



NATIONAL POSTPARTUM HAEMORRHAGE MANAGEMENT

FACILITATORS TRAINING MANUAL



FEDERAL MINISTRY OF HEALTH AND SOCIAL WELFARE

ABUJA, NIGERIA

August , 2024.



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May I recognize the outstanding contributions of JPIEGHO, BMGF , Africa Center of Excellent for Population Health and Policy (ACEPHAP), the Departments and Agencies of Government, National Primary Health Care Development Agency (NPHCDA), National Health Insurance Authority (NHIA) , National Blood Services Commission (NBSC) Nursing and Midwifery Council of Nigeria (NMCN), Medical and Dental Council of Nigeria (MDCN) , Community Health Practitioner Board, Academia, Society of Gynaecology and Obstetrics of Nigeria (SOGON), Association of Feto-Maternal Specialists of Nigeria (AFEMSON), Association of Public Health Physicians of Nigeria, WHO, UNICEF, UNFPA, USAID, , MCGL and Engender Health for their contribution to the development of this National Training Manual for the Management of Postpartum Haemorrhage, for the improvement of maternal and newborn health in Nigeria.

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Dr. Binyerem Ukaire

Director, Family Health Department
August 2024.

FOREWORD

Maternal mortality is a public health problem in the Low- and Middle-Income Countries (LMIC) such as Nigeria and it is one of the strongest indicators of a country's standard of living and maternity care. Every year, an estimated 14 million cases of PPH and 70,000 related maternal deaths are recorded globally. This implies that one woman dies of PPH every four minutes.

Postpartum haemorrhage accounts for 13.4 % of maternal deaths in high-income countries. In Asia and Africa however, it is responsible for 30.8 % and 33.9 % of maternal deaths, respectively. In Nigeria, PPH accounts for one-third of all hospital admissions due to complications of obstetric haemorrhage, and 42% of maternal deaths arise from these complications.

Maternal deaths death can be prevented through the implementation of evidence-based strategies as articulated in the National Safe Motherhood Strategy and Guidelines towards attainment of SDG target 3 on Maternal and Newborn Health (MNH). To operationalize the strategy, there is need to develop appropriate training manual in line with new approaches in the management of PPH which include E-MOTIVE to address the leading cause of maternal morbidity and mortality. This national training manual is developed to provide knowledge and skills for the management of Postpartum haemorrhage at the national and sub-national levels of health care.

I therefore recommend this training manual for health care providers, health professionals, professional associations, regulatory bodies, private sector, Non-Governmental Organizations, civil society groups, implementing partners, donor partners and other stakeholders in the Reproductive Health space at all levels of care in the country for training on Postpartum haemorrhage management.

Mohammad Ali Pate, CON

Coordinating Minister of Health and Social Welfare.

