Prevention of postpartum hemorrhage: Active management of the third stage of labor

Mentor’s Guide for on-site and individual (SAIN) learning approach
This guide was adapted with permission from:

Prevention of postpartum hemorrhage: Active management of the third stage of labor (AMTSLS)

Mentor’s Guide for on-site and individual (SAIN) learning approach

2009

Prevention of Postpartum Hemorrhage Initiative (POPPHI)

Development of these learning materials is made possible through support provided to the POPPHI project by the Office of Health, Infectious Diseases and Nutrition, Bureau for Global Health, US Agency for International Development, under the terms of Subcontract No. 4-31-U-8954, under Contract No. GHS-I-00-03-00028. POPPHI is implemented by a collaborative effort between PATH, RTI International, and EngenderHealth.
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Acknowledgments

POPPHI learning materials for training in AMTSL were adapted by Susheela M. Engelbrecht for use with the on-site and individual (SAIN) learning approach.

Format for the guide and key content on self-paced learning were adapted with permission from the self-paced learning materials developed the PRIME II project, a USAID project led by IntraHealth International, Inc. Harber L, Engelbrecht SM, Murphy C. Self-Paced Learning Course in Prevention of Postpartum Hemorrhage Initiative. IntraHealth International, Inc: Chapel Hill, January 2004.

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Proofreader: Rachel Moorhead

About POPPHI

The Prevention of Postpartum Hemorrhage Initiative (POPPHI) is a USAID-funded, five-year project focusing on the reduction of postpartum hemorrhage, the single most important cause of maternal deaths worldwide. The POPPHI project is led by PATH and includes four partners: RTI International, EngenderHealth, the International Federation of Gynaecology and Obstetrics (FIGO), and the International Confederation of Midwives (ICM).

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### Acronyms

<table>
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<tr>
<th>Acronym</th>
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<tr>
<td>AMTSL</td>
<td>active management of the third stage of labor</td>
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<tr>
<td>BPP</td>
<td>birth-preparedness plan</td>
</tr>
<tr>
<td>CRP</td>
<td>complication-readiness plan</td>
</tr>
<tr>
<td>FIGO</td>
<td>International Federation of Gynaecology and Obstetrics</td>
</tr>
<tr>
<td>HLD</td>
<td>high-level disinfection</td>
</tr>
<tr>
<td>ICM</td>
<td>International Confederation of Midwives</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
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<tr>
<td>IU</td>
<td>international units</td>
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<tr>
<td>MTCT</td>
<td>mother-to-child transmission of HIV/AIDS</td>
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<tr>
<td>PMTSL</td>
<td>physiologic management of the third stage of labor</td>
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<tr>
<td>POPPHI</td>
<td>Prevention of Postpartum Hemorrhage Initiative</td>
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<tr>
<td>PPH</td>
<td>postpartum hemorrhage</td>
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<td>PPPH</td>
<td>prevention of postpartum hemorrhage</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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**Introduction**

In many developing countries, national health statistics are characterized by high rates of maternal morbidity and mortality. Complications during pregnancy and childbirth are the most significant causes of death among women of reproductive health age. Less than one percent of these deaths occur in more developed countries, showing that the large majority of these deaths can be prevented if there are sufficient resources and health services available.

Most maternal deaths are attributable to direct causes. Direct maternal deaths follow complications of pregnancy and childbirth, or are caused by any interventions, omissions, incorrect treatment or events that result from these complications. The five major direct causes are hemorrhage, infection, eclampsia, obstructed labor, and unsafe abortion (see Figure 1). The levels of maternal mortality depend on whether these complications are dealt with adequately and in a timely manner.

More than half of these maternal deaths occurring globally do so in the first 24 hours after childbirth, and most of these deaths are due to postpartum haemorrhage. Postpartum hemorrhage (PPH) or excessive bleeding after childbirth is the single most important direct cause of maternal deaths in developing countries. Approximately 25 percent of all maternal deaths are due to haemorrhage; with percentages varying from less than 10 percent to almost 60 percent in different countries. Postpartum bleeding can kill even a healthy woman within two hours, if unattended. It is the quickest of maternal killers. Even if a woman survives a PPH, she could be severely anemic and suffer chronic health problems.

The proportion needing hospital care depends, to some extent, on the quality of the first-level care provided to women; for example, active management of the third stage of labor reduces total blood loss, incidence of retained placenta, length of third stage, and PPH. An injection of oxytocin given immediately after the baby is born is very effective in...

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Notes: (1) Other direct causes include ectopic pregnancy, embolism, anesthesia-related. (2) Indirect causes include: anemia, malaria, heart disease, HIV/AIDS.

**Figure 1. Global Data: Causes of Maternal Death (2005)**

More than half of these maternal deaths occurring globally do so in the first 24 hours after childbirth, and most of these deaths are due to postpartum haemorrhage. Postpartum hemorrhage (PPH) or excessive bleeding after childbirth is the single most important direct cause of maternal deaths in developing countries. Approximately 25 percent of all maternal deaths are due to haemorrhage; with percentages varying from less than 10 percent to almost 60 percent in different countries. Postpartum bleeding can kill even a healthy woman within two hours, if unattended. It is the quickest of maternal killers. Even if a woman survives a PPH, she could be severely anemic and suffer chronic health problems.

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reducing the risk of bleeding. If a woman has bleeding after childbirth, she requires urgent care which may include a fairly simple—but urgent—intervention such as uterotonic drugs (oxytocin) and uterine massage for uterine atony, manual removal of the placenta, or suturing of genital lacerations. Other women may need a surgical intervention or a blood transfusion, both of which require hospitalization with appropriate staff, equipment and supplies. The proportion of women who die depends on whether appropriate care is provided rapidly.

**Prevention of Postpartum Hemorrhage Initiative (POPPHI)**

Fortunately, research shows that using simple, low-cost interventions can help avoid most of these tragic outcomes. Current evidence indicates active management of the third stage of labor (AMTSL)—administration of a uterotonic drug after ruling out the presence of a second baby, controlled cord traction with counter-traction of the uterus, and fundal massage after delivery of the placenta—can reduce the incidence of postpartum hemorrhage by up to 60 percent in situations where:

- National guidelines support the use of AMTSL.
- Health workers receive training in using AMTSL and administering uterotonic drugs.
- Injection safety is ensured.
- Necessary resources (uterotonic drugs and cold chain for storage of uterotonic drugs; equipment, supplies, and consumables for infection prevention and injection safety) are available.

Ongoing research in various settings continues to identify the best approaches for preventing and managing postpartum bleeding and its complications. By developing national guidelines, training skilled birth attendants, improving work environments of skilled providers, and supporting the development of improved access to care, more women will have access to this lifesaving intervention.

**Why focus on preventing PPH?**

International and national programs focus on preventing PPH because:

- Every year there are 14 million cases of obstetrical hemorrhage, most of which occur in the postpartum period.
- PPH is the single most important cause of maternal death worldwide. It accounts for 20 to 60 percent of maternal deaths.
- For severely anemic women, blood loss as little as 200 to 250 mL can be fatal.
- Predicting who will have PPH based on risk factors is difficult because two-thirds of women who have PPH have no risk factors.
- Preventing PPH will significantly reduce maternal mortality and morbidity.
- There is scientific evidence that AMTSL is a low-cost, evidence-based practice that can prevent up to 60 percent of PPH cases and improve maternal survival, which is linked to infant survival.

**What can be done to prevent PPH?**

In the community:
Mentor’s Guide

• Families and caregivers, together with pregnant women, can develop birth preparedness and complication readiness plans, including actions to take when there is excessive bleeding during labor and childbirth.

• Pregnant women and their families and caretakers can be educated about the importance of having birth attendants skilled in prevention and control of bleeding during childbirth.

• Resources can be mobilized for rapid transfer of women with excessive bleeding to essential obstetric care facilities for appropriate care.

At health facilities:

Facilities can implement active management of the third stage of labor, a process aimed at accelerating delivery of the placenta and contraction of the uterus through:

• Administering a uterotonic drug within one minute of birth.

• Applying controlled cord traction with counter-traction to the uterus.

• Massaging the fundus of the uterus through the abdomen.

“At the third stage of labor is the period between the birth of the infant and delivery of the placenta.”

About the learning materials

The on-site and individual (SAIN) learning package on the prevention of postpartum hemorrhage consists of a Mentor’s Guide, a Learner’s Guidebook, and a Learner’s Notebook. This learning package was developed for use by nurses, midwives, and doctors providing childbirth and immediate postpartum care. These documents comprise a set and should be used together. These resources are distinguished within the series by a corresponding icon located at the top of the right-hand page:

Learner’s Guidebook

Learner’s Notebook

Mentor’s Guide

These learning materials were developed for in-service training of skilled birth attendants using a mixed- or blended-learning approach that combines self-paced study for the theoretical portion of the course followed by a clinical practicum. This training course should assist providers in offering the crucial care needed to prevent PPH.

The Mentor’s Guide should be used by mentors working on the prevention of PPH initiative. The purpose of this guide is to help mentors do their job when conducting PPPH training programs that include training for competency in AMTSL. The guide has the following components:

Popphi – 2009 – In-Service Training for Skilled Birth Attendants
SAIN learning approach
• General information about using the SAIN learning approach.
• A detailed plan for evaluating the knowledge and skills of learners.
• An agenda for the training program.
• A copy of the pre-course, mid-course, post-course, and alternate post-course questionnaires.
• Answers for the knowledge evaluation questionnaires.
• Model forms to track skilled birth attendants trained in AMTSL, collect baseline data, and collect data for monitoring and evaluation.

The **Learner’s Guidebook** is the reference book for the course and provides general information on the SAIN learning approach, essential information for each session, and answers to the learning activities. The **Learner’s Guidebook** should be used in conjunction with the **Learner’s Notebook**. There are seven topics, four that are considered core topics and three that are considered additional topics.

The core topics are:
• Review of the third stage of labor and evidence for use of AMTSL.
• Causes and prevention of postpartum hemorrhage.
• Review and management of uterotonic drugs.
• AMTSL.

Additional topics that some countries may include during the training include:
• Infection prevention.
• Birth preparedness and complication readiness.
• Managing complications during the third stage of labor.

The **Learner’s Notebook** should be used by the learner throughout the training program. The purpose of this notebook is to help the learner successfully complete the program with a minimum of stress. The notebook has the following components:
• Forms for the learner to record knowledge and skills assessment scores.
• Learning activities for each topic.
• Practice checklist for AMTSL and monitoring during the first six hours postpartum.
• Evaluation checklist for AMTSL and monitoring during the first six hours postpartum.
• Job aids for storage and documentation of uterotonic drugs, AMTSL, and monitoring the woman and newborn during the first six hours postpartum.
• Evaluation of the in-service training program.
• An action plan.
Blended learning approach for AMTSL

Goal

This training in active management of third stage of labor will assist providers in offering the crucial care needed to prevent PPH, and to apply this new knowledge and these skills to improving the clinical services they provide, and to training other providers. The mentors will help these participants learn to:

• **Give safe, respectful, and friendly care to mothers and families, thereby encouraging mothers and families to return for care again and again.**

• **Follow a suggested protocol for safe care during delivery, including active management of third stage of labor, and in the immediate postpartum, including clear guidelines on times for referral with a complication, so that timely action is taken.**

• **Provide greater protection from infection for their clients and themselves.**

• **Store uterotonic drugs in such a way that their potency is maintained and ensured.**

• **Store uterotonic drugs in such a way that their availability is always guaranteed.**

All of these components can improve the quality of care provided that will lead to a healthier outcome for women, who are mothers, wives, and important members of the community.

Blended learning approach

The blended learning approach can be used for **on-site and individual training (SAIN)** and combines self-paced learning for the theoretical portion with a clinical practicum. This learning approach can be adapted to different contexts for expanding and scaling up AMTSL services. This strategy seeks to address disadvantages of training providers in clinical skills using the traditional group-based training techniques, including:

• Learners are often away from their facilities for a substantial amount of time, thus restricting access to services.

• Many learners are not able to complete their practical training due to a combination of low caseloads of appropriate clients and the existence of many learners in the training sites at one time, thus reducing the probability that they will transfer newly learned skills to the work place.

• The traditional group-based training sessions are costly, often have low facilitator:learner ratios (>4 learners / facilitator), and often result in poor transfer of clinical skills.

The blended learning approach uses AMTSL mentors to assist learners and combines a self-paced learning (SPL) component for the didactic portion combined with a clinical practicum for the clinical portion. This learning approach has been designed to address challenges encountered with traditional group-based training techniques, as well as the significant challenge of sustainability: establishing an effective approach to preparing providers to offer AMTSL services consistent with performance expectations and service standards. The goal of this strategy is to train the maximum number of providers to apply AMTSL to standard.
Highlights of the blended learning approach

The blended learning approach combines:

- **Self-directed learning**: Print-based modules are adapted for self-paced learning; a strong learner support system is put into place to ensure effective facilitation and support for each learner; learners are encouraged to work in teams.

- **Clinical practicum**: Sufficient opportunities are provided for learners to practice, receive feedback, and become competent in AMTSL skills; AMTSL mentors at each clinical site are trained to provide and correct knowledge assessment questionnaires, do demonstrations of AMTSL on an obstetric manikin, evaluate learners with a checklist on manikins and in the clinical area, and follow learners going through their clinical practicum.

- **Follow-up and supportive supervision**: Post-training follow-up and supervisory visits are planned to ensure providers’ application and retention of skills on the job.

Advantages and challenges of the blended learning approach

The blended learning approach combines elements of SPL with clinical skills training during a clinical practicum. This type of learning approach may sometimes ensure a more efficient transfer of knowledge as well as an easier way to adapt to each learner’s particular learning needs. A blended learning approach is designed to facilitate the acquisition of new knowledge and skills that will assist providers to become more productive and provide quality services. This learning strategy gives regional health management teams an opportunity to enrich their training activities as well as to better manage time dedicated to training regional personnel.

**Advantages of the blended learning approach:**

- It is flexible:
  - The provider is able to study without interrupting her/his work schedule.
  - The provider can do it at home or at her/his place of work.
  - The learner studies at her own pace and time (allowing the learner to tend to other work and family responsibilities).

- A disciplined, independent provider is developed. Self-paced learners develop valuable problem-solving skills by managing their own learning, and they assume responsibility for their own learning as they:
  - Independently identify their learning needs.
  - Seek information or clarification.
  - Initiate communication with their tutor/mentors and in-charges.
  - Organize their time.
  - Prioritize learning tasks.

- Courses may be less expensive as they eliminate accommodation costs and reduce the learner’s time away from his/her post.

- Education is made accessible to many providers and especially women, who may not attend residential courses due to family commitments.

- Materials are specially designed and oriented to provider needs. They are interactive and user-friendly.

- The providers are able to immediately apply their learning to their own work situation.
Mentor’s Guide

- Learners are required to demonstrate acquisition of knowledge before beginning demonstrations or the clinical practicum. New knowledge is acquired during the self-paced portion of the course, and new skills are acquired during practical training. The learner will not begin his/her clinical practicum until the mentor declares that he/she has mastered the knowledge necessary to practice the skills being taught.

- Learners and mentors can immediately evaluate if the learner has been able to assimilate newly acquired knowledge and skills.

**Challenges of the blended learning approach:**

The blended learning approach has distinct challenges that the mentors, clinical preceptors, and learners should be aware of and try to overcome in day-to-day operations. These challenges include:

- Delay in communication and feedback.
- Limited face-to-face contact and opportunities for consultation with experts.
- Isolation of learners.
- Personal problems interfering with studies.
- Courses often take longer to complete than group-based courses.
- The learning approach does not match the provider’s learning style.
Creating a supportive learner support system

Supporting learners
To facilitate self-paced learning, most programs create/use an infrastructure or system of support for the learners. This support may include:

- Trained staff (e.g., mentors, clinical preceptors, ward staff).
- Specially designed training/learning materials.
- Mechanisms for sharing information/communicating.
- Inclusion of multiple learning activities that give the learner the opportunity to evaluate how well she/he has understood the presented materials.
- Immediate feedback for learning activities—answers for all of the learning activities can be found in the Learner’s Guidebook so that learners can immediately compare their answers to the learning activities with suggested answers.
- Scheduled time with the mentor to review course content before taking the mid-course questionnaire.
- Evaluation of newly acquired knowledge before beginning demonstrations on an obstetric manikin.
- Scheduled time to develop skills on the obstetric manikin before beginning the clinical practicum.
- Immediate and objective feedback when practicing or applying AMTSL.
- Supportive supervision and counseling.

