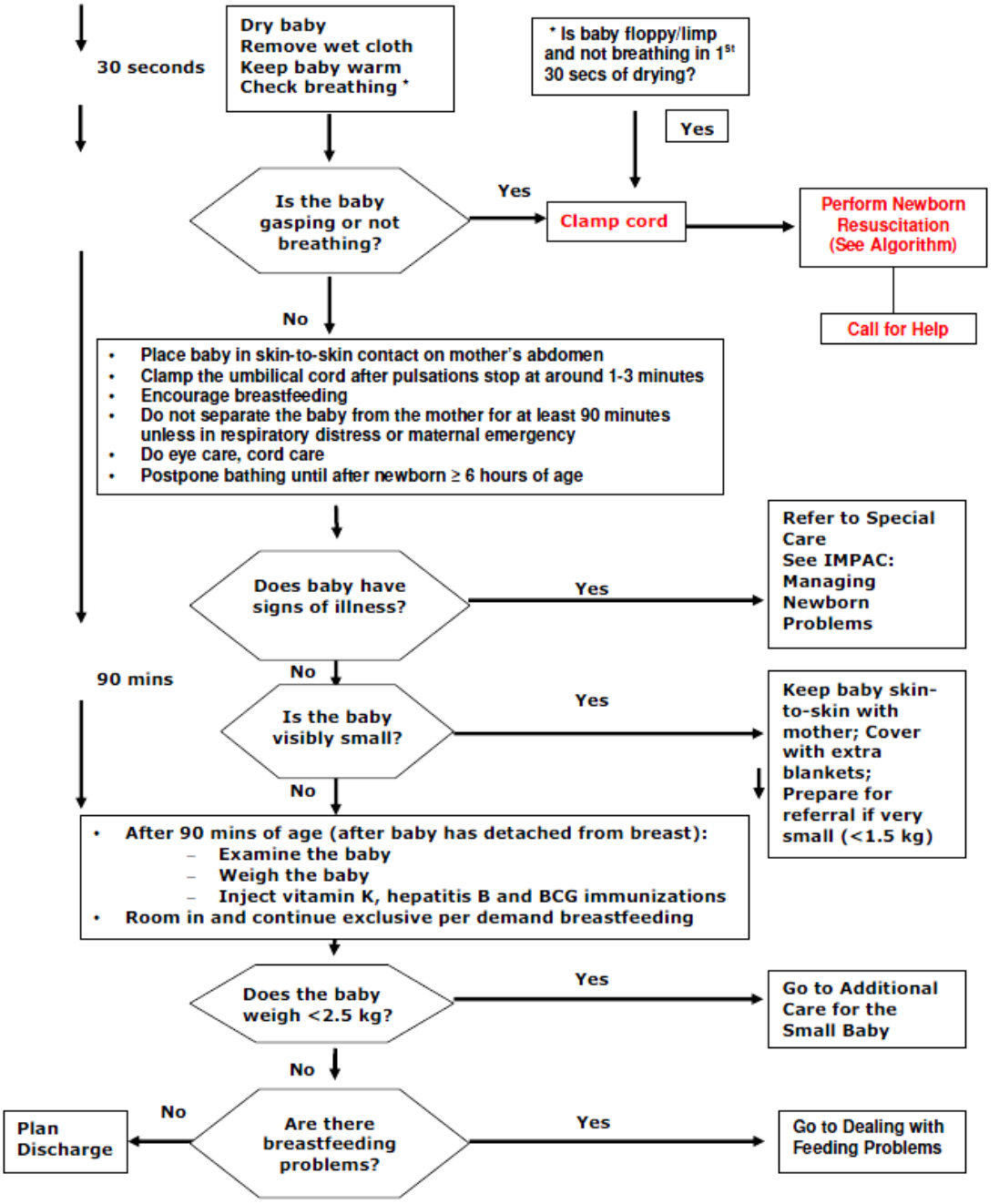
- **Vitamin A deficiency**

  Women should be given the following information:
  o Vitamin A deficiency causes night-blindness.
  o Vitamin A deficiency may be prevented by increasing dietary intake of Vitamin A-rich foods such as yellow and orange fruits and vegetables (e.g., carrots, mangoes, and squash) and dark green vegetables.

  Provide 200,000 IU as a single dose of Vitamin A taken by mouth immediately postpartum up to eight weeks postpartum.

NEWBORN CARE

Immediate Newborn Care

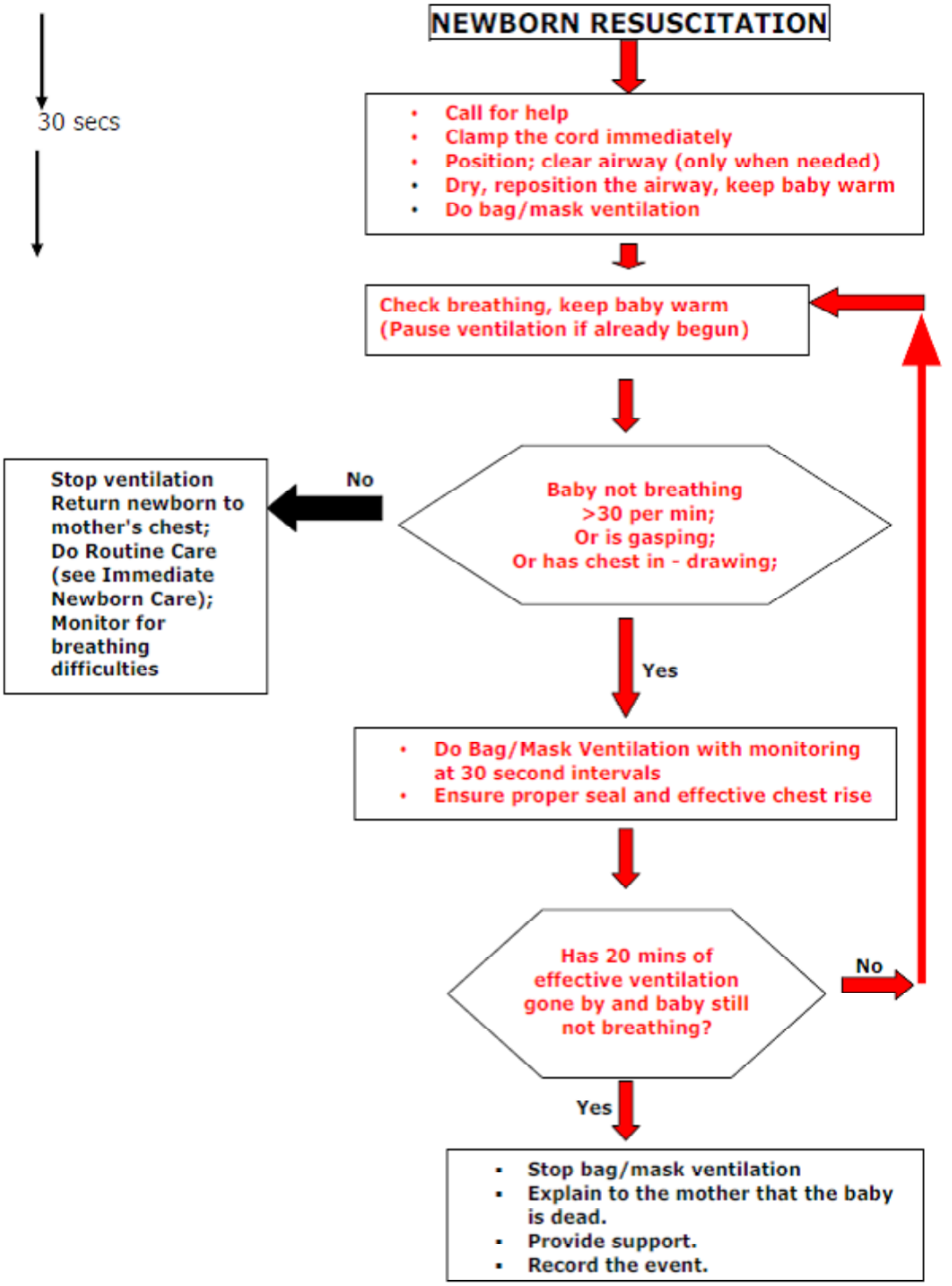


Immediate Newborn Care (the first 90 minutes)

OBSERVATIONS	INTERVENTION	ACTION
At perineal bulging with presenting part visible (2nd stage of labor)	Prepare for delivery	Ensure that delivery area is draft-free. Wash hands with soap and water. Double gloves just before delivery.
WITHIN THE FIRST 30 SECONDS		
		Call out the time of birth.
These are the **Four Essential Time-Bound Interventions for Immediate Care of Normal Newborn.**	**1. Dry and provide warmth. (1st 30 seconds)**	Use a clean, dry cloth to *thoroughly* dry the baby by wiping the eyes, face, head, front and back, arms and legs for at least 30 seconds. Do not wipe off the vernix. Remove the wet cloth. Do a quick check of newborn's breathing while drying. *(See page 66 – flow chart: Immediate Newborn Care).* ***NOTE:*** ***During the first 30 seconds:*** • ***Do not ventilate unless the baby is floppy/limp and not breathing.*** • ***Do not suction unless the mouth/ nose is blocked with secretions or other material.***
If after thorough drying, **newborn is not breathing or is gasping**	Re-position, suction and ventilate.	Clamp and cut the cord immediately. Call for help. Transfer to a warm, firm surface. Inform the mother that the newborn has difficulty breathing and that you will help the baby to breathe. Start resuscitation protocol. *(See page 70).* ***NOTE:*** ***If the baby is non-vigorous (limp/floppy and not breathing) and meconium-stained:*** • ***Clear the mouth.*** • ***Start bag/mask ventilation.*** • ***Refer and transport.***

OBSERVATIONS	INTERVENTION	ACTION
If newborn is breathing or crying	**2. Do skin-to-skin contact (within ONE minute of delivery)**	Avoid any manipulation, such as routine suctioning, that may cause trauma or introduce infection. Place the newborn prone on the mother's abdomen or chest skin-to-skin. Cover newborn's back with a dry, warm blanket and head with a bonnet. Place identification band on ankle (NOT WRIST) *Notes:* • Do not separate the newborn from mother, as long as the newborn does not exhibit severe chest in-drawing, gasping or apnea and the mother does not need urgent medical stabilization, e.g., emergent hysterectomy. • Do not put the newborn on a cold or wet surface. • Do not wipe off vernix, if present. Do not bathe the newborn earlier than 6 hours of life. • Do not do footprinting. If the newborn must be separated from his/her mother, put him/her on a warm surface, in a safe place close to the mother.
	3. Delayed or properly timed cord clamping (between 1 to 3 minutes)	• Wait for the cord to stop pulsating or 2-3 minutes after the baby's birth (whichever comes first) before clamping and cutting the cord. • Remove the first set of gloves before handling the cord. • Tightly tie around the cord 2 cm from the baby's abdomen and another tie 5 cm from the baby's abdomen. • Cut between ties (but closer to the first tie) with sterile instrument.

OBSERVATIONS	INTERVENTION	ACTION
	4. Non-separation of newborn from mother for early breastfeeding (within 90 minutes)	Ensure non-separation of mother and newborn while on skin-to-skin contact; initiate early breastfeeding as soon as the newborn shows signs of readiness to breastfeed: opening of mouth, licking, rooting, tonguing – these feeding cues may appear between 20 minutes to two hours after birth because the newborn is usually tired, needing time to rest first and may NOT be ready to be fed immediately after being delivered. **Do not** do the following **BEFORE** the newborn's first breastfeeding session: eye care, Vitamin K injection, immunization, weighing, measurements, etc.



Adapted from ***"Newborn Care until the First Week of Life"***. Department of Health. September 2009.

INTERVENTION	ACTION
WITHIN 90 MINUTES OF AGE	
Provide breastfeeding support for initiation of breastfeeding	• Leave the newborn on mother's chest in skin-to-skin contact. • Observe the newborn. *Only once the newborn shows feeding cues (e.g., opening of mouth, tonguing, licking, rooting)*, make verbal suggestions to the mother to encourage her newborn to move toward the breast (e.g., nudging). Counsel on positioning and attachment as described below.
Do eye care	Administer erythromycin ophthalmic ointment to both eyes after newborn has located the breast and completed the first breastfeeding session. Do not wash away the eye antimicrobial.
Provide additional care for a small baby or twin	For a visibly small newborn or delivered > 1 month early: • Encourage the mother keep the small newborn in skin-to-skin contact with her as much as possible. Counsel her about Kangaroo Mother Care (see pp. 90-91). • Provide extra blankets to keep the baby warm. • If mother cannot keep the baby skin-to-skin because of complications, wrap the baby in a clean, dry, warm cloth and place in a cot. Cover with a blanket. Use a radiant warmer if room is not warm. • Do not bathe. Ensure hygiene by wiping with a damp cloth but only after 6 hours. If the newborn is delivered 2 months earlier or weighs < 1500 grams, **refer** to specialized hospital.
FROM 90 MINUTES-6 HOURS	
Give Vitamin K prophylaxis	Wash hands. Inject a single dose of vitamin K 1 mg. IM. (If parents decline intramuscular injections, offer oral vitamin K.)

INTERVENTION	ACTION
Inject hepatitis B and BCG vaccinations	Inject hepatitis B vaccine IM and BCG intradermally. Record.
Examine the baby Check for birth injuries, malformations, or defects	Thoroughly examine the baby. Weigh the baby and record. Look for possible birth injury: • Bumps on one or both sides of the head (cephalhematoma, molding, caput succedaneum, bruises, swelling on buttocks, abnormal position of legs (after breech presentation) or asymmetrical arm movement, or arm that does not move. If present: o Explain to parents that this does not hurt the newborn, is likely to disappear in a week or two and does not need special treatment. Asymmetric movement or no movement of the arms or legs o Gently handle the limb that is not moving. o Do not force legs into different position. o Refer Look for malformations: • Cleft palate or lip • Clubfoot • Odd looking, unusual appearance • Open tissue on head, abdomen or back If present: o Cover any open tissue with sterile gauze o Keep warm o Refer Refer for special treatment and/or evaluation, if available.
Cord care	Wash hands. Put nothing on the stump. Fold diaper below stump. Keep cord stump loosely covered with clean clothes.

INTERVENTION	ACTION
	If stump is soiled, wash with clean water and soap. Dry stump thoroughly with clean cloth. Explain to the mother to treat local umbilical infection 3x a day as follows: • Wash hands with soap and water. • Gently wash off pus and crusts with boiled and cooled water and soap. • Dry the area with clean cloth. Paint with gentian violet. Wash hands. • If no improvement in 2 days, or if worse, refer urgently to the hospital. Notes: • Do not bandage the stump or abdomen. • Do not apply any substances or medicine on the stump. • Avoid touching the stump unnecessarily.
AFTER 90 MINUTES - PRIOR TO DISCHARGE	
Support unrestricted, per demand breastfeeding, day and night.	Keep the newborn in the room with his/her mother, in her bed or within easy reach. Do not separate them (rooming-in). Support exclusive breastfeeding on demand day and night. Assess breastfeeding in every baby before planning for discharge. Ask the mother to alert you if with breastfeeding difficulty. Praise any mother who is breastfeeding and encourage her to continue exclusively breastfeeding. Explain that exclusive breastfeeding is the only feeding that protects her baby against serious illness. Define that exclusive breastfeeding means no other food except for breast milk.

INTERVENTION	ACTION
Look for danger signs.	Look for signs of serious illness which warrant referral: • Fast breathing (> 60 breaths/min.) • Slow breathing (< 30 breaths/min.) • Severe chest in-drawing • Grunting • Convulsions • Floppy or stiff • Fever (temperature > 38°C) • Temperature < 35°C not rising after re-warming • Umbilicus draining pus • More than 10 pustules or bullae, swelling, redness, or hardness of skin • Bleeding from stump or cut • Pallor
Look for signs of jaundice	Look at the skin. Is it yellow? Refer urgently, if jaundice is present: • On face of a < 24 hour old newborn • On palms and soles of a $\geq$ 24 hour old infant Encourage continuous breastfeeding. If with `feeding difficulty, give expressed breastmilk by cup.
Look for signs of local infection	Refer newborn to higher level of care if the following signs of infection are present: • Eyes swollen and draining pus • Redness of the umbilicus and the skin around it • Pus draining from the umbilicus • Pustules around the neck, armpits, or inguinal area
When to discharge (not earlier than 12 hours of life)	Plan to discharge when: • Breastfeeding well and gaining weight • Body temperature between 36.5°C and 37.5°C • Baby breathing without difficulty • Mother able and confident in caring for the baby

INTERVENTION	ACTION
Discharge instructions	Advise the mother to return to the facility or go to the hospital immediately if any the following is/are observed: • Jaundice down to the soles • Convulsions • Movement only when stimulated • Fast respiratory rate (≥ 60/minute) or slow respiratory rate (< 30/minute) or difficult breathing (e.g., severe chest in-drawing) • Temperature ≥ 38°C or < 35.5°C Schedule routine visits as follows: • 48-72 hours of life • At 7 days of life • Immunization visits: starting at 6 weeks of life
Referral	Refer baby urgently to the hospital: • After emergency treatment, explain to the parents the need for referral. • Organize safe transportation. • Always send the mother with the baby, if possible. • Send referral note with the baby. • Inform the referral center, if possible by radio or telephone.

COMPONENTS OF NEWBORN CARE	1st VISIT	SUBSEQUENT VISITS
ASSESSMENT		
Ongoing assessment of the newborn	Up to 6 hours after birth	
HISTORY		
Personal Information	✓	
Present labor/childbirth	✓	
Present newborn period	✓	
Interim history		✓

COMPONENTS OF NEWBORN CARE	1st VISIT	SUBSEQUENT VISITS
PHYSICAL EXAMINATION		
Overall appearance and general well-being • Weight • Respiration • Temperature • Color • Movements and posture • Level of alertness • Skin	✓	✓
Head, face and mouth	✓	✓
Chest, abdomen and cord, external genitalia	✓	✓
Back and limbs	✓	
Breastfeeding	✓	✓
Mother-baby bonding	✓	✓
CARE PROVISION		
Ongoing supportive care	Up to discharge from facility	
Early and exclusive breastfeeding	✓	Reinforce key messages
Newborn care and other healthy practices • Maintaining warmth • Prevention of infection; hygiene • Washing and bathing • Cord care • Sleep and other behaviors, needs	✓	Reinforce key messages
Immunizations and other preventive measures for the mother • Immunizations • Vitamin K	✓	Reinforce key messages

ONGOING ASSESSMENT and SUPPORTIVE CARE

After the newborn has undergone an immediate assessment and immediate care has been instituted as recommended above, the following are additional ongoing supportive care for the newborn:

ELEMENTS	RECOMMENDATIONS
Warmth	• Keep the mother and her newborn in skin-to-skin contact, covered with a clean cloth. If this is not possible, dress the newborn in an extra layer or two of clothing. • Avoid dressing the newborn in tight, restrictive clothing or blanket because this reduces the retention of heat. • Cover the newborn's head with a bonnet. • Keep the room warm (25°C or more) and free from drafts. • Do not bathe the newborn for at least 6 hours or until the newborn's temperature is stable.
Nutrition	• Encourage the mother to breastfeed on demand and exclusively as soon as possible.
Hygiene and infection prevention	• Keep the newborn's cord stump clean and dry. • Avoid sharing newborn equipment and supplies. Disinfect shared equipment and supplies before and after use if sharing is necessary. • Ensure that people who handle or touch the newborn wash their hands before and after handling the newborn. • Keep sick people away from the newborn because of the risk of cross-infection.

HISTORY

1. Personal Information

ELEMENTS	RECOMMENDATIONS
What is the baby's name?	• Use the information to identify the baby. • Use this opportunity to establish rapport.

2. Present Labor/Childbirth

ELEMENTS	RECOMMENDATIONS
• Did the mother have rupture of membranes more than 18 hours before birth?	• Use the information in the context of further assessing the newborn for possible signs of infection/sepsis such as: • Foul smell • Poor feeding/suckling after having • Breathing difficulty (e.g., respiratory rate less than 30 or more than 60 breaths/minute, grunting on expiration, chest in-drawing) • Severe vomiting • Diarrhea • Sluggishness or lethargy • Unstable body temperature • Convulsions or spasms • Abdominal distension
• Were there any complications that may have caused injury to the newborn such as shoulder dystocia, breech birth, large baby, or instrument assistance (e.g., forceps)	• Use the information to alert you on possible signs of birth injuries (e.g., cuts or scrape, bruises, swelling or tenderness of limbs or joints, asymmetrical movements of limbs).
• Did the baby require resuscitation at birth?	• Use the information to alert you on signs of breathing difficulty (e.g., abnormal respiration, chest in-drawing, grunting on expiration, gasping).
• What was the baby's weight at birth?	• Use the information to alert you on the possible complications for low birth weight (e.g., breathing problems, low body temperature, feeding problems) and large newborns (i.e., birth injuries, sleepiness, apnea, convulsions, jitteriness, breathing difficulty probably due to meconium aspiration, breathing difficulty). • Refer newborn to higher level of care (i.e., pediatrician or hospital) if complications arise.

3. Present Newborn Period

ELEMENTS	RECOMMENDATIONS
• Is breastfeeding going well?	• The information is in the context of further assessment. Be alert for signs of breastfeeding abnormalities.
• How often does the baby feed? • Does the baby seem satisfied after feeding?	• Normal variations: o The baby wakes every 2-3 hours to feed (but may sleep 4 hours between feeds at night). o The baby feeds at least 8 times per day. o The baby seems satisfied after feeding. • If not within the normal variations, assess to identify other signs of inadequate intake (e.g., urinating or passing stool very few times per day, dehydration).
• How often does the baby urinate?	• Normal variations: o The baby urinates at least once in the first 24 hours. o After the first 48 hours after birth, the baby urinates at least 6 times per day. • If frequency is not within normal, investigate for breastfeeding problems.
• Has the baby passed the first stool? • When was the last time the baby passed stool? • How often does the baby pass stool? • What is its color and consistency?	• If the baby does not pass stool in 48 hours, refer. • If baby has diarrhea, refer. • If baby passes stool fewer than 4 times per day, investigate breastfeeding practice.

Normal variations:

STOOL TYPE	WHEN PASSED	COLOR	CONSISTENCY
Meconium	W/in 1-2 days after birth	Tarry black/dark green	Thick, sticky
Transitional	W/in 3-5 days after birth	Brown to green	Thin
Breastmilk	After 5 days	Yellow	Watery, soft/mushy
Breastmilk substitute	After 5 days	Pale yellow	Formed, pasty

• Has the baby been diagnosed with a congenital malformation?	• **Refer.**

Schedule of infant immunizations

Vaccines	# of Doses	Age
Hepatitis B (Injection)	3 doses 4 doses (if birth weight < 2 kg)	At birth (within 24 hours) 2 months / 4 months 3 months (additional dose for BW < 2 kg)
BCG (Injection)	Single dose	At birth or any time after birth
Polio (Oral)	3 or more	1½ months 2½ month 3½ months
DPT (Injection)	3	1½ month 2½ months 3½ months
Measles	1	9 months

- Has the baby received all required vaccines to date?
- Have there been adverse reactions to immunization?

3. Interim (Current) History/Observations

QUESTIONS	ACTIONS
• Is the newborn having a problem? • Has the newborn had any problems (or significant changes) since the last visit?	• Use the information in the context of further assessing the newborn for possible signs of infection/sepsis such as: o Foul smell o Poor feeding or suckling o Breathing difficulty (e.g., respiratory rate less than 30 or more than 60 breaths/minute, grunting on expiration, chest in-drawing) o Severe vomiting o Diarrhea o Sluggishness or lethargy o Unstable body temperature o Convulsions or spasms o Abdominal distension o Jaundice

QUESTIONS	ACTIONS
• Has there been a change in baby's habits or behavior (e.g., decrease in feeding and urinating) since the last visit? • Has there been a change in the baby's medical history (e.g., diagnoses, injuries, hospitalization, and drugs or medications) since last visit?	• Use the information to: o Maintain accuracy of the newborn's medical records. o Determine changes that need to be made in the plan for care.

PHYSICAL EXAMINATION

After the newborn's history has been taken, perform a physical examination. Be sure to record all findings in the newborn's chart.

If this is the first visit, perform a complete physical examination. If this is a return visit, a shortened physical examination may be sufficient.

Before doing the Physical Examination, complete the following steps:
- Inform the mother what is going to be done. Encourage her to ask questions, and listen to what she has to say.
- Wash hands thoroughly with soap and water and dry them with a clean, dry cloth or allow them to air-dry.
- Wear examination gloves if the baby has not been bathed since birth, if the cord will be touched, or if there is blood, urine, and/or stool present.
- Place the baby on a clean, warm surface or examine him or her while in the mother's arms.
- Have clean clothes or blankets ready to dress the baby immediately after the examination.

1. Overall appearance and general well-being

ELEMENT	NORMAL	ACTION
Weight	• Birth weight is 2.5-4.0 kg • Most babies lose up to 10% of their birth weight in the first few days after birth. • The full term baby regains her/his birth weight by approximately 7 days of age. • The low birth weight baby regains her/his birth weight by about 10 days of age.	• If findings are not within normal, **refer**.

ELEMENT	NORMAL	ACTION
Respiration	• Respiratory rate is 30-60 breaths per minute. • No gasping • No chest in-drawing • No grunting on expiration	• If respiration is not within normal, **refer** to higher level of care.
Temperature	• Rectal temperature is 36.5-37.5°C.	• If not within normal limits, **refer** to higher level of care. • Rule out imperforate anus.
Color	• The baby's lips, tongue, nailbeds, palms of hands, and soles of the feet are pink. • No central cyanosis (bluish tongue and lips) • No jaundice • No pallor • Normal variation: cyanosis (blueness) of hands or feet in the first 12 hours	• If not within normal, **refer** to higher level of care.
Movements and posture	• Movements are regular and symmetrical (equal on both sides of the body). • No convulsions • No spasms • No opisthotonous (extreme hyperextension of the body, with arching of the body forward)	• If not within normal, **refer** to higher level of care.
Level of alertness and muscle tone	• Responds actively to handling and other stimuli • Can easily be roused from sleep Not limp or lethargic • Can be consoled when upset; not overly irritable	• If not within normal, **refer** to higher level of care.

ELEMENT	NORMAL	ACTION
Skin	• The skin is clear and free from bruises and cuts or abrasions.	• If bruises appear spontaneously within 2 to 3 days after birth, but there is no evidence of trauma at birth, **refer** to higher level of care. • If there are cuts or abrasions which are bleeding, press on the bleeding site. o If bleeding continues after 15 minutes, **refer** to higher level of care. o If bleeding stops, clean the area and cover with gauze. Apply topical antibiotics if infection of the wound is noted.

2. Physical Assessment

ELEMENT	NORMAL	ACTION
Head	• The head is symmetrical in shape. • Fontanels are soft and flat. • The distance between sutures is within normal range (i.e., they are not widely separated). • Head is proportionate to the body.	• If findings are not within normal, **refer**.
Face and mouth	• The baby's lips and tongue are pink. • Angles of mouth are symmetrical. • Tongue and mucus membranes are not dry.	• If not within normal, **refer** to higher level of care.

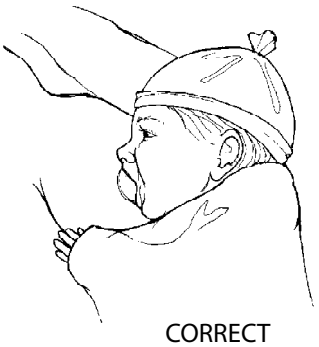
ELEMENT	NORMAL	ACTION
Eyes	• No discharges • Eyelids are not red or swollen.	• If not within normal limits, **refer** to higher level of care.
Chest	• Symmetrical • No chest in-drawing	• If not within normal, **refer** to higher level of care.
Abdomen and cord stump	• No abdominal distension • No tenderness • Abdominal movements normal and symmetrical • Cord stump not swollen, no pus, not foul-smelling • No bleeding from stump	• If not within normal, **refer** to higher level of care.
External genitalia and anus	• No tenderness • No abnormality • Patent anal opening	• If not within normal, **refer** to higher level of care. • Take rectal temperature to rule out imperforate anus.
Limbs	• Position and appearance of limbs, hands, and feet are normal and symmetrical. • Movement of limbs is regular and symmetrical. • No swelling over any bone. • No crying when arm, shoulder, or leg is touched.	• If not within normal, **refer** to higher level of care.

3. **Breastfeeding** (started immediately and within 90 minutes of age)

After examining the baby and before observing breastfeeding:

- Wash your hands.
- Help the mother feel relaxed and confident throughout the observation.
- Reinforce, through words and nonverbal behavior, that you are present to provide help and support, not to judge the mother or her newborn in any way.
- Do not hurry the mother and her newborn to breastfeed.
    - o Once the newborn shows feeding cues (e.g., opening of mouth, tonguing, licking, rooting), make verbal suggestions to the mother to give her breast to the newborn.

ELEMENT	NORMAL	ACTION
Positioning	• The mother is comfortable with back and arms supported. • Baby's head and body are aligned; baby's abdomen is turned toward the woman. • Make sure the baby's neck is not flexed or twisted. • Baby's face is facing the breast with nose opposite nipple. • Baby's body is held close to the mother. • Baby's whole body is supported, not just the neck and shoulders. • The baby is brought to nipple height.	• If positioning is incorrect, assist her to a correct breastfeeding position.

ELEMENT	NORMAL	ACTION
Holding	• The mother may support the weight of her breast with her hand and shape her breast by putting her thumb on the upper part, so that the nipple and areola are pointing toward the baby's mouth; OR • She may support the breast by cupping the breast with her fingers and hand while bringing the baby to her breast to suckle.	• If holding is incorrect, assist her to a correct breastfeeding holding position.
Attachment and suckling	4 cardinal signs of **good** attachment: 1. Chin of baby touches mother's breast. 2. Baby's mouth is wide open. 3. More areola seen on upper than lower part of the breast. 4. Lower lip is curled back below the base of the nipple. Other signs: • Nipple and areola are drawn into the baby's mouth rather than only the nipple into the mouth. • The baby takes slow, deep sucks with some pauses	• If attachment does not appear effective, assist her with correct attachment.  CORRECT  INCORRECT

ELEMENT	NORMAL	ACTION
Woman's comfort	• The woman does not complain of, or appear to have, nipple or breast pain during breastfeeding.	• If the woman has pain during breastfeeding, investigate further on correct position and attachment. • If the breast is engorged, express a small amount of breastmilk before starting breastfeeding to soften the nipple area so that it is easier for the baby to attach. Encourage the mother all the more to breastfeed. This will ease the engorgement.
Finishing the breastfeeding	• Wait for the newborn to release the breast instead of pulling out the breast. • Breasts are softer at the end of the feed compared to full and firm at the beginning. • Newborn looks sleepy and satisfied at the end of a feed.	• If newborn does not seem satisfied after the breastfeed, correct any mistakes (e.g., positioning, holding, attachment).

- Do not touch the newborn unless there is a medical indication.
- Do not give sugar water, formula or other prelacteals.
- Do not give bottles or pacifiers.
- Do not throw away colostrum.

Counsel an HIV positive mother on her choice of feeding her infant:

- Inform the woman about the options for feeding, the advantages, and risks:
  - Replacement feeding with commercial formula which could be costly.
  - Exclusive breastfeeding, stopping as soon as replacement feeding is possible.
  - Exclusive breastfeeding for 6 months, then continued breastfeeding with replacement feeding after 6 months.
  - Expressing and heat-treating her breast milk.
  - Wet nursing by a HIV-negative woman

- Explain the risks of HIV transmission through breastfeeding and not breastfeeding as follows:
  - 5 out of 20 babies born to known HIV-positive mothers will be infected during pregnancy and delivery without ARV medication. Three more may be infected by breastfeeding.
  - The risk may be reduced if the baby is breastfed exclusively using good technique, so that the breasts stay healthy.
  - Mastitis and nipple fissures increase the risk that the baby will be infected.
  - The risk of not breastfeeding may be much higher because replacement feeding carries risks of:
    - diarrhea because of contamination from unclean water, unclean utensils or because the milk stale.
    - malnutrition because of insufficient quantity given to the baby because the milk may be too watery or because of recurrent episodes of diarrhea.
  - Mixed feeding may also increase the risk of HIV transmission and diarrhea.
    - Help the woman assess her situation and decide on the best option for her, and support her choice.
  - If she chooses breastfeeding, give her special advice.
  - If she chooses replacement feeding, make sure that she understands that this is enriched by complimentary feeding up to 2 years. If this is not possible, she can exclusively breastfeed then stop when replacement feeding is feasible. All babies on replacement feeding must be followed-up more closely.

4. Mother-Baby Bonding

The mother-child relationship begins during pregnancy and develops rapidly after the birth of the baby. Normal maternal feelings vary, from the rush of affection that some women feel immediately after birth, to less dramatic, more gradually developing feelings that other women experience. In a healthy relationship, however, the woman will begin to demonstrate some degree of concern/nurturing toward her baby immediately after birth. Through careful observation, you may detect early problems in this area and help uncover the underlying reasons, so that appropriate action can be taken to allow a healthy mother-baby bond to develop.

ELEMENT	NORMAL	ACTION
Physical contact	• The woman appears to enjoy physical contact with her newborn and appears contented with the newborn.	• If findings are not within normal for the cultural context, investigate woman's feelings. o If she reports feelings of inadequacy, worry, or fear, do the following:

ELEMENT	NORMAL	ACTION
Communication	• She caresses, talks to, and makes eye contact with the newborn. • When holding or feeding the newborn, she and the newborn are turned toward each other.	– Assure her that she is very important to her baby's well-being and that no one else can care for her baby as well as she can. – Point out things that she is doing right in the care of her newborn. – Give her clear advise/ counseling on newborn care and self-care. – Allow her to ask questions and discuss her anxieties. Do not overwhelm her with too much information at one time. – Advise woman to return for care if signs and symptoms worsen.
Empathy	• She responds with active concern to the newborn's crying or need for attention.	

Newborn Care Provision

Based on history and findings, counsel the woman on proper newborn care with the following messages.

1. Early and Exclusive Breastfeeding

- Colostrum (first milk) is the perfect first food for a baby as it contains ingredients that boost immunity and provide all essential nutrients. As such, mothers should give her colostrum to the baby.
- Breastfeed her baby exclusively for the first six months of life. This means that the baby should not be given anything else to drink or eat during that time — no water, juice, infant formula, rice, or any other food or drink.

Note: In special cases, such as in cases of Low Birth Weight babies, the physician may decide to prescribe supplemental vitamins. This is still considered Exclusive Breastfeeding.

- Breastfeed her baby day and night (on demand). This is every 2-3 hours (or 8-12 times per 24 hours).
- To ensure that the baby is getting enough milk, mothers should note how often the baby urinates, which should be at least six times per day in the first week.

Note:
- Do not give sugar water, formula or other prelacteals.
- Do not give bottles or pacifiers.

2. Newborn Care and Other Healthy Practices

Maintaining Warmth

- The woman and baby should be kept in skin-to-skin contact, covered with a clean, dry blanket, as much as possible for the first six hours after birth. If immediate skin-to-skin contact cannot be done, dress the newborn with an extra layer or two of clothing or blanket.
- Do not bathe the baby for the first six hours.
- Avoid dressing the baby in tight, restrictive clothing or blankets because they reduce the retention of heat.
- Cover the baby's head with a bonnet.
- Keep the room warm (at least 25°C) and free from drafts.
- Check the newborn's feet at least every four hours for at least 24 hours or until temperature is stable.
    - If the baby's feet feel cold in comparison to normal adult skin, extra warmth is required immediately by adding a layer of clothing or blanket.
    - If the feet feel hot in comparison to normal adult skin, remove a layer of clothing or blanket.
    - Do not leave the baby in direct sunlight.

Kangaroo Mother Care (for a small baby)

Kangaroo mother care (KMC) is the best way to keep a small baby warm and helps establish breastfeeding. KMC can be started as soon as the baby's condition permits (i.e., the baby does not require special treatment with oxygen or IV fluids).

To begin KMC:

- Ensure that the mother is fully recovered from any childbirth complications.
- Ensure that the mother stays with her baby most of the time. She must have full support from the family to deal with responsibilities at home if she needs to be in the hospital with her small baby.

- Explain to the mother that this may be the best way for her to care for her small baby:
  - the baby will be warm;
  - the baby will feed more easily;
  - episodes of apnea will be less frequent;
  - babies can be cared for using KMC until they are 2.5 kg or 40 weeks post-menstrual age.

How to do KMC:

- Ask mother to wear loose clothing which can accommodate the baby.
- Clothe the baby with pre-warmed shirt open at the front, a diaper, a hat, and socks.
- Ensure that the room is about 25°C.
- While the mother is holding the baby, describe to her each step of KMC, demonstrate them, and then allow her to go through the steps herself.
- Place the baby in upright position on the mother's chest directly against the mother's skin (Fig. 2).
  - Ensure that the baby's hips and elbows are flexed into a frog-like position and the baby's head and chest are on the mother's chest, with the head in a slight extended position.
  - Use a soft piece of garment (about 1 square meter), folded diagonally and secured with a knot. Make sure it is tied firmly enough to prevent the baby from sliding out when the mother stands, but not so tightly that it obstructs the baby's movement or breathing.
  - After positioning, allow the mother to rest with the baby, and encourage her to move around when she is ready.

Figure 2. Baby in KMC position under the mother's clothes

Prevention of Infection; Hygiene

- Always wash hands before and after taking care of the baby.
- Do not share supplies with other babies.
- Limit the number of individuals handling the baby.
- Do not allow individuals to handle or come close to the newborn if they have acute infections (e.g., respiratory virus).

Washing and Bathing

- Do not bathe the baby at least for the first six hours of life.
- At birth, do not remove vernix. Remove only blood or meconium. Use a cotton cloth soaked in warm water to remove blood and other body fluids from the baby's skin and dry skin thoroughly.
- Later or when at home, wash the baby's face, neck and underarms daily.
- Clean the buttocks and perineal area of the baby each time the baby's diaper is changed or as often as required, using cotton soaked in warm, soapy water. Rinse and carefully dry.
- Bathe when necessary:
  - Ensure that the room is warm and there is no draft.
  - Use warm water for bathing.
  - Thoroughly dry, dress and cover the baby after the bath.

Cord Care

- Wash hands before and after cord care.
- Do not apply any substances or medicine to the stump.
- Do not bandage the stump or abdomen.
- Fold diaper below stump.
- Avoid touching the stump unnecessarily.
- Keep cord stump loosely covered with clean cloth.
- If stump is soiled, wash it with clean water and keep it dry.

Sleep and Other Behavior, Needs

- Use a bednet day and night for a sleeping baby.
- Let the baby sleep on his or her back or on his or her side.
- At night, let the baby sleep with the mother or within easy reach to facilitate breastfeeding.
- Keep the room or part of the room warm especially in cold weather.
- Keep the baby away from smoke or people smoking.
- Keep the baby away from sick children or adults.

3. Immunization and Other Preventive Measures

Immunization

- Immunization protects the baby against several infectious diseases. The baby should be vaccinated before discharge or within the first week of life with BCG, Hepatitis B (HB-1).
- If baby was not vaccinated within the first week of life, mother should bring baby for BCG vaccination from 1 to 4 weeks after birth.
- It is very important that mother should bring baby back for the next schedule of immunization.

- Schedule of Immunization:
  Birth <1 week ---- BCG, HB1 6 weeks ---- DPT, OPV-1, HB2

Note: For Low Birth Weight or Preterm Babies, Hepatitis B vaccine is given at birth for first dose, followed by second dose at 6 weeks of age and third dose at 10 weeks. A fourth dose is given at 14 weeks of age.

Normal babies are given hepatitis vaccine doses at birth, 6 weeks and 14 weeks of age only.

Vitamin K

- It is administered to help reduce the danger of bleeding.
- 1 mg of vitamin K is injected in the outer part of the thigh at 90 degrees.

Newborn Screening

- Newborn screening is the early detection and management of several congenital metabolic disorders, which if undetected, may lead to mental retardation or death. Babies with these disorders may look normal and the only way to detect abnormalities before they become irreversible is through screening.
- The five disorders include: congenital hypothyroidism (CH), congenital adrenal hyperplasia (CAH), galactosemia (GAL), phenylketonuria (PKU), and glucose-6-phosphatase deficiency (G-6PD) disorder.
- Blood sample is taken by heel prick. Only trained service providers are allowed to collect blood samples.
  - The **ideal time** for blood sample collection is **48 to 72 hours after birth**. However, as a policy, blood sample collection may be done **24 hours after birth**, before the mother is sent home.

Note: If the mother refuses to have her baby undergo newborn screening, she should sign a waiver form that documents such a refusal.

Newborn Hearing Screening

- Newborn hearing screening is the early detection of congenital hearing abnormalities, which if undetected, may lead to congenital hearing loss that will affect overall health and development of the infant.

  This non-invasive procedure requires an otoacoustic machine that makes use of a probe placed in the ear canal. The probe emits a frequency that the tympanic membrane detects and reflects back (echoes) towards the probe. The probe then picks up this response signifying a "pass" result.