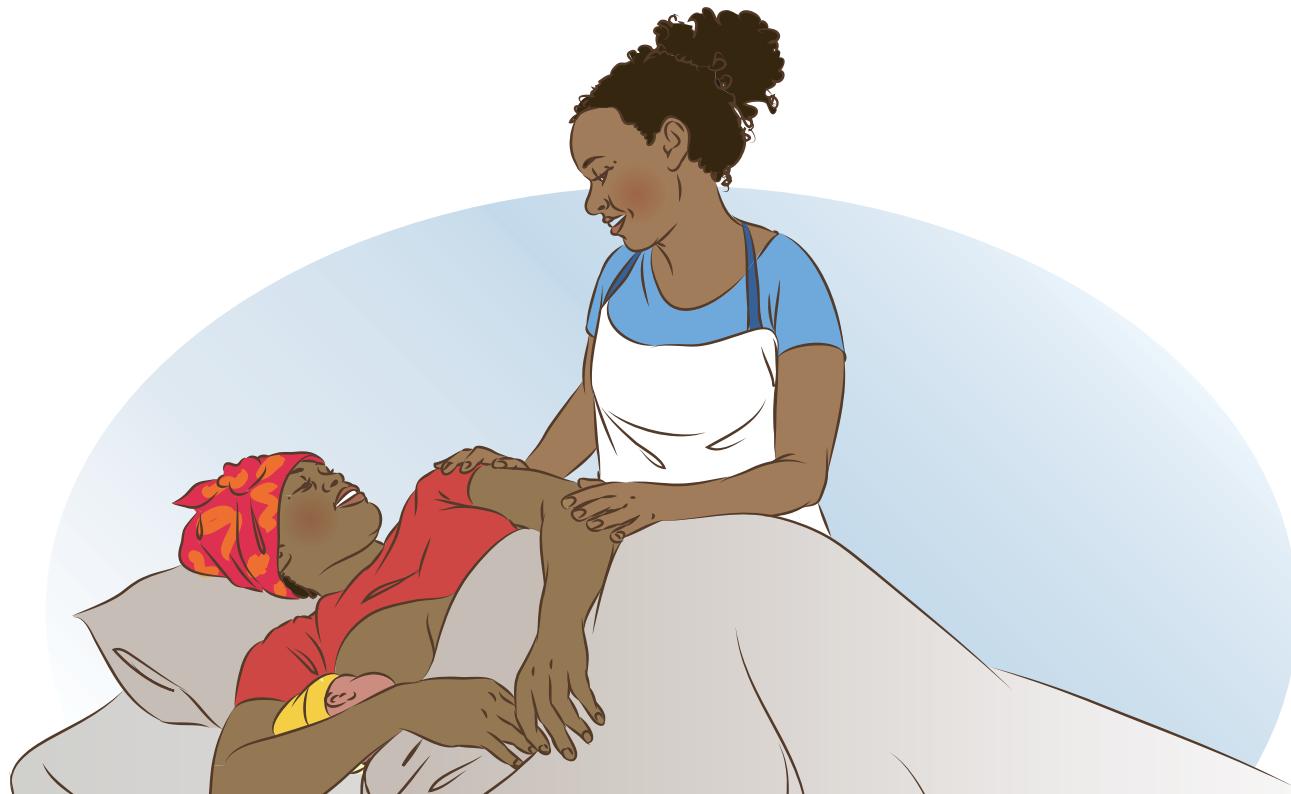
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NATIONAL POSTPARTUM HAEMORRHAGE MANAGEMENT TRAINING MANUAL

Prevention, early detection, and treatment of PPH Nigeria



What the facilitator needs to know and do

BEFORE - DURING - AFTER training day

Use this section to prepare yourself as a facilitator and guide the development of a Helping Mothers Survive program before, during, and after the training day.

As a facilitator, you are essential to achieving the goal of ensuring providers are skilled and equipped to deliver high quality, respectful care to women and their newborns.

BEFORE

Begin planning with local leaders for Helping Mothers Survive training well in advance

Dotted line icon: **Global Health Media Project**. You will use the video clips from this video book when you see this icon

Prepare yourself as a facilitator

- The duration of the course will depend on your audience and facility - carefully review the agenda based on the content you will be covering and if you will be including NASG repair of cervical tears, and UBT.
- As a facilitator you will have experienced anHMS training. Now it is important to carefully read the Provider's Guide and Flip chart. Read the "Discuss", "Facilitation Notes", and "Knowledge Checks," so you can lead discussions, answer questions, and get teaching tips.
- Carefully review the role plays and learning activities so you can engage participants. Practice each of the demonstrations and simulations in advance so you can be an effective facilitator.
- Arrange the space to facilitate learning with **1 facilitator for every 6 participants**.
- Conduct a planning meeting to prepare for the training as needed.

DURING

Evaluate knowledge and skills

- Evaluate the participants in a way that encourages further learning.
- Use the knowledge test for each module as a pretest and post-test.
- Use the OSCEs for each module to assess for transfer of skills at the end of the course.

Engage every participant in discussion and practice in pairs

- As you teach and demonstrate, involve participants by "Inviting Discussion", and engaging them in practice and role-plays.
- Spend more time in learning activities than talking to ensure skills are mastered. Tell participants to expect to do some short activities for several weeks after training to help improve their skills. Always emphasize and role model respectful care and good communication between the woman and provider, and also between providers.
- There are opportunities to demonstrate through videos. If you can show videos during training, download them in advance to show on a laptop screen or wall. The electronic version of this Flipbook has live links and the web addresses are spelled out on corresponding pages in the Provider's Guide. You will also find links on the HMS website for this module. If you cannot show videos, the steps for demonstration are carefully outlined for you.
- Use "Invite Discussion" questions to identify local problems and find solutions to overcome barriers to quality care.
- Identify 2 providers at each facility to help everyone practice after training. You will orient them as Peer Practice Coordinators after the training day.
- Debrief with facilitators at the end of each training day