Most learners need guidance while they are acquiring new skills and knowledge. Some self-paced learners may need additional support because:

- They may feel isolated when they encounter problems and need to problem-solve alone.
- Some learners may prefer learning with others rather than alone.
- Each learner needs to find internal motivation to keep going.
- They may get discouraged or feel isolated from mentors and other learners.

Development of the learner support system
Each district will take responsibility for ensuring that all skilled birth attendants serving in the district are trained in AMTSL. Decentralizing training activities to the district level makes training activities both easier and more complicated at the same time. When applying this strategy, each region will select two point persons who will be responsible for implementing the training strategy and following progress towards program goals. Each district will choose and develop a clinical training site where all skilled birth attendants in the district will come for their clinical practicum. The regional point persons will facilitate training the district mentors from the district clinical site who will in turn facilitate the training of all skilled birth attendants in their district.

These steps will be followed when developing the learner support system at the district level:
**Step 1: Train regional point persons** (at least two per region)

1. Representatives of the regional health management team (RHMT) select two skilled birth attendants (SBAs) who will serve in the role of regional point person for PPH prevention activities. Personnel selected to be regional point persons should:
   - Be a skilled birth attendant.
   - Regularly attend births.
   - Be able to train other providers.
   - Have the desire to train other providers.
   - Have the desire and the ability to conduct supervisory activities for newly trained birth attendants.
   - Have the desire and ability to monitor training activities and statistics pertaining to AMTSL.

2. National trainers will train regional trainers at the national level using the traditional group-based approach.

3. Point persons will return to their place of work and will be given an agreed-upon time frame to become proficient in performing AMTSL.

4. National trainers will conduct a post-training follow-up visit (no later than six weeks after the training) to validate the point persons’ competency:
   - If the point persons are found to be competent, national trainers will declare that they can now begin training district point persons.
   - If the point persons have not yet mastered the application of AMTSL, the national trainers will give the point persons additional time for mastery of the skills and set a date for re-evaluation of their competency.

**Step 2: Choose clinical training sites**

1. The RHMT and technical assistants validate selection criteria for clinical sites (each district will have a clinical site).

2. The RHMT and the district health management team (DHMT) choose one clinical site per district.

3. Once the clinical site is chosen, the RHMT and the DHMT will meet with the administration, personnel, and health committee members of the clinical site to:
   - Outline a plan to prepare the facility to receive trainees.
   - Make a list of purchases of necessary medications/supplies/equipment for infection prevention and to practice AMTSL.
   - Agree on criteria that indicate the site is ready to receive trainees.

4. Administration and site personnel will work together to ensure that criteria for site preparation are met:
   - All SBAs in the facility practice AMTSL to standard.
   - A system for internal supervision-peer evaluation of AMTSL practice is established.
Uterotonic drugs are stored in the pharmacy according to agreed-upon standards.

Pharmacy managers have a system for quantifying uterotonic drugs that takes into consideration vaginal births and additional needs for management of PPH and, where authorized, for induction and augmentation of labor.

A system is developed for tracking uterotonic drugs stored in the delivery room.

A system is developed for documenting AMTSL in the delivery logbook and the partograph.

Data are regularly collected on AMTSL coverage and numbers of cases of PPH.

Job aids for AMTSL, storage and documentation of uterotonic drugs, and monitoring in the immediate postpartum are posted.

Equipment for IP is available and in good working order.

Consumables and supplies for AMTSL and IP are available and ordered on a regular basis.

**Step 3: Train district mentors** (at least two per district)

1. Representatives of the DHMT select two SBAs working in the district clinical training site who will serve in the role of district mentors for PPH prevention activities. Personnel selected to be district mentors should:
   - Be a skilled birth attendant.
   - Regularly attend births.
   - Be able to train other providers.
   - Have the desire to train other providers.
   - Have the desire and the ability to conduct internal supervisory activities for newly trained birth attendants.

2. Regional trainers will train district mentors at the regional level using the traditional group-based approach.

3. Mentors will return to their place of work and will be given an agreed-upon time frame to become proficient in performing AMTSL.

4. Upon return to the clinical site, district mentors will:
   - Sensitize the health committee and health facility manager about needs for materials, consumables, and medications to ensure infection prevention practices and application of AMTSL.
   - Sensitize the pharmacy managers about the correct storage and quantification of uterotonic drugs.
   - Ensure that uterotonic drugs are correctly stored in the pharmacy and the delivery room.
   - Collect baseline data on the practice of AMTSL.
   - Sensitize women’s groups and community workers about the importance of giving birth with a skilled attendant and the need to develop a birth-preparedness plan.

5. Regional trainers will conduct a post-training follow-up visit (no later than six weeks after the training) to validate the district mentors’ competency:
• If the mentors are found to be competent, regional trainers will declare that they can now begin facilitating on-site training of skilled birth attendants at the clinical site.
• If the mentors have not yet mastered the application of AMTSL, the regional trainers will give the mentors additional time for mastery of the skills and set a date for re-evaluation of their competency.

Step 4: Conduct on-site training of SBAs working in the clinical training site

Mentors will guide all SBAs working at the clinical sites through the SAIN materials for AMTSL. All SBAs at the clinical site will be trained to: apply AMTSL to standard; provide updates on learners’ progress to the district point persons; and assist in ensuring the provision of quality care at the clinical training site.

Learners will follow the steps in the learning cycle outlined in the next chapter.

Step 5: Declare that the clinical site is ready

After all SBAs at the clinical site have completed training in AMTSL, mentors will work with newly trained SBAs to prepare the site to receive learners coming from peripheral health centers:

1. Newly trained birth attendants will be given an agreed-upon time frame to become proficient in AMTSL.
2. Mentors will conduct internal supervisory visits and periodic audits.
3. Representatives of the regional health management team will visit the site to ensure that it meets the criteria for accepting learners from peripheral sites using the SAIN mixed-learning approach. If the site does not meet the criteria, a plan will be made to improve the site and a follow-up visit scheduled.

SBAs working in peripheral health centers can begin training using the blended learning approach after the RHMT has declared the district clinical training site ready to receive learners.

Step 6: Train SBAs working in peripheral health centers

Mentors, representatives of the DHMT, and health facility managers will work together to develop a strategy and make a plan for training all SBAs in the district. An important part of the plan is making sure that no more than four learners are at the clinical site at a time.

Step 7: Provide supportive supervision

Formal supportive supervision will need to be provided by regional point persons of district mentors and mentors of all providers who have completed the blended learning course in AMTSL. During supervisory visits, the following aspects will be evaluated:

• Practice of AMTSL.
• Infection prevention practices.
• Documentation of AMTSL in the delivery logbook and on the partogram.
• Data collected on AMTSL coverage and PPH rates.
• Use of wall charts to follow progress made towards selected indicators.
• Storage of uterotonic drugs in the delivery room, pharmacy, and store room.
• Documentation of uterotonic drug use in the delivery room, pharmacy, and store room.
• Availability of uterotonic drugs and supplies, consumables, and equipment necessary for safe practice of AMTSL and infection prevention practices.
Providers in each facility can use the wall charts in Appendix D to keep track of: 1) the number of women who were offered and received AMTSL, 2) the number of cases of PPH in women who gave birth vaginally in the facility, and 3) the percentage of providers who are practicing AMTSL to standard. The last statistic can be found by instituting a system of peer evaluation, whereby peers evaluate each other on a monthly basis using the evaluation checklists. Having an internal mechanism to assure the quality of how providers apply AMTSL will go a long way to ensuring sustainability and transfer of training to the workplace.

**Step 8: Monitor all activities** (see the chapter on monitoring and evaluation)

Monitoring activities is an important mechanism for supporting new learners—it can provide objective information on how they are transferring their new knowledge and skills to the workplace and can serve as a point of discussion when developing plans to improve AMTSL practice at the facility. Monitoring will focus largely on training activities and AMTSL coverage.

**Training activities**

District and regional health management teams will need to find a mechanism to track skilled birth attendants who have completed a training course in AMTSL. Appendix A provides a template to register and keep track of skilled birth attendants who have completed a course in AMTSL.

When the learner has successfully completed the course, the mentor will need to provide the following information about the learners to the district and regional health management teams:

- Name.
- Cadre.
- Date the course was commenced.
- Date the provider was found competent in the clinical area.
- Scores for the pre-, mid-, and post-course questionnaires.
- Score received on evaluation on an anatomical model and in the clinical area.

Keeping track of providers who have completed a course in AMTSL will assist managers when they are planning training and supervisory activities.

**AMTSL coverage**

Facility, district and regional health managers will need to find a mechanism to collect baseline and monitoring data on AMTSL coverage. This is discussed at length in the chapter on monitoring and evaluation.
Learning cycle

When using the blended learning approach the learner will go through the following steps:

1) Introduction to the blended learning approach and learning materials:

- When learners begin the blended learning course in AMTSL, each learner will be oriented to the following to help them succeed in completing the course:
  - The training approach.
  - Roles of all of the different players.
  - How to select a learning partner.
- Evaluation is done by taking a pre-course questionnaire.
- The Learner’s Guidebook and Learner’s Notebook will be distributed and explained.
- A time line/action plan for completing learning activities is developed by each learner with his/her mentor.
- A tentative date is scheduled for the learner to take the mid-course questionnaire and begin demonstrations.

2) Read materials for the course:

- Learners should plan to set aside at least two hours per day to read the materials and complete the learning activities.
- Where possible, learning partners should work through the materials together.
- If the materials are used for on-site training, learners and mentors can set aside a time each day or each week to review materials and discuss problems in comprehension.
- Learners should follow their own progress by writing the date they completed each learning activity and topic in the Learner’s Notebook.

NOTE: Make sure to let the learners know that the time to complete the course may depend on each provider’s background. The learners should not be discouraged if they are taking longer than some of their colleagues. If they are having difficulties getting through the reading material and learning activities or understanding concepts, encourage them to reach out to their mentor or colleagues for help.

Mentor’s Guide
3) Meet with the mentor to review material in the Learner’s Guidebook and work through demonstrations / return demonstrations:

- When the learner has completed the module, she/he will need to contact the mentor at an agreed upon time to:
  - Review material in the Learner’s Guidebook to see if there are learning activities that the learner needs help with.
  - Give and grade the mid-course questionnaire.
  - Make a plan for areas to review in the Learner’s Guidebook based on results of the mid-course questionnaire.
  - Work through demonstrations/return demonstrations using the practice checklist in the Learner’s Notebook.

- When the learner feels comfortable, the mentor will evaluate skills on an anatomical model.
- When the mentor finds the learner has competently performed AMTSL on a model, she/he will sign the evaluation checklist to indicate that the learner is now ready for practice in the clinical area.

4) Work through clinical:

- When the learner has been found competent on models, she/he can present themselves to the clinical site to gain proficiency in AMTSL.
- Each learner will be assisted by a mentor as they practice, and when they are deemed competent, they will be evaluated on the evaluation checklists.
- Depending on volume at the clinical site, learners should expect to spend 1 to 2 days in the clinical area to become competent.
- When the learner has been found competent in the clinical area, she/he will take a post-course questionnaire.
5) **Develop facility-specific goals and action plan:**

- After completing the module, the learner and mentor will sit down together to develop facility-specific goals for mastering skills and ensuring that the new standards/skills are practiced to standard in the learner’s workplace.
- These goals will be translated into an action plan with measurable objectives towards achieving the goals.
- The learner’s action plan will be reviewed periodically during supervisory visits.

6) **Transfer learning to the workplace:**

District mentors will conduct a post-training follow-up visit (no later than six weeks after the training) to validate the provider’s competency. If the newly trained provider has not yet mastered the application of AMTSL, the district mentor will develop a plan with the provider and the health facility manager to strengthen AMTSL skills.
Roles and responsibilities of key players

Ministry of health

The success of the blended learning approach and a training strategy that is decentralized to the district level depends on the involvement of all the key players. Each player has a well defined role that plays an essential part in the overall running of the program. If the program is going to succeed, all of the key players need to work closely together from the beginning. If only one of the key players does not successfully fulfill his or her role, this could jeopardize the entire program. It is therefore imperative that each player knows his/her role and has a clear understanding of what is expected of him/her.

The roles and responsibilities of the different levels of the Ministry of Health (MOH) are as follows:

- **National Department of Health**
  - Develop a national strategy for scaling up AMTSL.
  - Appoint two national point persons.
  - Ensure quality assurance for training activities at all levels.
  - Evaluate the relevance and the feasibility of implementing the SAIN strategy for scaling up AMTSL.

- **Regional Health Management Team**
  - Validate selection criteria for mentors and criteria for certification in AMTSL.
  - Appoint two regional point persons.
  - Ensure quality assurance of training activities at the regional level.
  - Visit potential clinical sites with the DHMT and meet with staff at the sites to assess if the site meets the selection criteria and if staff at the site is willing and able to serve as a clinical site.
  - Visit sites with the DHMT to certify that they are ready to receive learners.

- **District Health Management Team**
  - Ensure that selection criteria are respected when mentors are selected.
  - Choose a clinical site that meets selection criteria.
  - With representatives of the RHMT and managers at the clinical site, appoint two mentors at each clinical site.
  - Ensure quality assurance of the clinical site and training activities.
  - Visit sites with the RHMT to certify that they are ready to receive learners.
Point persons

The roles and responsibilities of point persons are as follows:

• **National point persons**
  - Train regional point persons.
  - Support regional trainers during the first training cycle.
  - Conduct 6-monthly supervisory visits of training activities and the regional trainers.
  - Collect and analyze data on AMTSL at the national level (by region).
  - Keep the national registry of SBAs trained in AMTSL up to date.
  - Ensure adequate stocks of medications, consumables, and materials at the national level.
  - Ensure that uterotonic drugs are correctly stored at the national pharmacy.
  - Sensitize national pharmacy managers about storing and quantifying uterotonic drugs.

• **Regional point persons**
  - Train district point persons.
  - Conduct quarterly supervisory visits of clinical training sites and district point persons.
  - Collect and analyze data on PPH prevention activities at the regional level (by district) and send them to the national level.
  - Ensure adequate stocks of medications, consumables, and materials at the regional level.
  - Ensure that uterotonic drugs are correctly stored at the regional pharmacy.
  - Make a list of all SBAs in the region (by district) that have already been trained in AMTSL or still need training in AMTSL.
  - Keep the list of SBAs trained in AMTSL in the region (by district) up to date.
  - Sensitize regional pharmacy managers about storing and quantifying uterotonic drugs.

Mentors

The roles and responsibilities of mentors are as follows:

• Facilitate the learning process: Articulate MOH standards; Orient learners; Help develop learning plan/action plan with learners; Conduct skills and knowledge assessments; Review exercises and other learner activities; Work with models, demos/return demos; Monitor learners; Ensure availability of training materials; Set up training site and demonstration room; Help mentors and ward staff set up for learners at the work site; Provide clinical coaching while learners are acquiring new skills.

• Inform the DHMT when providers have successfully completed the training program in AMTSL.

• Ensure internal supervision of AMTSL at the clinical training site.

• Motivate the district and clinical site health committees and managers to purchase necessary materials, consumables, and medications for infection prevention and AMTSL.

• Ensure adequate stocks of medications, consumables, and materials at the district level and the clinical site.

• Sensitize pharmacy managers about storing and quantifying uterotonic drugs.
• Ensure that uterotonic drugs are appropriately stored at the pharmacy at both the district- and clinical-site levels, and in the delivery room.
• Collect and analyze data on PPH prevention activities at the district level (by facility) and send them to the regional level.
• Conduct monthly supervisory visits of peripheral health centers.
• Make a list of all SBAs in the district (by health facility) that have already been trained in AMTSL or still need training in AMTSL.
• Keep the list of SBAs trained in AMTSL in the district (by health facility) up to date.
• Sensitize women’s groups and community health workers about the importance of giving birth with an SBA and developing a birth preparedness plan (BPP).