Part 2
Special Procedures

Basic Principles for Procedures

Note: Procedures cited here are only for review. Only midwives trained to perform these procedures should attempt them, and only if necessary.

- Before any simple (non-operative) procedure, it is necessary to:
  - o Gather and prepare all supplies. Missing supplies can disrupt a procedure.
  - o Explain the procedure and the need for it to the woman and obtain consent.
  - o Place the patient in a position appropriate for the procedure being performed. The most common position used for obstetric procedures is the lithotomy position (Fig. 3).

Figure 3: The lithotomy position

- Wash hands with soap and water and put on gloves appropriate for the procedure.
- If the **vagina and cervix need to be prepared with an antiseptic** for a procedure:
  - o Wash the woman's lower abdomen and perineal area with soap and water, if necessary.
  - o Gently insert a high-level disinfected or sterile speculum or retractor(s) into the vagina.
  - o Apply antiseptic solution (e.g., iodophors, chlorhexidine) three times to the vagina and cervix using a high-level disinfected or sterile ring forceps and a cotton or gauze swab.

ABDOMINAL EXAMINATION

Examination of the abdomen should be performed in the following steps:

1. Inspection
2. Measurement
3. Palpation
4. Auscultation

Steps in performing abdominal examination

1. Instruct the woman to empty her bladder.
2. Assist the woman onto the examination table.
3. Have the woman lie on her back (i.e., supine position) with her knees slightly bent to relax the abdominal muscles.
4. Place a small pillow under her head for comfort.
5. Drape properly to maintain privacy. Uncover only parts being examined.
6. Explain procedure to the woman.
7. With the woman in a comfortable supine position, examine the surface of the abdomen for scars (i.e., from previous Caesarean section, uterine rupture, or other uterine surgeries).
8. Depending on the AOG, proceed with the examination as follows:
    - 12-22 weeks
        - o Gently palpate the abdomen above the symphysis pubis.
        - o Estimate the weeks of gestation by determining the distance between the top of the fundus and the symphysis pubis or umbilicus.
    - 22-24 weeks
        - o Check the fundal height with a tape measure (Fig.4).

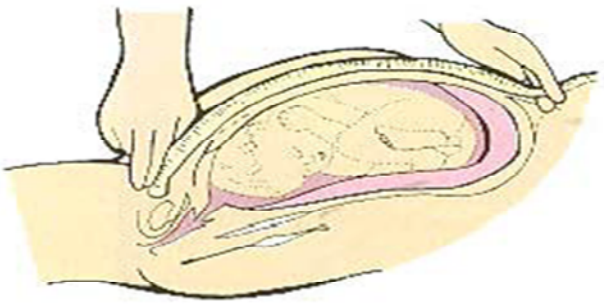


Fig. 4: Measuring the Fundic Height

Place the zero line of the tape measure on the upper edge of the symphysis pubis. Stretch the tape measure across the contour of the abdomen to the top of the fundus. Use the abdominal midline as the line of measurement.

- > 24 weeks
    - o Measure the fundic height.
    - o Perform Leopold's maneuver to determine fetal position and lie. The examiner's palm is used for this maneuver and not the fingers.

LEOPOLD'S MANEUVER

Leopold's maneuver is performed after 24 weeks gestation when the fetal outline can already be palpated.

First maneuver

This determines the fetal part that is located at the upper fundus. While facing the woman, palpate the woman's upper abdomen with both hands. The fetal head is hard, firm, round, and moves independently of the trunk while the buttocks feel softer, are symmetric, and have small bony processes; unlike the head, they move with the trunk (Fig. 5).

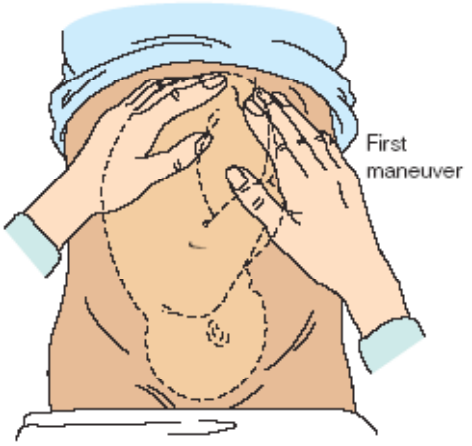


Fig. 5: First Maneuver

Second maneuver

This maneuver determines the location of the fetal back. Still facing the woman, palpate the abdomen with gentle, deep pressure using the palms of the hands. The right hand remains steady on one side of the abdomen while the left hand explores the right side of the woman's uterus. This is then repeated using the opposite side and hands. The fetal back will feel firm and smooth while fetal extremities (arms, legs, etc.) should feel like small irregularities and protrusions. The fetal back, once determined, should connect with the form found in the upper abdomen and also a mass in the maternal inlet at the lower abdomen (Fig. 6).

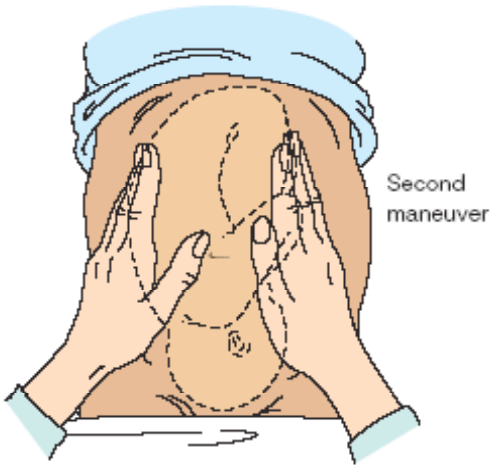


Fig. 6: Second Maneuver

Third maneuver

The third maneuver determines the fetal part lying above the inlet, or lower abdomen.
Grasp the lower portion of the abdomen just above the symphysis pubis with the thumb and fingers of the right hand. This maneuver should yield the opposite information and validate the findings of the first maneuver. If the head is at the lower abdomen, a hard mass with a distinctive round surface will be felt. This means that the presenting part is the fetal head. If the head is not engaged (it has not passed the symphysis pubis), the head can be moved from side to side (Fig.7).

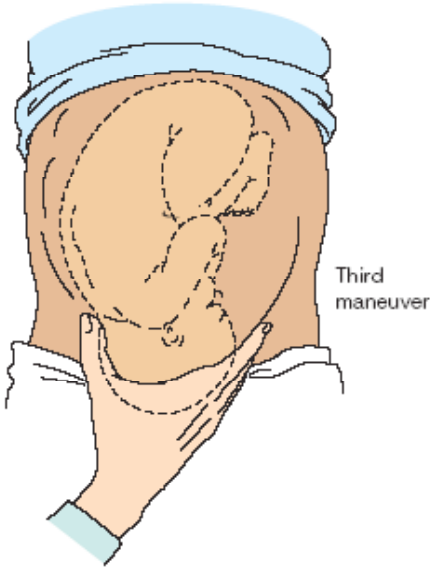


Fig. 7: Third Maneuver

Fourth maneuver

This maneuver determines the part of the fetal head that is presenting.
Facing the woman's feet, fingers of both hands are moved gently down the sides of the uterus toward the pubis. The side where resistance to the descent of the fingers toward the pubis is greatest is where the brow is located. If the head of the fetus is well flexed, it should be on the opposite side from the fetal back. If the fetal head is extended though, the occiput (back of the head) is felt instead and is located on the same side as the back (Fig. 8).

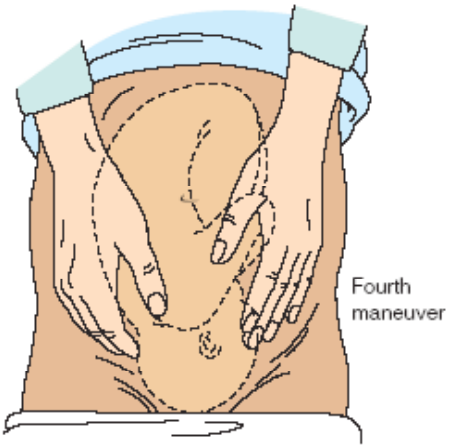


Fig. 8: Fourth Maneuver

CONTROLLED CORD TRACTION

- Clamp the cord close to the perineum using sponge forceps within one to three minutes of delivery of the baby. Hold the clamped cord and the end of the forceps with one hand.
- Place the other hand just above the woman's pubic bone and stabilize the uterus by applying counter traction during controlled cord traction. This helps prevent inversion of the uterus.
- Keep slight tension on the cord and await a strong uterine contraction (2 to 3 minutes).
- When the **uterus becomes rounded or the cord lengthens**, very gently pull downward on the cord to deliver the placenta. Do not wait for a gush of blood before applying traction on the cord. Continue to apply counter traction to the uterus with the other hand.
- If the **placenta does not descend** during 30 to 40 seconds of controlled cord traction (i.e., if there are no signs of placental separation), do not continue to pull on the cord:
  - Gently hold the cord and wait until the uterus is well contracted again. If necessary, use a sponge forceps to clamp the cord closer to the perineum as it lengthens;
  - With the next contraction, repeat controlled cord traction with counter traction.

- As the placenta delivers, the thin membranes can tear off. Hold the placenta in two hands and gently turn it until the membranes are twisted.
- Slowly pull to complete the delivery of the placenta.
- If the **membranes tear**, gently examine the upper vagina and cervix wearing high-level disinfected or sterile gloves and use a sponge forceps to remove any pieces of membrane that are present.
- Look carefully at the placenta to be sure none of it is missing. If a **portion of the maternal surface is missing or there are torn membranes with vessels**, suspect retained placental fragments and refer accordingly.

REPAIR OF VAGINAL AND PERINEAL TEARS

There are four degrees of tears that can occur during delivery:
- First degree tears involve the vaginal mucosa and connective tissue.
- Second degree tears involve the vaginal mucosa, connective tissue and underlying muscles.
- Third degree tears involve complete transection of the anal sphincter.
- Fourth degree tears involve the rectal mucosa.

Midwives are allowed to do repair of first and second degree perineal tears only.

Note: It is important that absorbable sutures be used for closure. Polyglycolic (Vicryl) sutures are preferred over chromic catgut for their tensile strength, non-allergenic properties and lower probability of infectious complications. Chromic catgut is an acceptable alternative, but is not ideal.

REPAIR OF FIRST AND SECOND DEGREE TEARS

Most first degree tears close spontaneously without sutures.
- Review general care principles.
  - Provide emotional support and encouragement.
  - Anesthesize the area by local infiltration with lignocaine.
  - Ask an assistant to massage the uterus and provide fundal pressure.
- Carefully examine the vagina, perineum and cervix.
  - If the **tear is long and deep through the perineum**, inspect to be sure that the anus and sphincter have not been injured, which will categorize the laceration as a third or fourth degree tear:

Note: Midwives are not allowed to repair third and fourth degree perineal tears.

- Place a gloved finger in the anus.
- Gently lift the finger and identify the sphincter.
- Feel for the tone or tightness of the sphincter.

If the **sphincter is injured**, refer to higher level facility. If the **sphincter is not injured**, proceed with repair.

- Change to clean, high-level disinfected gloves.
- Apply antiseptic solution to the laceration and the area around the tear.
- Make sure there are no known allergies to lignocaine or related drugs.
- Infiltrate not more than 15 ml of 0.5% lignocaine solution beneath the vaginal mucosa, beneath the skin of the perineum and deeply into the perineal muscle around the laceration.

Fig. 9 shows how to expose a perineal tear.

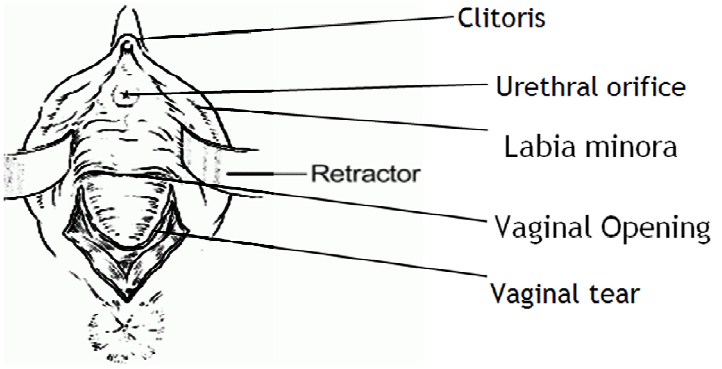


Figure 9: Exposing a perineal tear

Note: Aspirate (pull back the plunger) to be sure that no vessel has been penetrated. If **blood is returned in the syringe with aspiration**, remove the needle. Recheck the position carefully and try again. Never inject if blood is aspirated. T**he woman can suffer convulsions and even die if IV injection of lignocaine occurs.**

- At the conclusion of the set of injections, wait two minutes and then pinch the area with forceps. If the **woman feels the pinch**, wait two more minutes and then retest.
- Repair the vaginal mucosa with continuous stitches using a 2-0 suture (Fig. 10):
  - Start the repair about 1 cm above the apex (top) of the vaginal tear. Continue the suture to the level of the vaginal opening.
  - At the opening of the vagina, bring together the cut edges of the vaginal opening.
  - Bring the needle under the vaginal opening and out through the perineal tear and tie.

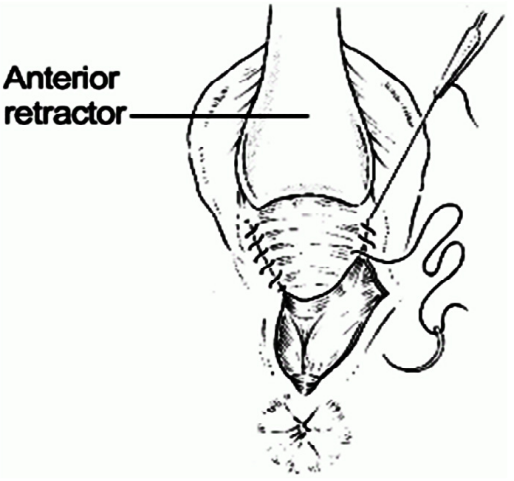


Figure 10: Repairing the vaginal mucosa

- Repair the perineal muscles using interrupted stitches with 2-0 suture (Fig. 11). If the **tear is deep**, place a second layer of the same stitch to close the space.

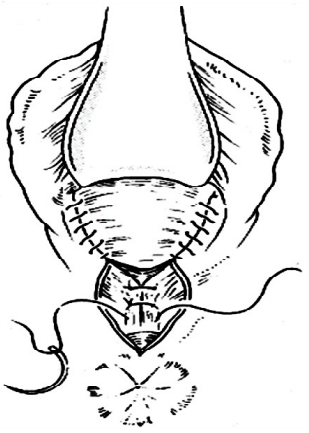


Figure 11. Repairing the perineal muscles

- Repair the skin using interrupted (or subcuticular) 2-0 sutures starting at the vaginal opening (Fig. 12).
- If the tear was deep, perform a rectal examination. Make sure no stitches are in the rectum.

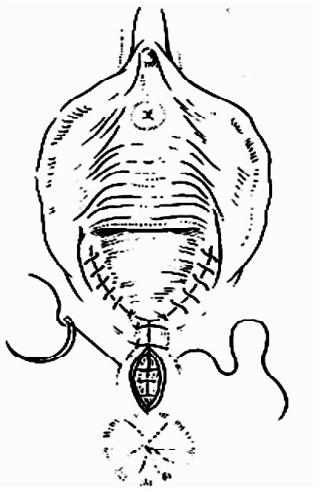


Figure 12.Repairing the skin

Bimanual Compression of the Uterus

Bimanual compression of the uterus (Fig. 13) and compression of the abdominal aorta (Fig. 14) are procedures employed to control profuse uterine bleeding during the transport of the woman to the hospital.

- Wear high-level disinfected gloves, insert a hand into the vagina and form a fist.
- Place the fist into the anterior fornix and apply pressure against the anterior wall of the uterus.
- With the other hand, press deeply into the abdomen behind the uterus, applying pressure against the posterior wall of the uterus.
- Maintain compression until bleeding is controlled and the uterus contracts.

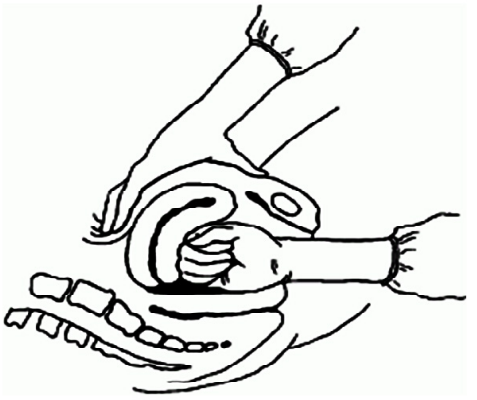


Figure 13: Bimanual Compression of the Uterus

COMPRESSION OF ABDOMINAL AORTA AND PALPATION OF FEMORAL PULSE

Compression of the abdominal aorta and palpation of the femoral pulse are procedures employed to control profuse uterine bleeding during the transport of the woman to the hospital.

- Apply downward pressure with a closed fist over the abdominal aorta directly through the abdominal wall.
  - The point of compression is just above the umbilicus and slightly to the left.
  - Aortic pulsation can be felt easily through the anterior abdominal wall in the immediate postpartum period.
- With the other hand, palpate the femoral pulse to check the adequacy of the compression.
  - If the **pulse is palpable during compression,** the pressure exerted by the fist is inadequate.
  - If the **femoral pulse is not palpable,** the pressure exerted is adequate.
- Maintain compression until bleeding is controlled.

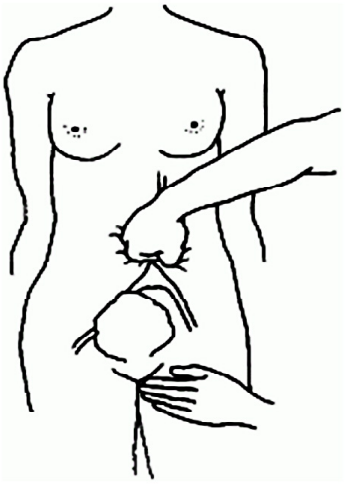


Figure 14: Compression of the Abdominal Aorta and Palpation of Femoral Pulse

RESUSCITATING THE NEWBORN

Start resuscitation if the newborn:

- Is completely floppy and not breathing before 30 seconds of drying
- Is not breathing or is gasping after 30 seconds of drying

Opening the Airway

- Position the newborn (Fig. 15):

- Place the newborn on its back on a firm, warm surface.
- Position the head in a slightly extended position to open the airway. A rolled up piece of cloth under the baby's shoulder may be used to extend the head.
- Keep the newborn wrapped or covered, except for the face and upper chest.
- Inform the mother that the newborn needs help to breathe.

Correct position of the head for ventilation;
note that the neck is less extended than in adults

Figure 15. Position of the Newborn

- Clear the airway by introducing the suction tube:
  - First, into the newborn's mouth 5 cm from the lips and suction while withdrawing.
  - Second, 3 cm into each nostril and suck while withdrawing.
  - Repeat once, if necessary, taking no more than a total of 20 seconds.
  - Suction the mouth first and then the nostrils.

  Note: If blood or meconium is in the baby's mouth, suction immediately to avoid aspiration. However, do not suction mouth and nose prior to delivery of the shoulders of babies with meconium-stained amniotic fluid. Do not suction deep in the throat as this may cause the baby's heart to slow or may stop breathing.

- Reassess the newborn:
  - If the newborn starts crying or breathing, no further immediate action is needed.
  - If the newborn is still not breathing, start ventilating.

Ventilating the Newborn

- Re-check the newborn's position as in Fig. 15.
- Position the mask and check the seal (Fig. 16).
  - Place the mask on the newborn's face. It should cover the chin, mouth, and nose.
  - Form a seal between the mask and the face.

- Squeeze the bag with two fingers only or with the whole hand, depending on the size of the bag.
- Check the seal by squeezing the bag twice and observing the rise of the chest.

Figure 16. Ventilating with bag and mask

- Once a seal is ensured and the chest movement is present, ventilate the newborn.
- Maintain the correct rate (approximately 40 breaths/minute) and pressure. Observe the chest for an easy rise and fall).
- If the **newborn's chest is rising**, ventilation pressure is adequate.
- If the **newborn's chest is not rising**,
  - Repeat suction of mouth and nostrils to remove blood, mucus, or meconium from the airway.
  - Re-check and correct, if necessary, the position of the newborn.
  - Reposition the mask on the newborn's face to improve the seal between the mask and the face.
  - Squeeze the bag harder to increase ventilation pressure.

- Re-assess at 30-second intervals:
  - If **breathing is normal** (30-60 breaths/minute), and there is no in-drawing of the chest and no grunting for one minute, no further resuscitation is needed.
  - If newborn is **not breathing or breathing is weak**, continue ventilating until spontaneous breathing begins.

- If the newborn starts crying, stop ventilating and continue observing breathing for five minutes after crying stops:
  - If **breathing is normal** and there is **no in-drawing of the chest** and **no grunting** for one minute, no further resuscitation is needed.
  - If **respiratory rate is less than 30 breaths/minute**, continue ventilating.
  - If there is **severe in-drawing of the chest**, ventilate with oxygen. Arrange to transfer the baby with its mother to the most appropriate service for the care of sick newborns.

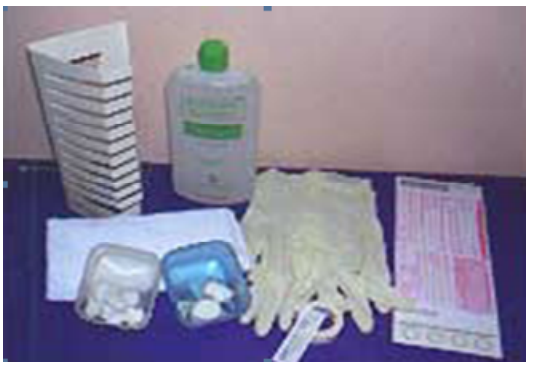
Note: Indiscriminate use of supplemental oxygen for premature infants has been associated with the risk for blindness.

- If the **newborn is not breathing regularly after 20 minutes of ventilation**:
  - Transfer the baby with its mother to an appropriate facility that can manage sick newborns.
  - During the transfer, keep the newborn warm and ventilated, if necessary.
- If there is **no gasping or breathing at all after 20 minutes of ventilation**, stop ventilating; the baby is stillborn. Provide emotional support to the family.

NEWBORN SCREENING

Heel prick method:

1. Prepare the necessary materials:
   - A warm moist towel
   - Clean gloves
   - 70% isopropyl alcohol or sterile water
   - Dry and wet cotton balls or swabs
   - NBS filter card (properly filled up)
   - Sterile lancets (3 mm)
   - Micropore tape
   - Drying rack



2. Warm the baby's feet (Fig. 17).
   - To facilitate sufficient and free flow of blood, hold the baby's leg lower than the head. Warm the baby's heel with a warm towel for three minutes.
   - The temperature should not exceed 40°C.
   - Gentle rubbing of the baby's heel is another method to warm the area.

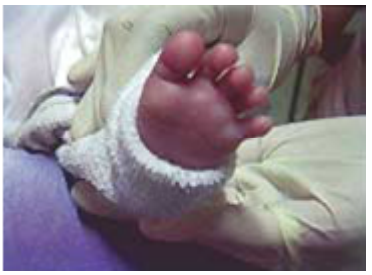


Figure 17. Warming the baby's feet

3. Clean the puncture site (Fig. 18).
   - Clean the area thoroughly with 70% isopropyl alcohol or sterile water swab.

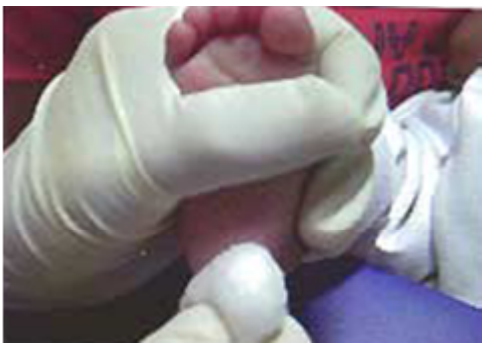


Figure 18. Cleaning the puncture site

4. Dry the puncture site.
   - Wipe the prospective puncture site with a dry cotton ball to prevent contamination of the specimen with the alcohol or sterile water.

5. Prick the heel (Fig. 19).
   - Make two punctures in quick succession on the lower lateral borders of the heel.

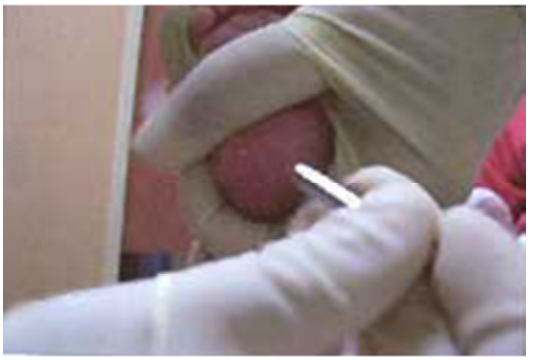


Figure 19. Pricking the baby's heel

Do not puncture the following sites:

- Arch of the heel
- Swollen area
- Previously punctured area
- Fingers

For babies weighing 4.4 lbs (2.0 kg) or less, the puncture wound should be less than 2.4 mm in depth. Appropriate lancet should be used.

6. Wipe the first drop of blood with dry sterile cotton to avoid contamination of the blood sample.

7. Apply intermittent pressure to the area surrounding the puncture site.
   - Do not squeeze the heel too hard because this may cause interstitial fluid to leak and contaminate the specimen.
   - If blood flow slows down, release your grip and then wipe the puncture site again with dry cotton to remove the clot.

8. Place the blood onto the filter card.
   - Allow a big drop of blood to form on the baby's heel before applying it onto the filter card.
   - Place one drop of blood on each of the four circumscribed circles. Aim for complete saturation of each of the four blood spots.

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Quality Assurance Package for Midwives

TOOLKIT FOR PRACTICING PROFESSIONAL MIDWIVES

SECTION 2

Clinic Operation Standards Manual

Part 1: Standard Operating Procedures

Part 2: Standard Clinic Forms

This publication is made possible with the generous support of the American People through the United States Agency for International Development (USAID). The contents of this publication are the sole responsibility of the Department of Health (DOH) and do not necessarily reflect the views of USAID or the United States Government.

CONTENTS

Part 1
Standard Operating Procedures

CLINICAL SERVICES

Outpatient Consultations (including FP services)

1. Greet client as she enters the clinic.
2. Ask client what you can do for her.
3. Ask if she is a new client/patient or a return client/patient.

   For new client/patient:
   - Prepare a clinical record.
   - Get the demographic data and record in the appropriate space in the clinical record.
   - Take the client/patient's weight, height, and vital signs and write them down in the clinical record.

   For return clients/patients:
   - Retrieve clinical record from file. Record retrieval should take no longer than three minutes.
   - Take the weight, height, and vital signs and write them down in the clinical record.

4. Ask the client to have a seat and wait for her name to be called if there is another client being attended to, or if there are other clients waiting.
5. If there are no other clients in the clinic, bring her and her record to the consultation room where privacy and confidentiality can be observed.
6. The MW or service provider takes the client's medical and obstetrical history, conducts a physical examination, requests appropriate laboratory procedures and writes down all findings in the clinical record.
7. Provide services as appropriate, including necessary instructions and follow-up schedule.
8. For family planning clients, do a complete FP counseling session using the GATHER approach.
9. Refer client to back-up doctor or to a higher level facility for complications or for services not available in the facility using the two-way referral form.
10. Emergency cases are directly brought to the consultation/examination room or the delivery room and attended to immediately.
11. File clinical records at the end of the day based on the filing system used by the facility.

Procedures for Performing Prenatal Check-Up

(Note: refer to Section 1: Clinical Care Manual for Midwives for detailed discussions)

1. A pregnant woman should have at least four prenatal check-ups for the duration of the pregnancy. The schedule is as follows:

   1st visit – before 4 months

   2nd visit – 6 months

3rd visit – 8 months
4th visit – 9 months

2. Using the clinic's maternal record form, get the patient's demographic data, medical and obstetrical history, paying particular attention to the last menstrual period, the expected date of confinement, and the age of gestation.
3. Do a complete physical examination to include the following:
   - Weight and vital signs
   - Heart and lungs auscultation (listening to the patient's heartbeat and breathing through a stethoscope)
   - Abdominal examination to check for scars and determine the following: size of the uterus, fetal heart tone, and fetal movement, if appropriate
   - Leopold's Maneuver, when appropriate
   - Internal examination, if necessary

Vaginal examination should not be done if a woman is bleeding or has a history of bleeding any time after seven months of pregnancy.

4. Request needed laboratory procedures: hemoglobin, hematocrit or complete blood count, VDRL, urinalysis, and ultrasound, if necessary.
5. Give tetanus toxoid when appropriate.
6. Give iron, folate and multivitamin supplement.
7. Prepare Birthing (Maternal Delivery) Plan with client.
8. Discuss danger signs of pregnancy with client.
9. Advise client on breastfeeding, nutrition and self-care, dental check-up, drug use and provide family planning counseling.
10. Refer client to back-up doctor or to a higher level facility for complications or for services not available in your facility.
11. Schedule next follow-up visit.

Admission Cases: Labor, Delivery, Immediate Postpartum and Newborn Care

(Note: Refer to the Clinical Care Manual for Midwives Part 1 for detailed discussions)

1. Retrieve client record.
2. Admit client.
3. Examine client and record findings in the record form.
4. Monitor progress of labor using the Partograph.
5. Transfer client to the delivery room when the baby's head becomes visible at the vaginal opening during contraction of uterus.
6. Attend to the delivery of the baby.
7. Assess baby's need for ventilation or resuscitation.
8. Dry the baby with dry cloth.

9. Keep baby warm by placing the baby in skin-to-skin contact on the mother's abdomen.
10. Clamp the cord.
11. Deliver the placenta, and check for completeness.
12. Check if uterus is well contracted. Give 10 IU oxytocin IM.
13. Check for lacerations. Suture perineal lacerations. Refer 3rd or 4th degree lacerations to back-up doctor (Ob-Gyne) or to a hospital.
14. Immediate Care of the Newborn: Follow the Essential Newborn Care Protocol (Note: *Refer to Clinical Care Manual for Midwives Part 1 pp. 90-91 for detailed discussions.)*
    - Dry the baby.
    - Keep baby warm by skin-to-skin contact with the mother.
    - Initiate breastfeeding when baby shows readiness which is usually within one hour after delivery.
    - Take baby's weight, temperature, head and chest circumference
    - Do not remove vernix (greasy deposit on baby's skin after birth) or bathe baby.
    - Apply antimicrobial (Erythromycin ophthalmic ointment) to both eyes of baby.
    - Give vitamin K injection.
    - Immunize baby.
15. Within the first hour of delivery of the placenta, monitor vital signs and assess vaginal bleeding every 15 minutes and record.
16. Refer to back-up doctor or to a higher level facility for complications encountered during labor or delivery.
17. For newborn screening, blood sample collection should be done 24 hours after birth, before sending the mother home.
18. Write all findings in the baby's clinical form or record.
19. Perform discharge internal examination and examine baby before discharging. Write findings in the clinical charts of the mother and the baby.
20. Advise mothers to return to the clinic within the first week after delivery for follow-up.

Postpartum Care (within six weeks after delivery)

1. Retrieve clinical record.
2. Bring client to consultation room for privacy and confidentiality.
3. Ask if there were problems encountered after discharge from clinic.
4. Check vital signs, take weight and temperature, examine perineum, observe vaginal discharge.
5. If no problems are presented, advise client on the following:
    - Breastfeeding and breast care, nutrition, Vitamin A, iron and folate supplementation, hygiene, and family planning
    - Immunization, if not yet complete
    - Cord care
    - Washing or bathing baby
6. Record all findings for both mother and baby in their respective clinical records.

7. If complications arise, refer client to back-up doctor or to a higher level facility for management.
8. Schedule next follow-up visit.

Referral of Clients

All cases of complications, whether emergency or not, should be referred to either the back-up doctors (Ob-Gyne or Pediatrician) or to a higher level facility for further evaluation and management.

1. The facility should have two back-up doctors, (an Ob-Gyne and a Pediatrician) to whom maternal and child complications can be referred accordingly.
2. For cases that need confinement, clients are referred to the nearest hospital (transfer referral).
3. All referrals should be accompanied by a two-way referral form.
4. For emergency cases, clients should be accompanied to the referral site by the referring service provider.
5. Accomplished referral forms are attached to the clinical records of the clients.

INFECTION PREVENTION PRACTICES

1. Wash hands:
   - Immediately upon arriving at work
   - Before and after handling each client
   - After touching anything that may be contaminated
   - Before putting on gloves for clinical procedures
   - After removing gloves
   - After using the toilet
   - Before leaving work

2. Always wear gloves when:
   - One expects that his/her hands will come in contact with the client's blood, other body fluids or tissue
   - One's hand may come in contact with medical waste

3. Follow these steps in giving injections:
   - Wash injection site with soap and water if the area is visibly dirty.
   - Swab the area with antiseptic (alcohol solution) in a circular motion starting from the intended injection site going outward.
   - Allow alcohol to dry.
   - Inform client that you are about to inject.
4. Needles should not be recapped. However, if recapping is necessary, follow the "one hand

technique."

5. Process used instruments accordingly. The steps are as follows:
   - Decontamination – immediately after using instruments on clients or patients, soak the instruments in 0.5% chlorine solution for 10 minutes.
   - Cleaning – rinse and wash the instruments with detergent and water.
   - Sterilization or high-level disinfection:
     - Sterilization
       - Autoclave – 106kPa 121°C for 20 minutes (unwrapped) or 30 minutes (wrapped)
       - Dry Heat - 170°C for 60 minutes.
       - Chemical (Cidex) – soak for 8 hours.
     - High level disinfection
       - Boiling – 20 minutes.
       - Steam – 20 minutes.
       - Chemical – soak for 20 minutes.
   - Use or store.

Waste Management

1. Classify waste generated in a birthing facility into general and medical waste.
2. Follow these steps in disposing waste:
   - Sort or segregate and containerize waste.
     - Use black container or plastic lining for dry, non-infectious general waste.
     - Use green container or plastic lining for wet, non-infectious general waste.
       - Use yellow for infectious or pathological waste (medical waste).
       - Sharps should be placed in a puncture-proof container.
   - Handling of waste
     - Close plastic liners with plastic string when waste container is ¾ full, place in a larger container for interim storage.
     - Wear heavy utility gloves when handling waste materials.
     - Wash hands after handling wastes and after removing gloves.
   - Interim storage – waste should never be stored in the facility for more than two days.
   - Final disposal
     - General waste – collected by the regular municipal collector and transported to final dump site
     - Solid medical waste -buried, or transported for off-site disposal by collector of hospital medical waste
     - Liquid medical waste – poured down a sink, drain, or flushable toilet

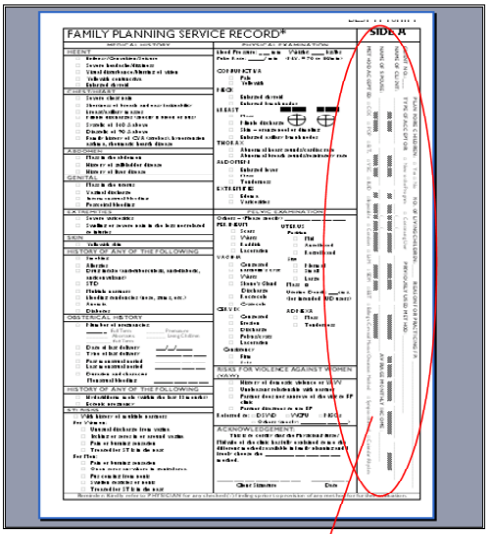
Part 2
Standard Clinic Forms

FAMILY PLANNING SERVICE RECORD (FORM 1)

This form is used to record information on FP services received by the client. This is accomplished for all clients receiving FP services who may either be new clients or transferees from other service outlets or clinics. The front page of the form should contain the personal information of the client, the medical and obstetrical history, and the findings on physical examination; while the back page should be used for documenting succeeding visits to the clinic.

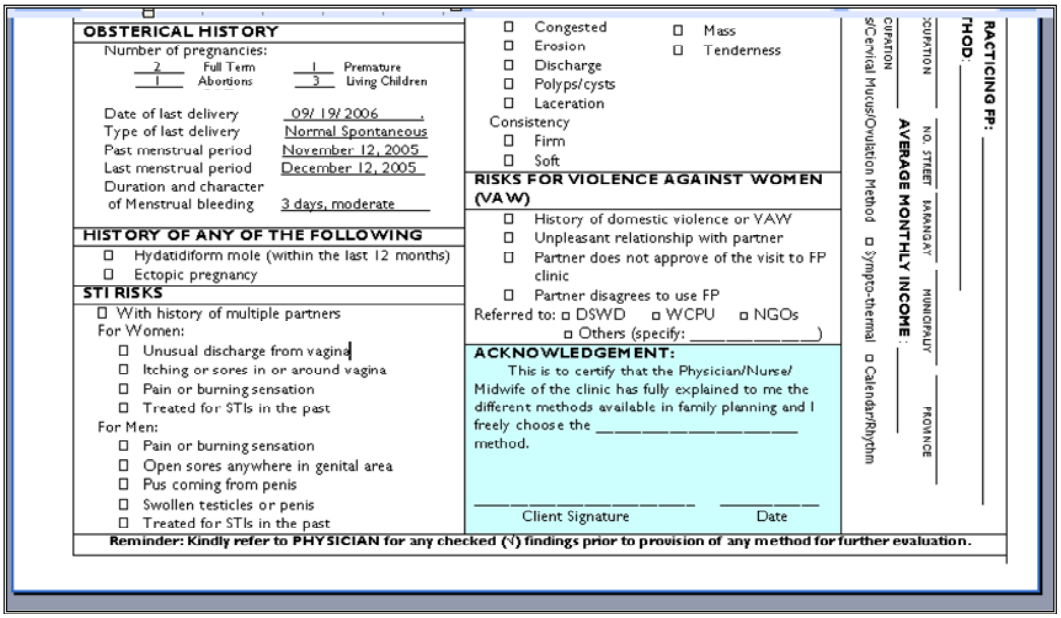
The following are the procedures for filling out Form 1:

1. Fill in the required information on the rightmost side of the form. It is important to fill in the date, time of arrival and the time of disposition of the client.



Client Number: **00 00 01** Date/Time of Arrival: **July 21, 2008 9:00 AM** Time of Disposition: **10:30 AM**
Name of Client: **dela Cruz , Antonia Q. July 20, 2006 Housewife 30 Maysilo Mapayapa Sta. Rosa Laguna.**
Last Name Given Name MI Date of Birth Occupation No./Street Barangay Municipality Province
Educational Background: **High School Graduate.**
Person to notify in case of emergency: **Juan dela Cruz** Address: **30 Maysilo, Mapayapa, Sta. Rosa, Laguna** Tel. Number: **None**
Plan more children: ____ Yes **√** No FP METHOD: Current Use: ____ Yes **√** No Previous Use: ___ Yes **√** No
FP METHOD USED: VSS IUD Pills Inj. DMPA NFP LAM Condom Others specify

2. Determine the presence of the conditions listed in the form and put a check (✓) in the box preceding each condition if present, or mark the box with an (**X**) if it is absent.
3. Fill in the blanks for other information required such as number of pregnancies that reach full term, number of preterm pregnancies, number of abortions, blood pressure, weight, height, etc.
4. In the **Acknowledgement** portion (shaded blue), fill in the type of method chosen by the client and ask the client to ***sign at the space provided*** to ensure ***informed choice.***



OBSTERICAL HISTORY

Number of pregnancies:
2 Full Term | 1 Premature
1 Abortions | 3 Living Children

Date of last delivery 09/ 19/ 2006
Type of last delivery Normal Spontaneous
Past menstrual period November 12, 2005
Last menstrual period December 12, 2005
Duration and character of Menstrual bleeding 3 days, moderate

HISTORY OF ANY OF THE FOLLOWING

- ☐ Hydatidiform mole (within the last 12 months)
- ☐ Ectopic pregnancy

STI RISKS

☐ With history of multiple partners

For Women:
- ☐ Unusual discharge from vagina
- ☐ Itching or sores in or around vagina
- ☐ Pain or burning sensation
- ☐ Treated for STIs in the past

For Men:
- ☐ Pain or burning sensation
- ☐ Open sores anywhere in genital area
- ☐ Pus coming from penis
- ☐ Swollen testicles or penis
- ☐ Treated for STIs in the past

- ☐ Congested
- ☐ Erosion
- ☐ Discharge
- ☐ Polyps/cysts
- ☐ Laceration

Consistency
- ☐ Firm
- ☐ Soft

- ☐ Mass
- ☐ Tenderness

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)

- ☐ History of domestic violence or VAW
- ☐ Unpleasant relationship with partner
- ☐ Partner does not approve of the visit to FP clinic
- ☐ Partner disagrees to use FP

Referred to: ☐ DSWD ☐ WCPU ☐ NGOs
☐ Others (specify: _____)

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/ Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

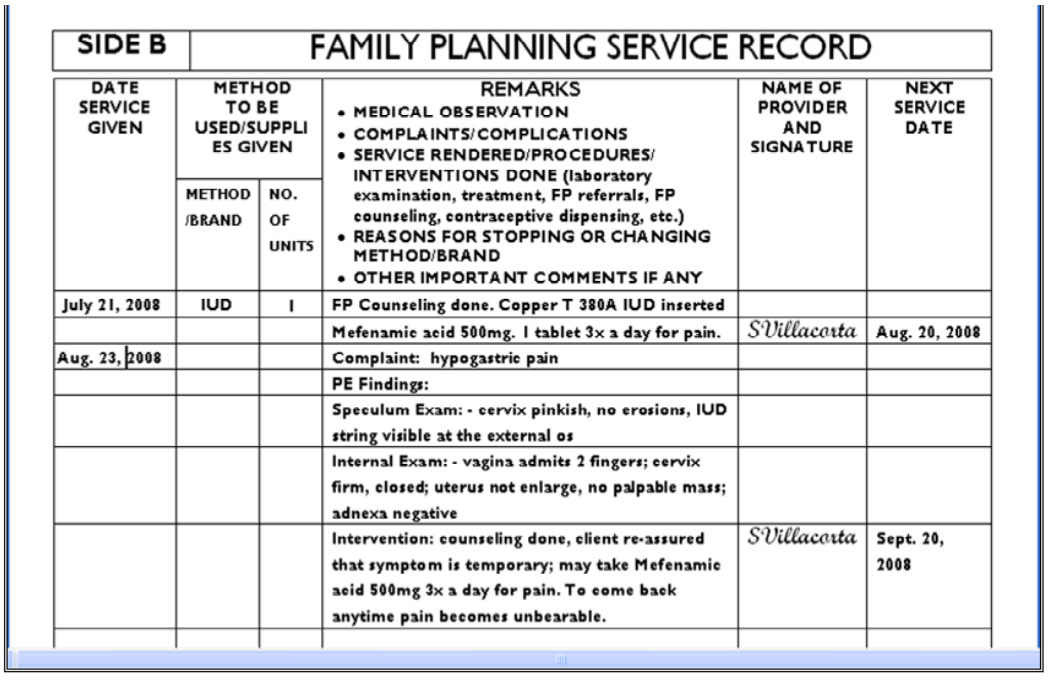
_____ _____
Client Signature Date

Reminder: Kindly refer to PHYSICIAN for any checked (√) findings prior to provision of any method for further evaluation.