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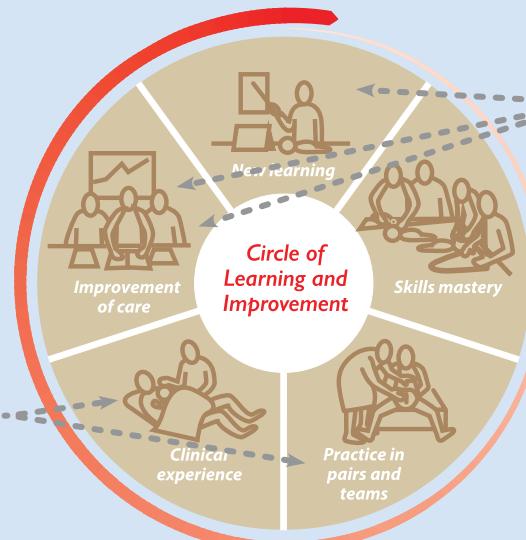
DURING

Engage participants in ongoing quality improvement

- Saving lives of women and their newborns after training requires ongoing low-dose, high-frequency practice and quality improvement activities in the facility in order to change clinical care.
- Reflect with the participants:
 - What are you going to do differently? What will you no longer do?
 - What do you need to make these changes happen?
 - Who needs to be involved?

Use the plan for weekly practice in the back of the Provider's Guide of each module and select two peers from each facility to facilitate practice.

- Help participants plan a change that will improve care in their facility.
- Resources:
LDHF Activities in the Provider's Guide for each module



AFTER

Identify and support leaders and practice coordinators at each facility who promote ongoing practice

- Orient practice coordinators to their role of facilitating ongoing practice activities after the training day. These will be short weekly activities that providers will do in groups or alone with the coordinator.
- Encourage providers to continue to use self-reflection, feedback, and review of their actions during practice and after managing complications.
- Promote collaboration with the local health system to collect clinical performance and outcome data, and to use that data for decision making.
- Support improvement activities and share experiences among facilities.



Saving lives at birth



Saving lives at birth

Saving lives at birth



This training targets all levels of providers who attend births or who are called to respond to emergencies. It will equip providers to promptly detect and manage PPH.

This training will use simulation and scenarios for learning and include hands on practice and feedback.

Training is followed by short, weekly activities at the worksite to strengthen and maintain skills.

To those who care for women at birth

- There are two people who need our care: the woman and her newborn. Survival of the baby can depend on survival of the mother.
- Bleeding after Birth (BAB) helps learners master competencies needed to safely and effectively prevent, detect, and manage postpartum hemorrhage (PPH)
- BAB is designed for on-site training. of the entire team.
- The duration of training will depend on the content designed for the setting and the scope of practice of participants.

Training materials include:

- Action Plans:
 - Bleeding after Birth: Prevention and Early Detection of PPH
 - MOTIVE to Manage PPH + Refractory Care
- This Flipchart - used for instruction
- The Provider's Guide - contains detailed information and support for ongoing practice.

Facilitation note

Have the Flip chart open to this page at the start of training. Prior to the training, all supplies necessary for a clean and safe childbirth and PPH (see page 5) should be out and ready. Have a simulator that can "bleed" ready. When you are done delivering content from this page, interrupt training with a **role play of a normal birth that progresses to PPH and leads to death**. If you are facilitating alone, prepare a volunteer in advance to wear the simulator and act as the woman while you call on learners to help.