Providers

• Personnel working at the clinical training site
  o Help create a positive learning environment at the clinical site.
  o Help learners feel welcome.
  o Ensure the availability of medications, consumables, and equipment that are necessary for the learners’ clinical experience.

• SBAs working at the clinical training site
  o Practice AMTSL to standard.
  o Help create a positive learning environment at the clinical site.
  o Help learners feel welcome.
  o Provide clinical coaching for learners.
  o Communicate the learners’ progress to persons responsible for training activities.
  o Help to ensure the provision of quality care at the training site.

• Learners
  o Collect baseline data on PPH prevention activities and send them to the district level.
  o Carefully read learning materials and complete learning activities.
  o Support the learning partner.
  o Meet deadlines set for completion of learning activities and meetings with focal points responsible for training activities.
  o Take the initiative to contact either the learning partner or the focal point in case they experience difficulties with the learning materials.
  o Actively participate in clinical training activities in order to get a maximum number of clinical experiences to gain competence.
  o Transfer newly acquired knowledge and skills to the work place.
  o Conduct continual self-evaluation of skills and take the initiative to contact the focal point, the learning partner, or a skilled and experienced birth attendant in case of difficulties.
**Newly trained birth attendants**

- Collect and analyze data on PPH prevention activities at the facility and send them to the district level.
- Coach other providers who are learning to perform AMTSL.
- Ensure internal supervision of AMTSL.
- Sensitize the health committee about need for materials, consumables, and medications for infection prevention and AMTSL.
- Ensure adequate stocks of medications, consumables, and materials at the health facility.
- Sensitize pharmacy managers about storing and quantifying uterotonic drugs.
- Ensure that uterotonic drugs are appropriately stored at the pharmacy and in the delivery room.
- Sensitize women’s groups and community workers on the importance of giving birth with a skilled birth attendant and developing a BPP.
Training curriculum

Training content
This clinical training facilitates the acquisition of knowledge and skills needed to perform AMTSL to standard and help prevent and quickly diagnose PPH. There are seven topics, four that are considered core topics and three that are considered additional topics. The core topics are:

- Review of the third stage of labor and evidence for use of AMTSL.
- Causes and prevention of PPH.
- Review and management of uterotonic drugs.
- AMTSL.

Additional topics that some countries may include during the training include:

- Infection prevention.
- Birth preparedness and complication readiness.
- Managing complications during the third stage of labor.

The time to complete the theoretical portion, which is self-paced, will depend upon the number of topics that will be covered in the training course. The clinical practicum should take a maximum of two days, regardless of the number of topics covered in the theoretical portion of the course.

Learning partners
Learners will be paired with a learning partner throughout the training course. The two learning partners work as a team while completing the self-paced portion of the curriculum and when doing demonstrations or practicing clinical skills in the clinical area. Learning partners should support, encourage, motivate, and help each other.

While doing demonstrations and practicing in the clinical area, each member of the learning pair will take turns being the person that either “performs” a skill or “observes” a skill. This system will help the learner to learn more from all clinical experiences, those that s/he does and those that s/he watches. When working with teams, the assistant will also help remind her partner when she forgets something or does not remember how to do it correctly.

The responsibilities of each team member include:

Learner who “PERFORMS” the skill:
1. Reviews the appropriate learning guide before performing the skill.
2. Performs the skill.
3. Evaluates her/himself using the learning guide before the evaluation meeting with the mentor.
4. Has an informal meeting to listen to and discuss with the mentor about the evaluation of her/his performance.
Learner who “OBSERVES” the skill:
1. Reviews the appropriate learning guide before assisting with the skill.
2. Observes the person “performing” the skill and reminds her/him of any forgotten step(s).
3. Evaluates the person “performing” the skill using the learning guide.
4. Has an informal meeting to discuss with the team “performer” about the evaluation of the skill with which she assisted.

If possible, mentors should allow learners to choose their own learning partner. Nevertheless, they should assess each learning pair to evaluate if there is a good mix of the following characteristics of each learning partner:
- Previous experience with AMTSL.
- Professional cadre.
- Previous experience attending births.
- Place of work.
- English level.

**Suggested prevention of postpartum hemorrhage (PPPH) course schedule**

The following table outlines the number of learning activities/exercises to complete and an estimated time to complete each topic. The self-paced module has been designed to take approximately two weeks (18 hours) to complete the core topics and two weeks (17 hours) to complete the additional topics, per learner, and the clinical practicum may take 1-2 days for each learner to have sufficient experience to become competent in the clinical setting.

**Table 1. Estimated time to complete each topic**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Number of learning activities/exercises</th>
<th>Estimated time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the third stage of labor and evidence for use of AMTSL.</td>
<td>2</td>
<td>2 hours</td>
</tr>
<tr>
<td>Review of uterotonics drugs.</td>
<td>3</td>
<td>3 hours</td>
</tr>
<tr>
<td>Management of uterotonics drugs.</td>
<td>3</td>
<td>3 hours</td>
</tr>
<tr>
<td>Causes and prevention of postpartum hemorrhage.</td>
<td>4</td>
<td>4 hours</td>
</tr>
<tr>
<td>AMTSL.</td>
<td>6</td>
<td>6 hours</td>
</tr>
<tr>
<td>Infection prevention.</td>
<td>6</td>
<td>6 hours</td>
</tr>
<tr>
<td>Birth preparedness and complication readiness.</td>
<td>4</td>
<td>4 hours</td>
</tr>
<tr>
<td>Managing complications during the third stage of labor.</td>
<td>7</td>
<td>7 hours</td>
</tr>
</tbody>
</table>

The suggested schedule for the PPPH course can be found on the next page. The schedule assumes that each learner will study about two hours per day to work through the activities/exercises for each topic.
# Core Topics

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>Orientation (female icon)</td>
<td>Review of the third stage of labor and evidence for use of AMTSL.</td>
<td>Causes and prevention of postpartum hemorrhage.</td>
<td>Review of uterotonic drugs.</td>
<td>Study and Review</td>
<td></td>
</tr>
<tr>
<td>Week 2</td>
<td>Management of uterotonic drugs (female icon)</td>
<td>AMTSL.</td>
<td></td>
<td></td>
<td>Study and Review</td>
<td></td>
</tr>
<tr>
<td>Week 3</td>
<td>Mid-course questionnaire (female icon)</td>
<td>Demonstrations, return demonstrations, clinical practice – 1 to 2 days</td>
<td></td>
<td></td>
<td>Study and Review</td>
<td></td>
</tr>
</tbody>
</table>

# Additional Topics

<table>
<thead>
<tr>
<th>Week x</th>
<th>Infection prevention.</th>
<th>Birth preparedness and complication readiness.</th>
<th>Study and Review</th>
<th>Study and Review</th>
<th>Study and Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week x</td>
<td>Managing complications during the third stage of labor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Denotes days that you will be in group session with other learners.
Assessment of learners

AMTSL mentors evaluate the learners’ knowledge and skills during the training program using a checklist to evaluate performance of tasks, skills, or activities and pre-, mid-, and post-course questionnaires to evaluate knowledge. Each topic has a set of learning activities, enabling the learner to practice applying the presented information.

Pre-course questionnaire

Prior to beginning the training program, learners should complete the pre-course questionnaire.

The objectives of this questionnaire are to:

• Assess what the learner knows about the course topics.
• Identify topics that may need additional emphasis during the course.
• Alert the learner to the content that will be presented in the course.

AMTSL mentors and learners may correct the pre-course questionnaire together using the answers found in the key in the Mentor’s Guide. Results of the pre-course questionnaire should be recorded in the Training Logbook and the Learner’s Notebook.

Learning exercises

These are activities that are part of the Learner’s Notebook. They include a variety of questions, case studies, and other exercises designed to help the learner understand the content. They act like an instructor asking a question in class or challenging a learner to try a new skill. They are intended to help the learner study the subject and understand it very well.

Learning partners or other providers working on the same sessions can work together on the in-built activities. AMTSL mentors should make sure that learners attempt all the activities, answer questions, and mark them themselves to ensure that they are learning. All of the answers are located in the back of the Learner’s Guidebook. The AMTSL mentor should review and discuss all the activities, especially any problems or questions the learners have about the activities, before administering the mid-course questionnaire.

Mid-course questionnaire

After completing the self-paced coursework, the AMTSL mentor will administer the mid-course questionnaire. This questionnaire is given after the learner has successfully completed all of the self-paced sessions and learning activities and is ready to work with the AMTSL mentor on demonstrations and return demonstrations.

The objectives of this questionnaire are similar to the pre-course questionnaire:

• Assess what the learner has learned about the course topics.
• Identify topics that may need additional emphasis during the clinical practicum.
• Identify each learner’s individual learning needs.
AMTSL mentors and learners may correct the mid-course questionnaire together using the answers found in the key in the Mentor’s Guide.

Learners should be encouraged to review course content for the questions they answered incorrectly and to talk with AMTSL mentors if they have questions about any of the answers.

Learners who do not achieve a score of at least 80 percent on the mid-course questionnaire will have a second chance to take it before the last day of training activities.

Results of the mid-course questionnaire should be recorded in the Training Logbook and the Learner’s Notebook.

**Assessment of clinical skills in a simulated setting (i.e., on anatomical models)**

When the learner has successfully completed the self-paced sessions and the mid-course questionnaire, the next step will be to arrange with the AMTSL mentor to go through the demonstrations and return demonstrations for each of the skills to be learned.

Teaching, demonstration, and return demonstration with models (and practice checklists) will be done when the learner has completed the content and learning activities, and before going to the clinical area.

When the learner is ready, the AMTSL mentor will use the evaluation checklist to evaluate each learner on an anatomical model.

Criteria for satisfactory performance by the learner are based on the knowledge, attitudes, and skills demonstrated and practiced during training. In preparing for formal evaluation by the AMTSL mentor, learners can familiarize themselves with the content of the checklist by critiquing each other's skills. When evaluating the learner, the AMTSL mentor will assess each step for competency.

A learner will be judged competent when she/he achieves at least an 80 percent when evaluated on a manikin. When determining competence, the judgment of a skilled AMTSL mentor is the most important factor. Thus, in the final analysis, competence carries more weight than the number of presentations (which may be only two or fewer depending on the number of learners attending the course). Because the goal of this training is to enable every learner to achieve competency, additional training or practice in these skills may be necessary.

When the AMTSL mentor determines a learner can competently perform the newly acquired skills on an anatomical model, he/she records the date on the wall chart, and records the date and the learner’s score in the Learner’s Notebook and in the Training Logbook.

Once the learner can competently perform the newly acquired skill on an anatomical model, the learner can practice the skill in the clinical area to gain competency and proficiency in the skills acquired.

**Assessment of clinical skills at the training site**

After demonstrating their skills in a simulated situation (i.e., on models), learners will spend time in the clinical area to observe and—when possible—apply the newly gained knowledge and skills in a clinical setting. AMTSL mentors are vital to a high-quality learning environment and will supervise the training.
Learners and AMTSL mentors keep track of progress in the clinical area by using the evaluation checklist found in the **Learner’s Notebook**.

When the AMTSL mentor determines a participant can competently perform the newly acquired skills in the clinical site, he/she records the date and the learner’s score in the **Learner’s Notebook**, on the wall chart, and in the **Training Logbook**.

### Post-course questionnaire

After the learner has been found competent in the clinical area, a post-course questionnaire is administered. The learner must achieve a score of at least 80 percent to be certified in AMTSL.

If the learner gets less than 80 percent on the post-course questionnaire, the AMTSL mentor will review any course content the learner had difficulty with, and then the learner will take the alternate post-course questionnaire.

A certificate may be provided when the learner has achieved:

- At least 80 percent on the post-course questionnaire.
- At least 80 percent on evaluation in the clinical area.

Results of the post-course questionnaire should be recorded in the **Training Logbook** and the **Learner’s Notebook**.

When the learner has successfully completed the course, the AMTSL mentor provides the following information about the learners to the district and regional health management teams: Name, cadre, date the learning materials were distributed, date the post-course questionnaire was taken, scores for the pre-, mid-, and post-course questionnaires, dates of the clinical practicum, and score received on evaluation in the clinical area.

### Recording scores for assessments

A vital part of guiding learners through the blended learning materials is making sure that knowledge and skill assessments are carefully recorded. Scores for each assessment should be recorded in the **Learner’s Notebook** and the **Training Logbook**. Below, you will find examples for how to record the knowledge and skills assessment scores for fictitious “Learner A”.

#### Recording knowledge assessments

First, record the score in the **Learner’s Notebook**.

Then, record the score in the **Training Logbook**.

### Knowledge Assessment – Learner A

<table>
<thead>
<tr>
<th>Knowledge Assessment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-course questionnaire</td>
<td>76</td>
</tr>
<tr>
<td>Mid-course questionnaire</td>
<td>72</td>
</tr>
<tr>
<td>Post-course questionnaire</td>
<td>96</td>
</tr>
</tbody>
</table>

#### Knowledge assessments

<table>
<thead>
<tr>
<th>Learner</th>
<th>Pre-course</th>
<th>Mid-course</th>
<th>Post-course</th>
<th>Score (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>76</td>
<td>72</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>48</td>
<td>52</td>
<td>84</td>
<td></td>
</tr>
</tbody>
</table>
**Recording skills assessments**

<table>
<thead>
<tr>
<th>Clinical skill</th>
<th>Date completed</th>
<th>Score</th>
<th>AMTSL clinical instructor signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active management of third stage of labour (AMTSL)</td>
<td>Model</td>
<td>23/6/09</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td>24/6/09</td>
<td>92</td>
</tr>
<tr>
<td>Monitoring the woman and newborn in the immediate postpartum</td>
<td>Clinical</td>
<td>24/6/09</td>
<td>88</td>
</tr>
</tbody>
</table>

First, record the score in the **Learner’s Notebook**.

Then, record the score in the **Training Logbook**.

**Skill assessments**

<table>
<thead>
<tr>
<th>Learner</th>
<th>AMTSL</th>
<th>Monitoring during the immediate postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On an anatomical model before the clinical practicum</td>
<td>Final observation in the clinical area</td>
</tr>
<tr>
<td></td>
<td>Final observation in the clinical area</td>
<td>Final observation in the clinical area</td>
</tr>
<tr>
<td></td>
<td>Score (Percentage)</td>
<td>Score (Percentage)</td>
</tr>
<tr>
<td>A</td>
<td>83</td>
<td>92</td>
</tr>
<tr>
<td>B</td>
<td>87</td>
<td>96</td>
</tr>
</tbody>
</table>
Teaching clinical skills


Steps for teaching a clinical skill

The process of learning a clinical skill can be broken down into the following three phases:

• Demonstration
  - The clinical skill or activity is explained, first by reading the learning material and then by the mentor.
  - Using a videotape, slide set, or DVD, the mentor shows the clinical skill or activity to be learned.
  - Following this, the mentor demonstrates the skill on an anatomical model using the practice checklist.

• Practice
  - The learner practices the new clinical skill or activity on an anatomical model using the practice checklist while the mentor provides clinical coaching.
  - The mentor observes and interacts with the learner to (1) provide guidance while acquiring the skill, (2) monitor progress, and (3) assist the learner to overcome any difficulties encountered.

• Evaluation
  - The learner evaluates his/her own performance using the evaluation checklist in a simulated situation.
  - The learner’s partner evaluates the learner’s performance using the evaluation checklist in a simulated situation.
  - The mentor evaluates the learner’s performance using the evaluation checklist in a simulated situation.
  - After competence is gained with models, the learner begins to practice the skill with clients under a mentor’s guidance.
  - Finally, the mentor evaluates the learner’s ability to perform the skill in the clinical setting according to the evaluation checklist.
Demonstrations and return demonstrations on anatomical models using the practice checklist

When teaching a clinical skill, the mentor will first explain the skill or activity, show it, and then demonstrate it on an anatomical model using the practice checklist. A practice checklist contains the individual steps or tasks in sequence required to perform a skill or activity in a standardized way. Practice checklists are designed to help the learner learn the correct steps and the sequence in which they should be performed, and measure progressive learning in small steps as the learner gains confidence and skill.