RACTICING FP: _____
THOD: _____

OCUPATION _____
NO. STREET BARANGAY MUNICIPALITY PROVINCE
AVERAGE MONTHLY INCOME: _____
CUPATION
s/Cervical Mucus/Ovulation Method ☐ Sympto-thermal ☐ Calendar/Rhythm

5. For follow-up visits, use the back page. Fill in the columns on **Date Service Given, Method to be Used/Supplies Given, Remarks, Name of Provider and Signature, and Next Service Date.**



SIDE B — **FAMILY PLANNING SERVICE RECORD**

DATE SERVICE GIVEN	METHOD TO BE USED/SUPPLIES GIVEN		REMARKS • MEDICAL OBSERVATION • COMPLAINTS/COMPLICATIONS • SERVICE RENDERED/PROCEDURES/ INTERVENTIONS DONE (laboratory examination, treatment, FP referrals, FP counseling, contraceptive dispensing, etc.) • REASONS FOR STOPPING OR CHANGING METHOD/BRAND • OTHER IMPORTANT COMMENTS IF ANY	NAME OF PROVIDER AND SIGNATURE	NEXT SERVICE DATE
	METHOD /BRAND	NO. OF UNITS			
July 21, 2008	IUD	1	FP Counseling done. Copper T 380A IUD inserted		
			Mefenamic acid 500mg. 1 tablet 3x a day for pain.	SVillacorta	Aug. 20, 2008
Aug. 23, 2008			Complaint: hypogastric pain		
			PE Findings:		
			Speculum Exam: - cervix pinkish, no erosions, IUD string visible at the external os		
			Internal Exam: - vagina admits 2 fingers; cervix firm, closed; uterus not enlarge, no palpable mass; adnexa negative		
			Intervention: counseling done, client re-assured that symptom is temporary; may take Mefenamic acid 500mg 3x a day for pain. To come back anytime pain becomes unbearable.	SVillacorta	Sept. 20, 2008

MATERNAL SERVICE RECORDS (FORM 2)

Maternal Service Records are the forms used to record information about mothers receiving maternal health services. It consists of **five parts** corresponding to the different services under maternal health, namely: **initial prenatal (in Form 2A), Maternal Birth Plan (in Form 2B), follow-up prenatal (in Form 2C), monitoring of progress of labor using the Partograph (in Form 2D) and postnatal services (in Form 2E).**

Form 2A is used for the **initial** visit of a pregnant woman seeking **prenatal services**. It is a one-page form that contains personal information, family planning, medical and obstetrical histories of the client; and physical examination (including pelvic examination) findings. It also includes the midwife's assessment and plans on managing the case. *(See Appendices)*

Form 2B is the Maternal Birth Plan, which is always used together with ***Form 2A.*** This form should record information needed by the midwife to help the pregnant woman plan for her safe delivery in a health facility or for immediate transport to a higher level facility in cases of emergency. *(See Appendices)*

Form 2C is used to record the **second** and **all succeeding follow-up prenatal visits**. This form records the date and time the client came to the clinic, her subjective complaint, the findings of the midwife on physical examination, the assessment of the case, and the plan on how to manage the case. *(See Appendices)*

Form 2D, the ***Partograph***, is a tool used in monitoring the progress of labor. It contains the information needed by the midwife to determine whether labor is progressing normally or it is in need of referral to a physician or a higher level facility. It also includes information on the baby as well as the delivery of the placenta. *(See Appendices)*

Form 2E, the ***Postnatal Service Record***, is used for clients who return to the facility or are visited at home **within six weeks after delivery**. The information contained in this form reflects the condition of the mother after delivery. *(See Appendices)*

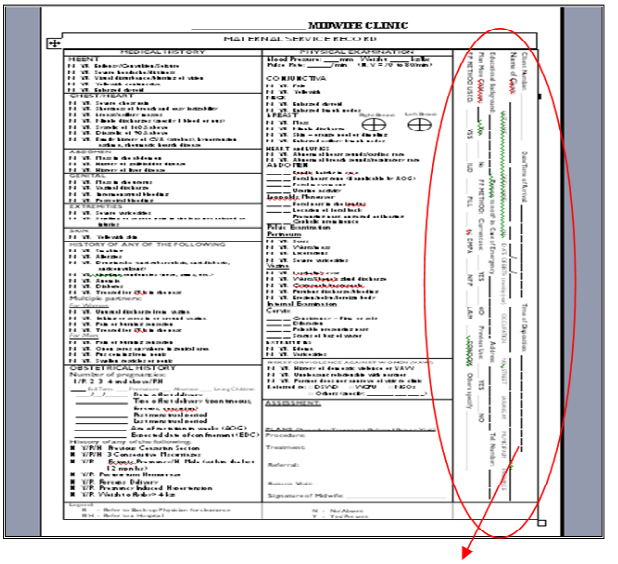
Examples of cases to illustrate use of the forms:

- A pregnant woman's first prenatal visit to the clinic: Maternal Service Record Form 2A is used together with Maternal Delivery Plan Form 2B. On succeeding prenatal visits, Form 2C is used, which will be attached to Form 2A
- A pregnant woman who is in the early stage of labor: Form 2A and Form 2D, and the Partograph (when she is already in active labor)
- A pregnant woman who is in the second stage of labor or who is about to deliver: Forms 2A and 2D.

The following are the procedures for filling out the forms:

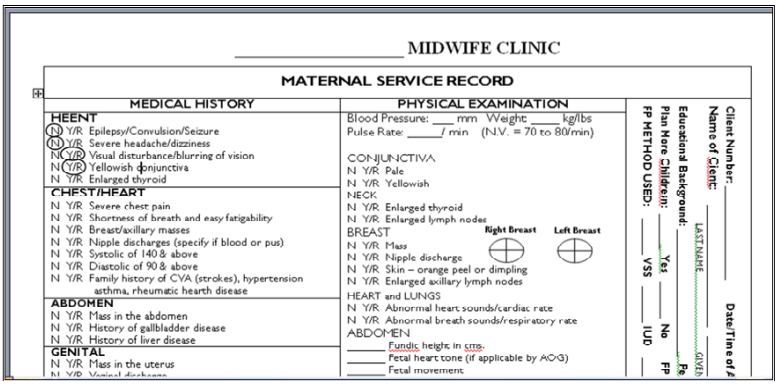
Form 2A: First Pre-natal Visit

1. Fill in the required information on the rightmost side of the form. **It is important to fill in the date and time of arrival of the client and the time of disposition.**



Client Number: 00 0011 Date/Time of Arrival: July 21, 2008 9:00 AM Time of Disposition: 10:30 AM
Name of Client: dela Cruz , Antonia Q. July 20, 2006 Housewife 30 Maysilo Mapayapa Sta. Rosa Laguna
Last Name Given Name MI Date of Birth Occupation No./Street Barangay Municipality Province
Educational Background: High School Gradnate...
Person to notify in case of emergency: Juan dela Cruz Address: 30 Maysilo, Mapayapa, Sta. Rosa, Laguna Tel. Number: None
Plan more children: ____ Yes _√_ No FP METHOD: Current Use: ____ Yes _√_ No Previous Use: _√_ Yes ____ No
FP METHOD USED: ___ VSS ___ IUD _√_ Pills ___Inj. DMPA ___ NFP ___ LAM ___ Condom Others specify _____

2. Proceed to the Medical History portion of the form. Each category is marked with **N** and **Y/R.** Encircle **N** for **NO/ABSENT** if the client/patient has not had this condition or **Y/R** for **YES/ PRESENT** if she has had this condition. The client/patient **should be referred to the back-up physician in any case where a Y/R is encircled.**



MIDWIFE CLINIC

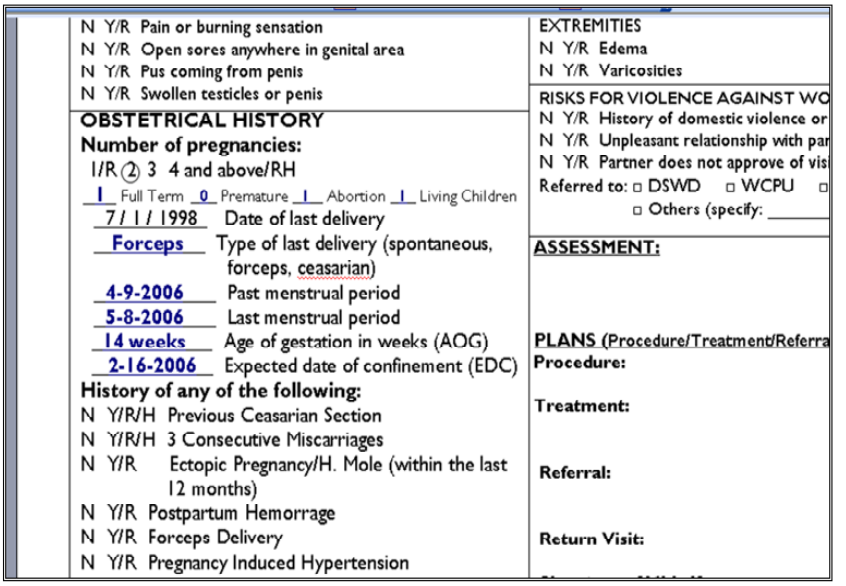
MATERNAL SERVICE RECORD

MEDICAL HISTORY	PHYSICAL EXAMINATION
HEENT (N) Y/R Epilepsy/Convulsion/Seizure (N) Y/R Severe headache/dizziness N (Y/R) Visual disturbance/blurring of vision N (Y/R) Yellowish conjunctiva N Y/R Enlarged thyroid	Blood Pressure: ___ mm Weight: ___ kg/lbs Pulse Rate: _____/ min (N.V. = 70 to 80/min) CONJUNCTIVA N Y/R Pale N Y/R Yellowish NECK N Y/R Enlarged thyroid N Y/R Enlarged lymph nodes
CHEST/HEART N Y/R Severe chest pain N Y/R Shortness of breath and easy fatigability N Y/R Breast/axillary masses N Y/R Nipple discharges (specify if blood or pus) N Y/R Systolic of 140 & above N Y/R Diastolic of 90 & above N Y/R Family history of CVA (strokes), hypertension asthma, rheumatic hearth disease	BREAST Right Breast Left Breast N Y/R Mass N Y/R Nipple discharge N Y/R Skin – orange peel or dimpling N Y/R Enlarged axillary lymph nodes HEART and LUNGS N Y/R Abnormal heart sounds/cardiac rate N Y/R Abnormal breath sounds/respiratory rate
ABDOMEN N Y/R Mass in the abdomen N Y/R History of gallbladder disease N Y/R History of liver disease	ABDOMEN _____ Fundic height in cms. _____ Fetal heart tone (if applicable by AOG) _____ Fetal movement
GENITAL N Y/R Mass in the uterus N Y/R Vaginal discharge	

Client Number: _____ Date/Time of A
Name of Client: _____
LAST NAME GIVEN
Educational Background: _____ Re
Plan More Children: ____ Yes ____ No FP
FP METHOD USED: ____ VSS ____ IUD ____

3. In the example above, the client has not yet experienced epilepsy, convulsion, seizure or severe headache/dizziness but had experienced visual disturbances and yellowish conjunctiva. Hence, she has to be referred to the back-up physician.

4. Proceed to the Obstetrical History and Physical Examination section. Fill in the blanks with the information needed such as the number of living children, number of abortions, past menstrual history, age of gestation, etc.(see section of the form below).



N Y/R Pain or burning sensation
N Y/R Open sores anywhere in genital area
N Y/R Pus coming from penis
N Y/R Swollen testicles or penis

OBSTETRICAL HISTORY
Number of pregnancies:
I/R (2) 3 4 and above/RH
1 Full Term 0 Premature 1 Abortion 1 Living Children
7 / 1 / 1998 Date of last delivery
Forceps Type of last delivery (spontaneous, forceps, ceasarian)
4-9-2006 Past menstrual period
5-8-2006 Last menstrual period
14 weeks Age of gestation in weeks (AOG)
2-16-2006 Expected date of confinement (EDC)

History of any of the following:
N Y/R/H Previous Ceasarian Section
N Y/R/H 3 Consecutive Miscarriages
N Y/R Ectopic Pregnancy/H. Mole (within the last 12 months)
N Y/R Postpartum Hemorrage
N Y/R Forceps Delivery
N Y/R Pregnancy Induced Hypertension

EXTREMITIES
N Y/R Edema
N Y/R Varicosities

RISKS FOR VIOLENCE AGAINST WO
N Y/R History of domestic violence or
N Y/R Unpleasant relationship with par
N Y/R Partner does not approve of vis
Referred to: □ DSWD □ WCPU □
□ Others (specify: _____

ASSESSMENT:

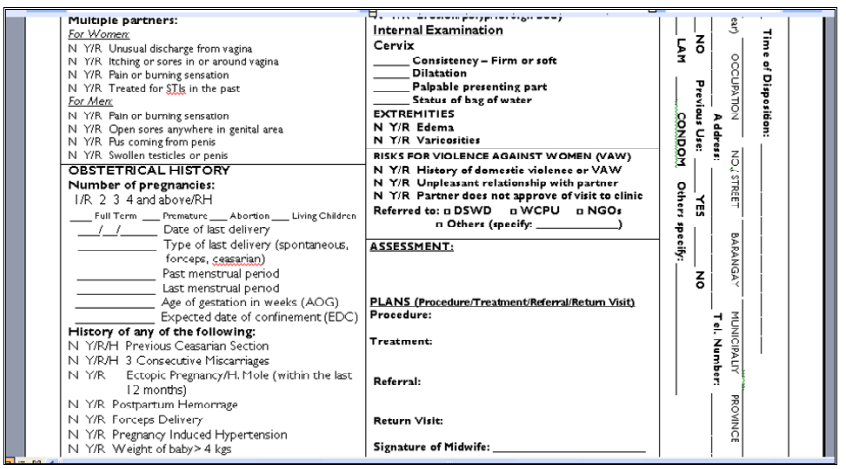
PLANS (Procedure/Treatment/Referra
Procedure:

Treatment:

Referral:

Return Visit:

5. For cervical findings under **Internal Examination**, indicate whether the cervix is firm or soft, the cervical dilatation in centimeters, the presenting part (cephalic or otherwise), and intact or ruptured bag of water (see section of the form below).



Multiple partners:
For Women:
N Y/R Unusual discharge from vagina
N Y/R Itching or sores in or around vagina
N Y/R Pain or burning sensation
N Y/R Treated for STIs in the past
For Men:
N Y/R Pain or burning sensation
N Y/R Open sores anywhere in genital area
N Y/R Pus coming from penis
N Y/R Swollen testicles or penis

OBSTETRICAL HISTORY
Number of pregnancies:
I/R 2 3 4 and above/RH
___ Full Term ___ Premature ___ Abortion ___ Living Children
___/___/_____ Date of last delivery
_____ Type of last delivery (spontaneous, forceps, ceasarian)
_____ Past menstrual period
_____ Last menstrual period
_____ Age of gestation in weeks (AOG)
_____ Expected date of confinement (EDC)

History of any of the following:
N Y/R/H Previous Ceasarian Section
N Y/R/H 3 Consecutive Miscarriages
N Y/R Ectopic Pregnancy/H. Mole (within the last 12 months)
N Y/R Postpartum Hemorrage
N Y/R Forceps Delivery
N Y/R Pregnancy Induced Hypertension
N Y/R Weight of baby> 4 kgs

Internal Examination
Cervix
_____ **Consistency – Firm or soft**
_____ **Dilatation**
_____ **Palpable presenting part**
_____ **Status of bag of water**

EXTREMITIES
N Y/R Edema
N Y/R Varicosities

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)
N Y/R History of domestic violence or VAW
N Y/R Unpleasant relationship with partner
N Y/R Partner does not approve of visit to clinic
Referred to: □ DSWD □ WCPU □ NGOs
□ Others (specify: _____)

ASSESSMENT:

PLANS (Procedure/Treatment/Referral/Return Visit)
Procedure:

Treatment:

Referral:

Return Visit:

Signature of Midwife: _____

Previous Use: ____ YES ____ NO
____ NO
____ LAM
____ CONDOM
Others specify: _____

Address: NO./ STREET ____ BARANGAY ____ MUNICIPALITY ____ PROVINCE
OCCUPATION ____
er) ____

Tel. Number: _____

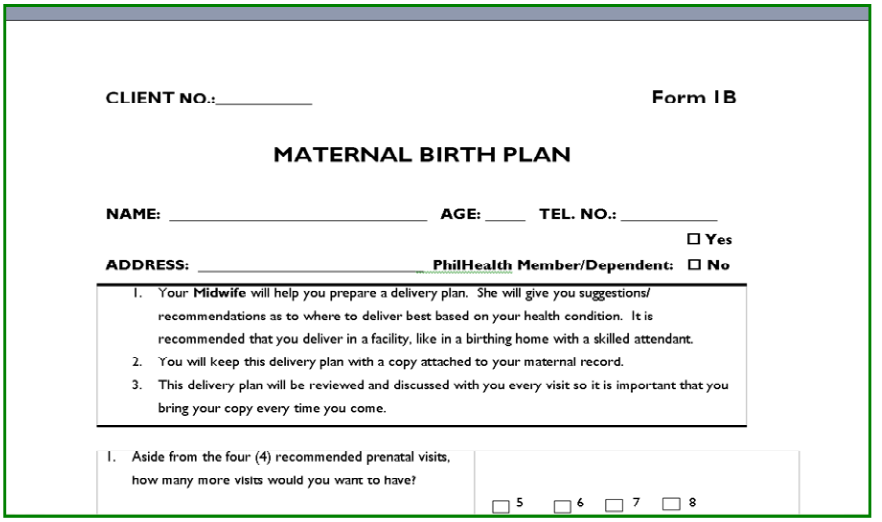
Time of Disposition: _____

6. Write down your diagnosis on the space provided under "Assessment."

7. For **Plans**, write down all the laboratory procedures requested under **Procedures,** the type and dosage of drugs or medicines the patient will have to take under **Treatment,** and the name of the health provider or the facility where the patient will be referred to. Indicate the date for return visit. Lastly, sign as the attending midwife.

Form 2B: Maternal Birth Plan

1. Fill in the required information in the upper portion of the form.



CLIENT NO.:_____ Form 1B

MATERNAL BIRTH PLAN

NAME: _____ AGE: ____ TEL. NO.: _____

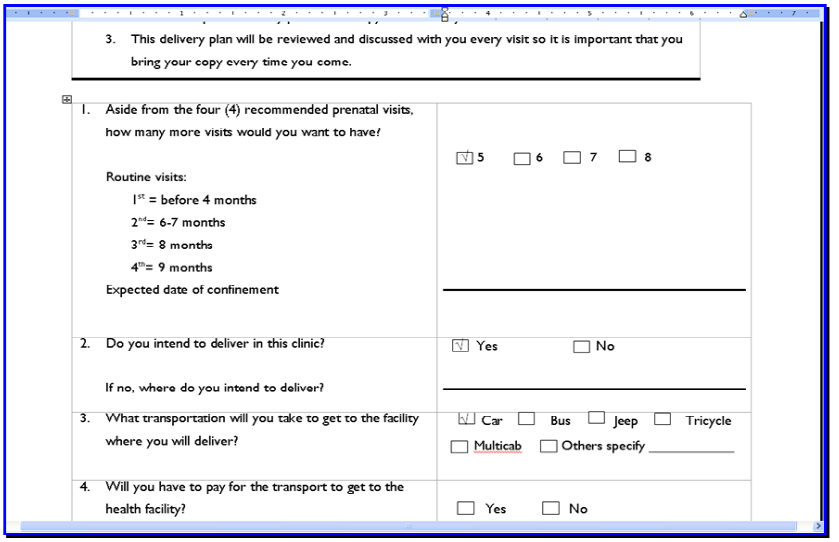
☐ Yes

ADDRESS: _____ PhilHealth Member/Dependent: ☐ No

1. Your **Midwife** will help you prepare a delivery plan. She will give you suggestions/ recommendations as to where to deliver best based on your health condition. It is recommended that you deliver in a facility, like in a birthing home with a skilled attendant.
2. You will keep this delivery plan with a copy attached to your maternal record.
3. This delivery plan will be reviewed and discussed with you every visit so it is important that you bring your copy every time you come.

1. Aside from the four (4) recommended prenatal visits, how many more visits would you want to have? ☐ 5 ☐ 6 ☐ 7 ☐ 8

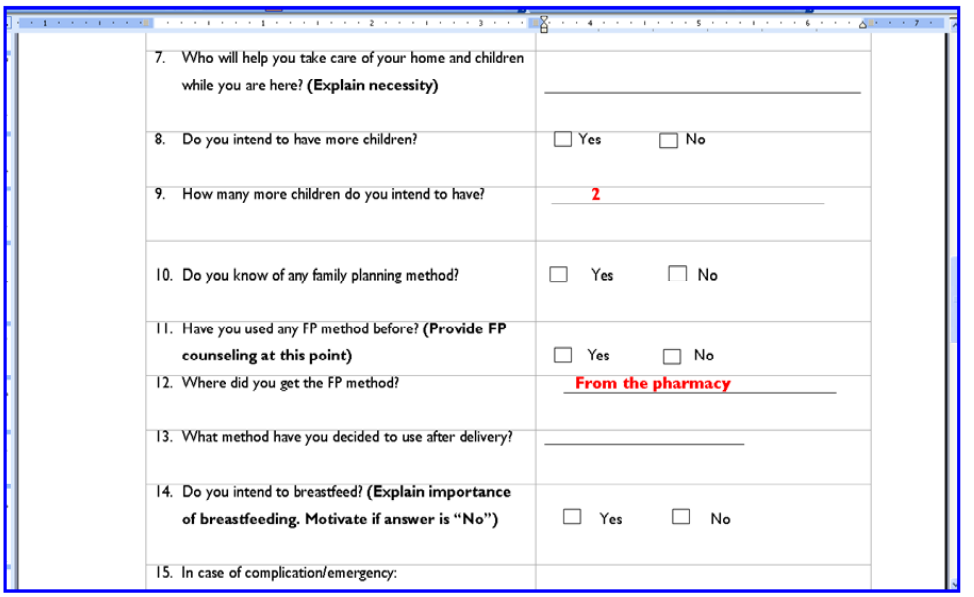
2. Tick the appropriate boxes corresponding to the answers of the pregnant woman.



3. This delivery plan will be reviewed and discussed with you every visit so it is important that you bring your copy every time you come.

1. Aside from the four (4) recommended prenatal visits, how many more visits would you want to have? Routine visits: 1st = before 4 months 2nd= 6-7 months 3rd= 8 months 4th= 9 months Expected date of confinement	☑ 5 ☐ 6 ☐ 7 ☐ 8 _____
2. Do you intend to deliver in this clinic? If no, where do you intend to deliver?	☑ Yes ☐ No _____
3. What transportation will you take to get to the facility where you will deliver?	☑ Car ☐ Bus ☐ Jeep ☐ Tricycle ☐ Multicab ☐ Others specify _____
4. Will you have to pay for the transport to get to the health facility?	☐ Yes ☐ No

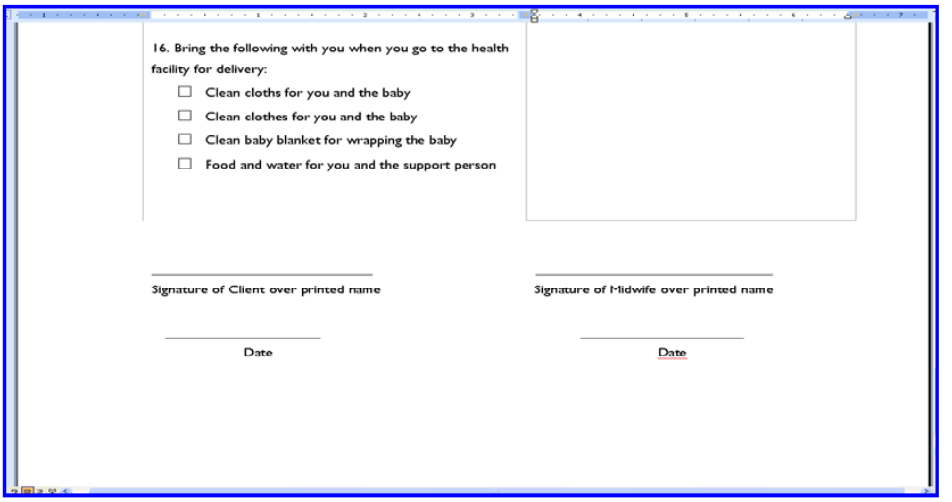
3. For items that require specific information from the client, write her answer/s on the blank opposite each question.



7. Who will help you take care of your home and children while you are here? **(Explain necessity)**	
8. Do you intend to have more children?	☐ Yes ☐ No
9. How many more children do you intend to have?	2
10. Do you know of any family planning method?	☐ Yes ☐ No
11. Have you used any FP method before? **(Provide FP counseling at this point)**	☐ Yes ☐ No
12. Where did you get the FP method?	From the pharmacy
13. What method have you decided to use after delivery?	
14. Do you intend to breastfeed? **(Explain importance of breastfeeding. Motivate if answer is "No")**	☐ Yes ☐ No
15. In case of complication/emergency:	

4. At the bottom of the form, write the name of the pregnant woman on the space provided for and have her sign over her printed name. Also, write the date of consultation on the space below the name of the patient.

5. The attending service provider will likewise sign over his/her printed name and indicate the date when the consultation services were provided.



16. Bring the following with you when you go to the health facility for delivery:

- ☐ Clean cloths for you and the baby
- ☐ Clean clothes for you and the baby
- ☐ Clean baby blanket for wrapping the baby
- ☐ Food and water for you and the support person

Signature of Client over printed name

Date

Signature of Midwife over printed name

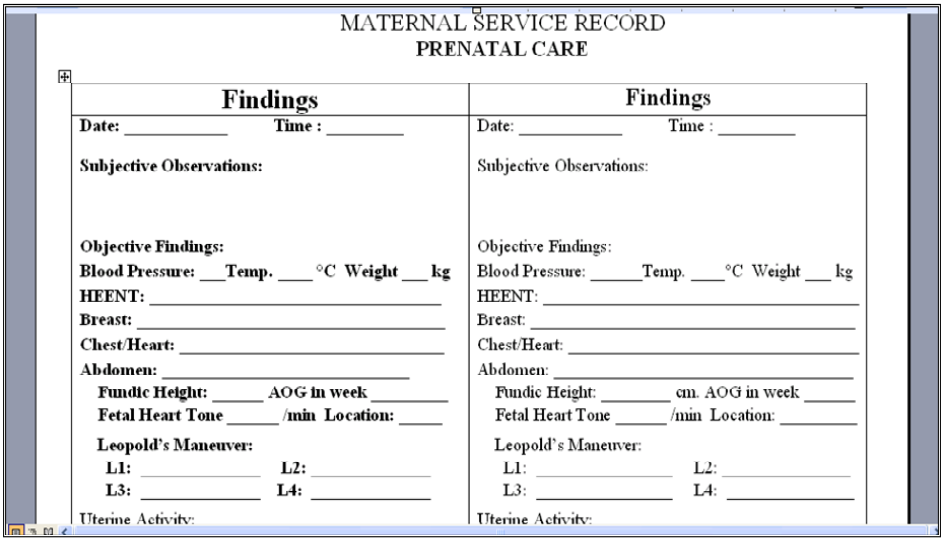
Date

Form 2C: Second and Succeeding Prenatal Visits

1. Fill in the date and the time the client came to the clinic.

2. Write down all the complaints of the client under **Subjective Observations**.

3. Your findings during physical examination are the **Objective Findings**. Write down the results or findings of your examination such as BP, weight in kilograms, temperature in centigrade, etc. on the appropriate space provided for under this heading.



MATERNAL SERVICE RECORD
PRENATAL CARE

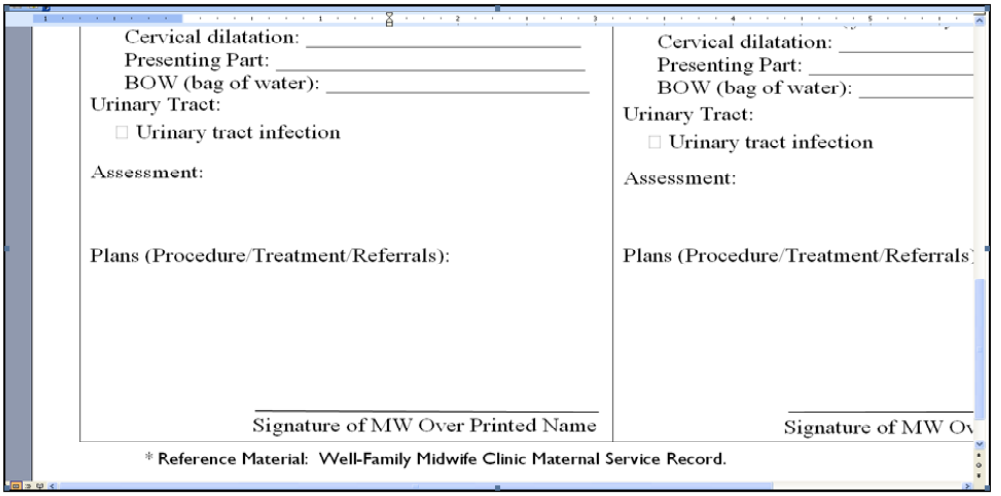
Findings	Findings
Date: _____ **Time :** _____	Date: _____ Time : _____
Subjective Observations:	Subjective Observations:
Objective Findings:	Objective Findings:
Blood Pressure: ___**Temp.** ____°C **Weight** ___ **kg**	Blood Pressure: _____Temp. ____°C Weight ___ kg
HEENT: _____	HEENT: _____
Breast: _____	Breast: _____
Chest/Heart: _____	Chest/Heart: _____
Abdomen: _____	Abdomen: _____
Fundic Height: _____ **AOG in week** _____	Fundic Height: _____ cm. AOG in week _____
Fetal Heart Tone _____ **/min Location:** _____	Fetal Heart Tone _____ /min Location: _____
Leopold's Maneuver:	Leopold's Maneuver:
L1: _____ **L2:** _____	L1: _____ L2: _____
L3: _____ **L4:** _____	L3: _____ L4: _____
Uterine Activity:	Uterine Activity:

4. For Uterine Activity, record any uterine contractions noted upon examination (see section of the form below).

5. Under Pelvic Examination, put a (✓) on the box when the condition is present and an (X) if otherwise. **Do an internal examination only when it is needed**. Determine the cervical dilatation, the presenting part, and whether the bag of water is intact or ruptured.

6. As in **Form 2A**, write down your diagnosis under **Assessment**. Indicate all procedures undertaken, treatment provided and referrals made in the remaining appropriate spaces.

7. As the service provider, sign over your printed name.



Cervical dilatation: _____
Presenting Part: _____
BOW (bag of water): _____
Urinary Tract:
☐ Urinary tract infection
Assessment:
Plans (Procedure/Treatment/Referrals):
_____
Signature of MW Over Printed Name

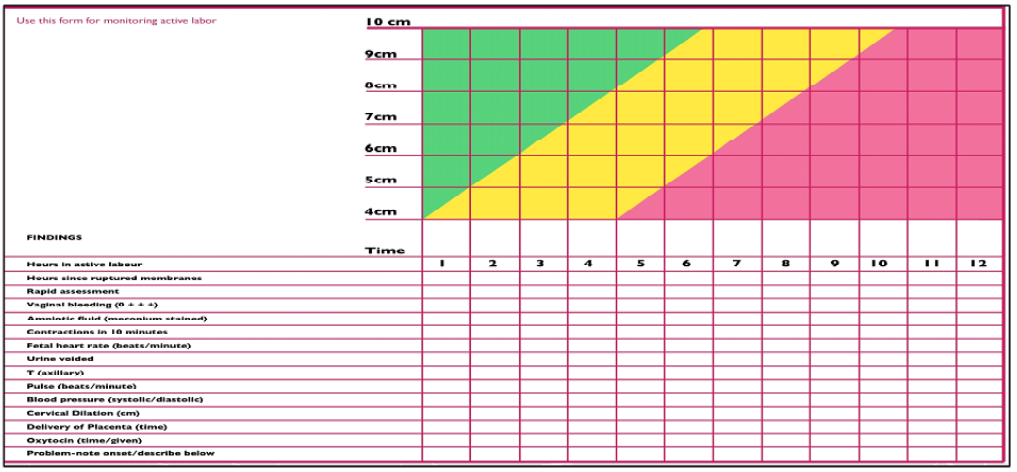
Cervical dilatation: _____
Presenting Part: _____
BOW (bag of water): _____
Urinary Tract:
☐ Urinary tract infection
Assessment:
Plans (Procedure/Treatment/Referrals)
_____
Signature of MW Ov

* Reference Material: Well-Family Midwife Clinic Maternal Service Record.

Form 2D: The Partograph

PARTOGRAPH **Form 2D**

Name: _____ **Date of admission:** _____
Age: _____ **G** ____ **P** ____ **Time of admission:** _____
Time elapsed since rupture of membranes: _____



Use this form for monitoring active labor

10 cm
9cm
8cm
7cm
6cm
5cm
4cm

FINDINGS / Time	1	2	3	4	5	6	7	8	9	10	11	12
Hours in active labour												
Hours since ruptured membranes												
Rapid assessment												
Vaginal bleeding (0 + + +)												
Amniotic fluid (meconium stained)												
Contractions in 10 minutes												
Fetal heart rate (beats/minute)												
Urine voided												
T (axillary)												
Pulse (beats/minute)												
Blood pressure (systolic/diastolic)												
Cervical Dilation (cm)												
Delivery of Placenta (time)												
Oxytocin (time/given)												
Problem-note onset/describe below												

Time baby delivered: _____ **Delivery of Placenta:**
Baby ventilated or resuscitated: ☐Yes ☐No **Complete:** ____ **Incomplete:** ____
Sex of the baby: ____ **Weight of baby:** _____

1. The use of a partograph must be started only when the woman is in active labor (i.e., cervical dilation is at least 4 cm with at least 1 contraction in 10 minutes which lasts for 20 seconds or longer).

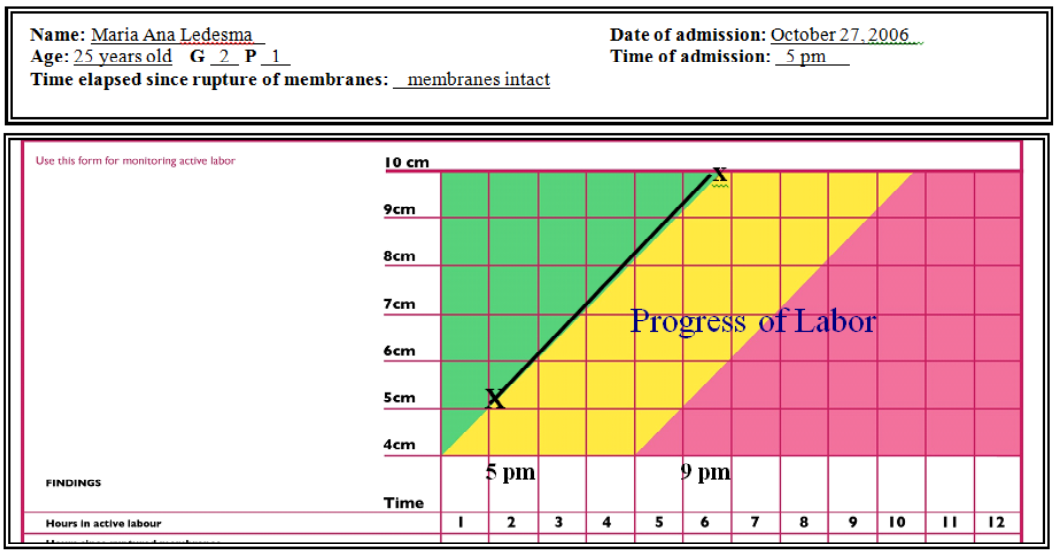
2. Fill in the name, age, gravida (number of pregnancies), para (number of deliveries), the date and time of admission, and time elapsed since rupture of membranes (if rupture occurred before charting on the partograph began).

3. Plot the **cervical dilatations** using the symbol **X** on the alert line (boundary of the green and yellow parts of the partograph) on admission and every four hours thereafter, or as necessary.

4. The symbol "**X"** should be placed in the ***intersection*** of the vertical (cervical dilatation) line and the horizontal (time) line.

5. Write the time the internal examination was done **on the line** itself where you plot the "X," **not in the space after it** (see example below).

6. Connect all the "**X**" to demonstrate the pattern of labor.



7. The lower portion of the partograph is where other observations are to be recorded, particularly the findings of the monitoring of maternal and fetal well-being.

8. Record the findings during admission in the box corresponding to the items located on the left side of the form (see example below).

FINDINGS Time												
Hours in active labour	1	2	3	4	5	6	7	8	9	10	11	12
Hours since ruptured membranes												
Rapid assessment												
Vaginal bleeding (0 + + +)												
Amniotic fluid (meconium stained)												
Contractions in 10 minutes												
Fetal heart rate (beats/minute)												
Urine voided												
T (axillary)												
Pulse (beats/minute)												
Blood pressure (systolic/diastolic)												
Cervical Dilation (cm)												
Delivery of Placenta (time)												
Oxytocin (time/given)												
Problem-note onset/describe below												

9. Fill in the information on the delivery of the baby including time of delivery, sex and weight of the baby. It is also important to record whether the baby was ventilated or resuscitated at the time of delivery. Also, record the time the placenta was delivered and whether it was completely delivered or not.

Maternal and fetal well-being

Pulse (beats/minute)												
Blood pressure (systolic/diastolic)												
Cervical Dilation (cm)												
Delivery of Placenta (time)												
Oxytocin (time/given)												
Problem-note onset/describe below												

Time baby delivered: 5 am
Sex of the baby: F **Weight of baby:** 7 lbs
Baby ventilated or resuscitated: □YES □NO

Delivery of Placenta:
Complete: √
Incomplete: _____

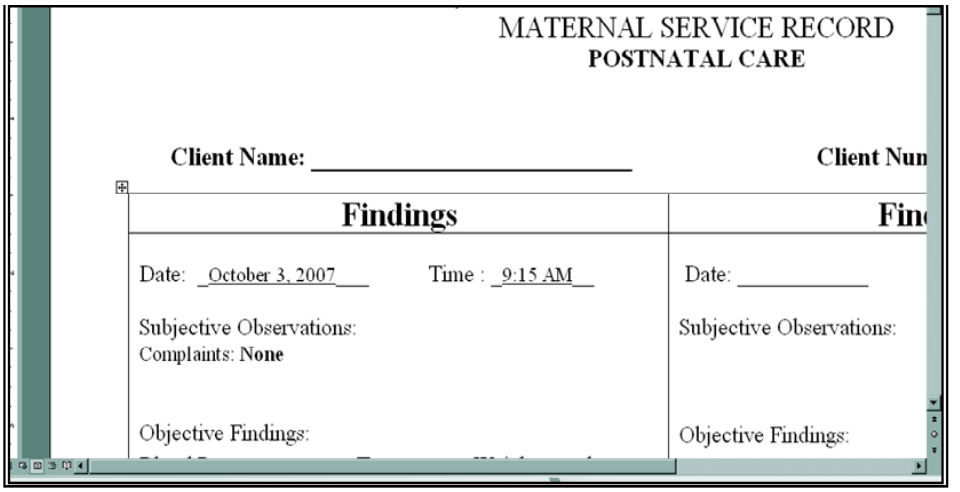
Form 2E: Postnatal Care

The Postnatal Service Record is used when the mother returns to the facility (or is visited by the provider at home) for postnatal care (from time of discharge to six weeks after delivery).