Discuss

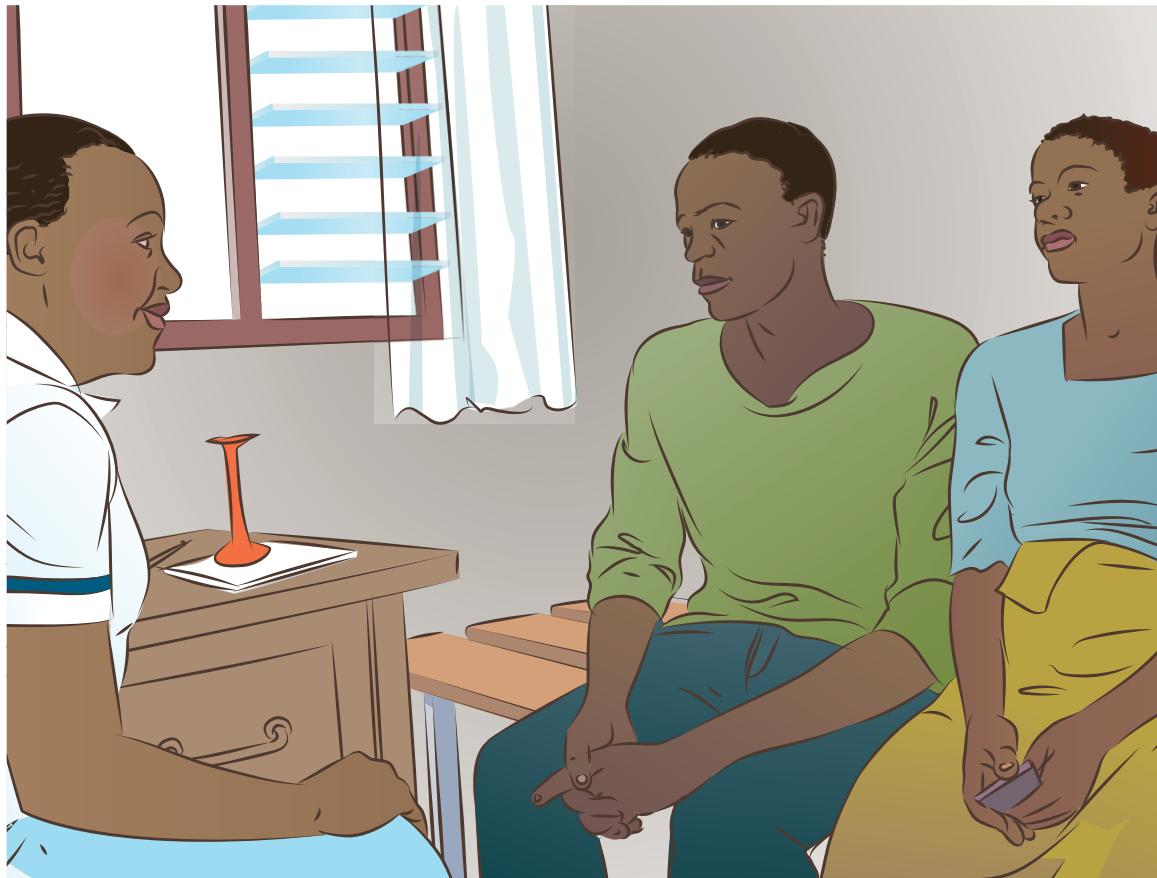
- 1.Did you ever see someone die from bleeding after birth?**
- 2.What happened?**
- 3.Was there anything else that could have been done if the woman had been somewhere else?**

Knowledge check

Why is it important for the health and survival of the baby that the baby's mother is well cared for? If the mother dies, the baby is at greater risk of dying too.

Module 1

**Provide respectful care and communication
to women and their families**



Explain

Provide respectful care and communication to women and their families



- All healthy relationships begin with respect. This is especially true in healthcare where people trust us to help them.
 - **Respectful Care**
Women are worthy of respect regardless of ethnic background, culture, social standing, religion, educational level, and marital or economic status.
 - Respectful care saves lives; women may not seek care if they think they will not be treated well.
- Respectful actions to take**
- Women have a right to privacy and confidentiality during counseling, physical exam, clinical procedures, and in the handling of their records.

- Respect a woman's right to a companion. A companion improves outcomes and can shorten labor.
- Respect a woman's right to information about her status and options for care including risks and benefits so she can make informed choices.
- Share decision-making with the woman and, if she wants, her companion.
- Women have a right to decline care or to seek care elsewhere.
- Give age-appropriate care.
- Respect a woman's right to freedom from harm & abuse
- Be gentle when giving hands-on care.

Discuss

Ask learners, "*What are ways that you can demonstrate respect for the women in your care?*"

Appropriate responses include:

- Introduce yourself and address the woman's name.
- Look at women when speaking to them.
- Use simple, clear language the woman understands.
- Speak calmly.

Ask learners,
"Have you ever had a client who declined your care? Was this woman handled with respect? Would you do anything differently in a similar situation in the future?"

MODULE 2

Communicate effectively and respectfully with team members



Explain



Good communication with team members saves lives and poor communication can result in bad outcomes.

Team members include midwives, doctors, nurses, and other allied health staff at your facility, staff at the referral site, and the woman and her family

Have an emergency plan in place and know whom to call in an emergency. Quickly alert others on your team to an emergency so they can act fast.