When planning and giving a demonstration of a clinical procedure using anatomical models, the mentor should use the following guidelines:

- Use notes or a personalized reference manual.
- State the objective(s) as part of the introduction.
- Present an effective introduction.
- Arrange demonstration area so that learners are able to see each step in the procedure clearly.
- Never demonstrate an incorrect procedure or shortcut.
- Communicate with the model or client during demonstration of the skill/activity.
- Asks question and encourage learners to ask questions.
- Demonstrate or simulate appropriate infection-prevention practices.
- When using model, position model as an actual client.
- Maintain eye contact with learners as much as possible.
- Project voice so that all learners can hear.
- Provide learners opportunities to practice the skill/activity under direct supervision.

After demonstrating the skill, the mentor will ask learners if they have questions. The mentor will answer the learners’ questions and demonstrate the skill or steps of the skills as often as necessary.

When the learners have had the opportunity to observe the demonstration and ask questions, they will practice the skill on an anatomical model using the practice checklist. The number of procedures a learner needs to observe, assist with, and perform using models will vary depending on their backgrounds. When the learner can apply the skill with some confidence on the anatomical model without needing to refer to the practice checklist, she/he will ask to be evaluated by the mentor on the model.

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

Clinical coaching

An essential component of competency-based training is coaching, which uses positive feedback, active listening, questioning, and problem-solving skills to encourage a positive learning environment. To use coaching, the mentor should first explain the skill and then demonstrate it using an anatomical model, while following the steps outlined in the learning guide. Once the procedure has been demonstrated and discussed, the
The mentor then observes and interacts with the participant to provide guidance in learning the skill or activity, monitors progress, and helps the participant overcome problems. The coaching process ensures that the participant receives feedback regarding performance:

- **Before practice:** The mentor and participant should meet briefly before each practice session to review the skill, including the steps/tasks that will be emphasized during the session.

- **During practice:** The mentor observes, coaches and provides feedback to the participant as s/he performs the steps/tasks as outlined in the learning guide.

- **After practice:** This feedback session should take place immediately after practice. Using the learning guide, the mentor discusses the strengths and weaknesses of the participant’s performance and also offers suggestions for improvement.

Before a learner should attempt any clinical procedure with a client, two learning activities need to take place:

- The mentor should demonstrate on an anatomical model the skills and client-provider interaction necessary for competency as many times as necessary. The evaluation checklist for competency should always be followed and learners should be asked to refer to the practice checklists that are in the Learner’s Notebook.

- Any demonstrations should simulate the usual working conditions of the learners.

**Giving feedback before a demonstration or practice session**

- The learner and mentor discuss previous practice sessions.

- The learner reviews her/his performance in previous practice sessions.

- The mentor asks the participant which steps or tasks s/he would like to work on during the practice session.

- The learner and mentor review any difficult steps or tasks in the checklist that will be practiced during the session.

- The learner and mentor review specific goals set for the practice session.

- The learner and mentor discuss how they will interact while they are with the client.

**Giving feedback during a demonstration or practice session**

The mentor:

- Observes the learner as s/he practices the procedure.

- Provides positive reinforcement and suggestions for improvement as the participant practices the procedure.

- Refers to the checklist during observation.

- Records notes about participant performance on the checklist during the observation.
Is sensitive to the client when providing feedback to the participant during a clinical session with clients.

Provides corrective comments only when the comfort or safety of the client is in doubt.

**Giving corrective feedback during a demonstration or practice session**

- A look or hand gesture can be as effective as words and less worrisome to the client.
- Simple suggestions to facilitate the procedure can be made in a quiet, direct manner.
- To help a participant avoid making a mistake, the trainer can calmly ask a simple, straightforward question about the procedure itself.
- The mentor should be prepared to step in and take over the procedure at a moment’s notice.
- The best approach to providing corrective feedback is to minimize, or even eliminate, the need for it by conducting effective practice sessions in the classroom and helping the learners become competent on models.

**Giving feedback after a demonstration or practice session**

The mentor:

- Greets the participant.
- Asks the participant to share feelings about the practice session.
- Asks the participant to identify those steps performed well.
- Asks the participant to identify those steps where performance could be improved.
- Refers to notes on the checklist.
- Provides positive reinforcement regarding those steps or tasks the participant performed well.
- Offers specific suggestions for improvement.
- Determines if the learner is qualified or if additional practice is needed.

**Evaluation using competency-based evaluation tools**

There are two types of checklists: practice and evaluation checklists.

- **Practice checklist:** While learning and practicing the skills being taught in this course, the learner will use the practice checklist. The practice checklist contains the individual steps or tasks in the sequence required to perform all the skills or activities being taught in a standardized way.

- **Evaluation checklist:** The evaluation checklist is less detailed than the practice checklist and is used to objectively evaluate the learner’s ability to competently complete the skills being taught in this course.

A practice checklist contains the individual steps or tasks required to perform a skill or activity in a standardized way. They are designed to help the learner learn the correct steps and sequence in which they should be performed (skill acquisition). They can also be used to measure progress in learning as the learner gains confidence and skill (skill
A practice checklist differs from an evaluation checklist because it contains information about how and why a particular task is performed, rather than just listing the task that the learner needs to perform.

Using practice checklists in competency-based clinical training:

- Ensures that training is based on a standardized procedure.
- Standardizes training materials and audio-visual aids.
- Forms the basis of classroom or clinical demonstrations as well as learner practice sessions.

Because the practice checklist is used to assist in developing skills, it is important that learners understand how to use them. Learners can use the practice checklists as a self- or peer-assessment tool.

The evaluation checklist is first used to assess the learner's performance on models and then is used again to assess their performance on clients. When evaluating the learner’s performance, it is important to carefully use the evaluation checklist to ensure that scoring is as objective as possible.

When using the practice and evaluation checklists, the rating (scoring) needs to be done carefully and as objectively as possible. When practicing the skill, the learner's performance on each step/task is graded using the following scale:

1 = Performs the step or task completely and correctly.

0 = Unable to perform the step or task completely or correctly.

0 = Not observed: Step, task, or skill not performed by learner during evaluation by AMTSL mentor.

N/A (Not applicable) = Step is not needed.

Calculating a score using evaluation checklists

To determine if a learner has qualified or not, the AMTSL mentor will observe the learner and give a score for each step/task. The learner should achieve at least an 80% in a simulated setting and then in the clinical area to be considered competent. From the example below (see Figure 2), you can see that the learner was evaluated first in a simulated setting (M) and then in the clinical setting (C). In both the simulation and the clinical case, the baby breathed immediately, making step 2 "not applicable (N/A)" for both cases observed.
Figure 2. Example of checklist filled in for the sub-skill/activity “Immediate newborn care”

<table>
<thead>
<tr>
<th>Steps</th>
<th>Rating</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation type: model (M) or clinical practice (C)</td>
<td></td>
<td>4/3/09</td>
</tr>
<tr>
<td>Immediate newborn care (3 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Thoroughly dries the baby while assessing the baby’s breathing.</td>
<td>1 1</td>
<td></td>
</tr>
<tr>
<td>2. If the baby is not crying or breathing at least 30 times per minute within 30 seconds of birth calls for help and begins resuscitation.</td>
<td>N/A N/A</td>
<td></td>
</tr>
<tr>
<td>3. Places the baby in skin-to-skin contact with the mother and covers with a clean, dry cloth; covers head.</td>
<td>1 1</td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>2 2</td>
<td></td>
</tr>
</tbody>
</table>

When evaluating the learner using the evaluation checklist, it will be necessary to total up the scores for all of the sub-skills/activities that make up the competency. For this example, the learner received the following scores for the sub-skills/activities:

Figure 3. Calculating the score after evaluating the learner using a checklist

<table>
<thead>
<tr>
<th>Steps</th>
<th>Rating</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation type: model (M) or clinical practice (C)</td>
<td></td>
<td>4/3/09</td>
</tr>
<tr>
<td>Emotional support (2 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>1 2</td>
<td></td>
</tr>
<tr>
<td>Preparation (6 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>4 6</td>
<td></td>
</tr>
<tr>
<td>Immediate newborn care (3 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>2 2</td>
<td></td>
</tr>
<tr>
<td>AMTSL step 1: Administration of a uterotonic drug (2 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>2 2</td>
<td></td>
</tr>
<tr>
<td>AMTSL step 2: Controlled cord traction (9 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>8 9</td>
<td></td>
</tr>
<tr>
<td>AMTSL step 3: Uterine massage (4 points)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>3 4</td>
<td></td>
</tr>
</tbody>
</table>
### Evaluation Checklist: AMTSL

<table>
<thead>
<tr>
<th>Steps</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate postpartum care (7 points)</td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>5 6</td>
</tr>
<tr>
<td>Infection prevention (6 points)</td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>5 5</td>
</tr>
<tr>
<td>Care after placenta is delivered (5 points)</td>
<td></td>
</tr>
<tr>
<td>Points for skill/activity</td>
<td>4 5</td>
</tr>
</tbody>
</table>

From the example above, there were a total of 44 possible points for the competency (2+6+3+2+9+4+7+6+5). You can see that the learner received a total of 36 points (1+4+2+2+8+3+5+5+4) when performing the skill in a simulated setting (M) and 41 points (2+6+2+2+9+4+6+5+5) when performing the skill in the clinical setting (C).

Before calculating the percentage she received, you must go back over the checklist and count the number of “non-applicable” steps there were for the case you observed. For the sake of this example, we will say that there were 2 non-applicable steps when the learner performed in a simulated setting and 3 non-applicable steps when the learner performed in the clinical area. Before calculating the learner’s score you must subtract the number of non-applicable steps from the total points (44) to get the total possible points for the case observed. In the case below (see Figure 4), the total possible points are 42 for the simulated case observed (44-2=42) and 41 for the clinical case observed (44-3=41).

**Figure 4. Calculating the total possible points for the case observed**

<table>
<thead>
<tr>
<th>A: Total points for case observed</th>
<th>36</th>
<th>41</th>
</tr>
</thead>
<tbody>
<tr>
<td>B: Total points that were N/A</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>C: Total possible points for the case observed = 44 minus B</td>
<td>42</td>
<td>41</td>
</tr>
</tbody>
</table>

After calculating the total possible points for the case observed you can now calculate the learner’s score for each of the times you observed her (see Figure 5). To calculate her score, you will divide the total points earned for the case observed by the total possible points for the case observed and then multiply this by 100. For this example:

- **Score for simulation**: (36/42) x 100 = 85.7%
- **Score in clinical setting**: (41/41) x 100 = 100%
Figure 5. Calculating the learner’s score for the case observed

\[
\text{Score} = \left( \frac{A}{C} \right) \times 100
\]

Make sure to always sign for the case you observed! This is important to ensure accountability for the evaluation.
Meetings with the learners

First meeting: orientation and schedule

Materials needed:
- Mentor’s Guide
- Learner’s Guidebook
- Learner’s Notebook

Goals of the meeting:
- Familiarize the learners with the learning materials, the learning approach, and how the learner will be evaluated.

Guidelines for the first meeting:
1. Distribute the learning materials (Learner’s Guidebook and Learner’s Notebook), then explain:
   - The training content for the Prevention of Postpartum Haemorrhage Initiative (POPHI).
   - The team approach to learning.
   - The learning cycle.
   - How to use the practice checklist.
   - How learners’ knowledge and skills will be evaluated, including knowledge tests, and assessment of the learners using the evaluation checklist, first on anatomical models, and then on clients in the clinical setting.
2. Review the content of the Learner’s Guidebook and the Learner’s Notebook and explain the significance of the icons that distinguish each of the manuals used.
3. Explain that each learner will need to first read a short part of text, complete the learning exercises, correct the learning exercises, and then review any questions that were missed. The learner will continue like this until all of the sessions have been completed.
4. Ask learners to choose a learning partner.
5. Review the timeline and the sessions to be covered. Set a deadline for completing each session and write this in the Learner’s Notebook.
6. Review the section “Guidelines for learning on your own” in the Learner’s Guidebook and facilitate a discussion on how to find time to study. Develop a work plan for studying, including how to complete the self-paced portion of the course and how to find a place and time to study.
7. Ask learners to call their AMTSL mentor when they have completed the session on prevention of PPH so that they can schedule their clinical practicum.
8. If learners are from a different facility than the AMTSL CI, distribute forms for baseline data collection (see Appendix B), explain how to fill them in, and tell learners to collect data for the three months preceding their training.

**Pre-clinical meeting**

**Materials needed:**
- Mentor’s Guide
- Learner’s Notebook

**Goals of the pre-clinical meeting:**
Before beginning clinical practice, the AMTSL mentor again meets with the learner. The purpose of this meeting is to:

1) “Sign off” the participant on skills using the models.
2) Review goals for the clinical practice and clinical skills that will be evaluated.
3) Plan her/his schedule for the practicum.

**Guidelines for the pre-clinical meeting:**
Before beginning clinical practice, the AMTSL mentor will meet with the learner and:

1. Check that the learner was found competent on an anatomical model for all of the skills to be evaluated.
   - When a learner has been found competent on an anatomical model:
     - The AMTSL mentor writes the date and signs his name in the form “Conclusions and final recommendations” in the Learner’s Notebook (see Figure 6).
     - The AMTSL mentor writes the learner’s score in the Training Logbook and the Learner’s Notebook.
   - If a learner has not yet been found competent on an anatomical model, she/he will need to practice on an anatomical model until an AMTSL mentor finds her/him competent. The learner will not be able to practice in the clinical setting until she/he has been found competent on an anatomical model.

**Figure 6. Form for recording skill assessments**

<table>
<thead>
<tr>
<th>Clinical skill</th>
<th>Date the participant was found competent</th>
<th>Signature of the AMTSL mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active management of the third stage of labor</td>
<td>Anatomical model</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td></td>
</tr>
<tr>
<td>Monitoring the woman and newborn in the immediate postpartum period</td>
<td>Clinical</td>
<td></td>
</tr>
</tbody>
</table>

2. Review the learner’s checklists and set individual goals for the clinical practicum.
3. Plan her/his schedule for the practicum, including times and clinical area.
4. AMTSL mentors will take the learners on a tour of the clinical site to familiarize them with the site and accommodations, and to be introduced to staff working at the site.
The goals of the site visit are to ensure that learners feel comfortable at the site, that ward staff recognize learners and understand the goals and objectives of the clinical practicum, and to reassure ward staff that all of the learners have been found competent on anatomical models and are ready for supervised clinical practice. AMTSL mentors need to reassure ward staff that they will be present during the practicum.

**Final meeting**

**Materials needed:**
- Mentor’s Guide
- Learner’s Notebook

**Goals of the final meeting:**
- Check that the learner was found competent in the clinical area for all of the skills to be evaluated.
- Check that there is an AMTSL mentor’s signature for each skill that was evaluated.
- Ask the learner to share feelings about the clinical practicum.
- Make a plan for applying the new skills and knowledge at the workplace.
- Provide final recommendations and observations.
- Make a plan for follow-up after the training program is completed.

**Guidelines for the final meeting:**

1. The last meeting between the facilitator and participant will take place after the clinical experience has been completed. During this meeting, the facilitator and learner will review the form “Conclusions and final recommendations” (see Figure 6) and make sure that all clinical skills have been signed off in the clinical area as planned.

   If there are any signatures missing, the facilitator will need to review all of the learner’s evaluation checklists and decide if she/he was found competent. If the learner was not yet found competent, she/he will need to remain in the clinical area until competency is achieved.

   **Form – Conclusions and final recommendations**

<table>
<thead>
<tr>
<th>Clinical skill</th>
<th>Date the participant was found competent</th>
<th>Signature of the AMTSL mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active management of the third stage of labor</strong></td>
<td>Anatomical model</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical</td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring the woman and newborn in the immediate postpartum period</strong></td>
<td>Clinical</td>
<td></td>
</tr>
</tbody>
</table>

2. Final comments and recommendations from both learner and AMTSL mentor should be discussed and filled in on the form in the space provided for each of them (see
3. The learner and AMTSL mentor work together to complete the action plan found in the Learner’s Notebook.