1. Fill in the required information on the rightmost corner of the form.

2. Write the date and time the client came to the clinic/was visited at home.

3. Write down all the pertinent complaints of the client under **Subjective Observation**.

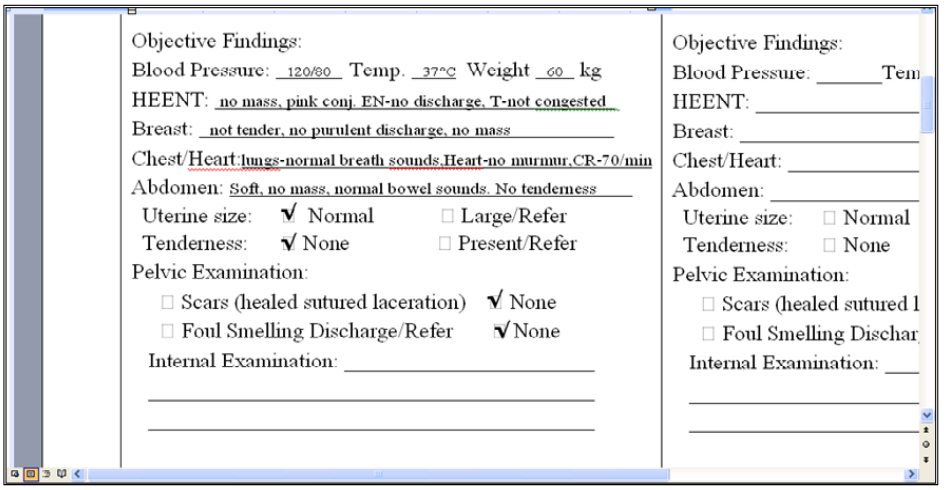

MATERNAL SERVICE RECORD
POSTNATAL CARE

Client Name: _____ Client Nun

Findings	Fin
Date: _October 3, 2007___ Time : _9:15 AM__	Date: _____
Subjective Observations: Complaints: **None**	Subjective Observations:
Objective Findings:	Objective Findings:

4. Under **Objective Findings**, write down all the findings of the physical examination such as blood pressure, weight in kilograms, temperature, etc. Under **abdominal examination**, if the uterus is small, put a check on the space before the word **Normal**. If the uterus is large, put a check on the space before the phrase **Large/Refer** and refer to back up doctor, as appropriate. The same procedure is done for the other items listed on the form.

5. Write the findings on internal examination on corresponding blanks .

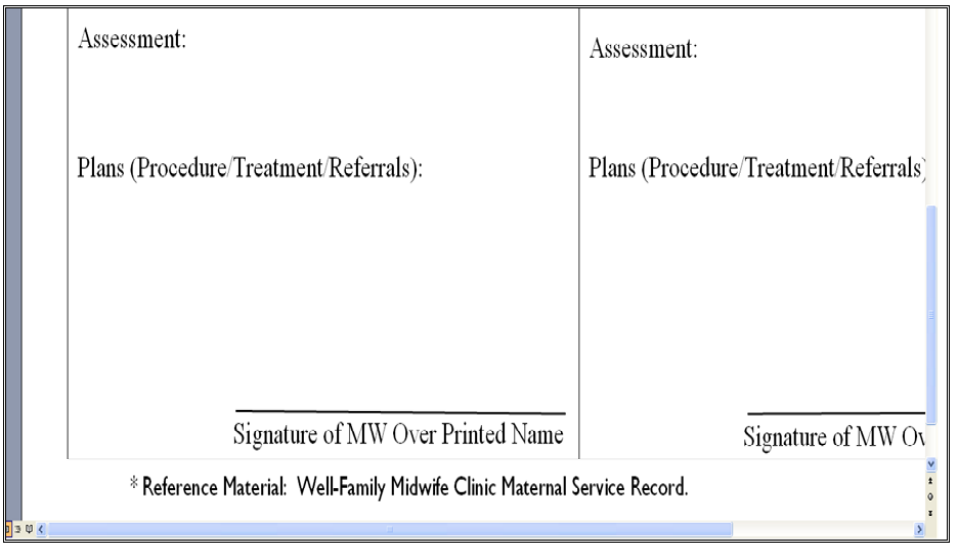

Objective Findings:
Blood Pressure: 120/80 Temp. 37°C Weight 60 kg
HEENT: no mass, pink conj. EN-no discharge, T-not congested
Breast: not tender, no purulent discharge, no mass
Chest/Heart:lungs-normal breath sounds,Heart-no murmur,CR-70/min
Abdomen: Soft, no mass, normal bowel sounds. No tenderness
Uterine size: √ Normal ☐ Large/Refer
Tenderness: √ None ☐ Present/Refer
Pelvic Examination:
☐ Scars (healed sutured laceration) √ None
☐ Foul Smelling Discharge/Refer √ None
Internal Examination: _____

Objective Findings:
Blood Pressure: _____Tem
HEENT: _____
Breast: _____
Chest/Heart: _____
Abdomen: _____
Uterine size: ☐ Normal
Tenderness: ☐ None
Pelvic Examination:
☐ Scars (healed sutured l
☐ Foul Smelling Dischar
Internal Examination: ___

6. Under **Assessment,** write down the diagnosis.

7. Under **Plans (Procedures/Treatment/Referrals)**, write down all the recommendations including the date for the next visit or follow-up.

8. As the service provider, sign over your printed name.



PEDIATRIC SERVICE RECORD (FORM 3)

The Pediatric Service Record Form is used for all pediatric cases seeking services in the clinic. The front page should contain personal data, information on the development of the baby, past medical history including immunizations given or scheduled to be given. The back portion of the form should have the information on the current status or condition of the patient. *(See Appendices)*

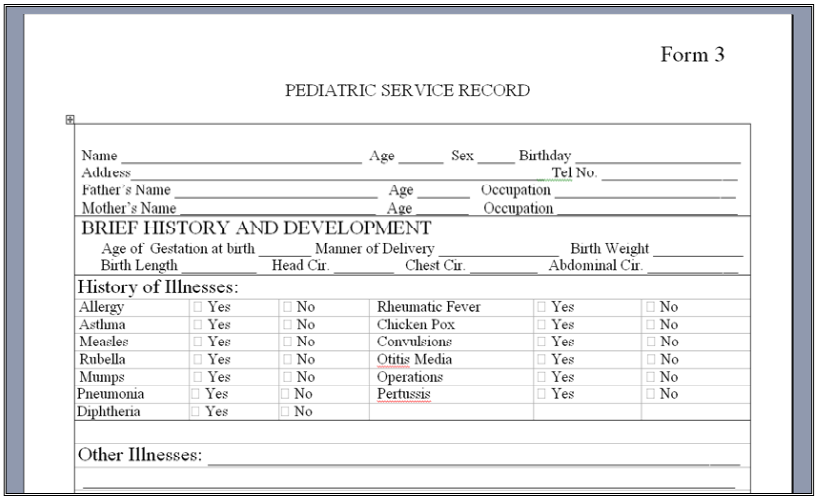
The following are the procedures for filling out Form 3:

1. Fill in the information needed, i.e., name of the child, age, sex, etc.

2. Under **Brief History and Development,** write down the information as follows:
   a. Age of Gestation – age of baby in weeks using the Ballard Score or Neuromuscular and Physical Maturity Rating
   b. Manner of delivery (the type of delivery) - spontaneous, forceps, or Caesarean section, etc.
   c. Birth weight – weight of the baby in kilograms immediately after delivery
   d. Birth length – measurement of the baby from head to foot
   e. Head circumference – measurement of the head
   f. Chest circumference – measurement of the chest
   g. Abdominal circumference – measurement of the abdomen

3. **Illnesses** – put a check on the blank after each condition if the child has had the disease, or an **X** if otherwise.

4. For **Other Illnesses** – write down the diseases the child has had which were not included in the list.



Form 3

PEDIATRIC SERVICE RECORD

Name _____ Age _____ Sex _____ Birthday _____
Address _____ Tel No. _____
Father's Name _____ Age _____ Occupation _____
Mother's Name _____ Age _____ Occupation _____

BRIEF HISTORY AND DEVELOPMENT

Age of Gestation at birth _____ Manner of Delivery _____ Birth Weight _____
Birth Length _____ Head Cir. _____ Chest Cir. _____ Abdominal Cir. _____

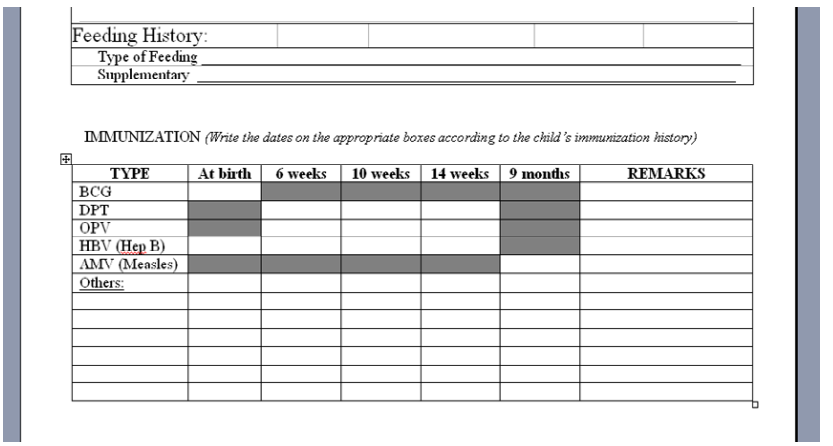
History of Illnesses:

Allergy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No
Measles	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No
Rubella	☐ Yes	☐ No	Otitis Media	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Operations	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Pertussis	☐ Yes	☐ No
Diphtheria	☐ Yes	☐ No			

Other Illnesses: _____

5. **Feeding History** – to record the type of feeding given to the baby.
   - **Type of feeding** – whether the baby was breastfed or bottle-fed (Counsel the mother on breastfeeding the baby.)
   - **Supplementary-** refers to the supplemental food given (Counsel mother on feeding baby only breastmilk for 6 months.)

6. On **Immunization** – indicate the date when immunizations were given. Put the dates under the corresponding column, e.g. if OPV was given at age six weeks, put the date in the second column. Enter any observations you have under the column **REMARKS**.



Feeding History:
Type of Feeding _____
Supplementary _____

IMMUNIZATION *(Write the dates on the appropriate boxes according to the child's immunization history)*

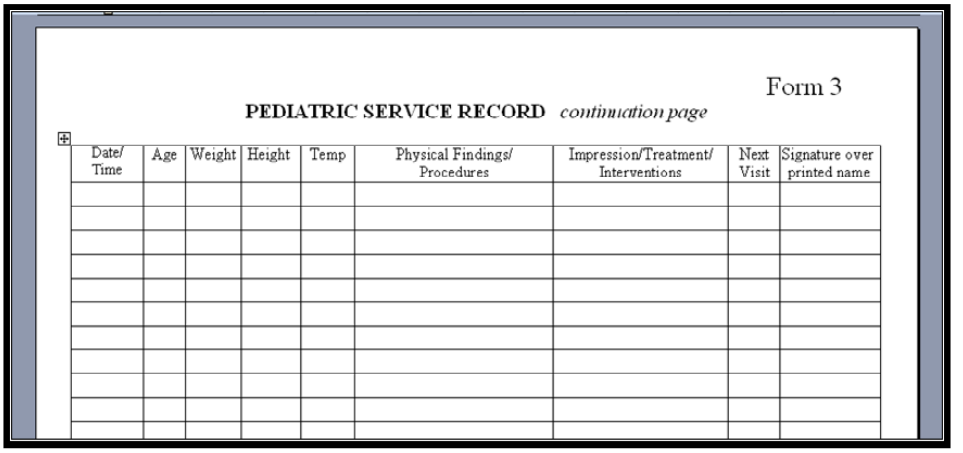
TYPE	At birth	6 weeks	10 weeks	14 weeks	9 months	REMARKS
BCG						
DPT						
OPV						
HBV (Hep B)						
AMV (Measles)						
Others:						

7. For the back portion, fill in the date and the time when the baby was brought to the clinic. Write down the age, weight, height, and temperature in the corresponding columns during each visit. After performing the physical examination, write down the findings and the procedures done in the column **Physical Findings/Procedures**.

8. Write down the diagnosis and the drugs or medicines given (including the correct dosage and strength) under **Impression/Treatment/Interventions**. Interventions would include referral/s for other services not provided in the clinic or center or for further evaluation and management.

9. Indicate under **Next Visit** the date when the client is supposed to come back for follow-up.

10. As the service provider, sign over your printed name.



Form 3

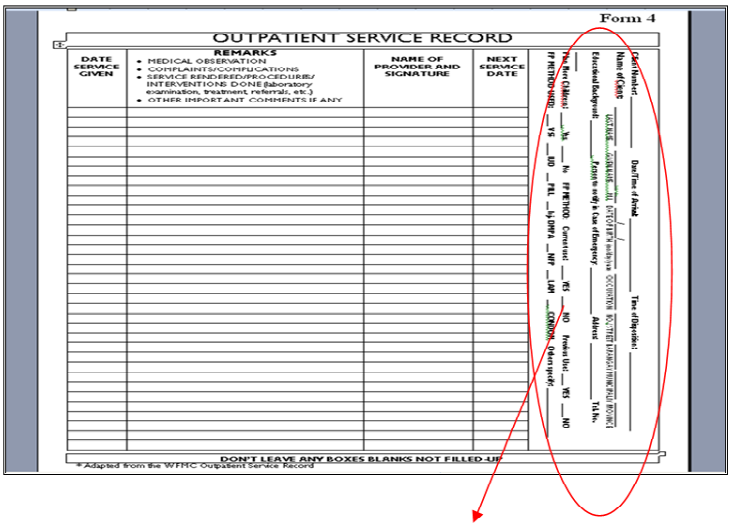
PEDIATRIC SERVICE RECORD *continuation page*

Date/ Time	Age	Weight	Height	Temp	Physical Findings/ Procedures	Impression/Treatment/ Interventions	Next Visit	Signature over printed name

OUTPATIENT SERVICE RECORD (FORM 4)

This form is used for clients needing services other than family planning, maternal or child care. *(See Appendices)*

The following are the procedures for filling out this form.


Form 4

OUTPATIENT SERVICE RECORD

DATE SERVICE GIVEN	REMARKS • MEDICAL OBSERVATION • COMPLAINTS/COMPLICATIONS • SERVICE RENDERED/PROCEDURES/ INTERVENTIONS DONE (laboratory examination, treatment, referrals, etc.) • OTHER IMPORTANT COMMENTS IF ANY	NAME OF PROVIDER AND SIGNATURE	NEXT SERVICE DATE

DON'T LEAVE ANY BOXES BLANKS NOT FILLED-UP

* Adopted from the WFHC Outpatient Service Record

Client Number: 00 00 01 Date/Time of Arrival: March 4, 2008 – 10AM Time of Disposition: 10:30AM

Name of Client: Chua Sheila C 9 / 8 / 1965 Vendor 3 Grant Batasan Quezon City
Last Name Given Name M I Date of Birth (mo/day/year) Occupation No/ Street Barangay/Municipality/Province

Educational Background: High School Person to notify in Case of Emergency: David Chua Address: 3 Grant Batasan QC Tel. No. 9510396

Plan More Children: Yes √ No FP METHOD: Current use: √ YES NO Previous Use: √ YES NO

FP METHOD USED: VSS IUD PILL √ Inj. DMPA NFP LAM CONDOM Others specify:

1. Supply the required information in the rightmost section of the form.
2. The second column labeled **Remarks** is where the complaints, the observations and findings on physical examination are to be entered. These will include laboratory examinations requested as well as the results, and the type and dosage of drugs or medicines needed. Note any necessary referral to a back-up physician or hospital for services not available in your facility.

3. The third is where you affix your signature after providing the services.

4. On the last column labeled **Next Service Date** is where you indicate the date of the next visit of the client.

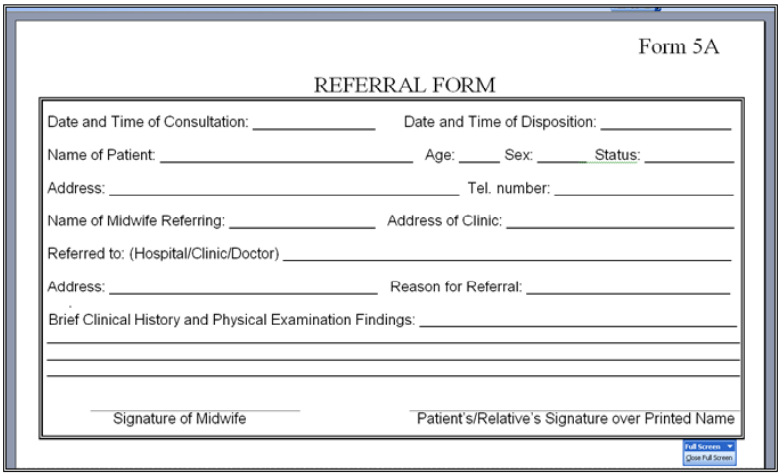
REFERRAL FORMS (FORM 5A AND 5B)

The referral form is used for referrals to a back-up doctor, hospital, or to another clinic in the following situations: *(See Appendices)*

a. Emergency cases
b. When complications arise in cases being handled in the clinic
c. When services requested are not available in the clinic

The form has two parts:

- The upper portion (Form 5A), which you (as referring unit) should fill in. This is retained at the referral facility/provider.



Form 5A

REFERRAL FORM

Date and Time of Consultation: _____ Date and Time of Disposition: _____

Name of Patient: _____ Age: ____ Sex: _____ Status: _____

Address: _____ Tel. number: _____

Name of Midwife Referring: _____ Address of Clinic: _____

Referred to: (Hospital/Clinic/Doctor) _____

Address: _____ Reason for Referral: _____

Brief Clinical History and Physical Examination Findings: _____

_____

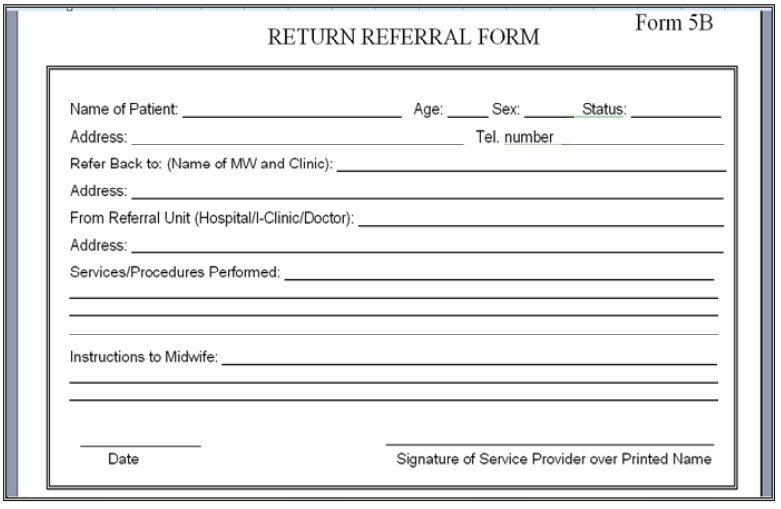
_____

_____

Signature of Midwife

Patient's/Relative's Signature over Printed Name

- The return referral form (Form 5B), which is filled in by the back-up doctor, hospital or clinic (referral unit) and returned to the referring unit (your facility).



RETURN REFERRAL FORM

Form 5B

Name of Patient: _____ Age: ____ Sex: _____ Status: _____

Address: _____ Tel. number _____

Refer Back to: (Name of MW and Clinic): _____

Address: _____

From Referral Unit (Hospital/I-Clinic/Doctor): _____

Address: _____

Services/Procedures Performed: _____

_____

_____

_____

Instructions to Midwife: _____

_____

_____

Date

Signature of Service Provider over Printed Name

The procedure for filling out this form is as follows:

1. Fill in the date and time the client consulted or came to the clinic.

2. Fill in the date and time of disposition of the client. Disposition describes the nature of completion of the provision of services for that particular client. Examples: "Referred to _____"; "Discharged improved with home medications of _____"; "Absconded"; and "Went Home against Advice," among others.

3. Fill in the information needed: name, age, sex, address of the client, name of referring midwife, address of the clinic, etc.

4. On the blank immediately after **Referred to,** write the name of the hospital, doctor or the clinic where the client is being referred.

5. On the blank after **Reason for referral,** write clearly the reason why the client is being referred.

6. It is very important to write down a short, comprehensive history of the illness and the findings of the physical examination.

7. As the service provider, sign over on the space provided.

8. Ask the client or his/her relative to sign on the space provided at the rightmost side of the form. The signature should be made above his/her printed name.

9. Write down the date and time the client or her relative signed the form.

10. The upper portion of the form must be done in duplicate. A copy must be filed in the clinic together with that particular client's records.

Appendices

Form I

FAMILY PLANNING SERVICE RECORD*

SIDE A

MEDICAL HISTORY

HEENT
- ☐ Epilepsy/Convulsion/Seizure
- ☐ Severe headache/dizziness
- ☐ Visual disturbance/blurring of vision
- ☐ Yellowish conjunctiva
- ☐ Enlarged thyroid

CHEST/HEART
- ☐ Severe chest pain
- ☐ Shortness of breath and easy fatigability
- ☐ Breast/axillary masses
- ☐ Nipple discharges (specify if blood or pus)
- ☐ Systolic of 140 & above
- ☐ Diastolic of 90 & above
- ☐ Family history of CVA (strokes), hypertension asthma, rheumatic hearth disease

ABDOMEN
- ☐ Mass in the abdomen
- ☐ History of gallbladder disease
- ☐ History of liver disease

GENITAL
- ☐ Mass in the uterus
- ☐ Vaginal discharge
- ☐ Intermenstrual bleeding
- ☐ Postcoital bleeding

EXTREMITIES
- ☐ Severe varicosities
- ☐ Swelling or severe pain in the legs not related to injuries

SKIN
- ☐ Yellowish skin

HISTORY OF ANY OF THE FOLLOWING
- ☐ Smoking
- ☐ Allergies
- ☐ Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant)
- ☐ STD
- ☐ Multiple partners
- ☐ Bleeding tendencies (nose, gums, etc.)
- ☐ Anemia
- ☐ Diabetes

OBSTETRICAL HISTORY

Number of pregnancies:
_____ Full Term _____ Premature
_____ Abortions _____ Living Children

Date of last delivery _____
Type of last delivery _____
Past menstrual period _____
Last menstrual period _____
Duration and character of menstrual bleeding _____

HISTORY OF ANY OF THE FOLLOWING
- ☐ Hydatidiform mole (within the last 12 months)
- ☐ Ectopic pregnancy

STI RISKS
- ☐ With history of multiple partners

For Women:
- ☐ Unusual discharge from vagina
- ☐ Itching or sores in or around vagina
- ☐ Pain or burning sensation
- ☐ Treated for STIs in the past

For Men:
- ☐ Pain or burning sensation
- ☐ Open sores anywhere in genital area
- ☐ Pus coming from penis
- ☐ Swollen testicles or penis
- ☐ Treated for STIs in the past

PHYSICAL EXAMINATION

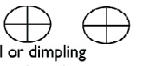
Blood Pressure: _____ mm Hg Weight: _____ kg (or lbs)
Pulse Rate: / min (N.V. = 70 to 80/min)
Height: _____ cm

CONJUNCTIVA
- ☐ Pale
- ☐ Yellowish

NECK
- ☐ Enlarged thyroid
- ☐ Enlarged lymph nodes

BREAST

Right Breast Left Breast



- ☐ Mass
- ☐ Nipple discharge
- ☐ Skin – orange peel or dimpling
- ☐ Enlarged axillary lymph nodes

THORAX
- ☐ Abnormal heart sounds/cardiac rate
- ☐ Abnormal breath sounds/respiratory rate

ABDOMEN
- ☐ Enlarged liver
- ☐ Mass
- ☐ Tenderness

EXTREMITIES
- ☐ Edema
- ☐ Varicosities

PELVIC EXAMINATION

PERINEUM
- ☐ Scars
- ☐ Warts
- ☐ Reddish
- ☐ Laceration

VAGINA
- ☐ Congested
- ☐ Bartholin's cyst
- ☐ Warts
- ☐ Skene's Gland Discharge
- ☐ Rectocoele
- ☐ Cystocoele

CERVIX
- ☐ Congested
- ☐ Erosion
- ☐ Discharge
- ☐ Polyps/cysts
- ☐ Laceration

Consistency
- ☐ Firm
- ☐ Soft

UTERUS

Position
- ☐ Mid
- ☐ Anteflexed
- ☐ Retroflexed

Size
- ☐ Normal
- ☐ Small
- ☐ Large

Mass ☐

Uterine Depth: ___cm. (for intended IUD users)

ADNEXA
- ☐ Mass
- ☐ Tenderness

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)
- ☐ History of domestic violence or VAW
- ☐ Unpleasant relationship with partner
- ☐ Partner does not approve of the visit to FP clinic
- ☐ Partner disagrees to use FP

Referred to: ☐ DSWD ☐ WCPU ☐ NGOs
☐ Others (specify: _____)

ACKNOWLEDGEMENT:

This is to certify that the Physician/Nurse/ Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.

_____ _____
Client Signature over Printed Name Date

CLIENT NO.: ___ **PLAN MORE CHILDREN :** ☐ Yes ☐ No **NO. OF LIVING CHILDREN:** ___ **REASON FOR PRACTICING FP:** _____

NAME OF CLIENT: LAST NAME | GIVEN NAME | M.I. | DATE OF BIRTH (mo/day/year) | HIGHEST EDUC | OCCUPATION | NO. STREET | BARANGAY | MUNICIPALITY | PROVINCE

TYPE OF ACCEPTOR: ☐ New to the Program ☐ Continuing User **PREVIOUSLY USED METHOD:** _____

NAME OF SPOUSE: LAST NAME | GIVEN NAME | M.I. | DATE OF BIRTH (mo/day/year) | HIGHEST EDUC | OCCUPATION **AVERAGE MONTHLY INCOME :** _____

METHOD ACCEPTED: ☐ COC ☐ POP ☐ BTL ☐ VSC ☐ IUD ☐ Injectable ☐ Condom ☐ LAM ☐ SDM ☐ BBT ☐ Billings/Cervical Mucus/Ovulation Method ☐ Symptc-thermal ☐ Calendar/Rhythm

Reminder: For further evaluation, kindly refer to PHYSICIAN for any checked (√) findings prior to provision of any method Aug 2012

SIDE B	**FAMILY PLANNING SERVICE RECORD**

DATE SERVICE GIVEN	**METHOD TO BE USED/SUPPLIES GIVEN**		**REMARKS** • **MEDICAL OBSERVATION** • **COMPLAINTS/COMPLICATIONS** • **SERVICE RENDERED/PROCEDURES/ INTERVENTIONS DONE** (laboratory examination, treatment, FP referrals, FP counseling, contraceptive dispensing, etc.) • **REASONS FOR STOPPING OR CHANGING METHOD/BRAND** • **OTHER IMPORTANT COMMENTS, IF ANY**	**NAME OF PROVIDER AND SIGNATURE**	**NEXT SERVICE DATE**
	METHOD /BRAND	**NO. OF UNITS**			

FILL UP ALL BOXES

August 2012

FORM 2A

MATERNAL SERVICE RECORD *(for first prenatal consultation)*

Client Number: _____ Date/Time of Arrival: _____ Time of Disposition: _____

Name of Client: _____ (LAST NAME) _____ (GIVEN NAME) _____ M.I. _____ DATE OF BIRTH (mo/day/year) _____ OCCUPATION _____ NO./ STREET _____ BARANGAY _____ MUNICIPALITY _____ PROVINCE

Educational Background: _____ Person to notify in Case of Emergency: _____ Address: _____ Tel. Number: _____

Plan More Children? Yes ____ No ____ FP METHOD: Current use: YES ____ NO ____ Previous Use: YES ____ NO ____

FP METHOD USED: VSS ____ IUD ____ PILL ____ Inj. DMPA ____ NFP ____ LAM ____ CONDOM ____ Others specify: _____

MEDICAL HISTORY

HEENT
- N Y/R Epilepsy/Convulsion/Seizure
- N Y/R Severe headache/dizziness
- N Y/R Visual disturbance/blurring of vision
- N Y/R Yellowish conjunctiva
- N Y/R Enlarged thyroid

CHEST/HEART
- N Y/R Severe chest pain
- N Y/R Shortness of breath and easy fatigability
- N Y/R Breast/axillary masses
- N Y/R Nipple discharges (specify if blood or pus)
- N Y/R Systolic of 140 & above
- N Y/R Diastolic of 90 & above
- N Y/R Family history of CVA (strokes), hypertension asthma, rheumatic hearth disease

ABDOMEN
- N Y/R Mass in the abdomen
- N Y/R History of gallbladder disease
- N Y/R History of liver disease

GENITAL / URINARY
- N Y/R Mass in the uterus N Y/R Postcoital bleeding
- N Y/R Vaginal discharge N Y/R UTI
- N Y/R Intermenstrual bleeding

EXTREMITIES
- N Y/R Severe varicosities
- N Y/R Swelling or severe pain in the legs not related to injuries

SKIN
- N Y/R Yellowish skin

HISTORY OF ANY OF THE FOLLOWING
- N Y/R Smoking
- N Y/R Allergies
- N Y/R Alcohol Intake
- N Y/R Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant)
- N Y/R Bleeding tendencies (nose, gums, etc.)
- N Y/R Anemia
- N Y/R Diabetes
- N Y/R Treated for STIs in the past

Multiple partners:

For Women:
- N Y/R Unusual discharge from vagina
- N Y/R Itching or sores in or around vagina
- N Y/R Pain or burning sensation
- N Y/R Treated for STIs in the past

For Men:
- N Y/R Pain or burning sensation
- N Y/R Open sores anywhere in genital area
- N Y/R Pus coming from penis
- N Y/R Swollen testicles or penis

OBSTETRICAL HISTORY

Number of pregnancies:

1/R 2 3 4 and above/RH

____ Full Term ___ Premature ___ Abortion ___ Living Children

__/__/____ Date of last delivery

_____ Type of last delivery (spontaneous, forceps,

_____ Past menstrual period

_____ Last menstrual period

_____ Age of gestation in weeks (AOG)

_____ Expected date of confinement (EDC)

History of any of the following:
- N Y/R/H
- N Y/R/H 3 Consecutive Miscarriages
- N Y/R Stillbirths
- N Y/R Ectopic Pregnancy/H. Mole (within the last 12 months)
- N Y/R Postpartum Hemorrage
- N Y/R Forceps Delivery
- N Y/R Pregnancy Induced Hypertension
- N Y/R Weight of baby> 4 kgs

PHYSICAL EXAMINATION

Blood Pressure: ____ mmHg Pulse Rate: _____ / min
Weight: _____ kg/lbs. Height: ___m/ft Temp. ___°C

CONJUNCTIVA
- N Y/R Pale N Y/R Yellowish

NECK
- N Y/R Enlarged thyroid N Y/R Enlarged lymph nodes

BREAST — Right Breast / Left Breast
- N Y/R Mass
- N Y/R Nipple discharge
- N Y/R Skin – orange peel or dimpling
- N Y/R Enlarged axillary lymph nodes

HEART and LUNGS
- N Y/R Abnormal heart sounds/cardiac rate
- N Y/R Abnormal breath sounds/respiratory rate

ABDOMEN
- _____ Fundic height in cm.
- _____ Feral heart tone (if applicable by AOG)
- _____ Feral movement
- _____ Uterine activity

Leopold's Maneuver
- _____ Fetal part in the fundus
- _____ Location of fetal back
- _____ Presenting part, engaged or floating
- _____ Cephalic prominence

PELVIC EXAMINATION

Perineum
- N Y/R Scars N Y/R Lacerations
- N Y/R Severe varicosities N Y/R Warts/mass

Vagina
- N Y/R Bartholin's cyst
- N Y/R Warts/Skene's gland discharge
- N Y/R Cystocoele/rectocoele
- N Y/R Purulent discharge/bleeding
- N Y/R Erosion/polyp/foreign body

Internal Examination

Cervix
- _____ Consistency – Firm or soft
- _____ Dilatation
- _____ Palpable presenting part
- _____ Status of bag of water

EXTREMITIES
- N Y/R Edema N Y/R Varicosities

RISKS FOR VIOLENCE AGAINST WOMEN (VAW)
- N Y/R History of domestic violence or VAW
- N Y/R Unpleasant relationship with partner
- N Y/R Partner does not approve of visit to clinic

Referred to: □ DSWD □ WCPU □ NGOs
□ Others (specify): _____

Immunization: Tetanus Toxoid
- □ 1st dose (as early as possible) Date given _____
- □ 2nd dose (at least 4 weeks later) Date given _____
- □ 3rd dose (at least 6 months later) Date given _____
- □ 4th dose (at least 1 year late) Date given _____
- □ 5th dose (at least 1 year later) Date given _____

□ ***Child Protected At Birth***

ASSESSMENT:

PLANS (Procedure/Treatment/Referral/Return Visit)

Procedure:

Treatment:

Referral:

Return Visit:

_____
Signature of MW over printed name

Legend: **R - Refer to Back-up Physician for clearance**
R/H - Refer to a Hospital
N - No/Absent
Y - Yes/Present

August 2012

CLIENT NO.:_____ **Form 2B**

MATERNAL BIRTH PLAN

Please accomplish in duplicate during FIRST prenatal consultation.

NAME: _____ **AGE:** _____ **TEL. NO.:** _____

☐ **Yes**

ADDRESS: _____ **PhilHealth Member/Dependent:** ☐ **No**

1. Your **Midwife** will help you prepare a delivery plan. She will give you suggestions/ recommendations as to where to deliver best based on your health condition. It is recommended that you deliver in a facility, like in a birthing home with a skilled attendant.
2. You will keep this delivery plan with a copy attached to your maternal record.
3. This delivery plan will be reviewed and discussed with you every visit so it is important that you bring your copy every time you come.

1. Aside from the four (4) recommended prenatal visits, how many more visits would you want to have? ☐ 5 ☐ 6 ☐ 7 ☐ 8

   Routine visits:

   1st = before 4 months

   2nd= 6-7 months

   3rd= 8 months

   4th= 9 months

   Expected date of confinement _____

2. Do you intend to deliver in this health facility/clinic? ☐ Yes ☐ No

   If no, where do you intend to deliver? _____

3. What transportation will you take to get to the facility where you will deliver? ☐ Car ☐ Bus ☐ Jeep ☐ Tricycle ☐ Multicab ☐ Others specify _____

4. Will you have to pay for the transport to get to the health facility? ☐ Yes ☐ No

5. The cost of the delivery services including newborn screening (and newborn hearing screening) in this health facility/clinic is:

   Maternity Services Php _____

   Newborn Care Services Php _____

   • Newborn Screening Php _____

   • Newborn Hearing Screeening Php _____

   Cost to be covered by Philhealth

   Maternity Care Package Php _____

   Newborn Care Package Php _____

6. Who will go with you and support you during labor and delivery? **(Explain necessity)** _____

7. Who will help you take care of your home and children while you are here? **(Explain necessity)** _____

8. Do you intend to have more children? ☐ Yes ☐ No

9. How many more children do you intend to have? _____

10. Do you know of any family planning method? ☐ Yes ☐ No

11. Have you used any FP method before? **(Provide FP counseling at this point)** ☐ Yes ☐ No

12. Where did you get the FP method?

13. What method have you decided to use after delivery?

14. Do you intend to breastfeed? **(Explain importance of breastfeeding. Motivate if answer is "No")** ☐ Yes ☐ No

15. In case of complication/emergency:
    a. Who is the doctor to be called? (If none, MW to suggest clinic back-up doctor)
    b. Which hospital would you want to be referred to?
    c. What transport will be used?
    d. Is a blood donor available? ☐ Yes ☐ No
    e. My possible donors are:

Name	Address	Tel. no.

Inform client of **danger signs** which need immediate medical attention:

- ➔ Vaginal bleeding
- ➔ Puffiness of the face and hands
- ➔ Severe headache with blurred vision
- ➔ Fever and feeling weak
- ➔ Signs of labor before the 9th month of pregnancy (e.g., watery vaginal discharge, abdominal pain/contractions of the uterus)

16. Bring the following with you when you go to the health facility for delivery:

- ☐ Clean cloths for you and the baby
- ☐ Clean clothes for you and the baby
- ☐ Clean baby blanket for wrapping the baby
- ☐ Food and water for you and the support person

Signature of Client over printed name
Date: _____

Signature of Midwife over printed name
Date: _____

Form 2C

MATERNAL SERVICE RECORD
PRENATAL CARE *(for 2nd, 3rd, 4th, etc. prenatal visits)*

Client Name: _____ **Client Number:** _____

Findings	Findings
Date: _____ Time : _____	Date: _____ Time : _____
Subjective Observations:	**Subjective Observations:**
Objective Findings:	**Objective Findings:**
Blood Pressure: _____Temp. ____ °C Weight ___ kg.	Blood Pressure: _____Temp. ____°C Weight ___ kg.
HEENT: _____	HEENT: _____
Breast: _____	Breast: _____
Chest/Heart: _____	Chest/Heart: _____
Abdomen: _____	Abdomen: _____
Fundic Height: _____cm. AOG in week _____	Fundic Height: _____ cm. AOG in week _____
Fetal Heart Tone _____ /min. Location: _____	Fetal Heart Tone _____ /min. Location: _____
Leopold's Maneuver:	Leopold's Maneuver:
L1: _____ L2: _____	L1: _____ L2: _____
L3: _____ L4: _____	L3: _____ L4: _____
Uterine Activity: _____	Uterine Activity: _____
Pelvic Examination:	Pelvic Examination:
Perineum: ☐ Varicosities ☐ Warts/Eczema	Perineum: ☐ Varicosities ☐ Warts/Eczema
Speculum Examination: (if necessary)	Speculum Examination: (if necessary)
☐ Purulent Discharge ☐ Watery Discharge	☐ Purulent Discharge ☐ Watery Discharge
☐ Bleeding ☐ Others, specify _____	☐ Bleeding ☐ Others, specify _____
Internal Examination: (*if necessary only*)	Internal Examination: (*if necessary only*)
Cervical dilatation: _____	Cervical dilatation: _____
Presenting Part: _____	Presenting Part: _____
BOW (bag of water): _____	BOW (bag of water): _____
Urinary Tract:	Urinary Tract:
☐ Urinary tract infection	☐ Urinary tract infection
Assessment:	Assessment:
Plans (Procedure/Treatment/Referrals):	Plans (Procedure/Treatment/Referrals):
_____ Signature of MW Over Printed Name	_____ Signature of MW Over Printed Name

* Reference Material: Well-Family Midwife Clinic Maternal Service Record.

August 2012

Form 2D

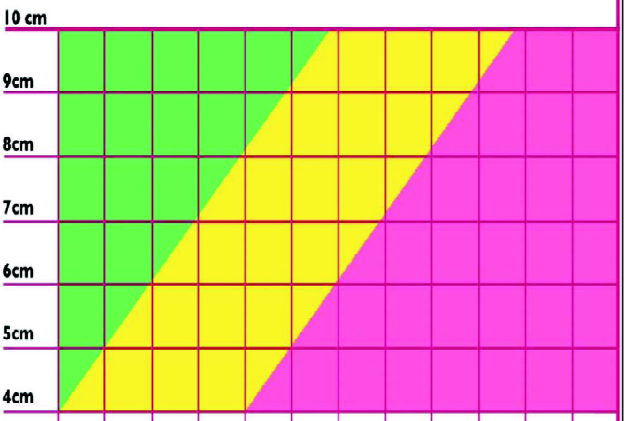
PARTOGRAPH

Client Number: _____

Name: _____ Date of admission: _____
Age: _____ G ____ P ____ Time of admission: _____
Time elapsed since rupture of membranes: _____

PARTOGRAPH

Use this form for monitoring active labor



FINDINGS / Time	1	2	3	4	5	6	7	8	9	10	11	12
Hours in active labour												
Hours since ruptured membranes												
Rapid assessment												
Vaginal bleeding (0 + + +)												
Amniotic fluid (meconium stained)												
Contractions in 10 minutes												
Fetal heart rate (beats/minute)												
Urine voided												
T (axillary)												
Pulse (beats/minute)												
Blood pressure (systolic/diastolic)												
Cervical Dilation (cm)												
Delivery of Placenta (time)												
Oxytocin (time/given)												
Problem-note onset/describe below												

Time baby delivered: _____
Sex of the baby: ____ Weight of baby: _____
Apgar Score: _____

Delivery of Placenta:
Complete: _____
Incomplete: _____

August 2012

Form 3

PEDIATRIC SERVICE RECORD

Name _____ Age _____ Sex _____ Birthday _____
Address _____ Tel. No. _____
Father's Name _____ Age _____ Occupation _____
Mother's Name _____ Age _____ Occupation _____

BRIEF HISTORY AND DEVELOPMENT

Age of Gestation at birth _____ Manner of Delivery _____ Birth Weight _____
Birth Length _____ Head Cir. _____ Chest Cir. _____ Abdominal Cir. _____

History of Illnesses:

Allergy	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No
Measles	☐ Yes	☐ No	Convulsions	☐ Yes	☐ No
Rubella	☐ Yes	☐ No	Otitis Media	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Operations	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Pertussis	☐ Yes	☐ No
Diphtheria	☐ Yes	☐ No			

Other Illnesses: _____

_____

_____

Feeding History:

Type of Feeding _____
Supplementary _____

IMMUNIZATION *(Check the appropriate boxes according to the child's immunization history.)*

TYPE	At birth	6 weeks	10 weeks	14 weeks	9 months	REMARKS
BCG						
DPT						
OPV						
HBV (Hep B)						
AMV (Measles)						
Others:						

Form 3

PEDIATRIC SERVICE RECORD *continuation page*

Date/ Time	Age	Weight	Height	Temp	Physical Findings/ Procedures	Impression/Treatment/ Interventions	Next Visit	Signature over printed name

Form 4

Use this form for clients consulting for conditions not related to Family Planning or pregnancy such as for BP check-up, Pap smear, others.