To ensure that all the necessary interventions are given and the woman is safely cared for and monitored:

- Communicate confidently and clearly do not assume others know what you are thinking

- Speak loudly enough so everyone knows what needs to be done.

Anxiety and fear are normal in an emergency, but these emotions can block communication. You must stay calm to be effective.

Once help has arrived:

- Identify team members, including team lead, and clearly establish roles for each member.
- Communicate findings about the woman's condition and what has already been done using the Situation-Background- Assessment-Recommendation with "closed loop" communication.
- Make sure that the provider you are speaking to understands what you are asking them to do by asking them to repeat what you have said, particularly with medication orders. This is called "closed loop" communication.

Demonstrate

Ask participants to refer to the SBAR tool on page 5 in the PG and briefly explain each element of the tool.

Then read this case, "**Ms. R is a 22 year old G1P1 who delivered without problems 30 minutes ago. She received 10 IU oxytocin IM for prophylaxis and her placenta delivered within 5 minutes of birth. Now she is bleeding heavily, there is 500 mL in the drape, her uterus is soft, and her bladder is empty. Vital signs are: Pulse 88 bpm, Blood pressure 118/68 mmHg, Respiration 22 breaths per minute.**"

Now demonstrate by pretending to speak to one of the participants, and say, "**Sister, I need some help here. This woman is having a PPH. Can you bring the emergency trolley?**"

Say to another who is there to help,

S = Situation: "*I am (name) caring for Ms. R who gave birth 30 minutes ago and is bleeding heavily.*"

B = Background: "*Ms. R is a 22 year old G1P1. There is 500ml of blood in the drape. During the most recent monitoring, her uterus was soft, her bladder is empty, her vital signs are: Pulse 88, Blood pressure 118/68, Respiration 22.*"

A = Assessment: "*I think she is having PPH due to uterine atony.*"

R = Recommendation: "*Please help me begin the treatment bundle for PPH.*"

End the role play here and begin Discuss below.

Discuss

1. *Do you currently use a communication strategy during emergencies? If so, please explain.*
2. *Do you see any challenges in using SBAR to communicate? If so, can we ask our volunteer to write these down so we can discuss further at the end of the day?*

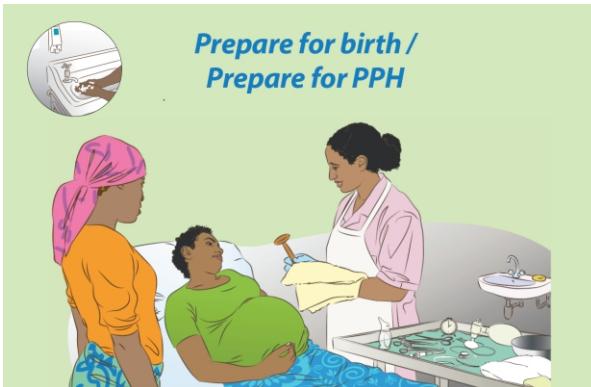


MODULE 3

Prepare for birth / Prepare for PPH



Explain



Prepare for birth as soon as the woman is close to the second stage.

- **Prevent Infection**

- Hand hygiene and wear sterile gloves
- Wear apron, mask, and eye shield to protect yourself
- Double glove before birth so you can remove soiled gloves before clamping and cutting the cord to protect the baby from infection.

- **Communication**

- Communicate what you are going to do and why to keep the woman and your team informed and help them to stay calm.

- **PPH can happen at any birth** so be ready before birth to reduce delays!

- **Enabling Environment**

- Supplies for every birth include: a device for objective measurement of blood loss, oxytotic medication, and an emergency trolley or case with emergency supplies.

- Environment: An enabling environment also includes where all present- the woman, her family and all care providers feel safe to speak, ask questions and participate in decision making.

- **Preparing for every birth**

- Check the **emergency trolley** is complete and prepared. PPH can happen at any birth so be ready before every birth to reduce delays!
 - Every birth should have a uterotonic ready to administer prior to birth.
 - Provide the **uterotonic drug within one minute of birth** to prevent PPH

It is very important that injectable uterotonic is drawn up into the syringe or misoprostol is ready to give BEFORE THE BABY IS BORN. This will allow you to give the medicine quickly to prevent the woman from bleeding and will reduce delays in life saving care if the baby needs help to breathe.