   Both will decide together on who is responsible, what supplies are needed, the estimated timeline to complete the plan, and a way to evaluate each activity. After the action plan is completed, both the learner and the AMTSL mentor sign it.

4. The learner fills in the form to evaluate the training program (in the Learner’s Notebook) and then gives the completed form to the AMTSL mentor.

5. If learners are from a different facility than the AMTSL mentor, the learner will be given the monitoring form (see Appendix C), the AMTSL mentor explains how to fill it in, and asks the learner to complete it and send it to the district point person at the end of every quarter.

6. If learners are from a different facility than the AMTSL mentor, the AMTSL mentor distributes copies of the wall charts (Appendix D), explains how to fill them in, and asks them to tape them up on the wall in the delivery room so that they can follow their own progress with implementing AMTSL.
Managing clinical practice


Introduction

Mentors must always be with learners when they are working with clients so that they can provide guidance and support, both individually and for the group, and continually evaluate their acquisition of new knowledge and skills. Clinical sites must be supervised by teams of two mentors (preferably one midwife and one physician).

Mentors can use the following methods to guide, support, and evaluate each learner during their clinical experience:

- Individual discussions.
- Observations during clinical practice.
- Discussions during post-clinical meetings.

In addition to clinical experiences, the learners should work on the site evaluation form.

Responsibilities of learners and mentors during clinical practice

When using the competency-based approach, the responsibility to meet learning objectives is shared by the mentor and the learner. The facilitator’s/mentor’s goal is to assist each learner to achieve mastery of each skill and not simply to get a good grade on a knowledge test. If one learner doesn’t achieve mastery, the mentor must not simply attribute this failure to the learner’s incompetence, but should find helpful learning approaches to assist the learner in achieving competence.

The role of the mentor is to facilitate learning. A mentor guides the learners in the discovery of new knowledge and toward the acquisition of new skills or improving existing skills. A mentor seeks to influence the learner’s attitude by modeling approved, agreed-upon standards of performance and behavior. For example, the mentor must always demonstrate the entire skill exactly as it should be practiced—demonstrating the “wrong” way to practice a skill is never acceptable.

Learners should be encouraged to be actively engaged in their own learning process and mentors must encourage them to share what they already know about subjects being taught. The knowledge and experience that the learners bring to any training is as important for the learning process as any knowledge or experience the mentor may have. The success of this program and learning approach depends upon the desire of learners to take an active part in their learning process and their willingness to share their experiences and knowledge with other learners.

Clients’ rights during clinical training

The following clients’ rights need to be routinely protected during clinical training:
• The right to **bodily privacy** – only one learning pair should take care of one woman at a time; the mentor should not allow additional learners to come and “observe” unless they have a defined role in caring for the woman.

• The right to **confidentiality**.

• The right to **be informed about the role of** each person involved and present in the room.

• The right to **refuse care provided by learners** – the client’s permission should be obtained before having a learner observe, assist with, or perform any procedures.

• The right to **withdraw permission** even if the learner has already begun observing, assisting with, or performing the procedure—should this occur, the mentor will need to inform ward staff that they will need to take over care.

• The right to **have a mentor or clinical trainer present** whenever the learner is providing care—the mentor will need to be ready to intervene if the client’s safety is in jeopardy or if the client is experiencing severe discomfort.

### Creating opportunities for learning

#### Planning for learning

• Develop a plan for each clinic day.

• Place learners in different areas at the clinical site:
  - **Delivery room** – learners can perform AMTSL, examination of the placenta, help initiate breastfeeding, and monitor the woman and baby during at least the first hour postpartum.
  - **Recovery room (room for monitoring the woman and baby during the first six hours postpartum)** - learners can monitor the woman and baby during the first six hours postpartum.
  - **Practice on anatomical models** (any learners that were not found competent on an anatomical model must do so before practicing on clients)

• Discuss learning objectives and the number of learners to expect with the ward staff and learners.

• Choose clients carefully and develop a system for assigning learners to each client—the client chosen should be appropriate for the clinical training purposes identified.

• Include other learning areas that impact client care, including but not limited to infection prevention practices, ordering and storage of uterotonic drugs, and client flow.

• Prepare additional activities for the learners for times when there are few or no clients in the clinic.

#### In the clinic

• The mentor must actively monitor the skills each participant is able to practice, and with what frequency, so that each participant has adequate opportunities to develop competency.

• It is essential that the mentor be flexible and constantly alert to learning opportunities as they arise in the clinic.
Learners should be encouraged to watch for learning opportunities in the clinic.

To take advantage of opportunities as they occur may require that the mentor modify the plan for that day and subsequent days.

Supplement the work done with clients with case studies and role plays.

The mentor must actively monitor the clinical experiences of each learner so that:

- Each learner receives appropriate and adequate opportunities for skill practice.
- Learners don't disrupt clinic functioning or interfere with ward staff or their duties.
- Care provided by each learner does not harm clients or place them in an unsafe situation.

**Pre- and post-clinical practice meetings**

**Pre-clinical practice meeting**

Items covered should include:

- The learning activities for the day.
- Any scheduling changes that may be needed.
- Learners’ roles and responsibilities for that day, including the work assignments and rotation schedule if applicable.
- Special assignments to be completed that day.
- The topic for the post-clinical practice meeting.
- Questions related to that day’s activities or from previous days if they can be answered. If not, they should be deferred until the post-clinical practice meeting.

**Post-clinical practice meeting**

- Review the day’s learning objectives and assess progress toward their completion.
- Present cases seen that day, particularly those that were interesting, unusual or difficult.
- Respond to clinical questions concerning situations and clients in the clinic or information in the Learner's Guidebook.
- Plan for the next clinical session, making changes in the schedule as necessary.
- Conduct additional practice with models if needed.
- Review and discuss case studies, role plays, or assignments that have been prepared in advance by the learners.

**Supervision in the clinical area**

- The mentor must always be with learners when they are working with clients.
- Learners must understand what they can do independently and what requires mentor supervision.
• Learners should be made responsible for ensuring that they are supervised when necessary.

• Additional activities that require no direct supervision will give participants the opportunity to be actively engaged in learning when they are not with clients.

• Clinic staff also can act as supervisors if the trainer is confident of their clinical skills and ability to provide appropriate feedback.

• If learners are placed in several clinical sites, take care that the ratio of four learners for one mentor is never exceeded.

• It is a good idea to share information about the learners with the clinical staff whenever they will have to take over a large part of the learner’s supervision.

• Clinic staff should be encouraged to do an initial assessment of learner’s skills before allowing them to work with clients so that they can feel confident that the learners are well-prepared.

• Clinic staff should be aware of the feedback the trainer would like to receive from them about the learners.

• The ultimate responsibility for supervision and evaluation of the learners always falls on the mentor.

Keeping track of clinical experiences and practice

To ensure that each learner receives appropriate and adequate opportunities for skill practice, learners will keep track of their experiences using a wall chart (see the following page). The wall chart is a way to keep track of skills they “performed,” skills they “assisted” another learner with, and skills they “observed” another participant or a provider performing.

The wall chart is a way to follow learners’ progress and assist mentors in ensuring appropriate clinical experiences for all of the participants. Make a copy of the following table on a flipchart and post it where learners can use it.

- Mentors will mark the date the participant was found competent in each skill on the wall chart. When the participant is found competent on the model, the date will be marked in the “demonstrated” column; when the participant is found competent in the clinical area, the date will be marked in the “performed” column.

- Participants will need to make a mark (a “|”) under each skill when they have observed another participant or a provider performing the skill in the clinical area on a client.
**Figure 8. Wall Chart - Clinical experiences**

<table>
<thead>
<tr>
<th>Learner</th>
<th>Skill</th>
<th>AMTSL</th>
<th>Monitoring the woman and newborn in the immediate postpartum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Planning for implementation

Once AMTSL mentors have been trained in each clinical training site, they will need to implement the on-site and individual learning strategy.

Developing a training strategy

Before beginning training activities, the AMTSL mentors will first need to make a list of all providers attending births in their health facility. If the provider has already been certified in AMTSL, the AMTSL mentor will indicate the dates each provider participated in training activities as well as the date he/she was found competent.

A *Training Logbook* (see Appendix A) will be used to track the providers who have been certified in AMTSL. The AMTSL mentors will complete the table for registering all learners that is found in the Training Logbook (see Figure 9). This table will be completed for each facility in the district and the AMTSL mentor will register the name, professional cadre, place of work, and dates the training was commenced and the provider found competent for each facility.

**Figure 9. Table found in the Training Logbook to track providers going through the blended learning course**

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Professional cadre</th>
<th>Place of work</th>
<th>Date training commenced</th>
<th>Date found competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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</tbody>
</table>

Once the AMTSL mentors have an idea of the number of people that need training, they will need to develop a strategy for guiding them through the learning materials. There are three different strategies that could be used in a facility:

**Strategy A: Train all providers at once**

In this strategy, all of the providers to be trained will be given the learning materials at the same time (see Figure 10).

The advantages for using this strategy are: 1) The AMTSL mentor will only need to monitor when each of the learning pairs have completed the course and 2) All of the providers can work together on the materials.

**Figure 10. Recording providers going through the blended learning course – Strategy A**

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Professional cadre</th>
<th>Place of work</th>
<th>Date training commenced</th>
<th>Date found competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Physician</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Physician</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>G</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>H</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>J</td>
<td>Midwife</td>
<td>Facility X</td>
<td>June 29, 2009</td>
<td></td>
</tr>
</tbody>
</table>
The disadvantage for using Strategy A is that if all of the providers complete the learning materials at the same time, there will be a large number of learners competing for clinical cases.

**Strategy B:** Train providers in groups of 2-4 and do not train other providers until the group has completed the entire course (see Figure 11).

In this strategy, learning materials will only be given to 1-2 learning pairs (2-4 learners) at a time. Learning materials will be given to another learning pair only after a learning pair has completed the course.

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Professional cadre</th>
<th>Place of work</th>
<th>Date training commenced</th>
<th>Date found competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>Midwife</td>
<td>Facility X</td>
<td>29 / 6 / 2009</td>
<td>17 / 7 / 2009</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Physician</td>
<td>Facility X</td>
<td>29 / 6 / 2009</td>
<td>17 / 7 / 2009</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>Midwife</td>
<td>Facility X</td>
<td>29 / 6 / 2009</td>
<td>10 / 7 / 2009</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Physician</td>
<td>Facility X</td>
<td>29 / 6 / 2009</td>
<td>10 / 7 / 2009</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>Midwife</td>
<td>Facility X</td>
<td>13 / 7 / 2009</td>
<td>24 / 7 / 2009</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Midwife</td>
<td>Facility X</td>
<td>13 / 7 / 2009</td>
<td>24 / 7 / 2009</td>
</tr>
<tr>
<td>7</td>
<td>G</td>
<td>Midwife</td>
<td>Facility X</td>
<td>20 / 7 / 2009</td>
<td>5 / 8 / 2009</td>
</tr>
<tr>
<td>8</td>
<td>H</td>
<td>Midwife</td>
<td>Facility X</td>
<td>20 / 7 / 2009</td>
<td>5 / 8 / 2009</td>
</tr>
</tbody>
</table>

**Figure 11. Recording providers going through the blended learning course – Strategy B**

The advantages for using this strategy are: 1) The AMTSL will only need to monitor 2-4 learners at a time and 2) There will not be competition for clinical cases because only 2-4 learners will be ready for clinical at the same time.

The disadvantages for using this strategy are: 1) Monitoring the learners may become increasingly complicated for the AMTSL mentor and 2) The learning pairs will be at different places in the learning cycle.

**Strategy C:** Train providers in “shifts,” giving one learning pair the learning materials each week until all of the providers have received the materials (see Figure 12).

In this strategy, learning materials will only be given to 1-2 learning pairs (2-4 learners) each week.

The advantages for using this strategy are: 1) There will not be competition for clinical cases because only 2-4 learners will be ready for clinical at the same time.

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Professional cadre</th>
<th>Place of work</th>
<th>Date training commenced</th>
<th>Date found competent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A</td>
<td>Midwife</td>
<td>Facility X</td>
<td>29 / 6 / 2009</td>
<td>17 / 7 / 2009</td>
</tr>
<tr>
<td>2</td>
<td>B</td>
<td>Physician</td>
<td>Facility X</td>
<td>29 / 6 / 2009</td>
<td>17 / 7 / 2009</td>
</tr>
<tr>
<td>3</td>
<td>C</td>
<td>Midwife</td>
<td>Facility X</td>
<td>6 / 7 / 2009</td>
<td>17 / 7 / 2009</td>
</tr>
<tr>
<td>4</td>
<td>D</td>
<td>Physician</td>
<td>Facility X</td>
<td>6 / 7 / 2009</td>
<td>17 / 7 / 2009</td>
</tr>
<tr>
<td>5</td>
<td>E</td>
<td>Midwife</td>
<td>Facility X</td>
<td>13 / 7 / 2009</td>
<td>31 / 7 / 2009</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Midwife</td>
<td>Facility X</td>
<td>13 / 7 / 2009</td>
<td>31 / 7 / 2009</td>
</tr>
<tr>
<td>7</td>
<td>G</td>
<td>Midwife</td>
<td>Facility X</td>
<td>20 / 7 / 2009</td>
<td>31 / 7 / 2009</td>
</tr>
<tr>
<td>8</td>
<td>H</td>
<td>Midwife</td>
<td>Facility X</td>
<td>20 / 7 / 2009</td>
<td>31 / 7 / 2009</td>
</tr>
<tr>
<td>9</td>
<td>I</td>
<td>Midwife</td>
<td>Facility X</td>
<td>27 / 7 / 2009</td>
<td>14 / 8 / 2009</td>
</tr>
<tr>
<td>10</td>
<td>J</td>
<td>Midwife</td>
<td>Facility X</td>
<td>27 / 7 / 2009</td>
<td>14 / 8 / 2009</td>
</tr>
</tbody>
</table>

**Figure 12. Recording providers going through the blended learning course – Strategy C**

The disadvantages for using this strategy are: 1) Monitoring the learners may become increasingly complicated for the AMTSL mentor and 2) The learning pairs will be at different places in the learning cycle.
Helping learners make a learning plan

There is a guide for developing a learning plan on page 1 of the Learner’s Notebook (see Figure 13). This will need to be filled in by the AMTSL mentor and the learner when materials are first distributed.

Information about the course

My mentor is: ____________________________

My mentor works at: ____________________________

My mentor’s telephone number is: ____________________________

My learning partner is: ____________________________

My learning partner works at: ____________________________

My learning partner’s telephone number is: ____________________________

<table>
<thead>
<tr>
<th>Topic</th>
<th>Start date</th>
<th>Due date</th>
<th>Completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third stage of labor and evidence for using AMTSL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of PPH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of uterotonics drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMTSL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth preparedness and complication readiness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing complications during the third stage of labor</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Site where I will do demonstrations on anatomic models: ____________________________

Health care facility where I will do my clinical practice: ____________________________

Date 1 began demonstration on anatomic models: ____________________________

Date 1 was found competent on anatomic models: ____________________________

Date 1 began my clinical practice: ____________________________

Date 1 was found competent in the clinical area: ____________________________

Figure 13. Page 1 from the Learner’s Notebook

It is important to set deadlines for learners during the self-paced portion of the course. This will help learners stay on course. When you distribute the materials, help the learner make a plan to study for at least 1-2 hours per day. Based on this and the suggested time it will take to complete each session, you will set a due date for each session.
Table 2. Estimated time to complete each topic

<table>
<thead>
<tr>
<th>Topic</th>
<th>Number of learning activities/exercises</th>
<th>Estimated time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Topic 1. Review of the third stage of labor and evidence for use of AMTSL.</td>
<td>2</td>
<td>2 hours</td>
</tr>
<tr>
<td>Core Topic 2a. Review of uterotonic drugs.</td>
<td>3</td>
<td>3 hours</td>
</tr>
<tr>
<td>Core Topic 2b. Management of uterotonic drugs.</td>
<td>3</td>
<td>3 hours</td>
</tr>
<tr>
<td>Core Topic 3. Causes and prevention of postpartum hemorrhage.</td>
<td>4</td>
<td>4 hours</td>
</tr>
<tr>
<td>Core Topic 4. AMTSL.</td>
<td>6</td>
<td>6 hours</td>
</tr>
<tr>
<td>Additional Topic 1. Infection prevention.</td>
<td>6</td>
<td>6 hours</td>
</tr>
<tr>
<td>Additional Topic 2. Birth preparedness and complication readiness.</td>
<td>4</td>
<td>4 hours</td>
</tr>
<tr>
<td>Additional Topic 3. Managing complications during the third stage of labor.</td>
<td>7</td>
<td>7 hours</td>
</tr>
</tbody>
</table>

The following is an example of how a learner completed her form.