OUTPATIENT SERVICE RECORD

Client Number: ______ **Date/Time of Arrival:** ______ **Time of Disposition:** ______

Name of Client: ______ ______ ______ ___/___/___ ______ ______

LAST NAME GIVEN NAME M.I. DATE OF BIRTH (mo/day/year) OCCUPATION NO./ STREET BARANGAY MUNICIPALIY PROVINCE

Educational Background: ______ **Person to notify in Case of Emergency:** ______ **Address:** ______ **Tel. No.** ______

Plan More Children: ___ **Yes** ___ **No** **FP METHOD: Current use:** ___ **YES** ___ **NO** **Previous Use:** ___ **YES** ___ **NO**

FP METHOD USED: ___ **VSS** ___ **IUD** ___ **PILL** ___ **Inj. DMPA** ___ **NFP** ___ **LAM** ___ **CONDOM** **Others specify:** ______

DATE SERVICE GIVEN	REMARKS • MEDICAL OBSERVATION • COMPLAINTS/COMPLICATIONS • SERVICE RENDERED/PROCEDURES/ INTERVENTIONS DONE (laboratory examination, treatment, referrals, etc.) • OTHER IMPORTANT COMMENTS, IF ANY	NAME OF PROVIDER AND SIGNATURE	NEXT SERVICE DATE

FILL UP ALL BOXES AND BLANKS

* Adapted from the WFMC Outpatient Service Record

Form 4

OUTPATIENT SERVICE RECORD *(continuation page)*

DATE SERVICE GIVEN	**REMARKS** • MEDICAL OBSERVATION • COMPLAINTS/COMPLICATIONS • SERVICE RENDERED/PROCEDURES/ INTERVENTIONS DONE (laboratory examination, treatment, referrals, etc.) • OTHER IMPORTANT COMMENTS, IF ANY	NAME OF PROVIDER AND SIGNATURE	NEXT SERVICE DATE

FILL UP ALL BOXES AND BLANKS

* Adapted from the WFMC Outpatient Service Record

Form 5A

August 2012

REFERRAL FORM

Date and Time of Consultation: Date and Time of Disposition:

Name of Patient: _____ Age: ____ Sex: _____ Status: _____

Address: _____ Tel. number: _____

Name of Midwife Referring: _____ Address of Clinic: _____

Referred to: (Hospital/Clinic/Doctor)

Address: _____ Reason for Referral: _____

Brief Clinical History and Physical Examination Findings: _____

_____

_____

Signature of Midwife Patient's/Relative's Signature over Printed Name

Form 5B

RETURN REFERRAL FORM

Name of Patient: Age: Sex: Status:

Address: _____ Tel. number _____

Refer Back to: (Name of MW and Clinic): _____

Address: _____

From Referral Unit (Hospital/Clinic/Doctor). _____

Address:

Services/Procedures Performed: .....

_____

_____

_____

Instructions to Midwife: _____

_____

_____

_____ _____

Date Signature of Service Provider over Printed Name

August 2012

Quality Assurance Package for Midwives

TOOLKIT FOR PRACTICING PROFESSIONAL MIDWIVES

SECTION 3

Monitoring Tool for Practicing Midwives

Part 1: Midwife Portion

Part 2: Supervisor Portion

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CONTENTS

Part 1
Midwife Portion

About this Monitoring Tool

Promoting and sustaining quality care is a priority of every health worker providing health services to individuals, families, and communities. At the individual or family level, improved quality of care ensures that clients receive respectful treatment by technically competent providers. At the community level, greater satisfaction with services should translate into better continuity of care and maximized preventive services.

This tool is designed for use by midwives who are either in public or private practice. It serves to both raise awareness of quality standards in midwifery practice, as well as a guide to monitor and evaluate the quality of services provided by midwives. Regular use of this tool by midwives and their supervisors leads to improved competence and skills. With this tool, gaps in providing quality service are continually identified and addressed by the midwives themselves, with technical assistance from supervisors.

This portion of the monitoring tool, which is actually a quality measurement or assessment tool, has two parts:

1. The **self-assessment part**, which allows the midwife to objectively assess herself against a checklist of quality standards. It shows the midwife's own perspective of the level of quality of FP-MCH services she provides in her facility.

2. The **action plan**, which provides an opportunity for the midwife to plan and record her own recommendations, using her own resources to address the gaps she identified, and using the tool as reference in providing quality services in her clinic. Self-empowerment results in quality care for the patient.

A third part, the supervisor's monitoring component, comprises the next portion of this toolkit. It is for the use of the midwives' supervisors. *It is only mentioned here to inform the practicing midwives about the role and expectations of the supervisors.* The supervisor portion determines the progress of the midwife in improving the quality of health services being provided. Using such tool, the supervisor is able to assist the midwife address deficiencies that may not be addressed using her own resources, especially if her supervisor can mobilize outside resources to improve the quality of FP-MCH services in her birthing home.

How to Use the Tool

The Monitoring Tool for Practicing Midwives: Midwife Portion is intended for the use of private or public practicing midwives. It aims to help them assess the level of quality of maternal and child health services (including family planning) they provide in their birthing homes.

A midwife profile or information sheet is included in this toolkit. Midwives will fill this out first and then submit to the supervisor during the latter's visit. This information sheet has two purposes: 1) to enhance the database of midwives and 2) to serve as baseline information where results of technical assistance and interventions can be measured against.

This quality improvement tool has two parts: the self-assessment portion and the action plan. A separate manual for supervisors is likewise included in this Quality Assurance Package.

The self-assessment portion has six components, each with several indicators. It is accomplished by the midwife to identify existing practices that facilitate the provision of quality health services, as well as factors that hinder these. She then formulates an action plan to address the barriers to quality services (those with scores of 0 or 1 to the questions corresponding to each component and each indicator).

The accomplished midwife profile is then provided to the supervisor during his/her visit. The supervisor will fill out his/her own monitoring tool. He or she will observe, review records and interview the midwife, her assistants or even the clients not only to determine his/her own assessment but also in order to validate the midwife's self-assessment results. Role-play may be employed if the supervisor would have no midwife-client interaction to observe during the visit.

After accomplishing the form, the supervisor reviews the action plan with the midwife. When necessary, both can come up with agreed-upon action plan revisions. The supervisor then completes the scoring sheet. *(Note: the Supervisor Portion of this toolkit has more detailed instructions intended for supervisors.)* Results of the supervisor's monitoring will be shared with the midwife during an exit feedback session.

Midwife Profile

PERSONAL INFORMATION

NAME *(Pangalan)*:				
	Surname *(Apelyido)*	Given Name *(Pangalan)*	Middle Name *(G. Apelyido)*	Nickname *(Palayaw)*

HOME ADDRESS *(Tirahan)*:				
	No. & Street	Barangay	Town/ City	Province	Zip Code

CONTACT NUMBERS *(Telepono at email)*	( )-	( )-		**DATE OF BIRTH**			**AGE** *(Edad)*
	Home phone	Cellphone	Email Address		Mo	Day	Yr

GENDER/ SEX *(Kasarian)*: (✓)	**CIVIL STATUS:** (✓)	**MIDWIFERY EDUCATION**	**MIDWIFE ASSOCIATION MEMBERSHIP/S:** (✓)		**PRC LICENSE**
☐ Female *(Babae)* ☐ Male *(Lalaki)*	☐ Single *(Walang asawa)* ☐ Married *(May asawa)* ☐ Widow/Widower *(Balo)* ☐ Other _____	SCHOOL NAME: SCHOOL ADDRESS: YEAR GRADUATED:	☐ IMAP ☐ MFPI ☐ PLGPMI	☐ None ☐ Other _____	Number Date of Expiry: Mo Day Yr

CLINIC INFORMATION

CURRENT PRACTICE TYPE: *Please check (✓) all types applicable to your practice.*	☐ *PRIVATE: SELF-EMPLOYED* *If you are self-employed, please answer succeeding details on this column.*	☐ *PRIVATE: EMPLOYEE* *If you are a private employee, please answer succeeding details on this column.*	☐ *GOVERNMENT EMPLOYEE* *If you are a government employee, please answer succeeding details on this column.*
NAME OF YOUR CLINIC/ FACILITY WHERE YOU CURRENTLY WORK:			
CLINIC ADDRESS:	No. & Street _____ Barangay _____ Town/ City _____ Province _____	No. & Street _____ Barangay _____ Town/ City _____ Province _____	No. & Street _____ Barangay _____ Town/ City _____ Province _____
CLINIC PHONE:	( )-	( )-	( )-
CURRENT CLINIC TYPE: *Please check (✓) all types applicable to your clinic/facility*	☐ Home-based/Home-visiting ☐ Outpatient Clinic ☐ Birthing home ☐ Other_____	☐ Hospital ☐ Birthing home ☐ Company Clinic ☐ NGO Clinic ☐ Other_____	☐ Hospital ☐ Rural/ Main Health Unit ☐ Barangay Health Station ☐ Other_____

PRACTICE AND PHILHEALTH ACCREDITATION

PHILHEALTH ACCREDITATION OF THIS FACILITY/CLINIC: *Please check (✓)*	☐ PhilHealth-accredited ☐ Not PhilHealth-accredited ☐ Application on-going ☐ Application denied ☐ Have not applied yet. Check all reasons that apply: ☐ Incomplete infrastructure ☐ Lacking equipment and instruments ☐ Lacking supplies ☐ Lacking transport ☐ Does not have partner obstetrician ☐ Does not have partner pediatrician	☐ PhilHealth-accredited ☐ Not PhilHealth-accredited, application ongoing ☐ Not PhilHealth-accredited, application denied ☐ Not PhilHealth-accredited, have not applied for accreditation, *because* _____	☐ PhilHealth-accredited ☐ Not PhilHealth-accredited, application on-going ☐ Not PhilHealth-accredited, application denied ☐ Not PhilHealth-accredited, have not applied for accreditation, *because* _____
NUMBER OF YEARS IN THIS POSITION:	☐ Owner _____ ☐ Manager _____ ☐ Staff midwife _____ ☐ Other _____	Position _____ Number of years _____	Position _____ Number of years _____
YOUR WORK HOURS IN CLINIC/FACILITY: *Please check (✓)*	☐ Full-time ☐ Part-time_____ ☐ Other _____	☐ Full-time ☐ Part-time _____ ☐ Other_____	☐ Full-time ☐ Part-time _____ ☐ Other_____
YOUR NO. OF YEARS IN THIS PRACTICE TYPE:	___ Years in solo private practice	___ Years as private employee	___ Years as government employee

TRAINING

TRAINING	
1. Have you been trained on Life-Saving Skills (LSS)?	☐ Yes ☐ No Why?
2. Have you been trained on Basic Emergency Obstetrics and Newborn Care (BEmONC)?	☐ Yes ☐ No Why?
3. Have you completed the postgraduate training course on expanded functions (suturing, internal examination, and intravenous insertion)?	☐ Yes ☐ No Why?
4. Have you attended a one-day orientation workshop on essential intrapartum and newborn care (EINC)?	☐ Yes ☐ No Why?

5. If yes in any of the above, please indicate relevant information about the training course(s) you attended:

Training Course	Training Date		Venue	Conducted By	Sponsor Agency
	Month	Year			
1.					
2.					
3.					
4.					
Other training courses: _____ _____					
_____ _____					

Self-Assessment Tool

Instructions:

1. Read each question carefully and record your answer in the appropriate column.
2. Record your answer following the instructions below.
   a. If your answer to the question is:
      - **Yes,** put a check (✓) under **Y** in the answer column.
      - **Yes, but needs improvement,** put a check (✓) under **NI** in the answer column.
      - **No,** put a check (✓) under **NO** in the answer column.
   b. If the question is not applicable to your clinic, put a check (✓) under **NA**.
3. After answering the questions under each component, record the items that were done well (those rated as Y), items that need improvement (those rated as NI and NO) in the comment boxes at the end of each component checklist.
4. After answering all questions, formulate an action plan with your recommendations on how to address the items that have been identified as needing improvement (the items rated NI and NO). The instructions on how to fill out the action plan are found on page 35. A sample action plan and an unfilled action plan template are part of the appendices.

Component I: Facility

This refers to the facility's capacity to provide a safe environment for health care. It also examines equipment, supplies, and medicines in the facility, and the condition of the clinic's infrastructure.

COMPONENT I: FACILITY	ASSESSMENT			
	Y	NI	NO	NA
Indicator A. Condition/Amenities				
Does the clinic have:				
1. A sign that bears the name of the facility?				
2. A big sign inside and outside the facility that lists the services offered?				
3. Sufficient seats for patients in a well-ventilated waiting area?				
4. A separate private area with a desk, two chairs, examining table for counseling, physical examinations, and procedures that cannot be observed or overheard by others?				
5. A locked cabinet for storage of medicines?				
6. A sheet in the examining table to cover client?				

COMPONENT I: FACILITY	ASSESSMENT			
	Y	NI	NO	NA
7. A container with 0.5% chlorine solution marked for				
decontamination of instruments immediately after use on a				
client/patient?				
8. Hand washing area with running water and soap?				
9. Separate receptacle for disposing pointed or sharp objects?				
10. Covered garbage containers with color-coded segregation?				
11. The required basic consultation and delivery room equipment?				
· Alligator forceps 10"				
· Ambu bag (adult)				
· Ambu bag (newborn) with appropriate face mask for term and preterm infants				
· Boiler/sterilizer Bassinet/newborn carrier				
· BP apparatus (non-mercurial)				
· Delivery table				
· Electric stove				
· Foot stool				
· Gooseneck lamp (2)				
· Haemostatic straight forceps				
· Instrument cabinet				
· Instrument table				
· IV stand				
· Jar with stainless cover				
· Jar without cover				
· Kelly pad				
· Needle holder				
· Ovum forceps				
· Oxygen gauge regulator				
· Oxygen tank (5 lbs minimum)				
· Pail				
· Pickup forceps				

COMPONENT I: FACILITY	ASSESSMENT			
	Y	NI	NO	NA
· Portable emergency light or flashlight				
· Rubber suction bulb syringe				
· Sponge holding forceps				
· Stainless bowl (kidney shaped)				
· Stainless bowl (round shaped)				
· Stainless iodine cup				
· Stainless instrument tray with cover				
· Stethoscope				
· Stool				
· Straight forceps 10"				
· Suction apparatus				
· Surgical scissors (straight)				
· Tenaculum forceps				
· Tissue forceps 6"				
· Uterine forceps 10"				
· Uterine sound 12"				
· Vaginal speculum (all sizes)				
· Wall clock with second hand				
· Weighing scale (adult)				
· Weighing scale (infant)				
12. The required standard supplies?				
· 70% isopropyl alcohol				
· Bed sheets				
· Butterfly set (G19)				
· D_5LR – 1 liter				
· Disposable syringes and needles				
· DR gown/scrub suit				
· IV tubing				
· Linen for bassinet/newborn carrier				
· Nasal cannula				

COMPONENT I: FACILITY	ASSESSMENT			
	Y	NI	NO	NA
· Plastern Plastic apron				
· Povidone iodine (Betadine)				
· Soaking/sterilizing solution (Cidex)				
· Sterile absorbable sutures with needle				
· Sterile cord clips/ties for baby				
· Sterile cotton balls				
· Sterile cotton pledgets				
· Sterile cutting needles				
· Sterile drapes				
· Sterile gauze				
· Sterile gloves				
· Sterile round needle				
· Surgical cap				
· Surgical mask				
· Tape measure				
· Thermometer (oral, non-mercurial)				
· Thermometer (anal, non-mercurial)				
· Xylocaine/Lidocaine				
· Oxytocin10IU ampule				
· Tetanus toxoid vaccines				
· Erythromycin ophthalmic ointment (0.5%)				
· Vitamin K ampule				
· Progestin-only pills				
· Dexamethasone 4mg ampule				
· D-Medroxyprogesterone acetate (DMPA) vials				
· Intrauterine device (Copper T 380A)				
Indicator B: Facility/Infrastructure				
Does the clinic have:				
1. A generally clean environment?				
2. Adequate potable water?				

COMPONENT I: FACILITY	ASSESSMENT			
	Y	NI	NO	NA
3. Covered container for water storage?				
4. Electricity and a reliable alternative source of light?				
5. A delivery room with required equipment and supplies?				
6. An area for cleaning/resuscitating the newborn?				
7. Fire safety provision (either fire exit or fire extinguisher)?				
8. A patients' room with bed(s) and linens?				
9. A toilet for client and staff?				
10. A lavatory for washing hands for staff and clients?				
11. Windows, electric fans, or air conditioner to ensure ventilation?				
12. A work area where instruments are cleaned?				
13. Hold-over/pre-transfer/pre-discharge area where mother and newborn stay together				
14. Counseling room with visual and auditory privacy				
15. Waste disposal system				
16. Placenta pit				
17. Emergency transport and communication system				
Indicator C: Educational Materials for Clients				
1. Does the clinic maintain a supply of educational materials on Family Planning, Maternal and Newborn Child Health and Nutrition, and Newborn Screening?				
2. Is the "All-FP Methods" poster displayed where clients can read it?				
3. Is a wall chart indicating available reproductive health services on display?				
Indicator D. Professional Appearance of Provider				
1. Do you wear clean and neat appropriate clothing and /or uniform or blazer with identification during working hours?				

Comments about the facility (Component I)

a.) Record what you have done well in this section. Use the questions where you answered **Y**.
b.) Record where you can improve. Use the questions where you answered **NI** or **NO**.

	Remarks/Recommendations
What you do well:	
1.	
2.	
3.	
Areas where you can improve:	
1.	
2.	
3.	

Component II – Technical Competence

Examines provider's performance and determines if it meets acceptable standards. These include performance in counseling, infection prevention (IP), prenatal care, care during labor and delivery, immediate newborn care, postpartum care, family planning and immunization.

COMPONENT II: TECHNICAL COMPETENCE	**ASSESSMENT**			
	Y	**NI**	**NO**	**NA**
Indicator A: Attitude, Behavior of Midwife				
As a midwife, are you:				
1. Punctual?				
2. Cordial in greeting clients?				
3. Competent in articulating information?				
4. Client-friendly?				
5. Caring and gender-sensitive?				
6. Culture-sensitive?				
7. With strong stress-tolerance?				
8. Complying with rules and regulations?				
9. Able to evaluate facts and courses of action?				
10. Decisive in solving problems?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
Indicator B: Standards of Care				
1. Do you have a copy of the most recent midwifery service delivery guidelines?				
2. Do you use the guidelines during your work?				
3. Do you have a summarized job aide to remind you of the core steps of focused ante- and postnatal care?				
Indicator C. Basic Counseling Guidelines				
1. Do you provide your client with information to make health-related decisions?				
2. Are clients informed of the services available in your facility?				
3. Do you use every opportunity of a client's visit for maternal and child health services to discuss additional issues like family planning?				
4. Are clients informed of their right to privacy and confidentiality?				
5. Do you take measures to ensure that counseling sessions and physical examinations are not interrupted?				
6. Do you explain the presence of or ask the client's permission if a third party is present during a counseling session, a physical examination or a procedure?				
Indicator D. Infection Prevention				
1. Do you wash your hands with soap and water before and after attending to each client?				
2. Do you clean the facility regularly?				
3. Do you soak soiled instruments in 0.5% chlorine solution immediately after use?				
4. Do you boil for 20 minutes instruments for high-level disinfection?				
5. Do you follow the "three steps" processing of instruments?				
6. Do you maintain single-use injection practice?				
7. Do you dispose of needles in a sharps container?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
8. Are placentas, other tissues, and blood products disposed of properly?				
9. Are medical wastes disposed of according to DOH standards?				
10. Do you wear protective garments in performing clinical procedures (plastic apron, eye goggles, and mask)?				
Indicator E: Prenatal Care				
Do you do the following during the initial prenatal visit?				
1. Determine the age of gestation based on the last menstrual period?				
2. Discuss with the woman the need to have at least four prenatal visits during pregnancy?				
3. Take the woman's complete history which includes:				
a. Personal history?				
b. Medical history (past and family)?				
c. Present pregnancy?				
d. Social history (e.g., daily habits, lifestyle, relationships)?				
e. Obstetrical history, including menstrual history?				
f. FP history/plans?				
4. Provide information about any health problems you discover and discuss about referral, if appropriate?				
5. Explain to the client the need to deliver in a facility like the birthing home?				
6. Discuss with the client the need to develop a birth plan that includes complication readiness such as early detection of warning signs, emergency transportation, designated decision-maker, and blood donor if necessary?				
7. Assist the client make a "Birth Plan?"				
8. Describe the "danger signs" for which she will need immediate consultation and referral such as:				
· Swelling of the legs, hands, and/or face				
· Severe headache				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
· Dizziness				
· Blurring of vision				
· Convulsions				
· Vaginal bleeding				
· Vaginal discharge				
· Watery vaginal discharge				
· Fever and chills				
· Vomiting				
· Fast or difficult breathing				
· Severe abdominal pain				
· Painful urination				
· Absence or reduced fetal movements				
9. Determine tetanus toxoid status and provide the vaccine as appropriate?				
10. Dispense or provide iron, folic acid tablets, and Vitamin A in appropriate doses?				
11. Determine the client's risk for STI?				
12. If at risk of STI, discuss with client how to avoid exposure to STI and HIV by being faithful and asking her partner to wear a condom?				
13. If at risk of STI, discuss with the client how to ask her partner to wear a condom?				
Do you do the following during each succeeding prenatal visit?				
1. Inform the client of her age of gestation?				
2. Explain about the importance of personal hygiene, e.g., bathing during pregnancy, washing breast daily with soft cloth, wearing support bra, cleaning external genitalia daily, wiping from front to back?				
3. Provide nutritional advice, e.g., eat a variety of nutritious foods, take folic acid and iron supplement, drink plenty of liquids, no alcohol, and gain an adequate amount of weight (12-16 kilos) in the entire period of pregnancy?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
4. Discuss with the woman and her partner the need for family planning and about their options for spacing or limiting birth?				
5. Discuss the importance of breastfeeding within one hour after birth and the minor discomfort the client may experience while doing so?				
6. Explain the importance of newborn screening?				
7. Explain the importance of newborn hearing screening?				
8. Describe the signs and symptoms of labor (i.e., bloody, sticky vaginal discharge, painful contractions every 20 mins. with decreasing intervals and increasing intensity, water from the vagina), and what to do when these occur?				
9. Discuss how to safely dispose of the placenta if she decides to bring it home?				
10. Discuss with the expectant mother the essential intrapartum care practices that will be done to her during labor and delivery?				
11. Discuss with the expectant mother the essential newborn care practices that will be done to her on delivery?				
Indicator F: Obstetrical (Physical) Exam				
Do you do the following during the initial prenatal check-up?				
1. Take and record vital signs?				
2. Take and record the weight?				
3. Inspect and palpate the breast?				
4. Perform abdominal examination and check for post-Caesarean scar?				
5. Determine the size of the uterus and assess compatibility of uterine size to age of gestation?				
6. Request for laboratory examinations like:				
· CBC, blood typing				
· Urinalysis				
· VDRL or RPR				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
In succeeding prenatal visits, do you do the following?				
1. Record and note changes in: Blood pressure? Weight? Uterine size/fundal height?				
2. Listen to fetal heart tones when the woman is on 18 week-gestation or more, or if the uterus is palpable near the umbilicus?				
3. Check the presenting part after 32 to 34 weeks by doing Leopold's maneuver? Refer to backup obstetrician if, by the 36th week, the presenting part is not the head?				
4. Check for warning/danger signs such as:				
• Vaginal bleeding?				
• Severe headache, visual changes or epigastric pain?				
• Swelling of the face or hands?				
• Leaking amniotic fluid?				
• Severe nausea or vomiting?				
• Fever (T≥38°C)				
• Severe abdominal pain?				
• Absence of fetal movement?				
5. Refer client to higher level of care (i.e., obstetrician or hospital) if any of the warning signs occurs?				
Indicator G: Labor and Delivery				
During labor, do you:				
1. Do a quick check at different times to ensure that the woman is normal?				
• Appears calm and relaxed between contractions				
• Has an oral temperature of 36-37°C				
• Has a pulse rate of 80-100 beats/min.				
• Has BP of 100/60 mmHg or above but less than 140/90				
2. Use partograph to chart the progress of labor?				
3. Encourage client to have a support person of her choice present with her?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
4. Encourage patient to continue taking liquids and eating light foods as she desires?				
5. Urgently refer the client to your backup obstetrician or hospital at any time the following danger signs are observed?				
• Vaginal bleeding of more than 100 ml since the start of labor				
(about 3 moderately soaked sanitary napkin)				
• High blood pressure ($\geq$ 140/90 mmHg)				
• Temperature > 38°C				
• Low blood pressure with a systolic BP< 90mmHg				
• Severe pallor				
• Epigastric or abdominal pain				
• Severe headache				
• Blurred vision				
• Convulsions or unconscious				
• Breathing difficulty				
• Fetal heart rate <100 beats/min. or >180 beats/min				
• Partograph plotting goes to the right of the "alert line"				
During delivery, do you:				
1. Ensure a safe and clean delivery by having:				
• Clean hands?				
• Clean and warm delivery area?				
• A clean surface for delivery?				
• Clean gloves?				
• All delivery equipment and supplies (e.g., gloves) including				
newborn resuscitation equipment available?				
• High-level disinfected (HLD) instruments to cut cord?				
2. Encourage the woman to assume the birthing position of her choice that is safe for her and the baby?				
3. Ensure controlled delivery of the fetal head by instructing the woman not to bear down?				
4. Support the perineum to avoid perineal laceration?				
5. Take note and record time of delivery?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
6. Assess the baby's breathing and ventilate or resuscitate, as needed?				
7. Take steps to clear the airway and stimulate the infant if he/she does not cry or breathe spontaneously?				
8. Place the baby in skin-to-skin contact on the mother's abdomen				
and wrap the baby in dry cloth/blanket to keep it warm?				
9. Palpate the abdomen to rule out another baby (multiple pregnancy)?				
10. Clamp and cut cord when pulsation stops?				
11. Inject 10 IU of oxytocin intramuscularly one minute AFTER delivery of the baby?				
12. Apply controlled cord traction with abdominal hand support to the uterus during contractions?				
13. Check the placenta for completeness?				
14. Massage the uterus through the abdomen immediately after delivery of the placenta?				
15. Refer to an obstetrician if the placenta is incomplete.				
16. Thoroughly dry the baby and keep it warm?				
17. Latch baby to mother's breast?				
18. Encourage the woman to breastfeed within one hour after delivery and assist her if she has difficulties?				
19. Administer eye prophylaxis (i.e., Erythromycin ophthalmic ointment) and Vitamin K to infant after the first full breastfeed has taken place?				
20. Provide the mother with Vitamin A 200,000IU as a single dose by mouth?				
21. Record details of birth, including:				
• Date and time of delivery and sex of the baby?				
• Baby's length and birth weight?				
• Condition of the perineum and if any suturing was done?				
• Estimated blood loss?				
• Any changes from normal and referral?				
22. Do you perform a complete examination of the baby within the first two hours of life and inform the mother of results?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
23. Refer newborn for further care if necessary based on examination of the baby?				
24. Do you continue to assess uterine tone, amount of vaginal bleeding, and mother's vital signs for at least two hours postpartum or until stable?				
25. Encourage the patient to continue taking liquids and eating light foods as she desires?				
Indicator H: Postpartum Care				
Before discharge from your health facility or within the first week postpartum, do you:				
1. Check maternal and neonatal vital signs?				
2. Perform newborn screening?				
3. Conduct physical exam of mother and baby and record any abnormal changes?				
4. Record findings and inform the mother of her condition and that of her baby?				
5. Teach how to care for the umbilicus?				
6. Assess mother's knowledge of and ability to breastfeed?				
7. Discuss the following with the mother:				
• Personal hygiene?				
• Nutrition and infant feeding?				
• Care of the baby?				
• Care of the perineum and breast?				
• Family support?				
• Family planning and how to avoid unwanted pregnancy?				
• Benefit of exclusive breastfeeding for six months?				
• Infant immunization?				
• Preventing infant diarrhea and dehydration				
8. Give the mother a schedule of immunizations for her baby and where to get these?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
9. Teach the mother about the following signs of potentially serious problems with the infant and instruct her to contact you for referral if the infant:				
• Does not feed well?				
• Has watery stools accompanied by blood?				
• Vomits or spits out a lot?				
• Has stiffness or convulsions?				
• Has yellow skin and eyes?				
• Has redness or foul discharge from the umbilicus or discharge from eyes?				
10. Teach the mother about postpartum danger signs and instruct her to contact you for referral if she has the following:				
• Excessive vaginal bleeding (one sanitary napkin fully soak per hour) anytime after delivery or bleeding for more than 2 weeks?				
• Vaginal discharge with a foul or fishy odor?				
• Severe abdominal pain?				
• Worsening perineal pain from repaired laceration?				
• Temperature $\geq$ 38°C?				
• Redness, warmth, or pain in the breast?				
• Pain on urination, difficulty in voiding, or defecating, or incontinence of urine or stool?				
11. Accomplish birth registration form and register?				
Indicator I: Family Planning: Information-Giving and Counseling				
For every encounter with clients do you:				
1. Use every opportunity to discuss family planning?				
2. Provide information on FP to the following types of clients				
• Adolescents and young adults, both female and male?				
• Women of all ages, regardless of their marital or reproductive status?				
• Men of all ages, regardless of their marital or reproductive status?				
• Clients with disability?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
3. Maintain eye contact with the client?				
4. Use appropriate tone of voice?				
5. Exhibit appropriate body language?				
6. Listen attentively to client's message?				
7. Use simple language?				
8. Use IEC materials effectively?				
9. Let the client make her own decision?				
10. Inform clients that the ideal gap between pregnancies is 3 years?				
11. Make clients realize that she can get pregnant in four weeks after delivery if she is not exclusively breastfeeding or is not using a family planning method?				
12. Discuss how the reproductive system works?				
13. Competently talk to clients about the following FP methods?·				
• Lactational Amenorrhea Method				
• Standard Days Method (SDM)				
• Other fertility awareness-based methods (BBT, Billings				
ovulation method, Symptothermal method)				
• Progestin-only pills				
• Progestin-only Injectable (DMPA)				
• Combined oral contraceptives				
• Contraceptive patch				
• Combined injectables				
• Intrauterine device				
• Condoms				
• BTL				
• Vasectomy				
14. Counsel clients on family planning by: Establishing rapport (i.e., greeting, introducing yourself)?				
· Making them comfortable (i.e., offering them a seat or being cheerful and friendly)?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
• Assuring confidentiality and providing privacy?				
• Using an appropriate form for obtaining and recording pertinent data (e.g., FP Service Record Form 2)?				
• Asking about her reproductive needs (having more children and by when, not having any more pregnancies)?				
• Asking about her decision on breastfeeding (exclusive for six months, expression of breastmilk while at work, not to breastfeed)?				
• Asking about what she knows about the FP methods?				
• Assessing her risk for STIs?				
• Asking about her experience of domestic violence?				
• Telling her about the FP methods based on her situation, knowledge, and needs?				
• Telling about the benefits, risks, possible side effects of FP methods appropriate to her needs and situation?				
• Helping her make a decision on choosing a method by asking her how she will cope with the possible side effects of the chosen method?				
• Explaining how to use the chosen method?				
• Explaining the warning signs of the chosen method and what she should do if these signs are observed?				
• Asking the client to repeat instructions on how to use her chosen method and what to do in case of warning signs?				
• Ensuring that she gets the method she chooses either from you or facilitating referral to a health care provider who can provide the method?				
• Telling the client when to return?				
• Explaining informed choice and ensuring that the informed consent form is signed if the woman or her partner chooses voluntary surgical sterilization (BTL or vasectomy)?				

COMPONENT II: TECHNICAL COMPETENCE	ASSESSMENT			
	Y	NI	NO	NA
15. Provide counseling to a revisit FP client by:				
• Asking if there has been any change in her situation that has				
affected her use of the FP methods since the last visit?				
• Asking if her reproductive intention has changed since the				
last visit?				
• Asking her if she is satisfied with her method?				
• Checking how she uses the method?				
• Helping her choose another method if she is not satisfied				
with the method she is currently using?				
16. Competently provide the following methods when chosen by				
clients?				
• Lactational Amenorrhea Method?				
• Standard Days Method?				
• Progestin-only pills?				
• Progestin-only injectables?				
• Combined oral contraceptives?				
• Combined injectables?				
• Contraceptive patch?				
• Condom?				
• IUD?				
Indicator J: Sexually transmitted infection:				
Patient counseling/ education				
1. Do you counsel and discuss with all clients:				
• What to do if client thinks he or she may have become infected?				
• When and where to go for STI screening and treatment if				
you are unable to provide those services?				

Comments about technical competence (Component II)

a.) Record what you have done well in this section. Use the questions where you answered **Y**.
b.) Record where you can improve. Use the questions where you answered **NI** or **NO**.

	Remarks/Recommendations
What you do well:	
1.	
2.	
3.	
Areas where you can improve:	
1.	
2.	
3.	

Component III - Continuity of Care

Examines functional referral systems when needed care is not available in your clinic. It includes knowing when and where to refer, procedures for referral, use of referral forms and client follow-up.

COMPONENT III: CONTINUITY OF CARE	**ASSESSMENT**			
	Y	**NI**	**NO**	**NA**
1. Have you established specific facilities or physicians for referral network?				
2. Do you have transport service for emergency referral available at all times?				
3. Do you send or accompany the client to the referral facility with a note describing the need for referral?				
4. Do you request information and feedback about the outcome of the visit from the referral facility (using the two-way referral form)?				
5. Do you call the referral facility doctor to get feedback about the client you have referred?				
6. Do you contact the client to find out the outcome of the referral visit?				
7. If you received information from the referral facility, do you record the outcome of the visit in the client's record?				
8. Do you follow-up on the newborn that you referred for intensive care?				
9. Do you or other members of your staff contact clients about missed follow-ups?				

Comments about continuity of care (Component III)

a.) Record what you have done well in this section. Use the questions where you answered **Y**.
b.) Record where you can improve. Use the questions where you answered **NI** or **NO**.

	Remarks/Recommendations
What you do well:	
1.	
2.	
3.	
Areas where you can improve:	
1.	
2.	
3.	

Component IV – Management

Refers to the health provider's capacity to plan, organize, implement, and maintain effective health delivery services. It includes using data for decision-making and proper tracking of finances and supplies.

COMPONENT IV: MANAGEMENT	**ASSESSMENT**			
	Y	**NI**	**NO**	**NA**
Indicator A. Review of practice, including review of action plan				
1. Do you know your scope of work according to your job description?				
2. Do you review your job description at least semi-annually?				
3. Do you use this review as a basis to improve the quality of services you provide to clients?				
4. Do you prepare an updated action plan to improve quality of services?				
5. Has any action been taken to address items in the plan to ensure quality of services?				

COMPONENT IV: MANAGEMENT	ASSESSMENT			
	Y	NI	NO	NA
Indicator B. Client records				
1. Do you have a written procedure to prevent infection in your facility?				
2. Do you maintain client records for every client?				
3. Are all the required records complete?				
4. Are your client records kept where it cannot be accessed by unauthorized persons?				
5. Do you maintain strict confidentiality concerning all personal information collected during a client visit?				
Indicator C. Supplies and consumable drugs, including vaccines				
1. Do you keep an inventory of consumable supplies and drugs, including vaccines?				
2. Do you keep a record or stock cards of consumable supplies in your facility?				
3. Did you do an updated inventory of your consumable supplies within the last three months?				
4. Does your list include expiration dates on drugs and supplies?				
5. Do you have a reliable supplier of drugs and other supplies?				
6. Do you order drugs and supplies based on your pharmaceutical needs?				
7. Have you been able to ensure availability of drugs, contraceptives, or other commodities in the last three months?				
8. Do you keep records about cold-chain conditions of vaccines?				
Indicator D. Medical equipment, instruments, and furniture				
1. Do you keep an inventory of equipment, instruments, furniture that includes date of purchase, projected date of repair, and replacement?				
2. Are the instruments, equipment, and furniture in working condition?				
Indicator E. Information on clinic operation hours				
1. Do you have a memorandum of agreement with a back-up obstetrician and pediatrician, which stipulates their roles, responsibilities and accountabilities?				

COMPONENT IV: MANAGEMENT	ASSESSMENT			
	Y	NI	NO	NA
2. Do you have a staff or reliever to take charge of your facility in				
your absence?				
3. In case of emergency and the clinic is closed, are there instructions				
posted, directing clients on what to do or where to go?				

Comments about management (Component IV)

a.) Record what you have done well in this section. Use the questions where you answered **Y**.
b.) Record where you can improve. Use the questions where you answered **NI** or **NO**.

	Remarks/Recommendations
What you do well:	
1.	
2.	
3.	
Areas where you can improve:	
1.	
2.	
3.	

Component V – Community Involvement

Refers to health providers' knowledge of the people in their communities and how effectively they market their services to maintain clients and attract new ones.

COMPONENT V: COMMUNITY INVOLVEMENT	ASSESSMENT			
	Y	NI	NO	NA
Indicator A. Client feedback				
1. Do you have a way to determine the satisfaction of your clients (for example, asking feedback or a suggestion box)?				
2. Do you act on feedbacks received from clients?				
3. Do you encourage clients to ask questions during visits?				

COMPONENT V: COMMUNITY INVOLVEMENT	ASSESSMENT			
	Y	NI	NO	NA
Indicator B. Advertising				
1. Do you promote your services to the community that you serve?				
2. Do you use other acceptable modes in promoting your services to				
clients and the community?				

Comments about community involvement (Component V)

a.) Record what you have done well in this section. Use the questions where you answered **Y**.
b.) Record where you can improve. Use the questions where you answered **NI** or **NO**.

	Remarks/Recommendations
What you do well:	
1.	
2.	
3.	
Areas where you can improve:	
1.	
2.	
3.	

Component VI – Business Practices

Examines health provider's goals, financial-management practices (including records keeping), resources for adequate financing, and allocation of resources.

COMPONENT VI: BUSINESS PRACTICES (for private practice midwives)	ASSESSMENT			
	Y	NI	NO	NA
Indicator A. Specific, measurable, attainable, realistic, and time-bound (SMART) goals				
1. Do you have SMART goals for the next year?				
2. Do you have a plan to achieve these goals?				

COMPONENT VI: BUSINESS PRACTICES (for private practice midwives)	ASSESSMENT			
	Y	NI	NO	NA
Indicator B. Financial practices and records				
1. Do you keep track of your:				
• Monthly cost or operating expenses?				
• Monthly earnings?				
• Collectibles (i.e., how much people owe you)?				
• Tax payments?				
2. Do you have a plan on:				
• Collecting debts of clients for services rendered?				
• How much you need to earn to cover for your expenses?				
3. Do you have a budget?				
4. Do you review your clinic's budget quarterly?				
5. Do you prepare/have financial records?				
• Balance sheet?				
• Income statement?				
• Cash flow statement?				
6. Do you use these records to:				
• Make management decisions?				
• Analyze cash flow?				
Indicator C. Functional pricing and collection system				
1. Do you know how much each type of service you provide costs				
(including the cost of your and your staff's labor time,				
commodities, supplies and the cost of operating your clinic)?				
2. Do you know how to price your products so that you can				
provide your clients with quality services and still cover your				
cost?				
3. In the last three months, were at least 75% of your clients able				
to pay the full amount of your service on the day of the visit?				
Indicator D. Profitable facility/practice				
1. Is your business profitable?				
Indicator E. Adequate financing				

1.	If you need additional financing, do you know where to go and				
	how to get it?				
2.	Have you ever received a loan?				
3.	Do you know where to access outside financing to grow your				
	business?				

Comments about business practice (Component VI)

a.) Record what you have done well in this section. Use the questions where you answered **Y**.
b.) Record where you can improve. Use the questions where you answered **NI** or **NO**.

	Remarks/Recommendations
What you do well:	
1.	
2.	
3.	
Areas where you can improve:	
1.	
2.	
3.	