- Every birth should have a **drape or calibrated objective blood loss measurement tool** nearby, place immediately after administration of the uterotonic drug to measure blood loss, before the placenta has delivered.

- **Facilitate demonstration**

or run simulations, be sure you model respectful care for the learners.

Have supplies for birth laid out neatly for demonstration.

- PPE: Sterile gloves, long gloves, apron, mask, and eye shield
- Drape/tray to measure blood loss, or other objective blood loss measuring tool
- Cord care: Scissors, ties/hemostats or clamps
- Baby care: cloths, hat
- Suction bulb, bag and mask
- Clock with a second hand
- BP cuff and stethoscope
- Mock medications - uterotronics (oxytocin, heat stable carbetocin (HSC), ergometrine /methyl ergometrine, fixed dose oxytocin and ergometrine), tranexamic acid (TXA), ampicillin with clavulanic acid IV or cefazolin IV, diazepam IV
- IV infusion materials, IV fluids, tape
- Syringes and needles
- Blood collection tubes
- Urinary catheter and collection bag

MODULE 4

Actively make decisions for woman and baby



Explain



Things can change quickly after birth. Both the woman and her baby must be closely watched. Keep the woman and baby in the delivery room for at least one hour after birth and always keep them together.

Actively look for danger signs, make decisions, and act quickly to save lives!

For the baby:

- The first minute is critical to be sure the baby is breathing well. Actively assess that the baby is breathing and responding as you dry the baby.
- If the baby is not breathing, keep warm and begin resuscitation within the first "golden minute".

- Keep mother and baby in skin-to-skin contact and initiate early breastfeeding
- Continue to carefully assess the baby's breathing, color and temperature and respond immediately if needed

For the woman:

- Carefully monitor blood loss, blood flow, BP, and pulse for signs that she may be losing too much blood – increased pulse, dropping blood pressure, or pale, clammy skin.
- Many deaths from PPH can be prevented with prompt recognition and proper treatment.
- Visual estimation of blood loss is inaccurate and can result in underestimation and delayed action.
- A calibrated blood collection drape or device to objectively measure blood loss gives an objective measurement of blood loss and allows for a more accurate and timely diagnosis of PPH than visual assessment.

To detect PPH immediately after birth, assess and record in the client record: blood loss, blood flow, BP and pulse **every 15 minutes.** Begin:

- Immediately after delivery of the placenta
- If the placenta is not out after 15 minutes
- If the placenta is incomplete
- Anytime the uterus is found to be soft

If there is heavy bleeding, begin PPH treatment immediately and call for help !

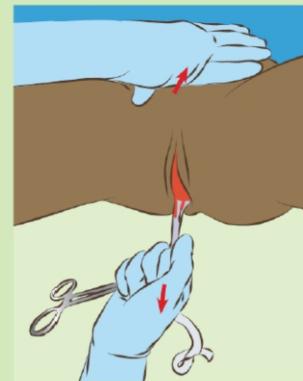
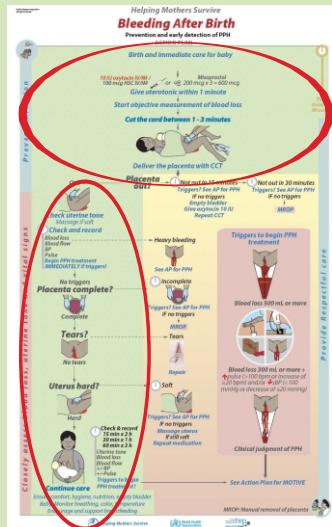
We will discuss this later today.

Facilitation note: If this facility has access to objective measurement tools such as calibrated drapes, trays or other measuring devices, be sure to incorporate their use into training on when to trigger treatment for PPH. If there is no objective measurement, clinical judgment is still used to trigger the PPH treatment bundle!

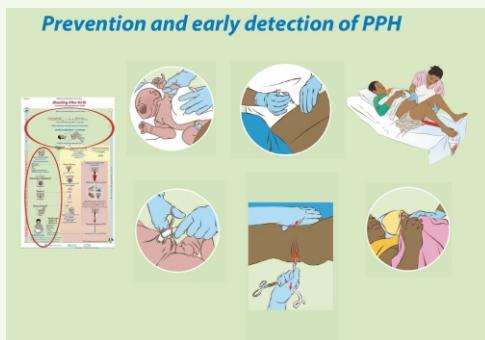
Demonstrating placement of the "Blood Collection Drape".