**Figure 14. Page 1 from the Learner’s Notebook completed for Learner X**
You can see from the form above that Learner X sometimes completed a session after the due date she wrote down at the beginning of the course. In the end, though, she completed some of the sessions more quickly than she anticipated and was able to complete the course before the due date established at the beginning.

Setting short-term goals with each learner will keep them motivated and help them keep moving forward with their reading.
Monitoring and evaluation of PPH prevention activities

Monitoring and supervision of ongoing activities are essential for the success of any intervention. Providers and supervisors will need to establish a baseline prior to beginning any training activities so that appropriate intervention strategies are developed and progress in implementation can be followed.

Indicators

There are two major indicators that need to be followed:

1) Number and percent of skilled birth attendants trained in AMTSL

**Baseline data:**

- Identify all SBAs in the region (by health facility and by district) that have already been trained in AMTSL.
- Identify all SBAs in the region (by health facility and by district) that have not yet been trained in AMTSL.
- Make a registry to keep track of all SBAs trained in AMTSL (see Appendix A).
- Calculate the number and percentage of SBAs in the district/region that have already been trained, and stratify results by professional cadre.
- Make a list of all personnel, by professional cadre, that need to be trained in AMTSL by health facility/district.

**Monitoring data:**

- Follow all SBAs newly trained in AMTSL in each district (by health facility).
- Calculate the number and percentage of SBAs in the district/region that have been trained, and stratify results by professional cadre.

2) Number and percentage of women who were offered and received AMTSL

**Baseline data** for each health care facility:

Each health care facility needs to collect the following information for the 3 months preceding any training activities (see Appendix B):

A. Number of women who gave birth at the health care facility with the assistance of a skilled birth attendant (SBA).
B. Number of women who were offered and received AMTSL practiced by an SBA.
C. Percentage of women who gave birth at the facility and were offered and received AMTSL practiced by a skilled birth attendant (B divided by A).

**Monitoring data** (see Appendix C):

Each health care facility needs to collect the following information and send them to the district AMTSL point person:

A. Number of women who gave birth at the health care facility with the assistance of a skilled birth attendant (SBA).
B. Number of women who were offered and received AMTSL practiced by an SBA.
C. Percentage of women who gave birth at the facility and were offered and received AMTSL practiced by a skilled birth attendant (B divided by A).

Wall charts

A simple but effective way to keep track of progress towards achieving 100% coverage for AMTSL is to use wall graphs that you can post in the delivery room. By posting these graphs, all of the midwives and doctors working in the unit can take credit for progress made and can also work together to make changes if these are needed.

Some examples of wall graphs that can be used are as follows (see Appendix D):

1. Percentage of women who gave birth at the facility and were offered and received AMTSL practiced by a skilled birth attendant

   The goal is to have 100% of births conducted by a SBA and to have 100% of women receiving AMTSL when they give birth vaginally.

   ![Wall chart to follow AMTSL coverage](image)

   **Figure 15. Wall chart to follow AMTSL coverage**

2. Number and percentage of cases of postpartum haemorrhage (PPH) in women who gave birth vaginally in the health care facility

   AMTSL can prevent up to 60% of cases of PPH in women who give birth vaginally. This graph is an indirect way of plotting how the number of PPH cases reduces when coverage for AMTSL increases.
Figure 16. Wall chart to follow PPH cases

3. Percentage of providers who practiced AMTSL to standard

Keeping this graph up to date will mean that you have set up a system for monthly peer review of the practice of AMTSL. Any providers who have been trained in AMTSL can use the Evaluation Checklist to evaluate their peers. Having a peer review system set up will ensure that midwives and doctors will continue to practice AMTSL to standard long after training activities were completed.

Figure 17. Wall chart to follow percentage of providers practicing AMTSL to standard
Pre-course questionnaire: AMTSL

Instructions:
Read each question carefully before choosing a response. Write the letter “T” for True or “F” for False in the space provided after each statement. If you do not understand a question, ask one of the mentors to assist you before you respond to the question. Each question is worth 1 point.

Scientific evidence:
1. Active management of the third stage of labor reduces the length of the third stage of labor.
   _______
2. The only difference between active and physiologic management of the third stage of labor is that oxytocin is administered within one minute of the birth of the baby in AMTSL.
   _______

Causes and prevention of PPH:
3. When a portion of the placenta—one or more lobes—is retained, it prevents the uterus from contracting effectively.
   _______
4. Immediate PPH is most commonly due to uterine atony (failure of the uterus to contract properly after the infant is born).
   _______
5. The best way to prevent PPH is to carefully identify risk factors in women during pregnancy and at the beginning of labor.
   _______
6. Monitoring labor using the partograph may help prevent PPH.
   _______

Review of uterotonic drugs:
7. Ergometrine is less stable than oxytocin when exposed to heat and light.
   _______
8. Temporary storage of oxytocin outside the refrigerator at a maximum of 30°C is acceptable for no more than three months.
   _______
9. Oxytocin should never be given to women with preeclampsia, eclampsia, or high blood pressure because it increases the risk of convulsions and cerebrovascular accidents.
   _______
10. Misoprostol is a uterotonic that can be used to treat PPH.
    _______
11. In the context of active management of the third stage of labor, if oxytocin is not available, SBAs should offer ergometrine/methylergometrine or the fixed drug combination of oxytocin and ergometrine to women without hypertension or heart disease for prevention of PPH.
    _______
AMTSL:
12. Active management of the third stage of labor should be practiced only on women who have a history of PPH.


13. Delayed clamping and cutting of the umbilical cord is helpful to both term and preterm babies.


14. CCT should be done only in between contractions to prevent uterine inversion.


15. CCT should never be applied without applying countertraction (push) to the uterus above the pubic bone with the other hand.


16. To help prevent PPH, if oxytocin is not available or birth attendants’ skills are limited, misoprostol should be administered soon after the birth of the baby.


17. Active management decreases the need for uterotonic drugs to manage PPH.


18. The provider should wait for signs of placental separation before beginning CCT.


Monitoring during the immediate postpartum period:
19. Ms. A gave birth to a healthy baby girl 30 minutes ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. You estimate that she lost about 300 mL of blood. Because the birth and third stage were normal, it is necessary only to monitor Ms. A’s uterus and vaginal bleeding every hour.


20. To ensure that the uterus remains contracted after delivery of the placenta, the provider should instruct the woman how the uterus should feel and how she can massage it herself.


Name: ________________________________
Facility: ______________________________
Date: _____/_____/20____
Pre-course questionnaire answer key

Instructions:
Read each question carefully before choosing a response. Write the letter “T” for True or “F” for False in the space provided after each statement. If you do not understand a question, ask one of the mentors to assist you before you respond to the question. Each question is worth 1 point.

Scientific evidence:
1. Active management of the third stage of labor reduces the length of the third stage of labor.  
   True  
2. The only difference between active and physiologic management of the third stage of labor is that oxytocin is administered within one minute of the birth of the baby in AMTSL.  
   False  

Causes and prevention of PPH:
3. When a portion of the placenta—one or more lobes—is retained, it prevents the uterus from contracting effectively.  
   True  
4. Immediate PPH is most commonly due to uterine atony (failure of the uterus to contract properly after the infant is born).  
   True  
5. The best way to prevent PPH is to carefully identify risk factors in women during pregnancy and at the beginning of labor.  
   False  
6. Monitoring labor using the partograph may help prevent PPH.  
   True  

Review of uterotonic drugs:
7. Ergometrine is less stable than oxytocin when exposed to heat and light.  
   True  
8. Temporary storage of oxytocin outside the refrigerator at a maximum of 30°C is acceptable for no more than three months.  
   True  
9. Oxytocin should never be given to women with preeclampsia, eclampsia, or high blood pressure because it increases the risk of convulsions and cerebrovascular accidents.  
   False  
10. Misoprostol is a uterotonic that can be used to treat PPH.  
   True
11. In the context of active management of the third stage of labor, if oxytocin is not available, SBAs should offer ergometrine/methylergometrine or the fixed drug combination of oxytocin and ergometrine to women without hypertension or heart disease for prevention of PPH.
   True

**AMTSL:**

12. Active management of the third stage of labor should be practiced only on women who have a history of postpartum hemorrhage.
   False

13. Delayed clamping and cutting of the umbilical cord is helpful to both term and preterm babies.
   True

14. CCT should only be done in between contractions to prevent uterine inversion.
   False

15. CCT should never be applied without applying countertraction (push) to the uterus above the pubic bone with the other hand.
   True

16. To help prevent PPH, if oxytocin is not available or birth attendants’ skills are limited, misoprostol should be administered soon after the birth of the baby.
   True

17. Active management decreases the need for uterotonic drugs to manage PPH.
   True

18. The provider should wait for signs of placental separation before beginning CCT.
   False

**Monitoring during the immediate postpartum period:**

19. Ms. A gave birth to a healthy baby girl 30 minutes ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. You estimate that she lost about 300 mL of blood. Because the birth and third stage were normal, it is necessary only to monitor Ms. A’s uterus and vaginal bleeding every hour.
   False

20. To ensure that the uterus remains contracted after delivery of the placenta, the provider should instruct the woman how the uterus should feel and how she can massage it herself.
   True
Mid-course questionnaire: AMTSL

Instructions:
Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the mentors to assist you before you respond to the question.

MULTIPLE CHOICE
Circle the best response for each question. Each question is worth 1 point.

Scientific evidence:
1) Which of the following statements describes an advantage of physiologic management of the third stage of labor?
   a) It increases the length of the third stage of labor.
   b) It does not interfere with the normal process of labor and childbirth.
   c) It reduces the risk of PPH.
   d) It reduces average amount of blood loss.

2) Which of the following statements describes a disadvantage of AMTSL?
   a) It requires the presence of an SBA who can administer injections.
   b) It increases the amount of blood loss after childbirth.
   c) It increases the risk of PPH during the third stage of labor.
   d) It increases the length of the third stage of labor.

Review of uterotonic drugs:
3) Which of the following statements about oxytocin is not true?
   a) Oxytocin acts within 6 to 7 minutes.
   b) Oxytocin has few or no side effects.
   c) Oxytocin is more stable than ergometrine when exposed to heat.
   d) Oxytocin is more stable than ergometrine when exposed to light.

4) Uterotonic drugs:
   a) Can be used to stimulate contractions.
   b) Are used to treat PPH.
   c) Help prevent uterine atony after childbirth.
   d) All of the above.

5) If the health facility does not have a refrigerator:
   a) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than two weeks.
   b) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than three months.
   c) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than one week.
   d) None of the responses is correct.
6) If a skilled birth attendant is not present at the birth:
   a) Oxytocin or misoprostol may be administered in the absence of AMTSL.
   b) AMTSL should still be practiced because it prevents PPH.
   c) Physiologic management of the third stage of labor may need to be practiced if
      the birth attendant cannot administer a uterotonic drug.
   d) (a) and (c).

7) WHO recommends oxytocin as the uterotonic drug of choice because:
   a) It is fast-acting.
   b) It is inexpensive.
   c) In most cases, it has no side effects or contraindications for use during the third
      stage of labor.
   d) It is more stable than ergometrine in hot climates and light.
   e) All of the above.

Prevention of PPH:

8) Which of the following can prevent the uterus from contracting properly?
   a) Clamping of the cord too quickly after childbirth.
   b) Emptying the bladder before placenta separation.
   c) Failure of the placenta to separate from the uterus.
   d) Failure to wait at least 15 minutes before massaging the uterus after the placenta
      has delivered.

9) Up to two-thirds of PPH cases:
   a) Can be predicted if women’s risk factors are identified during pregnancy.
   b) Occur in women who have no risk factors.
   c) Can be predicted if a thorough history is taken when the woman comes to the
      health facility in labor.
   d) Can be predicted by experienced SBAs.

10) The most important factor in determining a woman’s chances of surviving PPH is:
    a) The woman’s parity.
    b) Early diagnosis and management of PPH.
    c) Identification of risk factors during pregnancy.
    d) Identification of risk factors when a woman comes to the health facility to give
        birth.

11) Screening for, preventing, and treating anemia during pregnancy can:
    a) Prevent PPH.
    b) Reduce the risk of dying from PPH.
    c) Make AMTSL less risky.
    d) All of the responses are correct.
AMTSL:

12) Active management of the third stage of labor includes all of the following EXCEPT:
   a) Massaging the uterus.
   b) Applying upward pressure on the uterus with a contraction.
   c) Waiting for signs of placenta separation (e.g., lengthening of the cord).
   d) Giving a uterotonic drug within one minute after birth.

13) The main risk in performing active management of the third stage with oxytocin is:
   a) Retained placenta.
   b) Pulling the cord off.
   c) Causing uterine atony.
   d) None of the above.

14) CCT is applied only when countertraction is applied simultaneously because:
   a) Countertraction helps the placenta descend into the vagina.
   b) Countertraction supports the uterus and helps prevent uterine inversion during CCT.
   c) Countertraction reduces pain caused when CCT is applied.
   d) Countertraction reduces the risk of MTCT of HIV.

15) If the placenta does not descend during 30–40 seconds of CCT:
   a) Consider placenta accreta and prepare the patient for a surgical intervention.
   b) Do not continue to pull on thecord; gently hold the cord and wait until the uterus is well-contracted again.
   c) Administer a second injection of oxytocin 10 IU IM.
   d) Administer a different uterotonic because the first uterotonic was not effective.

16) Performing AMTSL:
   a) Will prevent all cases of PPH.
   b) Cannot prevent all cases of PPH.
   c) May increase the risk of PPH due to uterine inversion.
   d) Will only prevent PPH in women with risk factors for PPH.

17) Active management decreases:
   a) The incidence of PPH.
   b) The length of the third stage of labor.
   c) The percentage of third stages of labor lasting longer than 30 minutes.
   d) All of the responses are correct.
18) The umbilical cord should be cut:
   a) As soon as possible after birth of the baby to facilitate AMTSL and immediate
      newborn care.
   b) Immediately after birth of the baby if the newborn requires resuscitation.
   c) After the placenta is delivered to ensure transfer of blood to the newborn.
   d) At a time determined by cultural beliefs.

**Monitoring during the immediate postpartum period:**

19) Ms. A gave birth to a healthy baby girl one hour ago. You managed the third stage of
    labor actively, the placenta was complete, and she had no perineal or vaginal
    lacerations. How often should you monitor her uterus and vaginal bleeding during the
    second hour after delivery of the placenta?
   a) Every 10 minutes.
   b) Every 15 minutes.
   c) Continuously.
   d) Every 60 minutes.

20) Baby A was born at 3:15 p.m. She did not require resuscitation and has already begun
    breastfeeding. It is now 6:30 p.m. How often will you monitor her temperature?
   a) Every 10 minutes.
   b) Every 15 minutes.
   c) Continuously.
   d) Every 60 minutes.
Mid-course questionnaire answer key

Instructions:
Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the mentors to assist you before you respond to the question.

MULTIPLE CHOICE
Circle the best response for each question. Each question is worth 1 point.

Scientific evidence:
1) Which of the following statements describes an advantage of physiologic management of the third stage of labor?
   a) It increases the length of the third stage of labor.
   b) It does not interfere with the normal process of labor and childbirth.
   c) It reduces the risk of PPH.
   d) It reduces average amount of blood loss.

2) Which of the following statements describes a disadvantage of AMTSL?
   a) It requires the presence of a skilled birth attendant who can administer injections.
   b) It increases the amount of blood loss after childbirth.
   c) It increases the risk of PPH during the third stage of labor.
   d) It increases the length of the third stage of labor.