ACTION PLAN

Name of Midwife: _____ Date Prepared: _____

INSTRUCTIONS: *(See appendix for sample action plan and blank forms for your use.)*

1. In the monitoring tool, put a mark next to the questions you answered with **NO** and **NI**. Record the component and the question number in columns 1 and 2, respectively.
2. Write the issue (specific deficiency that needs to be improved or added) pertaining to the question in column 3.
3. In column 4, write down the root cause of the problem. You do this by asking yourself "Why?" until you get to the last answer. The last answer is the root cause.
4. List possible solutions to the problem in column 5.
5. In column 6, list the next steps for the solutions you have identified in column 5.
6. Assign a person who will be responsible for the actions/next steps to be done and record it in column 7.
7. In column 8, put the date when the actions will be ***completed***.
8. In column 9, put a check if the problem has been solved or task has been completed. If unresolved, put "not resolved."
9. Review this action plan each time you use this monitoring tool.
10. This action plan will be discussed with your supervisor during his/her monitoring visit.

APPENDIX A: Sample Action Plan

Component	Indicator/ Question Number	Issues	Root Causes (WHY)	Solution(s)	Actions/Next Steps	By Whom	By When	Status (after some time)
1	2	3	4	5	6	7	8	9
I. Facility	A. 7	No decontamination solution	Not aware of need for this	Prepare and always make this available	Buy Zonrox, container; prepare	Me (midwife)	Tomorrow morning	*(the following week)* DONE
II. Technical Competence	D. 1	No handwashing BEFORE attending to client	Usually done AFTER; forgets/not aware that it is needed	Make it a habit; put up reminders on desk and sink, etc.	Make posters or reminders; post at sink, desk	Assistant MW	This afternoon	

APPENDIX B: Blank Form for Action Plan

Component	Indicator/ Question Number	Issues	Root Causes (WHY)	Solution(s)	Actions/Next Steps	By Whom	By When	Status (after some time)
1	2	3	4	5	6	7	8	9

Part 2
Supervisor Portion

About this Monitoring Tool

Promoting and sustaining quality care is a priority of every health worker providing health services to individuals, families and communities. At the individual or family level, improved quality of care ensures that clients receive respectful treatment by technically competent providers. At the community level, greater satisfaction with services should translate into better continuity of care and maximized preventive services.

This tool is designed for use by supervisors of midwives who are either in public or private practice. Its aim is to serve as a guide to monitoring and evaluating the quality of services provided by midwives. Regular use of this tool by both midwives and their supervisors leads to improved competence and skills. With this tool, gaps in quality of service provision are continually identified and addressed by the midwives themselves with technical assistance from supervisors.

This is the supervisor's portion of the Monitoring Tool for Practicing Midwives, which is a quality measurement or assessment tool. Its companion portion is that for the midwife which should have been filled out by the midwives prior to the supervisor's visit. The midwife's portion has two parts:

1. The **self-assessment part** which allows the midwife to assess herself against a checklist of quality standards. It shows the midwife's own perspective of the level of quality of MCH/FP services she provides in her facility.

2. The **action plan** which provides an opportunity for the midwife to plan and record her own recommendations using her own resources to address the gaps she identified, and using the tool, to provide quality services in her clinic. This self-empowerment results in quality care for the patient.

The supervisor's monitoring component (this portion of the toolkit) is for the use of the midwives' supervisors. It is supposed to determine the progress of each midwife in improving the quality of health services she provides. This supervisor's portion also has two parts:

1. Supervisor's Assessment Tool which contains questions that are identical to the questions found in the midwife's self-assessment tool. However, in contrast to the midwife's self-assessment tool, the supervisor's tool contains numerous technical side notes that serve as reminders, tips, guides or reviewers to help the supervisor provide immediate, on-the-spot technical assistance to the midwife. In all occasions, corrections must be made whenever the supervisors encounter incorrect practices or knowledge.

2. **Supervisor's Scoring Sheet** which is the only portion of the toolkit that has the scoring sheet. The idea is for the supervisor to have an objective, numerically definable assessment of the quality of services that the midwife provides in her clinic. Each question's rating is recorded in the score sheet, summarized or added up, and then serves as a baseline numerical value against which future monitoring scores will be compared.

Two case studies are included as annexes for supervisors to practice their scoring.

Using this Supervisor's portion, and with the midwife's action plan, the supervisor can assist the midwife in addressing deficiencies that she may not be able to correct on her own. The improvement of the quality of MCH/FP services in the birthing home is even more likely if the supervisor has some access and ability to mobilize outside resources.

The supervisor, during his or her supervisory visit, must complete all the tasks of the monitoring: fill out the supervisory assessment tool and compute for the scores for each component. The supervisor should use this tool for recording the findings as he or she observes, for reviewing records, and for interviewing the midwife and her assistants or the patients and clients. Subsequently, the supervisor's ratings will be used to objectively validate the midwife's self-assessment results.

After completing the supervisory tasks, the supervisor then calls for an exit feedback, asks for the accomplished midwife profile, reviews the midwife's "comments tables" after each component, reviews the action plan with the midwife, and discusses and agrees with the midwife on any necessary revisions. Results of the supervisor's monitoring scores are then shared with the midwife.

How to Use the Tool

The Monitoring Tool for Practicing Midwives: Supervisor's Portion is intended for use by supervisors from the CHDs, such as the MCH and FP Coordinators. Health NGOs with nurses or midwives who function as program managers or who are in supervisory capacity may also use this tool. Officers or technical resource staff of midwife associations may likewise use this tool during their monitoring of member-midwives with birthing facilities, whether public or private.

A midwife profile or information sheet is included in the midwife portion of this toolkit. Midwives will fill this out first and submit to the supervisor during the latter's monitoring visit. This information sheet serves two purposes: a) to enhance the database of midwives and b) to provide baseline information where results of future technical assistance and interventions can be measured against.

The supervisor's role is to validate the midwife's self-assessment as documented in the midwife's portion of the tool. Validation is done by observation of the clinic itself, its surroundings and the

midwife's practices as she conducts regular business in the clinic. Role-playing may likewise be employed, along with interviews with the midwife, her assistant/s, and the patients or clients.

Suggested supervisor's steps in using this tool during monitoring:

1. Monitoring begins even before entering the lying-in clinic and meeting the midwife.

2. Observe the environment around the clinic for cleanliness. Look at the clinic's signages, garbage provisions, and waiting areas. Look for a vehicle that may be the clinic's "ambulance," etc.

3. Upon entering the clinic, establish rapport with the midwife and her staff as well as patients or clients who may be waiting inside.

4. Introduce yourself and companions. State your purpose for the visit and make sure the midwife and her staff are comfortable.

   NOTE: Observation IS the ideal and recommended method of monitoring. Therefore, the presence of patients in the clinic should NOT be a hindrance. It should actually facilitate monitoring as you can simply and quietly observe how the midwife conducts herself during a regular day at the clinic. You then record your findings in the tool.

5. It is advisable for you to **complete** all of your tasks **BEFORE** asking for the midwife's accomplished self-assessment form and reviewing/discussing it with the midwife. There are several advantages of conducting the monitoring this way:
   - The supervisor's assessment will not be influenced by the midwife's answers to the questions in the tool.
   - Time will be saved because the supervisor does not have to return to the clinic to re-validate the midwife's answers in the tool.
   - The midwife's business need not be interrupted and she can continue doing her clinic services and attending to patients, while the supervisor goes around the clinic and fills out her tool checklist. The presence of the midwife will be required only during the exit feedback.

6. Using the checklist and matrix in this **Supervisor's Assessment Tool**, rate the clinic or the midwife's performance by component and by indicator, per question, by doing the following:
   - Observing actual client-service provider interaction. The best scenario would be an unannounced supervisor's visit with mothers admitted or consulting the midwife. No interviews are necessary and the supervisor simply needs to observe actual regular clinic services and interactions. *(If there are no clients, for example, for family planning, during the monitoring visit, validation may be done by asking the midwife to role-play a situation.)*
   - Noting presence or absence of each item in the clinic.

- Observing conduct of regular business in the clinic.
- Interviewing the midwife, assistants, patients or clients.

7. Record in your **Supervisor's Assessment Tool** your own assessment rating under the column heading **SUPERVISOR/RATING,** as follows:
   - Put **2** if you assess the item as **Yes or Satisfactorily done.**
   - Put **0** in the box if you assess the item as **No or Not done.**
   - Put **NA** in the box if the question is not applicable to her clinic.
   - Put **1** in the box if your assessment is **Yes, but needs improvement.**

8. After answering the questions in ***each of the six components in the assessment tool***, proceed to computing the scores for each of the components and accomplish the **Supervisor's Scoring Sheet** *(see instructions on page 79)*.

9. Once the Scoring Sheet is completed, the supervisor then requests the midwife to participate in an exit feedback session.

10. The following steps may comprise the exit feedback:
    - Request for the accomplished Midwife Profile sheet (keep this as record for the database on midwives or simply as a baseline record for your office).
    - Review with the midwife her self-assessment answers either by going through each question one by one, or:
    - Look at the "comments table" after each component:
      - o Agree or disagree and discuss with the midwife her identified good points and areas needing improvement.
      - o Be sure to compliment and congratulate the midwife on her good points and encourage her to work on the areas needing improvement.
    - Review and discuss the midwife's Action Plan:
      - o Agree or disagree with the items.
      - o As much as applicable and appropriate, confirm or congratulate the midwife on recommendations she herself made and recorded in the action plan.
      - o Ask for updates on each of the recommendations made.
      - o Add or deduct actions or interventions that are not appropriate.
      - o Add recommendations, especially if the supervisor has access or ability to mobilize outside resources that will help address the identified gaps in quality care. *This will encourage the midwife and convince her of the supervisor's commitment to her improved ability.*
    - Share with the midwife the Scoring Sheet results and explain the scores.

11. You will then provide a recap of the agreed recommendations and next steps, together with the assessment scores. It would be ideal to leave a copy of the accomplished Supervisor's Scoring Sheet with the midwife for her record and reference.

SUPERVISOR'S ASSESSMENT TOOL

Name of Clinic: _____ Address: _____

Name of Midwife: _____ Date of Monitoring: _____

Component I: Facility

This refers to the facility's ability to provide a safe environment for health care. It also examines equipment, supplies, and medicines in the facility and the condition of the clinic's infrastructure.

COMPONENT I: FACILITY	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator A. Conditions/Amenities			
Does the clinic have:			
1. A sign that contains the name of the facility?			Check presence or absence of sign outside the clinic. Is it clean? Is the color faded?
2. A big sign inside and outside the facility that contains the services offered?			Check sign of services offered (look for logbook where services are recorded, and compare if services recorded are the same as those in the signage).
3. Sufficient seats for patients in a well-ventilated waiting area?			Waiting area should have a minimum of two chairs for the clients, and windows or electric fan or air-conditioner.
4. A separate private area with a desk, two chairs, examining table for counseling, physical examinations, and procedures that cannot be observed or overheard by others?			Observe if conversation inside the room can be heard outside.

COMPONENT I: FACILITY	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
5. A locked cabinet for storage of medicines?			Check for presence of cabinet with lock.
6. A sheet in the examining table to cover client?			Observe presence of a separate sheet for covering clients during examination.
7. A container with 0.5% chlorine solution marked for decontamination of instruments immediately after use on a client or patient?			Check for presence of container with 0.5 % chlorine solution.
8. Soap for hand washing?			See if there is soap in the lavatory. All lavatories should have one soap each.
9. Separate receptacle for disposing pointed/sharp objects?			Look for a puncture-proof container. Plastic containers of mineral water, IV fluids should not be used for pointed/ sharp objects.
10. Covered garbage containers with color-coded segregation?			Check if containers are covered and lined with yellow, green and black plastic.
11. The required basic consultation and delivery room equipment? ☐ Alligator forceps 10" ☐ Ambu bag (adult) ☐ Ambu bag (newborn) with appropriate face mask for term and preterm infants ☐ Boiler/sterilizer ☐ Bassinet/newborn carrier ☐ BP apparatus (non-mercurial) ☐ Delivery table ☐ Electric stove ☐ Foot stool			Check instruments and equipment and see if they are functional or not. Nonfunctional equipment and instruments should not be counted and will be considered absent.

COMPONENT I: FACILITY	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
☐ Gooseneck lamp (2) ☐ Haemostatic straight forceps ☐ Instrument cabinet ☐ Instrument table ☐ IV stand ☐ Jar with stainless cover ☐ Jar without cover ☐ Kelly pad ☐ Needle holder ☐ Ovum forceps ☐ Oxygen gauge regulator ☐ Oxygen tank (5 lbs. minimum) ☐ Pail ☐ Pick-up forceps ☐ Portable emergency light/flashlight ☐ Rubber suction bulb syringe ☐ Sponge-holding forceps ☐ Stainless bowl (kidney shaped) ☐ Stainless bowl (round shaped) ☐ Stainless iodine cup ☐ Stainless instrument tray with cover ☐ Stethoscope ☐ Stool ☐ Straight forceps 10" ☐ Suction apparatus ☐ Surgical scissors (straight) ☐ Tenaculum forceps ☐ Tissue forceps 6" ☐ Uterine forceps 10" ☐ Uterine sound 12" ☐ Vaginal speculum (all sizes) ☐ Wall clock with second hand ☐ Weighing scale (adult) ☐ Weighing scale (infant)			
12. The required standard supplies? ☐ 70% isopropyl alcohol ☐ Bed sheets ☐ Butterfly set (G19) ☐ D_5LR – 1 liter			Check presence of supplies.

COMPONENT I: FACILITY	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
☐ Disposable syringes and needles ☐ DR gown/scrub suit ☐ IV tubing ☐ Linen for bassinet/ newborn carrier ☐ Nasal cannula ☐ Plastern Plastic apron ☐ Povidone iodine (Betadine) ☐ Soaking/sterilizing solution (Cidex) ☐ Sterile absorbable sutures with needle ☐ Sterile cord clips/ties for baby ☐ Sterile cotton balls ☐ Sterile cotton pledgets ☐ Sterile cutting needles ☐ Sterile drapes ☐ Sterile gauze ☐ Sterile gloves ☐ Sterile round needle ☐ Surgical cap ☐ Surgical mask ☐ Tape measure ☐ Thermometer (axillary, non-mercurial) ☐ Thermometer (rectal, non-mercurial) ☐ Xylocaine/Lidocaine ☐ Oxytocin 10IU ampules ☐ Tetanus toxoid vaccines ☐ Erythromycin ophthalmic ointment (0.5%) ☐ Vitamin K ampules ☐ Dexamethasone 4mg ampules ☐ Progestin-only pills ☐ D-Medroxyprogesterone acetate (DMPA) ☐ Intrauterine device (Copper T)			

COMPONENT I: FACILITY	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator B. Facility Infrastructure:			
Does the clinic have: 1. A generally clean environment?			Observe cleanliness, presence or absence of insects, and if dust free.
2. Adequate potable water?			Check if there is running water. Ask midwife if water is potable.
3. Covered container for water storage?			Check if water container(s) is/are covered.
4. Electricity and a reliable alternative source of light?			Switch on light or look for flashlight or emergency light.
5. A delivery room with required equipment and supplies?			Check the delivery room.
6. An area for examination (after the first full breastfeeding) or resuscitation (if needed) of the newborn?			Presence of an area in the delivery room where baby is examined or resuscitated.
7. Fire safety provision (either fire exit or fire extinguisher)?			Look for the fire exit. Does it face an open space? If there is no fire exit, look for a fire extinguisher.
8. A patients' room with bed(s) and linens?			Determine presence of a room with bed(s) and linens where patients stay during labor, or rest after delivery.
9. A toilet for clients and staff?			Check if toilet is located inside the clinic or is accessible to clients.

COMPONENT I: FACILITY	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
10. A lavatory for washing hands for staff and clients?			Check presence of lavatory.
11. Windows, electric fans, or air conditioner to ensure ventilation?			Windows should be big enough to allow for good ventilation. Check for presence of functional electric fans or air conditioners.
12. A work area where instruments are cleaned?			Look for a separate area where instruments and used gloves are cleaned, and high level disinfection is done.
Indicator C. Educational Materials for Clients			
1. Maintains a supply of informational, education and communication (IEC) materials on family planning, reproductive health, maternal, neonatal, child health and nutrition, and newborn screening and newborn hearing screening?			Check if educational material on FP-MCH, Nutrition, and Newborn Screening are displayed and adequately stocked.
2. Is the "All-FP Methods" poster displayed where clients can read it?			See if "All- FP Methods" poster is posted or displayed in waiting or receiving area.
3. Is a wall chart displayed indicating that reproductive health services are provided and available?			Check if wall chart on reproductive services is present in waiting or receiving area.
Indicator D. Professional Appearance of Midwife			
1. Do you wear clean and neat appropriate clothing and/or uniform or blazer during work hours?			Observe if midwife is wearing appropriate clothing (uniform or blazer) during work hours.

Component II – Technical Competence

Examines the health provider's performance and determines if it meets acceptable standards. This includes performance in counseling, infection prevention (IP), prenatal care, care during labor and delivery, immediate newborn care, postpartum care, family planning, and immunization.

COMPONENT II: TECHNICAL COMPETENCE	MW	SUPERVISOR	
	RATING	RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator A. Attitude/Behavior of Midwife			
Is the midwife:			
1. Punctual?			Check logbook or do a random check of client records.
2. Cordial in greeting clients?			Observe (if there are clients) or ask the midwife how she greets each client.
3. Competent in articulating information? 4. Client-friendly? 5. Caring and gender-sensitive? 6. Culture-sensitive? 7. With strong stress-tolerance? 8. Complies with rules and regulations? 9. Able to evaluate facts and courses of action? 10. Decisive in solving problems?			Observe how numbers 3 – 10 are being done by the midwife. Ask midwife to role play using a scenario. E.g., a client comes in, wanting to have her menstruation regulated.
Indicator B. Standards of Care			
1. Do you have a copy of the most recent midwifery service delivery guidelines?			Look for copy of midwifery service delivery guidelines. Observe if it is readily available or kept somewhere else. If readily available, the probability of being used is higher.
2. Do you use the guidelines during work?			Ask sample questions like "Do you deliver multiple pregnancies? Do you perform episiotomy? Do you deliver breech presentation?"

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
3. Do you have a summarized job aide /procedural guidelines to remind you of the core steps of focused ante- and postnatal care?			Look for a summarized job aide/procedural guidelines.
Indicator C. Basic Counseling Guidelines			
1. Do you provide your clients with information for them to make health-related decisions?			This can be validated in FP counseling with the use of GATHER.
2. Are clients informed of the services available in your facility?			Ask midwife: "How do the clients know the other services offered in the facility aside from the one being sought for?"
3. Do you use every opportunity of a client's visit for maternal and child health services to discuss additional issues like family planning?			Ask midwife if FP counseling is provided to all prenatal clients.
4. Are clients informed of their right to privacy and confidentiality? 5. Do you take measures to ensure that counseling sessions and physical examinations are not interrupted? 6. Do you explain the presence of or ask the client's permission if a third party is present during a counseling session, a physical examination or a procedure?			Numbers 4-6 may be observed when midwife does a role play on FP counseling using the GATHER Approach. See Indicator A.
Indicator D. Infection Prevention			
1. Do you wash your hands with soap and water before and after attending to each client?			Observe (if there are clients) or ask midwife to enumerate the steps in attending to each client.
2. Do you clean the facility regularly?			Observe cleanliness in the clinic. Ask midwife for the schedule of general cleaning of the clinic.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
3. Do you soak soiled instruments in 0.5% chlorine solution immediately after use?			Ask how 0.5% chorine solution is prepared. *Using Zonrox, 100 ml Zonrox to 900 ml water.* Used instruments should be immediately soaked in 0.5% chlorine solution for 10 minutes.
4. Do you boil for 20 minutes instruments for high-level disinfection?			Ask midwife to enumerate the process/steps in doing high-level disinfection (HLD).

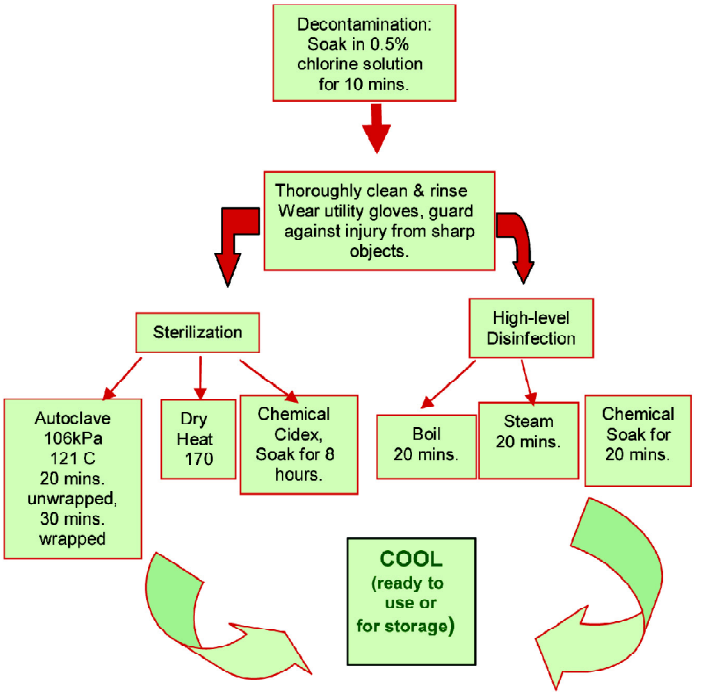
Steps of HLD by Boiling:

a. Decontaminate and clean all instruments and other items to be high-level disinfected.
b. Open all hinged instruments; disassemble those with sliding or multiple parts.
c. Completely submerge all instruments and other items in water in a pot or sterilizer. Place bowls and containers upright.
d. Cover the pot or close the lid on the boiler, bring water to a gentle rolling boil.
e. Start timing for 20 minutes when water comes to a rolling boil.
f. From this point on, do not open, add or remove water, instruments, or other items.
g. After 20 minutes, remove the instruments and other items using HLD pick-up forceps. Place in HLD tray and air dry.
h. Store in an HLD container, and use within one week.

5. Do you follow the "three steps" processing of instruments?			Ask midwife how to do "three steps" processing of instruments.

"Three Steps" Processing of Instruments:

Step 1: Decontamination: Soak instruments and other items in 0.5% chlorine solution for 10 minutes.
Step 2: Cleaning: Brush instruments with detergent and water.
Submerge instruments in water while brushing to avoid splashes.
Rinse in running water.
Step 3: Sterilization or High-Level Disinfection by:
Sterilization – steam under pressure or autoclave, dry heat or chemicals.
High-level Disinfection – performed by boiling, use of chemical or steaming.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Refer to diagram below for proper processing steps 			
6. Do you maintain single-use injection practice?			Ask midwife how many times she uses sterile plastic syringes.
7. Do you dispose of needles in a sharps container?			Look for the puncture-proof container.
8. Are placentas, other tissues, and blood products disposed of properly?			Ask how she disposes of placenta, other tissues and blood products. *Placentas are usually brought home by clients or relatives. Otherwise, these should be disposed as medical waste.*

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
9 Are medical wastes disposed of according to DOH standards?			Ask midwife how she disposes of medical waste. *Solid medical waste should be collected by the garbage collector of hospitals; liquid medical wastes should be poured into drains of lavatories.*
10. Do you wear protective garments in performing clinical procedures (e.g., plastic apron, eye goggles, mask)?			Observe if the midwife wears protective garments (if there are clients) or ask the midwife how she protects herself in performing clinical procedures, or check for presence of plastic apron, eye goggles, or face masks.
Indicator E. Prenatal Care			
Do you do the following during the initial prenatal visit?			
1. Determine the age of gestation based on the last menstrual period?			Ask the midwife how she determines the AOG. *How to determine AOG based on LMP:* 1. *Get first day of last menstrual period* 2. *Count the number of days from the first day of LMP to present (consultation date), then divide by seven.* 3. *Result will be AOG in weeks.*
2. Discuss with the woman the need to have at least four prenatal visits during pregnancy?			Observe (if there is client) or ask the midwife the minimum number of prenatal visits a client should have, and ask for the dates of the specific visits.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
3. Take the woman's complete history which includes: a. Personal history b. Medical history (past and family) c. Present pregnancy d. Social history (e.g., daily habits, lifestyle, relationships) e. Obstetrical history, including menstrual history f. FP history/plans			Check clinical record if these items (3.a to 3.f) are obtained and are recorded in the maternal record. Check for completeness of information recorded in the forms.
4. Provide information about any health problems discovered and discuss about referral, if appropriate?			Ask the midwife if there are instances where she discovers other health problems the clients may have during history-taking and physical examination. Ask her what she does if ever she finds other problems.
5. Explain to the patient the need to deliver in a facility like the birthing home?			Observe (if there is a client) or ask the midwife to tell you how she explains to client the need to deliver in a birthing home.
6. Discuss with the client the need to develop a birth plan that includes complication readiness, such as early detection of warning signs, emergency transportation, designated decision-maker, and blood donor, if necessary?			Look for birth or delivery plan. Ask the midwife to discuss with you the need to develop a birth plan (role play).
7. Assist the client in making a birth plan?			Observe (if there is a client) or look for an actual birth or delivery plan, check completeness.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
8. Describe the danger signs for which she will need immediate consultation and referral such as: • Swelling of the legs, hands, and/or face • Severe headache • Dizziness • Blurring of vision • Convulsions • Vaginal bleeding • Vaginal discharge • Watery vaginal discharge • Fever and chills • Vomiting • Fast or difficult breathing • Severe abdominal pain • Painful urination • Absence or reduced fetal movements			Ask the midwife to discuss with you and role play the danger signs of pregnancy, and what the client should do if she experiences any.
9. Determine tetanus toxoid status and provide the vaccine as appropriate?			Obtain a clinical record randomly (Maternal Record 1A). Check if TT is being provided and recorded. Check if the rural health midwife accomplishes the "Child Protection at Birth" FHSIS form.
10. Dispense or provide iron, folic acid tablets, and vitamin A in appropriate doses? 11. Determine the client's risk for STI?			Check in the clinical record if iron, folic acid tablets and vitamin A were provided and recorded. Randomly pull out Maternal Record 1A. Check record if STI risk assessment was done and recorded.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
12. If client is at risk of STI, discuss with client how to avoid exposure to STI and HIV by being faithful and asking her partner to wear a condom?			Ask the midwife what she would tell the client if she found out that the client is at risk of STI (midwife to role play, with supervisor as the client).
13. If she at risk of STI, discuss with the client how to ask her partner to wear a condom?			Ask the midwife how she would teach her client to ask her husband or partner to wear a condom.
Do you do the following during each succeeding prenatal visit?			
1. Inform the client of her age of gestation?			If there is no client, ask the midwife of the information she tells her client on succeeding prenatal checkups.
2. Explain about the importance of personal hygiene, e.g., bathing during pregnancy, washing breast daily with soft cloth, wearing support bra, cleaning external genitalia daily, wiping from front to back?			
3. Provide nutritional advice, e.g., eat a variety of nutritious foods, take folic acid and iron supplement, drink plenty of liquids, no alcohol intake, gain an adequate amount of weight (12-16 kilos)?			
4. Discuss with the woman and her partner the need for family planning and about their options for spacing or limiting birth?			

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
5. Discuss the importance of breastfeeding within one hour after birth and problems the client may have for doing this?			Same question as above. Also, check number 14 item of the delivery plan.
6. Explain the importance of newborn screening and newborn hearing screening?			If there is no client, ask if midwife is trained in newborn screening and newborn hearing screening. If trained, ask her how she explains the importance of newborn screening and newborn hearing screening to her client.
7. Describe the signs and symptoms of labor (i.e., bloody, sticky vaginal discharge, painful contractions every 20 mins. with decreasing intervals and increasing intensity, water from the vagina), and what to do when these occur?			If there is no client, ask the midwife to describe the signs and symptoms of labor and what the client should do if these occur.
8. Discuss how to safely dispose of the placenta if she decides to bring it home?			If there is no client, ask the midwife what she tells the client or her relatives if they want to bring the placenta home.
Indicator F. Obstetrical (Physical) Exam			
Do you do the following during the initial prenatal checkup?			
1. Take and record vital signs?			Randomly pull out one clinical record. Check if the vital signs were recorded.
2. Take and record the weight?			Check if weight was recorded.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
3. Inspect and palpate the breast?			Check if findings on breast exam were written down.
4. Perform abdominal examination and check for post-Cesarean scar?			Check if findings on abdominal exam were recorded.
5. Determine the size of the uterus and assess compatibility of uterine size to age of gestation?			Check if fundic height was taken and recorded.
6. Request for laboratory examinations like: • CBC, blood typing • Urinalysis • VDRL or RPR			Look for copy of results of laboratory exams attached to clinical record or see if results were written on the clinical record.
In succeeding prenatal visits, do you do the following?			
1. Record and note changes in: • Blood pressure? • Weight? • Uterine size/fundal height?			Using the same clinical record pulled out earlier, check if BP, weight, fundic height were taken on succeeding prenatal visits.
2. Listen to fetal heart tones when the woman is 18 weeks or more gestation or if the uterus is palpable near the umbilicus?			Check if FHT was taken, if appropriate, and written in the clinical record.
3. Check the presenting part after 32 to 34 weeks by doing Leopold's maneuver?			Refer to back-up obstetrician if, by the 36th week, the presenting part is not the head? Check if these were written down in the clinical record.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
4. Check for warning/danger signs such as: · Vaginal bleeding? · Severe headache, visual Changes or epigastric pain? · Swelling of the face or hands? · Leaking amniotic fluid? · Severe nausea or vomiting? · Fever (T≥38°C)? · Severe abdominal pain? · Absence of fetal movement?			Ask the midwife to enumerate the warning/ danger signs of pregnancy. Ask the midwife if she had a patient who had experienced these signs and symptoms. If yes, ask her to pull out such record.
5. Refer client to higher level of care (i.e., obstetrician or hospital) if any of the warning signs occurs?			Check if referral of such client was documented in the clinical record.
Indicator G. Labor and Delivery			
During labor, do you:			
1. Do a quick check at different times to ensure that the woman is normal? · Appears calm and relaxed between contractions · Has an axillary temperature of 36-37°C · Has a pulse rate of 80-100 beats/min. · Has BP of 100/60 mmHg or above but less than 140/90 mmHg			If there is no client, ask the midwife what she does when client comes for delivery.
2. Use partograph to chart progress of labor?			Look for partograph and check for correctness and completeness.
3. Encourage the client to have support person of her choice present with her?			Check delivery plan. Ask midwife if a plan for client's support person (of her choice) during labor and delivery is included in the delivery plan.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
4. Encourage the client to continue taking liquids and eating light foods as she desires?			Instead of asking this question, ask the midwife: "If client asks for food or fluids will you give her or allow her to eat or drink?"
5. Urgently refer the patient to your back-up obstetrician or hospital at any time the following danger signs are observed? • Vaginal bleeding of more than 100 ml since the start of labor • High blood pressure ($\geq$ 140/90 mmHg)· Temperature > 38°C • Low blood pressure with a systolic BP< 90mmHg • Severe pallor • Epigastric or abdominal pain • Severe headache • Blurred vision • Convulsions or unconsciousness • Breathing difficulty • Fetal heart rate <100 beats/ min. or >180 beats/min • Partograph plotting goes to the right of the "alert line"			Observe if client is present. Otherwise, check clinical records Look for accomplished return referral form.
During delivery, do you:			
1. Ensure a safe and clean delivery by having: • Clean hands? • Clean and warm delivery area? • A clean surface for delivery? • Clean gloves? • All delivery equipment and supplies (e.g., gloves), including newborn resuscitation equipment, are available? • High-level disinfected (HLD) instruments to cut cord?			Observe condition of the delivery room. Check if there is a sterile delivery pack.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
2. Encourage the woman to assume the birthing position of her choice that is safe for her and the baby?			Ask: "Have you encountered clients who do not want to assume the lithotomy position during delivery?" If yes, ask what position the client wanted and whether the midwife allowed it.
3. Ensure controlled delivery of the fetal head by instructing the woman not to bear down?			Ask:"How often do you encounter perineal lacerations?" If almost all clients sustain lacerations, the probability that the midwife does not instruct the woman not to bear down is high.
4. Support the perineum to avoid perineal laceration?			If answer to above question is "almost all clients," probably midwife does not know how to support perineum or does not support the perineum at all.
5. Take note and record time of delivery?			Check the partograph. This information should be found in the partograph.
6. Take steps to clear the airway and ventilate or resuscitate if he or she does not cry or breathe spontaneously?			Ask: "What do you do to the baby if he or she does not breathe spontaneously?"
7. Place baby in skin-to-skin contact on the mother's abdomen and wraps the baby in dry cloth/blanket to keep it warm?			Ask: "What do you do after delivering the baby and before the cord is cut?"

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
8. Palpate the abdomen to rule out another baby (multiple pregnancy)?			Ask: "After the delivery of the baby what do you do to rule out another baby (multiple pregnancy)?"
9. Clamp and cut cord when pulsation ceases?			Ask: "When the baby is already out, do you cut the cord immediately?"
10. Thoroughly dry the baby and keep it warm?			Ask: "Do you bathe the baby after delivery to remove vernix?"
11. Apply controlled cord traction with abdominal hand support to the uterus during contractions?			Ask: "Do you perform active management of third stage of labor?" If yes, "How is this being done?"
12. Inject 10 IU of oxytocin intramuscularly after delivery of the baby?			Ask: "Enumerate the signs of placental separation."
13. Massage the uterus through the abdomen immediately after delivery of the placenta?			No need to validate.
14. Check the placenta for completeness? Note: Emphasize that she should not do manual exploration of the uterus.			Ask: "Do you check the placenta to see that it is complete? How do you do this?"
15. Refer when the placenta is noted to be incomplete.			Ask: "What do you do if a part of the placenta is missing or is incomplete?"
16. Latch baby to mother's breast?			Ask: "How do you determine correct latching of the baby to the mother's breast?"

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
17. Encourage the woman to breastfeed within one hour after delivery and assist her if she has difficulties?			Ask: "Do you advise initiation of breastfeeding?"
18. Administer eye prophylaxis (i.e., Erythromycin ophthalmic ointment) and vitamin K to infant after the first full breastfeeding?			Ask: "What do you use for eye prophylaxis for a newborn?"
19. Provide the mother with Vitamin A 200,000IU as a single dose by mouth after a meal?			Ask: "Do you provide Vitamin A immediately postpartum? In what dose?"
20. Record details of birth, including: • Date and time of delivery and sex of the baby • Baby's length and birth weight • Condition of the perineum and if any suturing was done • Estimated blood loss • Any changes from normal and referral			Check the partograph and clinical record. You will find these information in the partogtraph and the clinical records.
21. Perform a complete examination of the baby within the first two hours of life and inform the mother of results?			Check clinical record.
22. Refer newborn for further care if necessary, based on examination of the baby?			
23. Continue to assess uterine tone, amount of vaginal bleeding, and mother's vital signs for at least two hours postpartum or until stable?			
24. Encourage woman to continue taking liquids and eating light foods as she desires?			Ask: "If the woman asks for light foods or liquids, would you allow her to eat or drink?"

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator H. Postpartum Care			
Before discharge from your health facility or within the first week postpartum, do you:			
1. Check maternal and neonatal vital signs?			Check clinical record of mother and baby.
2. Perform newborn screening?			
3. Refer newborn to a health facility for newborn hearing screening?			
4. Conduct physical exam of mother and baby and record any abnormal changes?			
5. Record findings and inform mother of her condition and that of her baby?			
6. Teach how to care for the umbilicus?			Ask: "What are the steps for caring of the umbilical cord?"
7. Assess mother's knowledge of and ability to breastfeed?			See Indicator E.
8. Discuss the following with the mother: · Personal hygiene? · Nutrition and infant feeding? · Care of the baby? · Care of the perineum and breast? · Family support? · Family planning and how to avoid unwanted pregnancy? · Benefit of exclusive breastfeeding for six months? · Infant immunization? · Preventing infant diarrhea and dehydration?			

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
9. Give the mother a schedule of immunizations for her baby and where to get these?			Check record of baby.
10. Teach the mother about the following signs of potentially serious problems with the infant and instruct her to contact you for referral if the infant: • Does not feed well? • Has watery, blood-tinged stools? • Vomits or spits out a lot? • Has stiffness or convulsions? • Has yellow skin and eyes? • Has redness or foul discharge from the umbilicus or discharge from eyes?			Ask:" Do you give instructions on to the mother upon discharge on danger signs to the baby? If yes, what are these signs?"
11. Teach the mother about postpartum danger signs, and instruct her to contact you for referral if she has the following: • Excessive vaginal bleeding (one sanitary napkin fully soaked per hour) anytime after delivery or bleeding for more than two weeks? • Vaginal discharge with a foul/ fishy odor? • Severe abdominal pain? • Worsening perineal pain from repaired laceration? • Temperature $\geq$ 38°C? • Redness, warmth, or pain in the breast? • Pain on urination, difficulty in voiding, or defecating, or incontinence of urine or stool?			Ask:" Do you give instructions on to the mother upon discharge on danger signs to the baby? If yes, what are these signs?"
12. Accomplish birth registration form and register?			Ask the midwife who registers the birth.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator I. Family Planning: Information-Giving and Counseling			
For every encounter with clients do you:			
1. Use every opportunity to discuss family planning to clients?			Ask: "When do you discuss FP with client?"
2. Provide information on FP to the following types of clients • Adolescents and young adults, both female and male? • Women of all ages, regardless of their marital or reproductive status? • Men of all ages, regardless of their marital or reproductive status? • Disabled clients?			Ask: "What type of clients do you provide FP counseling to?"
3. Maintain eye contact with the client? 4. Use appropriate tone of voice? 5. Exhibit appropriate body language? 6. Listen attentively to client's message? 7. Use simple language? 8. Use IEC materials effectively? 9. Let the client make her own decision? 10. Inform clients that the ideal gap between pregnancies is three years? 11. Make clients realize that she can get pregnant in four weeks after delivery if she is not breastfeeding and is not using a family planning method? 12. Discuss how the reproductive system works?			If there is a client in the clinic during the visit, observe how FP counseling is done. If there is no client during the visit, ask the midwife to role play the GATHER Approach in FP Counseling and observe her. All the items from numbers 3 to 16 should be performed by the midwife.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
13. Competently talk to clients on the following FP methods? • Lactational Amenorrhea Method • Standard Days Method (SDM) • Other fertility awareness- • based methods (BBT, Billings ovulation method, Symptothermal method) • Progestin-only pills • Progestin-only injectable (DMPA) • Combined oral contraceptives • Contraceptive patch • Combined injectables • Intrauterine device • Condom • BTL • Vasectomy			Midwife should be able to tell the client what each FP method is, how it works, its advantages and disadvantages, the possible side effects, and warning signs of each method's complications.
14. Counsel clients on family planning by: • Establishing rapport (i.e., greeting, introducing yourself), being cheerful and pleasant? • Making them comfortable (i.e., offering them a seat)? • Assuring confidentiality and providing privacy?			Bullets 1-3 are the tasks in the "G" Step.
• Using an appropriate form for obtaining and recording pertinent data (e.g., BEST Form 1 or FP Service Record Form 1)? • Asking about her reproductive needs (having more children and by when, not having any more pregnancies)? • Asking about her decision on breastfeeding (exclusive for six months, expression of breastmilk while at work, not to breastfeed)?			Bullets 4-9 are the tasks in the "A" Step.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
• Asking about what she knows about the FP methods? • Assessing her risk for STIs? • Asking about her experience of domestic violence?			
• Telling her about the FP methods based on her situation, knowledge, and needs? • Telling about the benefits, risks, possible side effects of FP methods appropriate to her needs and situation?			Bullets 10-11 are the tasks in the "T" Step.
• Helping her make a decision on choosing a method by asking her how she will cope with the possible side effects of the chosen method?			Bullets 12-13 are the tasks in the "H" Step.
• Explaining how to use the chosen method? • Explaining the warning signs of the chosen method and what she should do if these signs are observed? • Asking the client to repeat instructions on how to use her chosen method and what to do for warning signs? • Ensuring that she gets the method she chooses either from you or facilitating referral to health care provider who can provide the method?			Bullets 14-17 are the tasks in the "E" Step.
• Telling the client when to return? • Explaining informed choice and ensuring that the informed consent form is signed if the woman or her partner chooses voluntary surgical sterilization (BTL or vasectomy)?			Bullets 18-19 are the tasks in the "R" Step.

COMPONENT II: TECHNICAL COMPETENCE	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
15. Provide counseling to a revisit FP client by:			
• Asking if there has been any change in her situation that has affected her use of the FP methods since the last visit? • Asking if her reproductive intention has changed since the last visit? • Asking her if she is satisfied with her method?			"A" Step – Revisit client.
• Checking how she uses the method?			"E" Step —revisit client.
• Helping her choose another method if she is not satisfied with the method she is currently using?			"T" and "H" Steps
16. Competently provide the following methods when chosen by clients: • Lactational Amenorrhea Method? • Standard Days Method • Progestin-only pills? • Progestin-only injectables? • Combined oral contraceptives? • Combined injectables? • Contraceptive patch? • Condom? • IUD?			"E" Step
Indicator J. Sexually-Transmitted Diseases: Patient Counseling and Education			
1. Do you counsel and discuss with all clients: • What to do if client thinks he or she may have become infected? • When and where to go for STI screening and treatment if you are unable to provide those services?			Ask: "What do you do when a client comes to you and says he or she may have been infected or has STI?"