MODULE 5

Prevention and early detection of PPH



Facilitators will demonstrate prevention of PPH



Explain

The third stage of labor is the time between the birth of the baby and the placenta.

This is a critical time for both the woman and her baby and you will need to care for both. As you attempt to prevent PPH, you must continue to observe the baby to make sure she is breathing and is being kept warm.

If the baby needs resuscitation and the provider is alone, give preference to care for the baby. If possible, at least give the uterotonic to prevent PPH in the third stage of labor, even if CCT is not possible.

Actively preventing PPH is associated with a shorter third stage of labor, less blood loss, and fewer cases of PPH.

The **three steps to prevent PPH in third stage of labor** are:

- 1. Give a uterotonic after the last baby is born.** This is the most important step to prevent PPH.
Unfold the drape or place the blood collection device immediately after giving the uterotonic.
- 2. Perform controlled cord traction to deliver the placenta.**
- 3. Check uterine tone and massage if soft.**

After the above activities:

- Immediately check and record blood loss, blood flow, BP and pulse. **If there is heavy bleeding, immediately begin the treatment for PPH.**
- Check the placenta for completeness
- Check for genital tears
- Recheck uterine tone

To detect PPH immediately after birth, assess and record the following on the blood loss monitoring chart - blood loss, blood flow, BP and pulse **every 15 minutes.** Begin:

- After delivery of the placenta
- If the placenta is not out after 15 minutes
- If the placenta is incomplete
- Anytime the uterus is found soft

If there is heavy bleeding, immediately begin the treatment for PPH.

Discuss

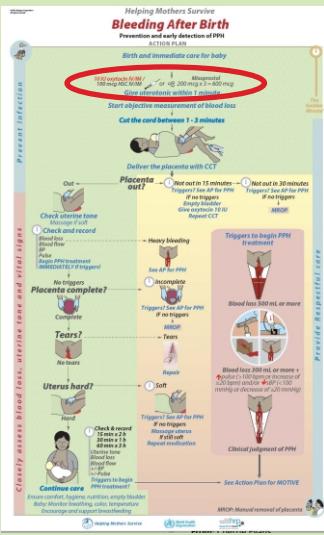
Ask, "**What uterotonic do you use to prevent PPH?**" Let participants know you will review the uterotronics recommended to prevent PPH - oxytocin, HSC, misoprostol, ergometrine / methylergometrine, fixed-dose oxytocin/ergometrine.

Begin this page with an introduction of the Action Plan. Then state:

"We are going to go through the care of a woman who had a normal labor and birth, to the end of the third stage. We will then circle back to abnormal after"

Next, go through the following pages of the Flip chart through "Continue Care". Emphasize each action from the Action Plan as you go and be sure to ask all Knowledge Check questions. When you have completed these pages, demonstrate the entire sequence from start to finish.

If you are conducting the training alone, ask for a volunteer to take on the role of the woman, so that you are able to demonstrate actions to prevent PPH and care of the newborn.



MODULE 6

Preventing PPH

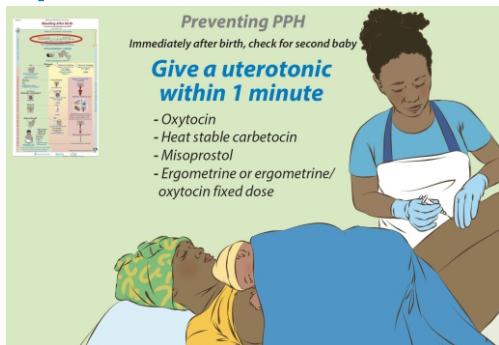
Immediately after birth, check for second baby

Give a uterotonic within 1 minute

- Oxytocin
- Heat stable carbetocin
- Misoprostol
- Ergometrine or ergometrine/oxytocin fixed dose



Explain



Oxytocin is a uterotonic that causes the uterus to contract. It is the preferred uterotonic for treatment of PPH because it is inexpensive, widely available, and it works quickly. The side effects are few and it can be used in all women. Oxytocin must be kept at 2-8°C (36 to 46°F), never frozen, to ensure quality. In settings where this cannot be guaranteed, another uterotonic should be used.

- **The correct dose of oxytocin to prevent a PPH is 10 IU IM or IV given within 1 minute of birth** of the last baby. IV is preferred IF already in place.