Review of uterotonic drugs:
3) Which of the following statements about oxytocin is not true?
   a) Oxytocin acts within 6 to 7 minutes.
   b) Oxytocin has few or no side effects.
   c) Oxytocin is more stable than ergometrine when exposed to heat.
   d) Oxytocin is more stable than ergometrine when exposed to light.

4) Uterotonic drugs:
   a) Can be used to stimulate contractions.
   b) Are used to treat postpartum hemorrhage.
   c) Help prevent uterine atony after childbirth.
   d) All of the above.

5) If the health facility does not have a refrigerator:
   a) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than two weeks.
   b) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than three months.
   c) Oxytocin may be stored outside the refrigerator at a maximum of 30°C for no more than one week.
   d) None of the responses is correct.
6) If a skilled birth attendant is not present at the birth:
   a) Oxytocin or misoprostol may be administered in the absence of AMTSL.
   b) AMTSL should still be practiced because it prevents PPH.
   c) Physiologic management of the third stage of labor may need to be practiced if 
      the birth attendant cannot administer a uterotonic drug.
   d) *(a) and (c).*

7) WHO recommends oxytocin as the uterotonic drug of choice because:
   a) It is fast-acting.
   b) It is inexpensive.
   c) In most cases, it has no side effects or contraindications for use during the third 
      stage of labor.
   d) It is more stable than ergometrine in hot climates and light.
   e) **All of the above.**

Prevention of PPH:

8) Which of the following can prevent the uterus from contracting properly?
   a) Clamping of the cord too quickly after childbirth.
   b) Emptying the bladder before placenta separation.
   c) **Failure of the placenta to separate from the uterus.**
   d) Failure to wait at least 15 minutes before massaging the uterus after the placenta 
      has delivered.

9) Up to two-thirds of PPH cases:
   a) Can be predicted if women’s risk factors are identified during pregnancy.
   b) **Occur in women who have no risk factors.**
   c) Can be predicted if a thorough history is taken when the woman comes to the 
      health facility in labor.
   d) Can be predicted by experienced SBAs.

10) The most important factor in determining a woman’s chances of surviving PPH is:
    a) The woman’s parity.
    b) **Early diagnosis and management of PPH.**
    c) Identification of risk factors during pregnancy.
    d) Identification of risk factors when a woman comes to the health facility to give 
        birth.

11) Screening for, preventing, and treating anemia during pregnancy can:
    a) Prevent PPH.
    b) **Reduce the risk of dying from PPH.**
    c) Make AMTSL less risky.
    d) All of the responses are correct.
AMTSL:
12) Active management of the third stage of labor includes all of the following EXCEPT:
   a) Massaging the uterus.
   b) Applying upward pressure on the uterus with a contraction.
   c) **Waiting for signs of placenta separation (e.g., lengthening of the cord)**.
   d) Giving a uterotonic drug within one minute after birth.

13) The main risk in performing active management of the third stage with oxytocin is:
   a) Retained placenta.
   b) Pulling the cord off.
   c) Causing uterine atony.
   d) None of the above.

14) CCT is applied only when countertraction is applied simultaneously because:
   a) Countertraction helps the placenta descend into the vagina.
   b) **Countertraction supports the uterus and helps prevent uterine inversion during controlled cord traction**.
   c) Countertraction reduces pain caused when CCT is applied.
   d) Countertraction reduces the risk of MTCT of HIV.

15) If the placenta does not descend during 30–40 seconds of CCT:
   a) Consider placenta accreta and prepare the patient for a surgical intervention.
   b) **Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well-contracted again**.
   c) Administer a second injection of oxytocin 10 IU IM.
   d) Administer a different uterotonic because the first uterotonic was not effective.

16) Performing AMTSL:
   a) Will prevent all cases of PPH.
   b) **Cannot prevent all cases of PPH**.
   c) May increase the risk of PPH due to uterine inversion.
   d) Will only prevent PPH in women with risk factors for PPH.

17) Active management decreases:
   a) The incidence of PPH.
   b) The length of the third stage of labor.
   c) The percentage of third stages of labor lasting longer than 30 minutes.
   d) **All of the responses are correct.**
18) The umbilical cord should be cut:
   a) As soon as possible after birth of the baby to facilitate AMTSL and immediate newborn care.
   b) **Immediately after birth of the baby if the newborn requires resuscitation.**
   c) After the placenta is delivered to ensure transfer of blood to the newborn.
   d) At a time determined by cultural beliefs.

**Monitoring during the immediate postpartum period:**

19) Ms. A gave birth to a healthy baby girl one hour ago. You managed the third stage of labor actively, the placenta was complete, and she had no perineal or vaginal lacerations. How often should you monitor her uterus and vaginal bleeding during the second hour after delivery of the placenta?
   a) Every 10 minutes.
   b) **Every 15 minutes.**
   c) Continuously.
   d) Every 60 minutes.

20) Baby A was born at 3:15 p.m. She did not require resuscitation and has already begun breastfeeding. It is now 6:30 p.m. How often will you monitor her temperature?
   a) Continuously.
   b) Every 15 minutes.
   c) Every 30 minutes.
   d) **Every 60 minutes.**
Post-course questionnaire

Instructions:
Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the mentors to assist you before you respond to the question.

MULTIPLE CHOICE
Circle the best response for each question. Each question is worth 1 point.

Scientific evidence:
1) Which of the following statements describes a disadvantage of physiologic management of the third stage of labor?
   a) It increases the length of the third stage of labor.
   b) It does not interfere with the normal process of labor and childbirth.
   c) It reduces the risk of PPH.
   d) It reduces average amount of blood loss.

2) Which of the following statements describes an advantage of AMTSL?
   a) It requires the presence of an SBA who can administer injections.
   b) It reduces the amount of blood loss after childbirth.
   c) It increases the risk of PPH during the third stage of labor.
   d) It increases the length of the third stage of labor.

Review of uterotonic drugs:
3) Under ideal condition, oxytocin should be stored:
   a) In a refrigerator, between 2°C –8°C.
   b) In an open kidney dish in the delivery room.
   c) In a drawer in the midwife’s office.
   d) In a coat pocket to facilitate its use.

4) Which of the following statements about augmentation of labor is false:
   a) Labor should be augmented only if clear emergency or obstetric conditions are present, and a physician is readily available to perform a cesarean delivery should complications arise.
   b) If a woman requires augmentation of labor, she should be immediately referred to a health care facility with the capacity to perform a cesarean operation.
   c) Oxytocin can be safely administered IM in labor if accompanied by an antispasmodic medication.
   d) If oxytocin is used for labor augmentation, it should be administered by controlled IV drip in a health facility that has an operating theater and qualified physician to perform an emergency cesarean operation.
5) Which of the following statements about oxytocin is true:
   a) Oxytocin acts within 6 to 7 minutes.
   b) Oxytocin is associated with the following side effects: chills and elevated temperature.
   c) Oxytocin is less stable than ergometrine when exposed to heat or light.
   d) Oxytocin has no known contraindications for postpartum use.

6) If the health facility does not have a refrigerator:
   a) Oxytocin may be stored outside the refrigerator at a maximum of 40°C for no more than three months.
   b) Unrefrigerated transport of oxytocin is possible if it is stored no more than six weeks at 30°C - 50°C.
   c) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no more than one month at 30°C.
   d) None of the responses is correct.

7) Which of the following elements need to be checked to ensure that oxytocin has not lost its effectiveness:
   a) The expiry date written on the ampoule.
   b) The color of the product.
   c) The drug company that produced it.
   d) The route of administration as written on the ampoule.

**Prevention of PPH:**

8) The most important factor in determining a woman’s chances of surviving PPH is:
   a) The woman’s parity.
   b) Early diagnosis and management of PPH.
   c) Identification of risk factors during pregnancy.
   d) Identification of risk factors when a woman comes to the health facility to give birth.

9) Which of the following statements is true:
   a) The majority (two-thirds) of PPH cases can be predicted by screening for risk factors during pregnancy.
   b) The majority (two-thirds) of PPH cases can be predicted by conducting a thorough history when women present at the health care facility in labor.
   c) The majority (two-thirds) of women who have PPH have no risk factors.
   d) The majority (two-thirds) of PPH cases can be predicted if the provider has enough labor and delivery experience.

10) Which of the following care should be provided routinely to all women to prevent PPH and ensure its early diagnosis and management:
    a) Using the risk-factor approach to identify women at high risk of suffering PPH.
    b) Developing a BPP and CRP during pregnancy.
    c) Augmenting labor when the cervical dilatation is to the left of the alert line.
    d) Applying AMTSL at all births.
11) Which of the following statements about PPH is **true:**
   a) The importance of a given volume of blood loss varies with the woman’s hemoglobin level.
   b) Nearly half of women who deliver vaginally often lose at least 1,000 mL of blood.
   c) Blood loss estimates made by providers are usually extremely accurate.
   d) Blood loss of less than 1,000 mL will have no effect on women who are not anemic.

**AMTSL:**

12) CCT is **not recommended** if:
   a) The provider has not been trained to apply it.
   b) The woman did not receive a uterotonic drug after birth of the baby.
   c) Labor was induced using oxytocin.
   d) (a) and (b).

13) CCT should never be applied except if countertraction is applied simultaneously because:
   a) Countertraction helps the placenta descend into the vagina.
   b) Countertraction supports the uterus and helps prevent uterine inversion during CCT.
   c) Countertraction reduces pain caused when CCT is applied.
   d) Countertraction reduces the risk of MTCT of HIV.

14) Active management of the third stage of labor includes which of the following elements:
   a) Waiting for signs of placental separation (e.g., lengthening of the cord).
   b) Administering a uterotonic drug after delivery of the placenta.
   c) Immediately clamping the cord after birth of the baby.
   d) Performing CCT with simultaneous countertraction.

15) If the placenta does not descend after two attempts of CCT:
   a) Consider placenta accreta and prepare the patient for a surgical intervention.
   b) Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well-contracted again.
   c) Administer a second injection of oxytocin 10 IU IM.
   d) Administer a different uterotonic because the first uterotonic was not effective.

16) What should an SBA rule out before administering a uterotonic drug?
   a) Pulsation of the umbilical cord.
   b) Uterine contractedness.
   c) The presence of another baby.
   d) Signs of placenta separation (e.g., lengthening of the cord).
17) Which of the following statements about cutting the cord is **true**:
   a) Delaying cord clamping will interfere with the application of AMTSL.
   b) The practice of waiting to clamp the cord until at least two to three minutes after birth of the baby has proven beneficial to the baby, as it results in higher hemoglobin and hematocrit values and possibly lower levels of early childhood anemia and greater iron stores.
   c) Cutting the cord assists with separation of the placenta from the uterine wall.
   d) Waiting more than 30 seconds to cut the cord is only helpful for premature infants.

18) To help prevent PPH, if the birth attendant cannot administer oxytocin, then management of the third stage of labor will include the following elements:
   a) Wait for signs of placental separation (e.g., lengthening of the cord).
   b) Early cord clamping.
   c) CCT.
   d) Uterine massage to facilitate separation of the placenta from the uterine wall.

**Monitoring in the immediate postpartum period:**

19) Ms A just gave birth to a healthy baby boy. Her perineum is intact. How often should the provider monitor the woman’s vaginal bleeding during the third hour after giving birth?
   a) Every 10 minutes.
   b) Every 15 minutes.
   c) Every 30 minutes.
   d) Every 60 minutes.

20) If a woman gave birth at 1:00 p.m. and it is now 1:15 p.m., how often should the provider monitor her new baby’s temperature?
   a) Every 10 minutes.
   b) Every 15 minutes.
   c) Every 30 minutes.
   d) Every 60 minutes.

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**Name:** __________________________

**Facility:** __________________________

**Date:** _____/_____/20____
Post-course questionnaire answer key

Instructions:
Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the mentors to assist you before you respond to the question.

MULTIPLE CHOICE
Circle the best response for each question. Each question is worth 1 point.

Scientific evidence:
1) Which of the following statements describes a disadvantage of physiologic management of the third stage of labor?
   a) **It increases the length of the third stage of labor.**
   b) It does not interfere with the normal process of labor and childbirth.
   c) It reduces the risk of PPH.
   d) It reduces average amount of blood loss.

2) Which of the following statements describes an advantage of AMTSL?
   a) It requires the presence of an SBA who can administer injections.
   b) **It reduces the amount of blood loss after childbirth.**
   c) It increases the risk of PPH during the third stage of labor.
   d) It increases the length of the third stage of labor.

Review of uterotonic drugs:
3) Under ideal condition, oxytocin should be stored:
   a) **In a refrigerator, between 2°C –8°C.**
   b) In an open kidney dish in the delivery room.
   c) In a drawer in the midwife’s office.
   d) In a coat pocket to facilitate its use.

4) Which of the following statements about augmentation of labor is false:
   a) Labor should be augmented only if clear emergency or obstetric conditions are present, and a physician is readily available to perform a cesarean delivery should complications arise.
   b) If a woman requires augmentation of labor, she should be immediately referred to a health care facility with the capacity to perform a cesarean operation.
   c) **Oxytocin can be safely administered IM in labor if accompanied by an antispasmodic medication.**
   d) If oxytocin is used for labor augmentation, it should be administered by controlled IV drip in a health facility that has an operating theater and qualified physician to perform an emergency caesarean operation.
5) Which of the following statements about oxytocin is **true**:
   a) Oxytocin acts within six to seven minutes.
   b) Oxytocin is associated with the following side effects: chills and elevated temperature.
   c) Oxytocin is less stable than ergometrine when exposed to heat or light.
   **d) Oxytocin has no known contraindications for postpartum use.**

6) If the health facility does not have a refrigerator:
   a) Oxytocin may be stored outside the refrigerator at a maximum of 40°C for no more than three months.
   b) Unrefrigerated transport of oxytocin is possible if it is stored no more than six weeks at 30°C–50°C.
   c) Unrefrigerated transport of ergometrine is possible if kept **in the dark** and for no more than one month at 30°C.
   **d) None of the responses is correct.**

7) Which of the following elements need to be checked to ensure that oxytocin has not lost its effectiveness:
   a) **The expiry date written on the ampoule.**
   b) The color of the product.
   c) The drug company that produced it.
   d) The route of administration as written on the ampoule.

**Prevention of PPH:**

8) The most important factor in determining a woman’s chances of surviving PPH is:
   a) The woman’s parity.
   **b) Early diagnosis and management of PPH.**
   c) Identification of risk factors during pregnancy.
   d) Identification of risk factors when a woman comes to the health facility to give birth.

9) Which of the following statements is **true**:
   a) The majority (two-thirds) of PPH cases can be predicted by screening for risk factors during pregnancy.
   b) The majority (two-thirds) of PPH cases can be predicted by conducting a thorough history when women present at the health care facility in labor.
   **c) The majority (two-thirds) of women who have PPH have no risk factors.**
   d) The majority (two-thirds) of PPH cases can be predicted if the provider has enough labor and delivery experience.

10) Which of the following care should be provided routinely to all women to prevent PPH and ensure its early diagnosis and management:
   a) Using the risk factor approach to identify women at high risk of suffering PPH.
   **b) Developing a BPP and CRP during pregnancy.**
   c) Augmenting labor when the cervical dilatation is to the left of the alert line.
   d) Applying AMTSL at all births.
11) Which of the following statements about PPH is true:
   a) The importance of a given volume of blood loss varies with the woman’s hemoglobin level.
   b) Nearly half of women who deliver vaginally often lose at least 1,000 mL of blood.
   c) Blood loss estimates made by providers are usually extremely accurate.
   d) Blood loss of less than 1,000 mL will have no effect on women who are not anemic.

AMTSL:

12) CCT is not recommended if:
   a) The provider has not been trained to apply it.
   b) The woman did not receive a uterotonic drug after birth of the baby.
   c) Labor was induced using oxytocin.
   d) (a) and (b).

13) CCT should never be applied unless countertraction is applied simultaneously because:
   a) Countertraction helps the placenta descend into the vagina.
   b) Countertraction supports the uterus and helps prevent uterine inversion during controlled cord traction.
   c) Countertraction reduces pain caused when CCT is applied.
   d) Countertraction reduces the risk of MTCT of HIV.