Component III - Continuity of Care

Examines functional referral systems in cases when needed care is not available in the midwife's clinic. It includes knowing when and where to refer, procedures for referral, use of referral forms and client follow-up.

COMPONENT III: CONTINUITY OF CARE	MW RATING	SUPERVISOR RATING	
Client Referrals			
1. Have you established specific facilities or physicians for referral?			Who are your back-up doctors? How long does it take before he/she arrives at the clinic when called?
2. Do you send or accompany the client to the referral facility with a note describing the need for referral?			Look for a copy of the accomplished referral form.
3. Do you request information and feedback about the outcome of the visit from the referral facility (using the two-way referral form)?			Look for a copy of the accomplished return referral form.
4. Do you contact the client to find out the outcome of the referral visit?			Ask the midwife how she contacts the client to find out the outcome of the referral.
5. If you received information from the referral facility, do you record the outcome of the visit in the client's record?			Check clinical records if information from referral facility is recorded in the client's clinical record.
6. Do you follow-up on the newborn that you referred for higher level of care or intensive care?			Ask: "How do you follow-up the newborn that you have referred for intensive care?"
7. Do you or other members of your staff contact clients about missed follow-ups?			Ask: "How do you handle clients who do not return for follow-up?"

Component IV – Management

Refers to the provider's capacity to plan, organize, implement, and maintain effective health delivery services. It includes using data for decision-making and ensuring proper tracking of finances and supplies.

COMPONENT IV: MANAGEMENT	MW RATING	SUPERVISOR RATING	
Indicator A. Review of Practice, Including Review of Action Plan			
1. Do you know your scope of work according to your job description?			Ask the midwife to enumerate her roles and responsibilities. Validate against her scope of work.
2. Do you review your job description at least semi-annually? 3. Do you use this review as a basis to improve the quality of services you provide to clients? 4. Do you prepare an updated action plan to improve the quality of your services? 5. Has any action been taken to address items in the plan to ensure quality of services?			Check if the midwife does self-assessment every six months.
Indicator B. Client Records			
1. Do you have a written procedure to prevent infection in your facility?			Look for infection prevention procedures.
2. Do you maintain client records for every client?			Check filed client records.
3. Are all the required records complete?			Randomly pull out 3-5 clinical records and check for completeness.
4. Are your client records kept where unauthorized persons have no access?			Check where records are kept.
5. Do you maintain strict confidentiality concerning all personal information collected during a client visit?			

COMPONENT IV: MANAGEMENT	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator C. Supplies and Consumable Drugs, Including Vaccines			
1. Do you keep an inventory of consumable supplies and drugs, including vaccines?			Look for accomplished inventory forms.
2. Do you keep a record or stock cards of consumable supplies in your facility?			Look for accomplished stock cards.
3. Did you conduct an updated inventory of your consumable supplies within the last three months?			Look for list of consumables for the past three months.
4. Does your list include expiration dates of drugs and supplies?			Check if expiration dates are reflected in inventory form and stock cards or inventory list.
5. Do you have a reliable supplier of drugs and other supplies?			Ask: "Who supplies your drugs and other supplies?"
6. Do you order drugs and supplies based on your pharmaceutical needs?			Pharmaceutical needs should be based on the services offered. Check stock cards.
7. Have you been able to ensure availability of drugs, contraceptives, or other commodities in the last three months?			Check if inventory of drugs and supplies is accurately done quarterly.
8. Do you keep records about cold-chain conditions of vaccines?			Where do you immunize? How do you transport your vaccine/s if immunization needs to be done outside the clinic?

COMPONENT IV: MANAGEMENT	MW RATING	SUPERVISOR RATING	SUPERVISOR TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator D. Medical Equipment, Instruments, and Furniture			
1. Do you keep an inventory of equipment, instruments, furniture that includes date of purchase, projected date of repair, and replacement?			Check accomplished inventory forms.
2. Are the instruments, equipment, and furniture in working condition?			Test the functionality of the equipment and instruments.
Indicator E. Information on Clinic Operation Hours			
1. Do you have a memorandum of agreement with a back-up obstetrician and pediatrician stipulating their roles, responsibilities and accountabilities?			Look for MOAS (not applicable for public sector).
2. Do you have a staff or reliever to take charge of your facility in your absence?			Ask: "Was there a time when your clinic was closed?"
3. In case of emergency and the clinic is closed, are there instructions posted, directing clients on what to do or where to go?			If answer above is no, no further validation is needed. If yes, ask "If an emergency case arrives in the clinic, what would happen?"

Component V – Community Involvement

Refers to provider's knowledge of the people in their communities and how effectively he or she markets his/her services to maintain clients and attract new ones.

COMPONENT V: COMMUNITY INVOLVEMENT	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator A. Client Feedback			
1. Do you have a way to determine the satisfaction of your clients (for example, asking feedback, suggestion box)?			Look for suggestion box. If none, ask the midwife how she determines satisfaction of clients.
2. Do you act on feedback received from clients?			Ask: "What do you do with feedback that you receive from clients?"
3. Do you encourage clients to ask questions during visits?			
Indicator B. Advertising			
1. Do you promote your services to the community that you serve? 2. Do you use other modes in promoting your services to clients and the community?			Ask""How do you promote clinic services in the community?"

(This section is for supervision of private midwives or government facilities that are also engaged in private business enterprise as a clinic.)

Component VI – Business Practices

Examines health provider's goals, financial-management practices (including records keeping), resources for adequate financing, and allocation of resources.

COMPONENT VI BUSINESS PRACTICES: (for private practice midwives)	MW	SUPERVISOR	
	RATING	RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator A. Specific, Measurable, Attainable, Realistic, and Time-bound (SMART) Goals			
1. Do you have SMART goals for the next year? 2. Do you have a plan to achieve these goals?			Ask the midwife if she has undergone training in business. If yes, ask all questions directly and ask her to show you all the financial records.
Indicator B. Financial Practices and Records			
1. Do you keep track of your: • Monthly cost or operating expenses? • Monthly earnings? • Collectibles (i.e., how much people owe you)?			
2. Do you have a plan on: • Collecting debts of clients for services rendered? • How much you need to earn to cover for your expenses?			
3. Do you have a budget?			
4. Do you review your clinic's budget quarterly?			
5. Do you prepare or have financial records? • Balance sheet? • Income statement? • Cash flow statement?			
6. Do you use these records to: • Make management decisions? • Analyze cash flow?			

COMPONENT VI BUSINESS PRACTICES: (for private practice midwives)	MW RATING	SUPERVISOR	
		RATING	TIPS/VALIDATION BY OBSERVATION OR ROLE PLAY
Indicator C. Functional Pricing and Collection System			
1. Do you know how much each type of service you provide costs (including the cost of your and your staff's time, commodities, supplies and the cost of operating your clinic)?			
2. Do you know how to price your products so that you can provide your clients with quality and affordable services and still cover your cost?			
3. In the last three months, were at least 75% of your clients able to pay the full amount of your service on the day of the visit?			
Indicator D. Profitable Facility/Practice			
1. Is your business profitable?			
Indicator E. Adequate Financing			
1. If you need additional financing, do you know where to go and how to get it?			
2. Have you ever made a loan?			
3. Do you know where to access outside financing to grow your business?			

Scoring the Midwife's Performance

Improving quality should result in quantitative or numeric changes in the use of services, contraceptive use, effective operating procedures, and positive health outcomes. By summarizing the midwives' scores on each of the dimensions and indicators, you will see how to best help the midwives improve. These scores, together with the action plans, will be your guide in helping the midwives resolve their issues.

Instructions:

1. Go through the Supervisor's Assessment Tool and review your rating of each of the items in the indicators under the six components.

2. Use the **scoring sheet** to record the score for each question (copy your ratings on to the appropriate blanks provided in the scoring sheet).

3. Record the answers in the scoring sheet per component, per indicator, and per question.

4. Computing the score per indicator:

    - To get the numerator for each indicator, add all the numerical answers (that is, all 2s, 1s, or 0s).

    - To get the denominator, subtract the number of items with NA answers from the total number of items for the indicator, and multiply the answer by 2.

5. Computing the score per component: To get the numerator, add the numerators of all indicators. To get the denominator, add the denominators of all indicators.

6. Each component will then have a total score which is expressed as a fraction, e.g., a component 1 score of **48/56**.

7. Component scores that are recorded for the first time will comprise **the clinic's baseline component scores.** Scores recorded from subsequent monitoring visits will objectively document whether the facility is improving or deteriorating in the quality of its FP-MCH services and supplies.

SUPERVISOR PORTION
SCORING SHEET

1. FACILITY					
Indicator A. Conditions/Amenities (12 items)	Indicator B. Facility/ Infrastructure (12 items)	Indicator C. Educational Materials for Clients (3 items)	Indicator D. Professional Appearance of Provider (1 item)	Total Score (28 items)	Comments
1. _____ 8. _____ 2. _____ 9. _____ 3. _____ 10. _____ 4. _____ 11. _____ 5. _____ 12. _____ 6. _____ 7. _____ Score: ___/___	1. _____ 8. _____ 2. _____ 9. _____ 3. _____ 10. _____ 4. _____ 11. _____ 5. _____ 12. _____ 6. _____ 7. _____ Score: ___/___	1. _____ 2. _____ 3. _____ Score: ___/___	1. _____ Score: ___/___	Score: ___/___	

II. TECHNICAL COMPETENCE					
Indicator A. Attitude, Behavior of Midwife (10 items)	Indicator B. Standards of Care (3 items)	Indicator C. Basic Counseling Guidelines (6 items)	Indicator D. Infection Prevention (10 items)	Indicator E. Pre-Natal Care (21 items)	Indicator F. Obstetrical (Physical) Exam (11 items)
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ Score: ____/___	1. _____ 2. _____ 3. _____ Score: ____/___	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ Score: ____/___	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ Score: ____/___	*Initial visit* 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ 13. _____ *Succeeding visits* 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ Score: ____/___	*Initial visit* 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ *Succeeding visits* 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ Score: ____/___

II. TECHNICAL COMPETENCE					
Indicator G. Labor and Delivery (27 items)	Indicator H. Postpartum Care (11 items)	Indicator I. Family Planning: Info-Giving & Counseling (16 items)	Indicator J. Sexually-Transmitted Diseases: Patient Counseling & Education (1 item)	Total Score	Comments
During Labor 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ *During Delivery* 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ 13. _____ 14. _____ 15. _____ 16. _____ 17. _____ 18. _____ 19. _____ 20. _____ 21. _____ 22. _____ 23. _____ 24. _____ Score: ____/___	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ Score: ____/___	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____ 13. _____ 14. _____ 15. _____ 16. _____ Score: ____/___	1. _____ Score: ____/___	Score: ____/___	

III. CONTINUITY OF CARE		
	Total Score	Comments
1. _____ 5. _____ 2. _____ 6. _____ 3. _____ 7. _____ 4. _____ Score: ____/____	Score: ___/__	

IV. MANAGEMENT						
Indicator A. Review of Practice, including Review of Action Plan (5 items)	Indicator B. Client Records (5 items)	Indicator C. Suppliers, Consumable Drugs, including Vaccines (8 items)	Indicator D. Medical Equipment, Instruments, Furniture (2 items)	Indicator E. Information on Clinic Hours (3 items)	Total Score	Comments
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ Score: ___/__	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ Score: ___/__	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ Score: ___/__	1. _____ 2. _____ Score: ___/__	1. _____ 2. _____ 3. _____ Score: ___/__	Score: ___/__	

V. COMMUNITY INVOLVEMENT			
Indicator A. Client Feedback (3 Items)	Indicator B. Advertising (2 Items)	Total Score	Comments
1. _____ 2. _____ 3. _____ Score: ____/____	1. _____ 2. _____ Score: ___/___	Score: ___/___	

VI. BUSINESS PRACTICES (for private -practice midwives)						
Indicator A. SMART Goals (2 items)	Indicator B. Financial Practices (6 items)	Indicator C. Pricing and Collection System (3 items)	Indicator D. Profitable Facility-Practice (1 item)	Indicator E. Adequate Financing (3 items)	Total Score	Comments
1. _____ 2. _____ Score: ___/___	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ Score: ___/___	1. _____ 2. _____ 3. _____ Score: ___/___	1. _____ Score: ___/___	1. _____ 2. _____ 3. _____ Score: ___/___	Score: ___/___	

APPENDIX A: Case Study 1

INSTRUCTIONS: Accomplish the Supervisor's Assessment Tool based on the following observations. What is not mentioned is presumed to be absent. Complete the assessment by putting a score for each of the components in the tool.

You visited the clinic of Emma Gonzales and noted the following:

Physical Environment

- There is a big sign that says "Mother and Baby-Friendly Birthing Home" placed on a post outside the clinic.
- The sign that bears the services the clinic offers is small and can hardly be noticed.
- As you enter the clinic you are greeted by Emma and her assistant. Both are in clean uniforms. You see a long bench and several chairs in a waiting area that is well-ventilated and cool.
- You enter the consultation room, which has a desk, a chair behind and another in front of it for counseling, and an examination table with clean linen. Also in the room is an adult weighing scale, a sphygmomanometer, and a tape measure. There is also a locked cabinet with medicines like iron and folate tablets and prenatal vitamins. Only Marvelon is noted as a contraceptive supply.
- Separately packed are medium-sized vaginal specula.
- A basin with chlorine solution is noted under the examining table. When asked how it was prepared, Emma said that she just pours some chlorine solution in a half-basinful of water.
- At the foot of the examining table is a sink with a bar of soap and faucet with running water.
- In the patients' room are two beds with pillows and covered by clean linen. The room has a ceiling fan.
- The air-conditioned delivery room has a delivery table topped by thin upholstered cushion with Kelly pad. The room is noted to be clean and orderly. There is an area for cleaning and resuscitating the newborn. The room has the required equipment except for a bassinet and another gooseneck lamp (there should be two). At the corner of the room near the delivery table is a receptacle for used needles.
- The delivery room also has a locked cabinet for high-level disinfected, wrapped instruments and another for medicines and supplies needed for delivery.
- A clean toilet with water supply is noted adjacent to the patients' room. It has a sink and toilet bowl.
- In the work area is a small electric stove with a pan for boiling instruments.
- Outside the work area and at the back of the clinic, are three covered garbage receptacles lined with colored plastic bags (black for dry wastes, green for wet wastes, and yellow for infectious clinic wastes). This area also has an emergency or fire exit.

Technical Competence

Service protocols to service provision

- The midwife does not have a copy of the most recent midwifery service delivery guidelines nor a job aide with core steps of focused antenatal care.

Basic counseling guidelines

- Clients are not given complete information to make health-related decisions. They are not told of the importance of having at least four antenatal visits and when during pregnancy these visits should occur. They are also not told of the importance of newborn screening.
- Clients know that the clinic provides maternal and newborn care services but not family planning.
- Clients' rights to privacy and confidentiality are not discussed.
- Emma ensures that she is not disturbed when she attends to a client.
- The client is not asked if she would like to allow Emma's assistant to be in the consultation room during counseling and examination.

Infection prevention protocols

- Washes hands after attending to each client
- Facility cleaned regularly
- Soaks used instruments immediately but in an undetermined strength of chlorine solution
- Boils instruments but does not time the duration of roll boiling
- Follows the three steps of processing (i.e., decontamination, cleaning, and high-level disinfection) but incorrectly performed
- Maintains a single-use injection practice and disposes of disposable needles in a sharps container
- Blood, urine and feces collected in the pail are flushed in the toilet. The placenta is given to the family but she does not give instructions on how to dispose of it.
- Uses a plastic apron, cap, mask, and gloves during deliveries

Preparing the pregnant woman appropriately

During the initial visit:

- Determines the age of gestation based on the last menstrual period
- Does not discuss with the woman the need for at least four prenatal visits and at what recommended period each of these visits should occur. She does not talk about tetanus toxoid immunization.
- Takes the woman's medical history but does not ask about her family history, does not assess her risk for STIs and the possibility of domestic violence

- Tells the woman of specific health problems she discovers during examination and tells her to come back for follow-up
- Does not tell the woman the need to deliver in a facility and is open to delivering at home
- Does not discuss or help the woman develop a birthing plan
- Describes swelling of the legs, hands, and/or face, vaginal bleeding, and fever and chills as danger signs for which the woman must seek immediate consultation
- Does not ask the woman about her tetanus immunization status nor provide or refer for tetanus toxoid immunization
- Provides iron and folate tablets as well as multivitamins containing Vitamin A to pregnant women
- Does not discuss STI with clients

During succeeding visits:

- Informs the client of her age of gestation
- Explains the importance of personal hygiene but does not describe how to wash her external genitalia
- Provides nutritional advice but does not inform the woman that she should be gaining weight 10-12.5 kg. or 22-28 lbs. during the entire pregnancy
- Does not discuss FP and newborn screening with pregnant women
- Discusses the importance of breastfeeding immediately after delivery but does not ask about possible problems the woman may have to be able to start breastfeeding
- Describes the onset of labor signs and what the woman should do if any of these occur

Performs obstetrical examination during prenatal visits

During initial visit

- Performs the following according to standards:
  - Takes and records vital signs
  - Takes and records the client's weight
  - Inspects and palpates the breast
  - Does abdominal examination
  - Determines the size of the uterus and assesses compatibility of uterine size to age of gestation
- Requests for laboratory examinations except that to determine exposure to syphilis (i.e., VDRL or RPR)

During succeeding visits

- Performs the following according to standards:
  - Records and notes changes in blood pressure, weight and uterine size
  - Listens to the fetal heart tones at ≥18 weeks age of gestation
  - Checks for warning or danger signs and refers women with any one of these to an obstetrician or hospital

- Checks the presenting part but does not do Leopold's maneuver

During labor and delivery

- Performs the following according to standards:
  - Does a "quick check" at different times during labor
  - Encourages the woman to have a companion of her choice
  - Ensures safe and clean delivery
  - Does not do an episiotomy
  - Ensures controlled delivery of the head
  - Records time of delivery
  - Thoroughly dries the baby and keeps it warm
  - Clears the baby's airways and ensures that it cries
  - Assesses baby's breathing and ventilates, if needed
  - Excludes a second baby
  - Checks the placenta for completeness
  - Encourages the woman to breastfeed within one hour after delivery
  - Does a complete examination of the baby and refers to the hospital for abnormalities
  - Checks uterine tone and woman's vital signs within two hours postpartum
  - Encourages woman to take liquids and light food
- Urgently refers woman to backup obstetrician when any of the danger signs is observed
- Does not do partography
- Delivers only in lithotomy position
- Clamps the cord immediately after delivery of the baby
- Waits for the signs of placental separation for delivering the placenta
- Administers Terramycin ophthalmic ointment to both eyes of the baby
- Records details of birth but does not estimate blood loss

Postpartum care

Before discharge

- Performs the following according to standards:
  - Checks maternal and neonatal vital signs
  - Conducts complete physical examination on the mother and baby, and records findings
  - Informs the woman of the results of the examination
  - Discusses personal hygiene, nutrition and breastfeeding, care of the baby, care of the perineum and breast, family support, infant immunization and when and how to get her baby immunized
  - Teaches the mother how to recognize danger signs in the baby and what to do in case would be any

    - Teaches the mother how to recognize danger signs that she may experience and what to do in case there would be any
- Does not perform newborn screening
- Instructs the mother to apply alcohol regularly to the umbilical stump
- Instructs mother to breastfeed her baby without assessing her knowledge and ability to do this
- Does not discuss family planning, benefits of breastfeeding, and ways of preventing diarrhea and dehydration

Family planning

- Does not introduce family planning to clients
- Looks at the client while she talks but writes when the client talks
- Exhibits appropriate body language and uses simple language which the client understands
- Allows the client to make her own decision
- Does not have IEC materials on family planning
- Does not inform clients of the ideal gap between pregnancies and the earliest she can be pregnant if not practicing exclusive breastfeeding and family planning
- Does not inform clients on how the reproductive system works
- Does not talk about FP methods except when asked about the pill and BTL; information about these two methods is incomplete
- Forgets to introduce self to clients but ensures comfort during counseling
- Does not assure confidentiality but provides privacy
- Does not have copies of FP Form 1
- Cannot conduct FP counseling using the GATHER approach
- Explains how to use the pill which she recommends and tells her to come back for re-supply, but does not mention the warning signs
- Does not perform the tasks as recommended for counseling revisit clients
- Only provides Marvelon but cannot give complete information about it

Sexually-transmitted infections

- Does not provide STI counseling

Continuity of Care

- Has established specific facilities and back-up physicians for referral
- Contacts referred clients to find out the outcome of the referral
- Instructs the client to go to the hospital for complaints that she cannot handle but does not give her a referral note or use a two-way referral form
- Does not have a record of the outcome of the referral
- Follows up the outcome of a newborn referral when she remembers and has time
- Waits for clients to return but says she does not have the time to follow up when they miss scheduled visits

Management

- Used the self-assessment tool once but has not updated the action plan, nor has used it to guide herself in her performance
- Has no written procedure to prevent infection
- Keeps records of her clients but not all are complete
- Keeps records in an orderly fashion, in a filing cabinet which is not locked
- Does not talk to others about other client's situation and circumstances
- Does not keep an inventory of equipment, furniture and supplies
- Has a reliable supplier of drugs and other supplies
- Orders drugs and supplies based on a rough estimate of how many have been used/ consumed for the month, and is proud to say that she has not run out of stocks for the last three months
- Does not have stocks of vaccines in the clinic
- Keeps instruments, equipment, and furniture in good working condition, though she does not have an inventory of these items
- Has a partner midwife who also attends to patients in the clinic, and who relieves her when she is not available
- Says that there is no need to post instructions on what to do when there are emergencies when the clinic is closed, as it is always open 24/7
- Posts a list of services offered, outside the clinic but none inside
- At times asks new clients about what they think of services being provided, makes an effort to improve based on feedback, and encourages them to ask questions
- Does not have time to regularly conduct marketing activities in the community, but holds "Buntis Party" once in a while

Business Practices

- Has not thought of a goal for the succeeding year
- Has an idea of the average operating expenses she incurs in a month, and has a record of her monthly earnings and collectibles
- Does not have a definite plan for collecting debts for services rendered, except to ask for it when clients return for follow-up (there are times they do not return)
- Has set a definite amount she has to earn to cover for her expenses
- Has a budget and reviews this quarterly
- Only keeps a cash flow statement and uses only this to make decisions
- Has a rough estimate of how much her services should cost, considering the different costs she incurs to provide these
- In the last three months about 80% of her clients were able to pay the full amount of services she rendered
- If she needs additional financing she can probably borrow from her brother who works overseas and who has given her a loan to start running this clinic. She knows that she can also access a loan from the bank.

APPENDIX B: Case Study 2

INSTRUCTIONS: Accomplish the Supervisor's Assessment Tool based on the following observations. What is not mentioned is presumed to be absent. Complete the assessment by putting a score for each of the components in the tool.

You visited the clinic of Rebecca Aquino and observed the following:

Physical Environment

- There is a big sign that says "Rebecca Aquino Birthing Home" placed on a post outside the clinic.
- Below the name of the clinic is an equally big sign that lists the services the clinic offers.
- As you enter the clinic you are greeted by Rebecca herself, her receptionist, and her daughter who is a newly licensed midwife. All are in clean uniforms.
- You see a sofa and several chairs in the waiting area for clients and the area is well ventilated and cool.
- IEC materials on MCH and FP, though few, are available for clients to read.
- You enter the consultation room which has a desk, a chair behind and another in front of it for counseling, and an examination table with clean linen. Also in the room is an adult weighing scale, a sphygmomanometer, and a tape measure. There is also a locked cabinet with medicines like iron and folate tablets, prenatal multivitamins, and FP commodities like combined oral contraceptives, Progestin-only pills, DMPA and SDM.
- Separately packed are different sizes (i.e., large, medium and small) of vaginal specula.
- At the foot of the examining table is a sink with a bar of soap and faucet with running water.
- In the patients' room are two beds with pillows and covered by clean linen. The room has a ceiling fan.
- The air-conditioned delivery room has a delivery table topped by thin upholstered cushion with Kelly pad. The room is clean and orderly. There is an area for cleaning and resuscitating the newborn. The room has all the required equipment. At the corner of the room near the delivery table is a receptacle for used needles.
- The delivery room also has a locked cabinet for high-level disinfected, wrapped instruments and another for medicines and supplies needed for delivery.
- There is a clean toilet with water supply near the patients' room, with sink and toilet bowl.
- In the work area is a small electric stove with a pan for boiling instruments.
- Outside the work area, and at the back of the clinic, are three covered garbage receptacles lined with colored plastic bags (black for dry wastes, green for wet wastes, and yellow for infectious clinic wastes). This area also has an emergency or fire exit.
- There is no decontaminating solution seen anywhere in the clinic.

Technical Competence

Service protocols to service provision

- The midwife does not have a copy of the most recent midwifery service delivery guidelines nor a job aide with core steps of focused antenatal care.

Basic counseling guidelines

- Clients are not given complete information to make health-related decisions. They are not told of the importance of newborn screening.
- Clients know that the clinic provides maternal and newborn care services and also family planning.
- Clients' rights to privacy and confidentiality are not discussed.
- Rebecca ensures that she is not disturbed when she attends to a client.
- The clients' permission is asked to allow Rebecca's assistant to be in the consultation room during counseling and examination.

Infection prevention protocols

- Washes hands after attending to each client
- Facility cleaned regularly
- Boils instruments but does not time the duration of roll boiling
- Does not know the three steps of processing (i.e., decontamination, cleaning, and high-level disinfection) and does not practice it. She does not do decontamination.
- Uses disposable needles two times. She says that a newly opened needle is washed after use and soaked in alcohol. After the second use, these are disposed of in a separate container. She finds this practice economical.
- Blood, urine and feces collected in the pail are flushed in the toilet. The placenta is given to the family but she does not give instructions on how to dispose of it.
- Uses a plastic apron and gloves during deliveries

Preparing the pregnant woman appropriately

During the initial visit:

- Determines the age of gestation based on the last menstrual period
- Discusses with the woman the need for at least four prenatal visits and at what recommended times each of these visits should occur
- Takes the woman's medical history but does not ask about her family history, does not assess her risk for STIs and the possibility of domestic violence
- Tells the woman of specific health problems she discovers during examination and discusses the probability of referral
- Tells the woman about the need to deliver in a birthing facility and its advantages

- Discusses with the woman the need to have a plan for her delivery which includes readiness for complications and emergencies and the need to be financially prepared for these, but does not assist the woman to make a written birth plan
- Describes all the danger signs for which the woman must seek immediate consultation with her
- Determines the woman's tetanus immunization status and instructs her where and when to get her tetanus toxoid immunization, as needed
- Provides iron and folate tablets and multivitamins containing Vitamin A to pregnant women
- Does not discuss STI with clients

During succeeding visits:

- Provides complete health information to the woman except on newborn screening
- Instructs the woman to bury the placenta but does not tell her of the depth of the burial site

Performs obstetrical examination during prenatal visits

During initial visit

- Performs the following according to standards:
  - Takes and records vital signs
  - Takes and records the client's weight
  - Inspects and palpates the breast
  - Does abdominal examination
  - Determines the size of the uterus and assesses compatibility of uterine size to age of gestation
- Requests for laboratory examinations except that to determine exposure to syphilis (i.e., VDRL or RPR)

During succeeding visits

- Performs the following according to standards:
  - Records and notes changes in blood pressure, weight and uterine size
  - Listens to the fetal heart tones at $\geq$18 weeks age of gestation
  - Checks for warning or danger signs and refers women with any of these to an obstetrician or hospital
  - Performs Leopold's maneuver

During labor and delivery

- Performs the following according to standards:
  - Does a "quick check" at different times during labor
  - Encourages the woman to have a companion of her choice

  - Ensures safe and clean delivery
  - Does not do an episiotomy
  - Ensures controlled delivery of the head
  - Records time of delivery
  - Thoroughly dries the baby and keeps it warm
  - Clears the baby's airways and ensures that it cries
  - Assesses baby's breathing and ventilates, if needed
  - Excludes a second baby
  - Checks the placenta for completeness
  - Encourages the woman to breastfeed within one hour after delivery
  - Examines the baby completely and refers to the hospital for abnormalities
  - Checks uterine tone and woman's vital signs within two hours postpartum
  - Records details of birth completely
- Rebecca does not encourage the client to take liquids and light food during labor because the client may vomit.
- Urgently refers the patient to back-up obstetrician when danger signs are observed
- Does not do partography
- Delivers only in lithotomy position
- Clamps the cord immediately after delivery of the baby
- Waits for the signs of placental separation before delivering the placenta
- Administers Terramycin ophthalmic ointment to both eyes of the baby
- Encourages the woman to take light food after delivery

Postpartum care

Before discharge

- Performs the following according to standards:
  - Checks maternal and neonatal vital signs
  - Conducts complete physical examination on the mother and baby and records findings
  - Informs the woman of the results of the examination
  - Discusses personal hygiene, nutrition and infant breastfeeding, care of the baby, care of the perineum and breast, family support, family planning, infant immunization and when and how to get her baby immunized, and prevention of diarrhea and dehydration in the infant
  - Teaches the mother how to recognize danger signs in the baby and what to do in case there would be any
  - Teaches the mother how to recognize danger signs that may experience and what to do in case there would be any
  - Instructs the mother on breastfeeding taking into consideration her knowledge and experience in breastfeeding
- Does not perform newborn screening.

Family planning

- Uses every opportunity to discuss family planning with clients
- Provides information on FP to all types of clients, including the male partners of clients, except among adolescents
- Maintains eye contact during client interactions
- Uses appropriate tone of voice, exhibits appropriate body language and uses simple language which the client understands
- Allows the client to make her own decision
- Has a few IEC materials on family planning and uses these effectively
- Informs clients of the ideal gap between pregnancies and the earliest she can be pregnant if not practicing exclusive breastfeeding and family planning
- Informs clients about how the reproductive system works
- Talks competently about FP methods except for fertility awareness-based methods like the BBT, Billing's Ovulation Method, and the Symptothermal Method.
- Competently counsels new and revisit clients by performing all the tasks on counseling according to standard
- Competently provides all the methods listed

Sexually Transmitted Infections

- Does not provide STI counseling

Continuity of Care

- Has identified specific facilities and back-up physicians for referral
- Refers clients to other facilities (they are usually accompanied by her assistant, with an accomplished two-way referral form)
- At times, the other half of the two-way referral form is not returned to her. In such cases, she contacts the client to find out the outcome of the referral.
- Records the outcome of the referral
- Follows up the outcome of a newborn referral when she remembers and has time
- Waits for the clients to return but says she does not have the time to follow them up when they miss scheduled visits

Management

- Used the self-assessment tool once and has not updated the action plan, nor has not used it to guide herself in her performance
- Has no written procedure to prevent infection
- Keeps complete records of her clients
- Keeps records in an orderly fashion in a locked filing cabinet
- Does not talk to others about other client's situation and circumstances
- Does not keep an inventory of equipment, furniture and supplies
- Has a reliable supplier of drugs and other supplies

- Orders drugs and supplies based on a rough estimate of how many have been used or consumed for the month. She is proud to say that she has not run out of stocks for the last three months
- Does not have stocks of vaccines in the clinic
- Instruments, equipment, and furniture in the clinic in good working condition though, she does not have an inventory of these items
- Has a substitute (her daughter) when she is not available
- Says that there is no need to post instructions on what to do when there are emergencies when the clinic is closed, as it is open 24/7
- Posts the list of services the clinic offers outside and at the reception area of the clinic
- At times asks new clients about what they think of services being provided and makes an effort to improve based on feedback
- At all times encourages clients to ask questions
- Regularly conducts marketing activities in the community like holding "Buntis Party" and health education (conducted by her daughter) regularly. She is keen on finding out the cost of services of her competitors and tries to see how she can package her services. Her daughter visits the homes of mothers and babies who fail to return for follow-up.

Business Practices

- Has not thought of a goal for the succeeding year
- Has an idea of the average operating expenses she incurs in a month and has a record of her monthly earnings and collectibles
- Does not have a definite plan on collecting debts for services rendered except to ask for it when the clients return for follow up (there are times they do not return)
- Has set a definite amount she has to earn to cover for her expenses
- Has a budget and reviews this quarterly
- Keeps only a cash flow statement and uses only this to make decisions
- Has a rough estimate of how much her services should cost, considering the different costs she incurs to provide these
- Reports that in the last three months about 80% of her clients were able to pay the full amount of services she rendered
- Can probably borrow from her sister who works as a nurse in Australia in case she needs additional funding. Her sister has given her a loan to start running the clinic. She knows that she can also access a loan from the bank.

Quality Assurance Package for Midwives

TOOLKIT FOR PRACTICING PROFESSIONAL MIDWIVES

SECTION 4

A Guide to Organizing and Managing the Conduct of Clinical Case Conference for Midwives

CONTENTS

Introduction

One of the top priorities of the health sector is to reduce maternal deaths related to pregnancies and deliveries as well as infant deaths. The maternal mortality ratio (MMR) in the Philippines is still quite high compared to that of neighboring countries at 162 per 100,000 live births (Family Planning Survey 2006). This translates to approximately 10 Filipino mothers dying everyday from complications related to pregnancy and childbirth. Among women aged 15-49, 14 percent of the maternal deaths are due to pregnancy and birth delivery complications. The Philippines is still far from achieving the Millennium Development Goal (MDG) of reducing MMR to 52 by 2015.

On the other hand, the country's infant mortality rate (IMR) is at 25 per 1,000 live births. Although our IMR appears to be on track toward achieving the MDG target of 19 by year 2015, the fact that the country is still among only 40 countries contributing to 90 percent of infant deaths worldwide remains.

There are many reasons for these relatively high rates. In the Philippines, however, the main factor is that majority of births (56.5%) still occur at home, and 36.1 percent of deliveries are attended by unskilled health workers. To address this issue and to help achieve the MDG goals, one of the strategies that the Department of Health (DOH) employed is to increase the number of birth deliveries at health facilities attended by skilled birth attendants.

The USAID, through the Private Sector Mobilization for Family Health (PRISM) Project, supports government efforts to achieve the MDGs. Since 2004, the Project has been providing technical assistance to private practicing midwives all over the country so that they, along with their birthing home facilities, can qualify for Philippine Health Insurance Corporation (PHIC) accreditation.

Ensuring quality in providing family planning and expanded maternal, neonatal and child health and nutrition services is the prime and common concern of DOH, USAID and PRISM. Doing its share, PRISM initiated the conduct of the Clinical Case Conferences for Midwives (CCC for MWs) in September 2007. This technical meeting has become a venue not only for exchange of technical expertise, but also for facilitating closer working relationships between referral doctors, hospitals and the private midwives who operate the birthing facilities. The updates provided by the obstetricians and pediatricians, together with the resulting rapport established between these medical professionals and their midwife counterparts, are expected to result in improved quality of services for maternal and child health.

Background

History

The CCC for MWs was a result of a series of Consultative Working Group (CWG) meetings that PRISM organized in its third year of project implementation. Composed of a small group around five private practicing midwives (PPMs) and one business person, the CWGs were held at least twice in each of the three PRISM Regional Offices in Manila, Cebu City and Davao City. The meetings aimed at ensuring that the PRISM project remained relevant and responsive to the needs of PPMs. During several of these meetings, the idea of gathering obstetricians and midwives in one forum for continuing updates for midwives surfaced.

The first CCC for MWs was held on 25 September 2007 at the Cebu Midtown Hotel in Cebu City. It was initiated and organized by the PRISM-Visayas Regional Office in coordination with the DOH Center for Health Development (CHD) Region 7, the Philippine Obstetrical and Gynecological Society (POGS), the Philippine Pediatric Society (PPS) and the Integrated Midwives Association of the Philippines (IMAP). The PRISM Cebu staff drafted this manual based on their initial experience in organizing the conference. Subsequently, other PRISM sites held their own CCC for MWs.

Originally intended to guide other PRISM staff in organizing CCCs, this manual has evolved into a guide primarily to be used by PRISM's sustainability partners, more particularly the CHDs. Aside from the CHDs, non-government organizations (NGOs) and midwives associations (MWAs) that have worked with PRISM under its grants program may also opt to take on this continuing quality improvement activity. DOH, being the guardian of quality service, and the MWAs, being more specifically interested in enhancing the professional practice of midwives, are among the best candidates to continue this initiative. Health NGOs that have been working with midwives are also likely to benefit from organizing these conferences.

Manual Description

This manual seeks to formalize and sustain the conduct of the Clinical Case Conference (CCC) for Midwives (MWs) as a Continuing Quality Improvement (CQI) activity for the professional practice of midwifery. Intended for organizers of the event, this serves as a user-friendly guide on how to organize and manage the conduct of CCCs for midwives.

This guide may be used by the following agencies and organizations:

1. Centers for Health Development (CHDs) – as regional DOH offices, each CHD oversees the entire health sector at the regional level, and is tasked to ensure quality health services among areas of coverage
2. Local government health offices – which include Provincial, Municipal, and City Health Offices that may want to upgrade their midwives' skills and knowledge;

3. Non-government organizations (NGOs) such as:
    - Local or regional chapters of midwives associations:
        - Integrated Midwives Association of the Philippines, Inc. (IMAP)
        - Philippine League of Government and Private Midwives, Inc. (PLGPMI)
        - Midwives Foundation of the Philippines, Inc. (MFPI)
    - Health training or service delivery NGOs working with midwives such as:
        - Institute of Maternal and Child Health (IMCH)
        - Kinasang-an Foundation, Inc. (KsFI)
        - Integrated Maternal and Child Care and Social Development Inc. (IMCCSDI)

While principles in organizing and managing the event may remain relatively the same, the content of this manual may be enhanced to accommodate additional experiences and practical lessons.

This manual has nine sections, dealing with a specific component or aspect of the CCC's organizing process. Annexes to this manual include documents and templates which may facilitate the preparations, actual conduct, and evaluation of a conference. Organizers, however, are free to modify any part of these materials to suit specific circumstances.

ORGANIZING GUIDELINES

General Guidelines

CCCs are meant to be positive venues for learning, and are definitely not conducted for medical auditing or for evaluating a midwife's performance. Neither are these court cases where each midwife is to face trial, and where back-up doctors function as defense. The conferences have to be conducted in a friendly and facilitative environment where each midwife's genuine desire to learn is nurtured, and where each medical doctor's effort to impart medical updates is supported – all for the cause of improving care-giving and preventing maternal and neonatal deaths.

Midwives, physicians and participants should come out of the conferences not only with improved knowledge, but more importantly with the assurance that they have gained partners, not competitors, in improving the lives of mothers and children.

Organizing CCCs requires team effort. It is important, however, for an entity or agency to take the lead. As mentioned in the introduction, this entity may be a CHD, an LGU, an MWA, or a health NGO that has been previously assisted by PRISM. Organizing CCCs has been proven to open new opportunities and facilitate network building.

The lead agency must designate a point person for each event. This person must have the necessary authority and must be known by other cooperating organizations such as the DOH,

POGS chapters, PPS chapters, and midwife organizations. Representatives from these agencies will form the core team or organizing committee for the event.

Tasking

The distribution of tasks is a critical issue and must be addressed right at the start. The members of the organizing committee should know their tasks as well as the responsibilities of other members. It is likewise important to have a list of the activities and corresponding point person/s for easy reference.

The following are the recommended tasks for each of the organizations involved in this event.

Lead Agency/Organizing Body (CHD, LGU, MWA or health NGO):

- Identify the members of the organizing body prior to the formation of the organizing committee
- Identify and designate one person as focal point in charge of coordinating the activity
- Serve as secretariat to the organizing committee and take charge in executing the following:
    - Preparation meetings
    - Invitations
    - Venue and meal arrangements
    - Supplies and materials, etc.
    - During the event:
        - Registration
        - Ushering
        - Participant assistance
        - Event documention
    - Handle financial and administrative matters, and event after-care
    - Possibly, host all the meetings prior to and after the conference

As applicable:
CHD:

- Host all preparatory meetings of the committee
- Endorse invitation letters to panel members
- Do the public endorsement of the activity
- Provide technical assistance in the selection of the case for review
- Prepare or finalize case write-up
- Present the rationale during the event
- Gather and provide regional or local health statistics and other information as needed

Midwives' Associations:

- Gather at least three prospective cases based on the following criteria:
    - Have consulted,tried to deliver or delivered at the midwife's birthing facility

  - May or may not have been a major challenge to the midwife
  - May or may not have needed back-up or referral support
  - May or may not have been managed successfully
  - In writing the case:
    - Be as faithful to the clinical record as possible. Do not add information that does not appear in the patient's record (quality improvement includes improvement in documenting or records-keeping).
    - Do not indicate the names of the patient, midwife, back-up doctor, lying-in clinic (including address/location), and referral hospital. This is NOT an investigation or litigation.
- Invite midwife-participants
  - Pay for the costs of the national president's participation in the activity as panel chair (if applicable)
  - Give the welcome remarks during the conference (as appropriate)

POGS/PPS:

- Act as co-presentor/organizer of the activity.
- Mobilize and assign officers or members as panelists or case reactors.
- Provide inputs to the selection, formatting and styling of the case.
- Review case study and give reactions and inputs during the conference.
- Present a brief lecture-discussion on a topic related to the case and applicable to midwifery practice. Prepare 10-15 pre- and post-test questions relevant to the lecture to gauge additional knowledge to be gained by midwife-participants.
- Present other interventions or support that POGS or PPS can provide as partners of midwives in improving quality of care. For example, PPS may initiate a training session on newborn resuscitation for midwives.
- Synthesize the case and lessons learned.

Determining the Participants

Participants to the conference should include professional practicing midwives from both private and government sectors. The conference should be open to all midwives, regardless of their membership affiliation or type of practice.

Other participants may come from the different stakeholders that may have programs or projects in maternal, newborn and child health. This may include other USAID projects or other donors.

It would be advisable to invite a PhilHealth representative (technical and/or accreditation staff) to this conference so that lessons learned may likewise inform the existing PhilHealth standards and benefit packages for accredited birthing facilities. PhilHealth has its own quality assurance activities and it is quite certain that they may want to provide inputs to the discussions, especially as regards its maternity care and newborn care packages.

Setting and Meeting Deadlines

Strict observance of agreed schedules and deadlines is necessary. Setting a common available schedule among representatives of participating organizations is a bit challenging. Thus, consult each member on the best time for meetings and completion time of assigned roles (gathering and reviewing case studies, conference date, etc.) ahead of time. Details of the conference content, including the case study, should be available to panelists a few days before the actual conduct of the conference.

During the Conference

Make a detailed list of who has to do what during the conference. This should be done in advance, and thoroughly discussed with all the people/groups involved. The list should include tasks ranging from managing participant queries to required quantity of conference room microphones, location of registration desk, meals, technical support, etc. Make sure there are enough options.

Preparatory Activities

Since this manual may be used by different lead agencies, preparatory activities will vary. As such, there may be other preparatory activities that are not included among the recommended preparatory activities listed below. Similarly, some of these recommendations may be revised based on various situations.

1. The lead agency must name its point person who will be in-charge of managing the activity. If the lead is:
    - The CHD or the LGU health office - the point person may be the FP coordinator or the MCH coordinator
    - An MWA - the point person may be the chapter president or his/her designate
    - An NGO - the point person may be the project coordinator or the program manager

2. The lead agency must study and know the details of the activity, such as:
    - Information shared (see Introduction)
    - Activity concept
    - Mechanics
    - Possible members of organizing committee and their roles
    - Possible panelists and participants
    - Timetable for the event

In short, the lead agency must develop the concept first before organizing the event.

3. The lead agency should initiate communication with potential members of the organizing committee for the event.
    - Members of the committee may include the CHD, LGU health offices, MWA regional or local chapter presidents, regional or local POGS officers, PPS officers or their designee/s.
    - Communication should preferably begin with a personal visit to the concerned persons/ offices to explain what the CCC for MWs is for.

The visit should tackle the background, rationale, overview, as well as related information on the CCC for MWs conducted in the past, if any. (See Introduction).

A formal letter of communication inviting the potential member to the organizing committee may be transmitted, if requested or needed. The letter should state the following:

- A brief introduction of the activity (objectives, background, etc.)
- Invitation to become a member of the organizing committee
- Information on who the other members will be
- Expectations from the invitee as a member
- An invitation to the first meeting (indicate schedule and venue)

4. The lead agency should organize preparatory meetings prior to the conference proper. Meetings should tackle:
    - Presentations needed
    - Leveling of expectations among members of the organizing committees and the organizations they represent
        - o Discussion of roles and responsibilities or tasking assignments
        - o Scheduling of target dates for completion of assignments prior to the conference proper
    - Agreements on next steps, including scheduling of subsequent meetings
    - Tentative or final target date for the actual CCC for MWs

5. Subsequent preparatory meetings may be conducted to:
    - Discuss progress with regard to assigned tasks
    - Address emerging issues or concerns
    - Agree on next steps leading to the actual conduct of the conference

6. The lead agency should prepare the materials needed for the conference:
    - Enough copies of pre-test and post-test questionnaires
    - Enough copies of the clinical case to be discussed
    - Attendance sheets or registration forms for the participants
    - Meal stubs (if necessary)

- If available, copies of lecture notes or handouts from resource speakers (should be distributed AFTER the lecture)
- Audio-visual needs: sound system, LCD projector, laptop, whiteboard and markers

CONFERENCE OBJECTIVES

General Objective

The general objective of the CCC is to provide professional practicing midwives – both in government and private sectors – the opportunity to improve the quality of their services, and thus reduce maternal and infant mortalities and morbidities. This objective is aligned with the country's national health goals, and likewise mirrors the agenda of cooperating agencies such as the USAID.

To instill greater consciousness on proper maternal care, the DOH asserts that all pregnancies are to be considered high-risk, while stressing that some pregnancies may even be riskier than others. DOH identifies three factors contributing to maternal deaths: 1) delay in seeking medical care for perceived obstetrical complications, 2) delay in identifying and reaching the appropriate facility, and 3) delay in receiving appropriate and adequate care in the facility.

In response, the CCC is designed to mitigate the factors mentioned above in order to save women's lives through proper maternal care. Furthermore, as an institutionalized activity, it is not just a one-time opportunity for professional growth; it can actually serve as a continuing quality improvement "tool" that can meet the midwives' need for continuing professional education.

Again, it is NOT the objective of this conference to conduct a medical audit or performance evaluation of the midwife or his/her back-up doctors. All efforts must be made to make this a pleasant, positive learning experience for all participants. To achieve this, panelists should be encouraged and reminded to generate constructive lessons from the case review.

Specific Objectives

1. To improve the knowledge of midwives in providing care for mothers during pregnancy, delivery and postnatal period through a clinical case review with peers and medical specialists.

2. To improve delivery of health services by enhancing or strengthening the working relationships between the professional midwives and other medical professionals, particularly obstetricians and pediatricians, in an environment of learning and constructive dialogue.

3. STRUCTURE OF THE CONFERENCE

The program may include the following: opening activities introduction to the activity (background information, rationale, objectives and mechanics of the activity), conduct of the pre-test followed by case presentation, reactions from panelists, brief lecture on the topic, open forum, conduct of post-test followed by synthesis by the panel chair, and agreements on next steps.

Opening Activities

The lead agency or organizer and secretariat of the conference will be responsible for the registration of participants. The lead agency may likewise take (or designate to a committee member) the role of hosting.

Opening activities may include:

- Opening prayer – may be delegated to a midwife participant
- National anthem – may be delegated to a participant
- Introduction of participants – based on the registration forms or attendance sheets signed by participants
- Welcome remarks – by a representative of the lead organizer, event sponsor, local health office, or organizing committee

Introduction

The CHD can present national health goals and MDGs, as well as health statistics to provide a broader context and demonstrate the corresponding significance of the activity. A brief background and rationale of the event, highlighting its relevance to current DOH thrusts and directions along MCH, may likewise be presented in this portion. Information (data and objectives) stated in this manual's "Introduction" and "General Objective" may be mentioned in the presentation.

The mechanics to guide case discussion are as follows:

- A pre-test (i.e., to be given before the case presentation) and post-test (after the case presentation and open forum, but before the synthesis and next steps) will be conducted in order to document improvement in participants' knowledge. Midwives may use code names if they want anonymity.
- The case will be presented in an objective manner, focusing only on facts as documented or recorded in the patient's case record.
- The comments of or reactions from the medical experts should focus on the clinical case and NOT on the health worker. The experts will be given 10 minutes each.
- The specialists from POGS and PPS may opt to deliver a short lecture that will provide knowledge updates related to the topic.
- Open forum follows. *Note: The facilitator of the open forum MUST be well prepared and must*

be experienced in facilitating potentially emotional discussions. He or she should NOT allow accusations or fault-finding during any part of the conference. The facilitator MUST BE IN FULL CONTROL during the entire conference.

- Focus should be on how to further improve management of similar cases in the future.

Pretest and Case Presentation

Before the case is presented, conduct the pre-test within an allotted time of 5-10 minutes.

A three-minute PowerPoint presentation of the case will be done by the local MWA chapter president or designee. As mentioned above, the case MUST be presented as it is written in the clinical case record of the patient concerned. No additional information other than that written in the patient's record must be presented. Avoid mentioning names and addresses of patients, clinics, hospitals, and midwife or doctor who managed the case.

Reactions from Panelists

Each of the panelists will be given 5-10 minutes to provide reactions to the case. Comments, feedback or reactions MUST focus on the case alone and not on the personalities involved in the management of the case.

The recommended speaking assignment and order:

1. Midwife's perspective: MWA representative
2. Maternal care perspective: the Ob-Gyne
   Note: If the obstetrician will give the lecture, he or she can be the last reactor. This will facilitate a smooth transition to the lecture.
3. Newborn care perspective: the Pediatrician
4. Public health perspective: the CHD or the LGU health office representative

Short Lecture

Pre-test and post-test questions will be based on a short lecture on a topic that is relevant to the case presented. This lecture may be presented by one of the panelists. The topic/lecture should be based on the agreements made during the preparatory meetings of the organizing committee. The lecturer may want to show pictures relevant to the case. He or she must always consider providing updates that are relevant to, or are not beyond the coverage of, midwifery practice. The lecturer must also explicitly classify which cases or situations can be handled by the midwives and which, on the other hand, necessitate referrals to physicians and/or hospitals. The lecture should clearly answer all pre- and post-test questions.

Open Forum

After the reactions from panelists, the floor will be opened for questions from participants. At this point, the moderator should remind the participants that questions should focus only on the case presented. The moderator must also take control of the discussions and must sensitively

handle difficult (defensive/accusatory) arguments by reverting focus to the case and encouraging constructive solutions.

Post-test and Synthesis

Allow another 5-10 minutes for participants to answer the post-test (which should be composed of the same questions listed in the pre-test).

One of the panelists will be tasked to provide a synthesis of the important issues, comments lessons. Relevant updates must be summarized; responses to questions raised during the open forum must be reviewed. The assigned documentor may assist in the crafting of the synthesis by providing the presentor a documentation of the reactions and discussions during the open forum. The synthesis may be best presented through PowerPoint.

Next Steps

Agreements and resolutions should be summarized and presented at the end of the conference. Agreed next steps should include ensuing tasks (with assigned person/organization and schedule/ timeframe). An ideal schedule for the next CCC for MWs or organizing committee meetings may likewise be set.

STEPS IN ORGANIZING

For the convenience of future conference lead agencies or organizers, this manual outlines the general steps in organizing the conference. Steps may vary depending on the mandate/ organizational nature of the assigned lead. Please follow the steps as applicable, or modify accordingly.

STEP 1

Create the organizing committee.

Request for separate meetings with: DOH-CHD, LGU-HO, MWA,POGS, PPS or their equivalent in the area. Please refer to section on Preparatory Activities for other details.

1. Identify members of the organizing committee
.2. Meet individually with members of the committee to explain the CCC's rationale, background, objectives, mechanics, etc.
3. Agree on the relevance of the conference as an essential intervention to continually improve the quality of MCH service delivery provided by midwives.
4. Confirm committee members' willingness or commitment to be part of the committee and to help organize, support and sustain the activity.
5. Identify and assign point persons from each committee

member; get their contact numbers.

6. Organize the first meeting of the committee; be sure to relay the proposed date and venue of meeting.
7. If necessary or as requested, follow through with a formal/ official invitation.

STEP 2

Conduct first meeting of the organizing committee.

1. The assigned point person facilitates the meeting.
2. Review the rationale, background and objectives of the activity.
3. Discuss details of the conference.
4. Get inputs, comments, feedback and suggestions from members.
5. Agree on roles and responsibilities of members of the committee as well as tasks and target dates of completion.
6. Agree on priority topics (may be based on leading causes of maternal morbidities and mortalities in the LGU or region). Choice of midwife's case to be presented will depend on the topic.
7. Agree on the date of the conference.

STEP 3

Coordinate with the local MWA to gather and select the case for discussion in the conference.

1. Based on agreed criteria or topic in selecting the case, representatives of the MWA gather candidate-cases from member MWs (3 to 4 cases).
2. Candidate cases are submitted to organizing committee for review and selection.
3. DOH prepares or finalizes the case for discussion using appropriate format and style. *(See Appendix 1: Sample Case Study)*
    - Names and addresses of the patient, clinic, midwife and doctors should not appear in the case study (either for discussion or presentation).
    - Data must come from the midwife's clinic or patient record.
    - No additional information (as to history or physical examination or laboratory results and treatment or management of the patient while in the clinic) other than those that are in the patient's record must be included in the case study. (Completeness of clinic records and careful documentation of interventions performed in the clinic

are important aspects of quality care and can therefore be a case conference lesson in itself.)

STEP 4

Prepare budget.

1. The lead agency prepares the budget based on agreed activity objectives and design, including all anticipated logistical requirements.
    - Projected costs for holding this conference may include, but are not limited to, the following:
        - o Venue
        - o Snacks
        - o Reproducing or printing of materials such as handouts, pre- and post-test questionnaires, certificates of attendance and/or other informational materials
        - o Honoraria for speakers or reactors or panelists (as applicable, since most are willing to share their time pro-bono)
        - o Rental of LCD projector and laptop (if these are not provided by the lead agency or organizing committee for free)
    - Source of the budget depends on lead agency.
        - o CHD and LGU-health office may have budgeted line items for quality assurance activities
        - o MWAs and NGOs may look for sponsors from drug companies that market MCH products(except milk manufacturers), among others
        - o The lead agency may opt to invest in this activity without recovery
        - o The lead agency may consider charging participants a minimal fee to cover for snacks or meals, venue and materials
        - o Organizing committee members may each contribute to the holding of the conference, for example:
            - – CHD can offer one of its conference rooms as venue (perhaps including sound system, etc.).
            - – An NGO, MWA or the local POGS and PPS chapter may have a spare laptop and/or LCD projector that can be borrowed for the occasion.

  - LGU-HO can reproduce the needed materials using LGU equipment and supplies.
  - Participants can contribute PhP50-100 for the snacks (or forego snacks altogether).
- As a sustainability effort, the lead agency may opt to apply for accreditation with the Professional Regulation Commission (PRC) as an accredited Continuing Professional Education (CPE) provider and register this activity as an accredited CPE activity. Once registered, the activity will have a corresponding number of CPE units to be credited to midwives who participate. This will make the activity more attractive to midwives and add value to conference fees.

2. Canvass for items or services needed; book or procure items needed, which may include:
   - Venue
   - Snack or meal
   - Photocopying
   - Printing of certificates
   - LCD and laptop rental
   - Materials – name tags, notes, pencils or pens
3. Do in-house (lead agency) tasking: invitations and confirmations, conference management, documentation, etc.
4. Lead agency follows its regular accounting and financial procedures in accessing and processing the finances for the activity.

STEP 5

Conduct activity (refer to section on Structure of the Conference for additional details).

Pre-event

1. If necessary, conduct pre-activity meeting with MW group to discuss conference ground rules.
2. Inspect venue and check preparations. Set up secretariat and reception desk.
3. If lunch precedes activity, usher attendees to dining room after registration and issuance of conference materials; remind them of conference starting time.
4. Lunch provides organizers the opportunity to anticipate key and "sensitive" conference issues with panel members from POGS/PPS/DOH/IMAP. If managed properly, a general

approach or common position (or event statements) could be forged or agreed upon on these identified issues over lunch.

5. Alternatively, the pre-test may be administered while waiting for the conference to begin. However, organizers must ensure that all pre-test papers are taken back and that all midwives will have taken the pre-test BEFORE the conference starts.
6. Document the event. Important: highlights of comments by members of the panel will be needed by the panel chair when he or she makes the synthesis.

STEP 6

Post-event

1. Send out "thank you" letters to co-organizers and participants.
2. Provide copies of documentation to co-organizers who can then provide copies to their participants. *(See Appendix 2: Sample Actual Documentation)*
3. Assess the activity through a post-event meeting with the organizing committee members:
   a. What went well?
   b. What needs improvement (for the next CCC for MWs)?
   c. Tasking for improving the conduct of the next conference
   d. Setting next conference date, venue and possible topic
4. Follow-up and re-visit agreements for the next conference.

Finance and Administrative Matters

The lead organization is responsible for all the financial transactions in relation to the conduct of the case conference. *(See Step 4 under Steps in Organizing.)*

Lessons Learned

Clinical case conferences offer invaluable, true-to-life experiences and lessons to participating midwives. It enhances or updates their knowledge and skills in handling maternal and child cases that are appropriate under the existing Midwifery Law.

Each CCC serves not only as a learning venue but also allows for monitoring and supervising the different facets of midwives' clinical work. It reminds participants on the procedures that they are allowed to perform as midwives in birthing facilities. At the same time, the conference offers a venue for cooperation and communication between midwives and physicians - fostering a good working relationship between these medical professionals.

Some of the lessons learned from PRISM-sponsored clinical case conferences are provided below:

- Episiotomy, shaving of hair and enemas are no longer standard routine procedures in normal deliveries.
- Lacerations must be sutured immediately to avoid hematoma formation.

- The first 1-2 hrs after delivery of the placenta are the most critical, and must be closely monitored by midwives to watch out for complications.
- Midwives are NOT allowed to perform incision and drainage. These procedures must be referred to physicians.
- Complaints of pain in the anal area or difficulty urinating during the 4th stage of labor may mean hematoma formation, and therefore must be investigated and referred as necessary.
- Never explore the uterus.
- Use the partograph in order to detect prolonged labor and determine when to refer.
- Midwives should not handle breech deliveries.

Next Steps

(for the organizing committee and for midwife-participants)

The organizing committee should meet for a post-event evaluation, as mentioned in Step 6 under the "Steps in Organizing." Good points and points to improve on will both be discussed for the benefit of future conferences. Financial and logistical issues may likewise be discussed among the members.

The midwife-participants are expected to apply the recommendations and lessons learned from the conference. The local MWAs should be responsible in ensuring that their member midwives follow recommended guidelines and protocols in providing services.

Examples of identified next steps for midwives (gathered from previous PRISM-sponsored conferences) are listed below:

1. The obstetrician panelist suggested a committee among POGS members be formed to partner with a certain midwife who has had some complications in cases handled in her birthing homes. The MOA will be signed by members of the committee by rotation and will be renewable every year, subject to review each year by POGS.
2. IMAP National will call for a meeting to follow up PRC accreditation of the Life Saving Skills (LSS) training conducted by POGS.
3. PRISM will follow up on LSS accreditation with PHIC.
4. PRISM will conduct midwives' case conferences in other PRISM SIAs.
5. IMAP midwives will immediately apply all they have learned from this case conference.

Suggested Areas for Improvement

The main achievement of the first CCC conducted by PRISM-Visayas in Cebu City was being able to test the receptiveness, capacities, and aspirations of the cooperating organizations, in so far as conducting the activity is concerned. The next challenge is how to make the conference more responsive to the needs of midwives in improving the quality of their services, thus meeting project and national health objectives.

Some suggestions for improvement are as follows:

- Continuous and deliberate generation of prospective cases

The search for a suitable case study lies in the ability of organizers to first define what a "good" case study is and, secondly, the search for the case which suits this definition.

- Determining the ideal case for the first conference was broadly defined:
  - o Challenging or complicated enough to require a consultation with or referral to a back-up Ob-Gyne or hospital facility (EMOC site)
  - o Successfully managed: no death resulted from the management of the case

The second criterion was deliberate, as the organizers chose not to handle a controversial case (i.e., one that ended in maternal or child death) to avoid fault-finding during the conference. What the organizers considered paramount in the first conference was to create an atmosphere of openness, objective discussion of the case between and among health professionals, and acceptance by the participants of the review process. The case conference method, as a whole, had been an effective a teaching-learning methodology.

Having succeeded in handling a "simple" case in the first conference, participants will eventually have to be prepared to participate in the discussion of a "more complex" and, possibly, controversial case. To paraphrase the statement of a DOH official, "… *we cannot continue to close our eyes to controversial cases simply because we want to avoid offending personalities and shaking the fragile peace between midwives and OBs. These cases have to be openly discussed, the gaps have to be pointed out and corrected without having to resort to fault-finding.*" A stronger, more assertive DOH is required to realize this.

The generation of prospective cases should be a deliberate process for IMAP, or any midwife association, and its midwives – one that is integrated into the day-to-day clinical activities. Key to this is proper case recording. By strengthening case recording, the midwife is able to identify exactly the areas in which she experienced difficulties, and record the management steps taken. This is also the basis for review by the referral partner upon intake and during the case review process.

Midwives should be encouraged to keep a list of specific management issues or topics from their records, which they can relay to the MWAs. Each MWA, in turn, comes up with a monthly census of these issues or topics and determines topics or cases suitable for review based on the frequency of their incidence.

Subject-specific focus

As with the first case conference where the focus of the case was on the management of hematoma, future case conferences could take on a specific subject or topic along maternal and child care. These subjects or topics can be based on the incidence census/record of DOH or the MWAs (as

described above), and decided upon by a case selection committee which may introduce other criteria for its selection.

One good thing about having subject-specific conferences is that the knowledge (and perhaps attitude and skills) set requirements are predetermined, allowing organizers to take pre- and post-conference measurements on the knowledge of participants using tests. The other value is that, based on the predetermined set of knowledge, attitude and skills (KAS) requirements, panelists are able to focus their review, and later, specify teachings and other inputs on the same set, based on actual pre-test or baseline measurements of the participants.

Monitoring and Evaluation

After having determined the KAS sets per component or aspect of the practice of midwifery, development of monitoring and evaluation tools may now be facilitated. The CHDs and the LGUs' health offices have the mandate to ensure compliance with quality standards in both private and government health care delivery.

However, the organization in the best position to "police" its own ranks is the local MWA. MWAs must be strengthened or empowered to conduct monitoring visits among their members to determine compliance with the learning gleaned from the conferences.

It would be ideal for the lead agency to compile the documentations of all the CCCs for MWs in a locality. This will serve as basis for evolving professional midwifery practice guidelines that may be scaled up to serve as national policy guidelines.

Financing Future Conferences

Sustainability has always been a concern for any project. PRISM has taken steps to ensure that conferences of this nature will be institutionalized through one or more of its partners.

In Step 4 under "Steps in Organizing," some ideas or suggestions were made in terms of sustaining the activity financially.

The CHDs are the most potential partner that can institutionalize and support this activity through government funds. NGOs, however, may also be able to conduct and sustain this activity but a cost-recovery plan is needed by these NGOs to make this sustainable.

Appendices

APPENDIX 1:
Sample Case Study

The Clinical Case:
A case of 25-year old G1 P0 (F1-P0-A0-L0) female, married, Roman Catholic, a factory worker residing in Metro Cebu.

She was a walk-in patient at a private midwife birthing home. She brought with her prenatal records from a local health center in Metro Cebu. Per record, the patient had been taking multivitamins with iron since 3 months AOG. No history of food and drug allergy. No laboratory examination taken.

LMP – November 24, 2006
EDC – August 31, 2007
AOG – 39 wks 3/7 days

The patient arrived at the birthing home at 1:30 p.m. August 29, 2007. She was ambulatory, coherent, complaining of hypogastric and lumbar pains, associated with whitish mucoid vaginal discharge.

Vital signs were taken:	T – 36.8°C
	R- 25/min.
	P -72/min.
	BP – 100/70 mmHg
Upon palpation:	Presentation – Cephalic
	F H B – LLQ – 148/min.
	I.E. done – 3cm and 90% effaced
	B O W – Intact

Progress of labor was observed and uterine contractions were normal until patient delivered spontaneously a live baby boy on Aug. 29, 2007 at 11:20 p.m. with an APGAR Score of 7-8-9. Routine NB care done. Mouth was wiped with sterile gauze. Suction was done. Latching-on to mother's breast was done. Cord clamped with sterile forceps and cut. Cord dressing was done. Newborn wrapped well and placed beside mother. Vit K (0.1 ml) was given by IM and Gentamycin eye drops instilled to both eyes. An hour later, Hepa B vaccine was injected.

Placenta was expelled completely by Schultze Mechanism and Modified Crede's method. Ice pack was applied over the fundal area. Perineum with 2nd degree laceration. Patient waited for three hours for midwife to suture. While waiting for midwife to suture laceration, patient complained of pain at the anal area. On inspection, there was hematoma of the vulva. Immediately,

the patient was prepared for referral to a hospital. However, before transit, the patient became pale and weak, thus the midwife decided to incise and drain the hematoma with sterile scissors. The procedure done relieved the patient's condition. Suturing the laceration was not done since the patient was about to be transferred to a hospital.

She was hooked with D5LR + 1 amp. Oxytocin 20 IU. No bleeding noted. Two hours later, patient arrived at government hospital of her choice. Was seen and managed by resident physician on duty. V/S were taken. These were normal. Suturing was done at hospital.

A day after admission, patient was discharged.

APPENDIX 2:
Sample (Actual) Documentation of First Clinical Case Conference for Midwives

Documentation of the First Clinical Case Conference for Midwives

(Maternal and Child Mortality/Morbidity Case Review for Private Practice Midwives)
Argao Function Room, Cebu Midtown Hotel
September 25, 2007

Conference Proceedings

Attendees:
IMAP Officers

1. Ms. Patricia M. Gomez – IMAP National President
2. Mrs. Gertrudis Calzada – President, IMAP Cebu Chapter
3. Alejandra Socias – IMAP Officer, Bohol

Philippine Obstetrical and Gynecological Society (POGS)

4. Dr. Belinda Pañares – President, POGS Cebu
5. Dr. Feliciana Seguerra – Regional Chapter Director – POGS Region 7
6. Dr. Mila Chan – POGS, Cebu

Department of Health-Center for Health Development (DOH-CHD) Region 7

7. Dr. Elaine Teleron – Technical Services Division Head, DOH 7
8. Dr. Lutgarda Herbias – FP Cooordinator, DOH CHD 7
9. Alma Ludalyn Naboya – Regional Training Nurse – DOH 7
10. Mr. Pedro Robledo – DOH-CHD Local Health Assistance Division

PRISM

11. Dr. Lemuel Marasigan – Sr. Technical Director Private Practice Initiatives
12. Miguel Lucero – Technical Specialist, PRISM Visayas
13. Bong Fostanes – PRISM Field Implementation Coordinator (FIC)
14. Gala Enerio – PRISM FIC
15. Emmelyne Baroza – Project Assistant/ Documenter

PARTICIPANTS:

16. Stella Capacio – Midwife (MW)
17. Margarita Duhac – MW
18. Dorotea Pastorfide –MW
19. Julitinia Sumampong – MW

20. Lunita Tuñacao – MW
21. Lorina Pilapil – MW
22. Corazon Ortega – MW
23. Ortella Lepon – MW
24. Fe Duhaylungsod – MW
25. Luz Radaza – MW
26. Gemma Burlaos – MW
27. Renita Vargas – MW
28. Prima Estardo – MW
29. Luzviminda Cortez – MW
30. Vita Medida – MW
31. Bernadette Arcenal – representative of the Association of Philippine Schools of Midwifery

Rationale of the event:

- Half a million women die annually from pregnancy-related causes like hemorrhage, hypertension, infection and obstructed labor.
- DOH identifies the three factors that may have caused these deaths namely: 1) delay in deciding to seek medical care for a perceived obstetrical complications, 2) delay in identifying and reaching appropriate facility, and 3) delay in receiving appropriate and adequate care in the facility.
- The Philippines is committed to achieve the Millennium Development Goal of reducing MMR to ¾ (52 /100,000 LB) by the year 2015.
- A.O. 79, s. 2000 better known as Safe Motherhood Policy aims to improve the survival, health and well-being of mothers and the unborn through a package of services for the pre- pregnancy, prenatal, natal and postnatal stages.
- Quality prenatal, natal and postnatal services can prevent complications, detect problems early and allow prompt treatment and management (Emergency Obstetric Care or EMOC), mobilizing communities and local government will help improve the status of pregnant women who need help. Family planning can help avoid and prevent unplanned, too early, too late, too close, too sickly, and too many pregnancies.

The Clinical Case:
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She was a walk-in patient at a private midwife birthing home. She brought with her prenatal records from her local health center in Metro Cebu. Per record, the patient had been taking multivitamins with iron since 3 months AOG. No history of food and drug allergy. No laboratory examination taken.

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Placenta was expelled completely by Schultze Mechanism and Modified Crede's method. Ice pack was applied over the fundal area. Perineum with 2nd degree laceration. Patient waited for three hours for midwife to suture. While waiting for midwife to suture laceration, patient complained of pain at the anal area. On inspection, there was hematoma of the vulva. Immediately, the patient was prepared for referral to a hospital. However, before transit, the patient became pale and weak, thus the midwife decided to incise and drain the hematoma with sterile scissors. The procedure done relieved the patient's condition. Suturing the laceration was not done since the patient was about to be transferred to a hospital.

She was hooked with D5LR + 1 amp. Oxytocin 20 IU. No bleeding noted. Two hours after, patient arrived at government hospital of her choice. Was seen and managed by resident physician on duty. V/S were taken. These were normal. Suturing was done at hospital.

A day after admission, patient was discharged.

Reaction/Feedback from the Panelists:

Dr. Belinda Pañares: Why did the patient have to wait three hours to be sutured? The hematoma that developed could have resulted due to delayed suturing of the laceration. The midwife might have had good intentions in draining the hematoma, but it is not her job to drain it. The midwife should have packed the area before transporting the patient to the government hospital. It was not clear if the IV with 20 units of Oxytocin was hooked to the patient after the drainage of the hematoma or before the incision. If it was hooked after, it was too late. This was not indicated in the case.

Postpartum hematoma can occur in 1/300 to 1/1000 deliveries. Risk factors: episiotomy, polyparity and forceps delivery. There is no need to do an episiotomy now in order to prevent complications. Hematomas can come in small and moderate sizes which can be spontaneously absorbed, so there is no need for intervention. If it's too big, making the patient symptomatic and resulting in anemia, then it has to be incised and drained. Midwives have to refer their patients to the doctors if they have hematoma because midwives are not supposed to drain hematomas. Midwives can do a vaginal exam if the patient has problems urinating, and find out if there is hematoma present. If there is, refer right away to the nearest hospital facility. The treatment for hematoma is incision, but it is not the midwives' job to do the incision, it is the doctors who are supposed to do this.

The most critical time for those who just gave birth is the first two hours after giving birth. Please investigate and do not dismiss patients' complaints of pain in the anal area or trouble urinating . These may signify that there may be hematoma forming in these areas, so you should investigate so that hematomas are discovered and treated right away.

No laboratory tests were asked for, based on the history of the case. Minimum labs: CBC blood typing, hepatitis, urinalysis. This should be requested on the first prenatal visit of the patient. First prenatal visit should be on the first missed period. Minimum number of prenatal visits is four.

Dr. Feliciana Seguerra: In handling labor, the MW should identify the different stages of labor and the possible complications in each stage. During the 4th stage, the MW should have been careful since the placenta is already out. The MWs should know that the 4th stage is critical. The MW should have checked if there was bleeding in the laceration. If the lacerated area was monitored properly, the hematoma formation would have been prevented. The MW should not have waited three hours before suturing to avoid complications.

Dr. Mila Chan: (Dr. Chan started her reaction to the case with words of encouragement to the midwives.) "We are your partners. We are not here to oppose you. We cannot do all of these alone." After these, she gave her reactions: Labor was a little bit long – 10 hours. In the hospital, the patient is never left alone after she delivers. The patient is placed in the observation room for

two hours before she is transferred to her room. In this case, maybe the patient was bleeding but no one was able to notice because dizziness is not a result of hematoma.

She also noticed that an ice pack was placed on the fundus, thinking that it could help stop the bleeding. The ice pack does not do anything to the fundus. It would be better if it was placed in the perineum. She also wondered why it took three hours for the laceration to be sutured.

Dr. Chan is a bit apprehensive because in the new Midwifery Act, episiotomy is allowed. Episiotomy does more harm than good. There have been several studies which show that those who have undergone episiotomy have higher chances of 3rd and 4th degree lacerations, compared to those who have not undergone the procedure. Episiotomy should be avoided as much as possible, except when the mother is not pushing anymore or there is fetal distress.

Dr. Chan told the midwives that shaving the hair and doing enemas should not be done routinely. Infection rate has been shown to be higher when patients are shaved. Don't forget to give pregnant women Tetanus Toxoid vaccines.

Dr. Elaine Teleron: DOH has mandated that all births should be attended by skilled birth attendants only. DOH is planning to invite the midwives in the government sector so they will learn what the private practicing midwives are learning now in this case review. The goal here is to minimize the maternal and infant mortality/morbidity rate. Midwives have an important role in decreasing the infant and maternal mortality rate. If the midwives improve their skills in delivering children and know when to refer their patients, these would really reduce the infant and maternal mortality ratio faster than in the previous years.

Avoidance of the three delays: delay in seeking medical consult, delay in transporting to the health facility, delay in receiving proper medical assistance. In this case, there was no delay in the three that I mentioned, but there was a delay in the suture of the laceration.

It is imperative that midwives have to have partner obstetricians who can hand-hold them. It would be good if a dialogue were to take place between the doctors and the midwives so as to have a harmonious relationship and to improve the skills of the birth attendants.

Ms. Pat Gomez: Due to the lack of doctors and nurses in far-flung areas and provinces, it is the midwives who act as the "little doctors" in those areas. Midwives feel that two years of studies in midwifery are not enough to make them experts in the field of maternal and child care.

Midwives are not allowed to do episiotomy. IMAP is trying to work it out so that episiotomy will not be included in the new law.

Midwives who graduated after 1992 are already trained in IV insertion, IE and suturing. Those who graduated before 1992 are not trained in these skills, so they have to undergo training.

Dr. Mendiola, National President of the Philippine Obstetrical and Gynecological Society, is also the Chairman of the Board of Midwifery. He has initiated the Life Saving Skills (LSS) Training for the midwives for them to be trained on suturing, IE and IV insertion.

Midwives are allowed to do first and second degree lacerations, but not third degree lacerations.

The proposal to make midwifery a four-year course was approved last June by the Commission on Higher Education (CHED). Midwives should constantly update themselves and become more skilled in their areas of expertise.

Encourage your patients to have prenatal checkups.

Documentation by the midwives should be done religiously, because anything not written down in the patient's record is as good as not performed on the patient, even if the provider has done the procedure. The importance of using the partograph was emphasized as a guide as to when to refer for prolonged labor.

Open Forum

- Why were there lacerations? Big baby, midwife possibly did some exploring, thus causing the laceration. Midwives should never explore the uterus. It is not routinely done. It is not recommended. Exploring is done only as a maneuver to manually extract the placenta in cases where this is suspected to be causing postpartum hemorrhage. You will also know that there is postpartum hemorrhage by the amount of blood coming out.

- What will the midwives do if labor is too long? Do not push the baby out. You just have to assist the patient. If it's taking too long for the baby to come out, then refer to the nearest hospital. If the midwife puts pressure on the woman's womb, the midwife should be standing with two feet firmly planted on the floor. Do not straddle, do not stand on a pedestal. Use one hand only, because if you use two hands, you could rupture the patient's uterus.

- Reminder from Dr. Seguerra: Do not attempt to deliver breech babies. Always refer breech cases to the nearest hospital. As much as possible, if you have patients who are breech, hypertensive, with previous caesarean delivery, send them away. Refer them to hospitals so you can sleep well at night. If you say that 95 percent of the time you have successfully delivered a patient who was previous CS and you were unsuccessful in the delivery of the remaining five percent and they end up dead, it is not worth the risk.

- There are instances wherein there are high-risk patients that the midwives are referring to the hospitals, but the patients still go back to the midwives because they cannot afford to pay the hospitals.

- *Hilots* are not considered as skilled birth attendants. The only providers who are considered by the World Health Organization as skilled birth attendants in the Philippines are the doctors, nurses and the midwives.

- IMAP is concerned because each year 3,000 to 5,000 graduate from midwifery but they cannot work, because the local government executives who have vacancies due to an employee who has just resigned will not fill the vacancy anymore: They are trying to "save" their money. Dr. Chan also mentioned that there are cases in the LGUs wherein nurses and midwives go on indefinite leave, (some 20 years or so) and the plantilla cannot be filled because the position is reserved for them until they come back. Ms. Pat Gomez is hoping that the Magna Carta for public health workers be passed because right now rural health midwives are serving more than 20,000 people in their area, when the ideal ratio should only be one midwife to 4,000 clients.

- According to per Corazon Ortega, some women would rather go to the *hilots* because they will only pay P1,500 per delivery. The current rate for normal delivery in a midwife's birthing home is P4,500, while it is P10,000 in a private hospital.

- DOH is encouraging midwives with birthing homes to be licensed with DOH. Those who are not licensed with DOH are highly liable. If there are complaints against them, the complainant has to write a letter to DOH, and DOH will investigate the case.

- According to per Mrs. Calzada, they have a problem with some "hilots" putting up their own lying-in clinics in Talamban and they informed the City Health Officer, Dr. Cabugao, that they are going to write a formal letter of complaint against the *hilots*. Dr. Cabugao told them not to submit their letter now because the *hilots* are a big help to them in the city. Dr. Teleron said the City Health Office is running birthing homes being operated by the city government. Since they know that the *hilots* are not licensed or skilled birth attendants, they should not encourage them to run the birthing homes. Dr. Marasigan observed that maybe we can inform the local chief executives about the thrust of DOH and make them aware of the mandate of having skilled birthing attendants in the health facilities, so they can take proper action.

- Ms. Alejandra Socias of IMAP Bohol asked why their application for licensing with DOH is taking so long, and why their papers have been sent back to them four times already. They asked if there is a problem with their papers. Dr. Marasigan said if they have complied with the requirements, there should be no problem. Dr. Teleron had no idea about their application.

- One of the reasons for maternal deaths is the *hilots*. DOH has asked these *hilots* to be part of the RHU team during deliveries, and to help in the birth plan and other activities of the RHU.

- Is it true that there is an ordinance disallowing home deliveries? Ms. Pat Gomez said that is happening in Malolos, Bulacan. Usec. Padilla of DOH noted that 99 percent of the residents of Malolos are already registered with PHIC, which is why their deliveries are done in the provincial hospital. Ms. Gomez was concerned because it is the midwives who do the prenatal checkups of these women, and yet they are not given anything for the check ups because deliveries are made in the provincial hospital. Another concern of Ms. Gomez is that if the local executives decide to put up their birthing clinics attached to the RHUs, they are exempted from applying for a DOH license.

- Was it right that incision was done on the hematoma? Dr. Panares: No. The midwives cannot incise hematomas.

- For Dr. Chan, there is no family planning more dangerous than being pregnant. So if patients ask for a family planning method, give it to them, because it is more dangerous for patients with illnesses such as goiter and high-blood pressure to get pregnant.

- Dr. Seguerra mentioned the Life Saving Skills seminar for the midwives. It is a six-day seminar and costs P3,000 per participant. The course is divided into two parts: two days for lecture and four days practicum (10 to 15 participants per course). The course includes IV insertion, Internal Examination and Suturing. If the midwife passes the course, she will be given certificationby POGS.

- Per DOH, PHIC still has not approved of the LSS as a PHIC-accredited training for the midwives. Fabella is having problems with the LSS, a matter they have raised during the consultative meeting with DOH in Manila. Another problem that came up is that if the regional PHIC has approved of the LSS, PHIC National might say otherwise and not accept the training as PHIC-accredited.

- Once LSS has been accredited by PRC, will it also be accredited by PHIC? Reply: Yes, it will be accredited by PHIC.

- Ms. Calzada asked help from POGS for one midwife who needs a back-up POGS physician as a requirement for PHIC accreditation. POGS agreed to form a committee that will study the request, assign one member of the committee to sign the MOA, which will be good only for one year and the midwife shall be subject to close monitoring by the POGS doctor, with the MOA renewable every year. Dr. Marasigan asked the midwives to PROMISE that they will abide by all the advice that the POGS doctors will provide them, to which the midwives in attendance, and represented by Ms. Calzada, agreed.

Summary of lessons or updates learned during this conference:

- Episiotomy, shaving of hair and enemas are no longer standard routine procedures in normal deliveries.
- Lacerations must be sutured immediately to avoid hematoma formation.
- The first 1-2 hrs after delivery of the placenta are the most critical hours that must be monitored closely by midwives to watch out for complications.
- Midwives are NOT allowed to perform Incision and Drainage – these must be referred to physicians.
- Complaints of pain in the anal area, trouble in urinating and others in the 4th stage of labor may mean hematoma formation and, therefore, must be investigated and referred as necessary.
- Never explore the uterus!
- Use the partograph in order to detect prolonged labor and when to refer.
- Midwives should not handle breech deliveries.

Next Steps:

- Dr. Chan suggested a committee among POGS members be formed to partner with midwives who have birthing homes. The MOA will be signed by members of the committee by rotation and will be renewable every year subject to review each year by POGS.
- IMAP National will call for a meeting to follow up PRC accreditation of LSS. PRISM will follow up on LSS accreditation with PHIC.
- PRISM will share this pilot midwives case conference with other PRISM SIAs.
- IMAP midwives commit to immediate application of all that was learned from this case conference.

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