14) Active management of the third stage of labor includes which of the following elements:
   a) Waiting for signs of placental separation (e.g., lengthening of the cord).
   b) Administering a uterotonic drug after delivery of the placenta.
   c) Immediately clamping the cord after birth of the baby.
   d) Performing CCT with simultaneous countertraction.

15) If the placenta does not descend after two attempts of CCT:
   a) Consider placenta accreta and prepare the patient for a surgical intervention.
   b) Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well-contracted again.
   c) Administer a second injection of oxytocin 10 IU IM.
   d) Administer a different uterotonic because the first uterotonic was not effective.

16) What should a skilled birth attendant rule out before administering a uterotonic drug?
   a) Pulsation of the umbilical cord.
   b) Uterine contractedness.
   c) The presence of another baby.
   d) Signs of placenta separation (e.g., lengthening of the cord).
17) Which of the following statements about cutting the cord is true:
   a) Delaying cord clamping will interfere with the application of AMTSL.
   b) **The practice of waiting to clamp the cord until at least two to three minutes after birth of the baby has proven beneficial to the baby as it results in higher hemoglobin and hematocrit values and possibly lower levels of early childhood anemia and greater iron stores.**
   c) Cutting the cord assists with separation of the placenta from the uterine wall.
   d) Waiting more than 30 seconds to cut the cord is only helpful for premature infants.

18) To help prevent PPH, if the birth attendant cannot administer oxytocin, then management of the third stage of labor will include the following elements:
   a) **Wait for signs of placental separation (e.g., lengthening of the cord).**
   b) Early cord clamping.
   c) CCT.
   d) Uterine massage to facilitate separation of the placenta from the uterine wall.

**Monitoring in the immediate postpartum period:**

19) Ms A just gave birth to a healthy baby boy. Her perineum is intact. How often should the provider monitor the woman’s vaginal bleeding during the third hour after giving birth?
   a) Every 10 minutes.
   b) Every 15 minutes.
   c) **Every 30 minutes.**
   d) Every 60 minutes.

20) If a woman gave birth at 1:00 p.m. and it is now 1:15 p.m., how often should the provider monitor her new baby’s temperature?
   a) Every 10 minutes.
   b) **Every 15 minutes.**
   c) Every 30 minutes.
   d) Every 60 minutes.
Alternate post-course questionnaire

Instructions:
Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the mentors to assist you before you respond to the question.

MULTIPLE CHOICE
Circle the best response for each question. Each question is worth 1 point.

Scientific evidence:
1) Which of the following statements describes an advantage of physiologic management of the third stage of labor?
   a) It increases the length of the third stage of labor.
   b) It does not interfere with the normal process of labor and childbirth.
   c) It reduces the risk of PPH.
   d) It reduces average amount of blood loss.

2) Which of the following statements describes a disadvantage of AMTSL?
   a) It requires the presence of an SBA who can administer injections.
   b) It reduces the amount of blood loss after childbirth.
   c) It increases the risk of PPH during the third stage of labor.
   d) It increases the length of the third stage of labor.

Review of uterotonic drugs:
3) Oxytocin is considered to be the uterotonic drug of choice for AMTSL because:
   a) It does not require refrigeration.
   b) It can be stored in an open kidney dish in the delivery room.
   c) It acts within 2 to 3 minutes after IM injection.
   d) Its effects last up to 75 minutes after IM injection.
   e) C and d.
   f) All of the above.

4) Which of the following statements about augmentation of labor is true:
   a) Labor should be augmented only if clear emergency or obstetric conditions are present, and a physician is readily available to perform a cesarean delivery should complications arise.
   b) If a woman requires augmentation of labor, she should be immediately referred to a health care facility with the capacity to perform a cesarean operation.
   c) Use of a uterotonic drug to induce or augment labor may contribute to uterine atony and PPH.
   d) If oxytocin is used for labor augmentation, it should be administered by controlled IV drip in a health facility that has an operating theater and qualified physician to perform an emergency caesarean operation.
   e) a, b, and d.
   f) All of the above.
5) Which of the following statements about oxytocin is true:
   a) Oxytocin acts within six to seven minutes.
   b) The effects of oxytocin last up to 15-30 minutes after IM injection.
   c) Oxytocin is less stable than ergometrine when exposed to heat or light.
   d) Oxytocin has no known contraindications for postpartum use.
   e) B and d.
   f) A, b, and d.

6) When transporting ergometrine from one facility or depot to another:
   a) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no
      more than six weeks at 30°C.
   b) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no
      more than three weeks at 40°C.
   c) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no
      more than one month at 30°C.
   d) None of the responses is correct.

7) Which of the following elements need to be checked to ensure that ergometrine has not
   lost its effectiveness:
   a) The dosage written on the ampoule.
   b) The color of the product.
   c) The drug company that produced it.
   d) The route of administration as written on the ampoule.

**Prevention of PPH:**

8) Which of the following interventions can improve a woman’s chance of surviving PPH:
   a) Identification of risk factors during pregnancy.
   b) Identification of risk factors when a woman comes to the health facility to give birth.
   c) Close monitoring during the immediate postpartum period.
   d) Family planning to reduce the number of pregnancies and her parity.

9) Which of the following statements is false:
   a) Uterine atony is the leading cause of PPH.
   b) The majority (two-thirds) of PPH cases can be predicted by conducting a thorough
      history when women present at the health care facility in labor.
   c) The majority (two-thirds) of women who have PPH have no risk factors.
   d) Preventing prolonged labor by correctly using the partogram can help prevent PPH.

10) Which of the following care should be provided routinely to all women to prevent PPH:
    a) Using the risk factor approach to identify women at high risk of suffering PPH.
    b) Ensuring the presence of a skilled birth attendant during labor, childbirth, and the
        immediate postpartum.
    c) Augmenting labor when the cervical dilatation is to the left of the alert line.
    d) Cutting an episiotomy when it appears that the perineum will tear.
11) Which of the following statements about PPH is false:
   a) The importance of a given volume of blood loss varies with the woman’s hemoglobin level.
   b) nearly half of women who deliver vaginally often lose at least 500 mL of blood
   c) Women who give birth by cesarean delivery normally lose 1,000 mL or more.
   d) Blood loss estimates made by providers are usually extremely accurate.

AMTSL:
12) If the birth attendant’s skills are limited:
   a) He/she should apply CCT only if trained to do so.
   b) The woman should receive oxytocin or misoprostol after birth of the baby.
   c) The uterus should be massaged before delivery of the placenta.
   d) (a) and (b).
   e) All of the above.

13) Countertraction is applied simultaneously with CCT because:
   a) Countertraction helps the placenta descend into the vagina.
   b) Countertraction reduces pain caused when CCT is applied.
   c) Countertraction supports the uterus and helps prevent uterine inversion during controlled cord traction.
   d) Countertraction helps separation of the placenta from the uterine wall.

14) Physiologic management of the third stage of labor includes which of the following elements:
   a) Waiting for signs of placental separation (e.g., lengthening of the cord).
   b) Administering a uterotonic drug after delivery of the placenta.
   c) Immediately clamping the cord after birth of the baby.
   d) Performing CCT with simultaneous countertraction.

15) If the placenta does not descend after three attempts of CCT:
   a) Consider placenta accreta and prepare the patient for a surgical intervention.
   b) Do not continue to pull on the cord; gently hold the cord and wait until the uterus is well-contracted again.
   c) Administer a second injection of oxytocin 10 IU IM.
   d) Administer a different uterotonic because the first uterotonic was not effective.

16) When should a skilled birth administer a uterotonic drug for AMTSL?
   a) After pulsations of the umbilical cord have ceased.
   b) Before the uterus has contracted.
   c) When there are signs of placenta separation (e.g., lengthening of the cord).
   d) After ruling out the presence of another baby.
17) Which of the following statements about cutting the cord is true:
   a) Delaying cord clamping will interfere with the application of AMTSL.
   b) Cutting the cord assists with separation of the placenta from the uterine wall.
   c) If the baby is premature, the cord should not be clamped until at least 30 seconds after birth of the baby.
   d) The cord should not be clamped until at least two to three minutes after birth of the baby.

18) To help prevent PPH, if the birth attendant cannot administer a uterotonic drug, then management of the third stage of labor will include the following elements:
   a) Early cord clamping.
   b) CCT.
   c) Uterine massage to facilitate separation of the placenta from the uterine wall.
   d) Wait for signs of placental separation (e.g., lengthening of the cord).

Monitoring in the immediate postpartum period:

19) Ms A gave birth to a healthy baby boy at 2:15 am. Her perineum is intact, all her vital signs are within normal limits, her uterus is well contracted, and her vaginal bleeding appears to be within normal limits. When should the provider check Ms A again for vaginal bleeding?
   a) At 2:30 am.
   b) At 2:45 am.
   c) At 3:15 am.
   d) Since everything is stable, the provider can wait to check Ms A again if she begins complaining of unusual vaginal bleeding.

20) Ms B gave birth at 1:00 p.m. and it is now 4:00 p.m. When the provider checked the baby at 4:00 pm, the baby’s feet were warm, his breathing and color were within normal limits, and there was no bleeding from the cord. When should the provider next monitor the baby’s temperature by touching his feet?
   a) At 4:15 pm.
   b) At 4:30 pm.
   c) At 5:00 pm.
   d) Only if the mother says the baby’s feet are cold.

Name: __________________________
Facility: __________________________
Date: ____/____/20____
Alternate post-course questionnaire answer key

Instructions:
Read each question carefully before choosing a response. Choose only ONE response for each question. If you do not understand a question or response, ask one of the mentors to assist you before you respond to the question.

MULTIPLE CHOICE
Circle the best response for each question. Each question is worth 1 point.

Scientific evidence:
1) Which of the following statements describes an advantage of physiologic management of the third stage of labor?
   a) It increases the length of the third stage of labor.
   b) It does not interfere with the normal process of labor and childbirth.
   c) It reduces the risk of PPH.
   d) It reduces average amount of blood loss.

2) Which of the following statements describes a disadvantage of AMTSL?
   a) It requires the presence of an SBA who can administer injections.
   b) It reduces the amount of blood loss after childbirth.
   c) It increases the risk of PPH during the third stage of labor.
   d) It increases the length of the third stage of labor.

Review of uterotonic drugs:
3) Oxytocin is considered to be the uterotonic drug of choice for AMTSL because:
   a) It does not require refrigeration.
   b) It can be stored in an open kidney dish in the delivery room.
   c) It acts within 2 to 3 minutes after IM injection.
   d) Its effects last up to 75 minutes after IM injection.
   e) C and d.
   f) All of the above.

4) Which of the following statements about augmentation of labor is true:
   a) Labor should be augmented only if clear emergency or obstetric conditions are present, and a physician is readily available to perform a cesarean delivery should complications arise.
   b) If a woman requires augmentation of labor, she should be immediately referred to a health care facility with the capacity to perform a cesarean operation.
   c) Use of a uterotonic drug to induce or augment labor may contribute to uterine atony and PPH.
   d) If oxytocin is used for labor augmentation, it should be administered by controlled IV drip in a health facility that has an operating theater and qualified physician to perform an emergency caesarean operation.
   e) a, b, and d.
   f) All of the above
5) Which of the following statements about oxytocin is true:
   a) Oxytocin acts within six to seven minutes.
   b) The effects of oxytocin last up to 15-30 minutes after IM injection.
   c) Oxytocin is less stable than ergometrine when exposed to heat or light.
   d) Oxytocin has no known contraindications for postpartum use.
   e) B and d.
   f) A, b, and d.

6) When transporting ergometrine from one facility or depot to another:
   a) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no more than six weeks at 30°C.
   b) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no more than three weeks at 40°C.
   c) Unrefrigerated transport of ergometrine is possible if kept in the dark and for no more than one month at 30°C.
   d) None of the responses is correct.

7) Which of the following elements need to be checked to ensure that ergometrine has not lost its effectiveness:
   a) The dosage written on the ampoule.
   b) The color of the product.
   c) The drug company that produced it.
   d) The route of administration as written on the ampoule.

Prevention of PPH:

8) Which of the following interventions can improve a woman’s chance of surviving PPH:
   a) Identification of risk factors during pregnancy.
   b) Identification of risk factors when a woman comes to the health facility to give birth.
   c) Close monitoring during the immediate postpartum period.
   d) Family planning to reduce the number of pregnancies and her parity.

9) Which of the following statements is false:
   a) Uterine atony is the leading cause of PPH.
   b) The majority (two-thirds) of PPH cases can be predicted by conducting a thorough history when women present at the health care facility in labor.
   c) The majority (two-thirds) of women who have PPH have no risk factors.
   d) Preventing prolonged labor by correctly using the partogram can help prevent PPH.

10) Which of the following care should be provided routinely to all women to prevent PPH:
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   c) The uterus should be massaged before delivery of the placenta.
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   e) All of the above.

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   a) At 2:30 am.
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   c) At 3:15 am.
   d) Since everything is stable, the provider can wait to check Ms A again if she begins complaining of unusual vaginal bleeding.

20) Ms B gave birth at 1:00 p.m. and it is now 4:00 p.m. When the provider checked the baby at 4:00 pm, the baby’s feet were warm, his breathing and color were within normal limits, and there was no bleeding from the cord. When should the provider next monitor the baby’s temperature by touching his feet?
   a) At 4:15 pm.
   b) At 4:30 pm.
   c) At 5:00 pm.
   d) Only if the mother says the baby’s feet are cold.
Appendix A: Training logbook

Logbook for providers trained in AMTSL

District: ______________________

District mentors:
________________________________________
________________________________________

Region: ______________________

Regional point persons:
________________________________________
________________________________________
<table>
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<tr>
<th>No</th>
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<th>Professional cadre</th>
<th>Place of work</th>
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<th>Date found competent</th>
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## Skill assessments

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<th>Monitoring during the immediate postpartum</th>
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### Knowledge assessments

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Appendix B: Baseline data collection tool

Health care facility:
District:
Region:
Date training activities in AMTSL were started:

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<th>Month / Year*</th>
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<th>TOTAL</th>
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<tbody>
<tr>
<td>A. Number of women who gave birth at the health care facility with the assistance of a skilled birth attendant (SBA).</td>
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<td>B. Number of women who were offered and received AMTSL practiced by an SBA.</td>
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<td>C. Percentage of women who gave birth at the facility and were offered and received AMTSL practiced by a skilled birth attendant (B divided by A).</td>
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*Collect data for the three months preceding training activities in AMTSL
Appendix C: Monitoring form

Health care facility:
District:
Region:
Date training activities in AMTSL were started:
Reporting period: from ___/___/___ to ___/___/___

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<th>TOTAL</th>
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<td>A.</td>
<td>Number of women who gave birth at the health care facility with the assistance of a skilled birth attendant (SBA).</td>
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<tr>
<td>B.</td>
<td>Number of women who were offered and received AMTSL practiced by an SBA.</td>
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<tr>
<td>C.</td>
<td>Percentage of women who gave birth at the facility and were offered and received AMTSL practiced by a skilled birth attendant (B divided by A).</td>
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Appendix D: Wall charts to monitor AMTSL coverage and practice
Number and percentage of women in the health care facility who were offered and received active management of the third stage of labor (AMTSL) by a skilled birth attendant (SBA)

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A Vaginal births with AMTSL

B Vaginal births

% \( \frac{A}{B} \times 100 \)
### Number and percentage of providers who practiced AMTSL to standard

<table>
<thead>
<tr>
<th>A</th>
<th>Providers who received ≥80% when evaluated</th>
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<tr>
<td>B</td>
<td>Providers evaluated</td>
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<tr>
<td>%</td>
<td>(A ÷ B) x 100</td>
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</table>
### Number and percentage of cases of postpartum haemorrhage (PPH) in women who gave birth vaginally in the health care facility

<table>
<thead>
<tr>
<th>A</th>
<th>Cases of PPH (in women who gave birth vaginally in the facility)</th>
</tr>
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<tbody>
<tr>
<td>B</td>
<td>Vaginal births in the facility</td>
</tr>
<tr>
<td>%</td>
<td>((A \div B) \times 100)</td>
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<table>
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<th></th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
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<tbody>
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</table>
Endnotes


7 From USAID’s Call to Action: USAID’s Postpartum Hemorrhage Prevention Special Initiative. October, 2002.