Be sure to have oxytocin drawn up in the syringe BEFORE THE BIRTH so you can give it easily within one minute of birth!

Heat-stable carbetocin (HSC) is a long-acting uterotonic similar to oxytocin used for prevention only. It does not require refrigeration during transport and storage and keeps potency in hot climates. It must be protected from light, store at 15-30°C

- **Correct dose of HSC to prevent a PPH is 100 mcg (1mL) IM or IV** given within 1 minute of birth of the last baby. If giving IV, inject slowly over 1 minute.
- The sustained nature of uterine contraction is why **HSC should never be used for induction or augmentation at any dose**.

Misoprostol also causes the uterus to contract and can be used for prevention and treatment. It does not need to be kept cold but needs to be protected from humidity.

- **Correct dose of misoprostol to prevent a PPH is 400-600 mcg** by mouth or sublingual within 1 minute of birth of the last baby.

It comes in 200 mcg tablets. Give 2 or 3 tablets depending on local protocols.

Always check to see if there is another baby before giving any uterotonic to prevent PPH. NEVER give any uterotonic before birth of the last baby.

Ergometrine is a long-acting uterotonic used to prevent and treat PPH. It is also available in a fixed dose combination with oxytocin. Because it has some contraindications, and it can have more side effects, ergometrine or ergometrine in combination with oxytocin is **not the first choice to prevent PPH**. Ergometrine is more sensitive to heat than oxytocin and is also sensitive to light. Store any products with ergometrine in a refrigerator at 2-8°C (36 to 46°F) and do not freeze.

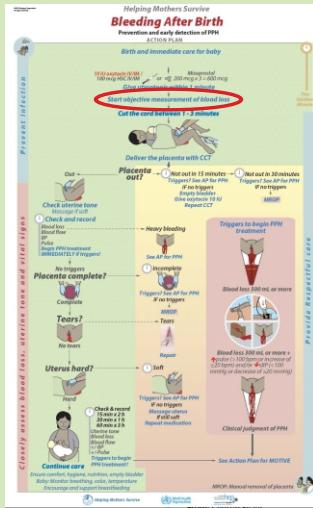
- **The correct dose is Ergometrine (0.2-0.5 mg) IM OR** The fixed drug combination of oxytocin and ergometrine: 1 mL = 5 IU oxytocin + 0.5 mg ergometrine IM.
- Only use ergometrine or ergometrine / oxytocin fixed dose if oxytocin, HSC, or misoprostol are not available.
- **It should never be used for induction or augmentation at any dose.**

Do not give ergometrine to women with pre-eclampsia, eclampsia or high blood pressure because it increases the risk of convulsions, stroke and death!

Knowledge check

Why is Oxytocin the preferred uterotonic compared to HSC, Misoprostol and Ergometrine?

Inexpensive, widely available, few side effects, no contraindications.



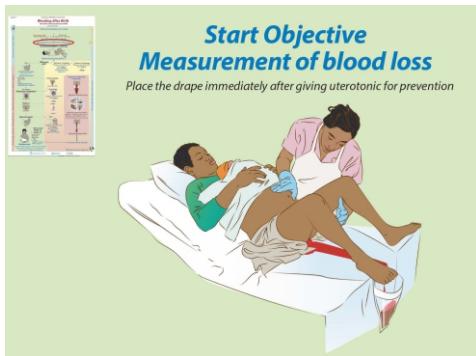
MODULE 7

Start Objective Measurement of blood loss

Unfold the drape immediately after giving the uterotonic.



Explain



Using an objective measurement of blood loss is key to save lives.

For all women giving birth, routine objective measurement of blood loss is recommended to improve the detection and allow for prompt treatment of PPH.

Visual estimation of postpartum blood loss is frequently inaccurate, thus PPH is often missed.

The most common objective measurement method is use of a drape that has a calibrated "pocket" to collect blood and allow for a quick and accurate assessment of the amount of blood lost.

Other methods include trays or other locally made tools. Objective methods of quantifying blood loss, are far superior to visual estimation, and are more likely to detect PPH.

- . Ensure the uterotonic medication is given within one minute. Unfold the drape immediately after giving the uterotonic.

Blood loss measurement is particularly critical in the first few hours after birth.

The use of a drape or other tool for objective postpartum blood loss measurement should not interfere with the woman's customary or cultural desires including choice of birth position.

In case of other birthing position support the woman to lie down, then unfold the drape.

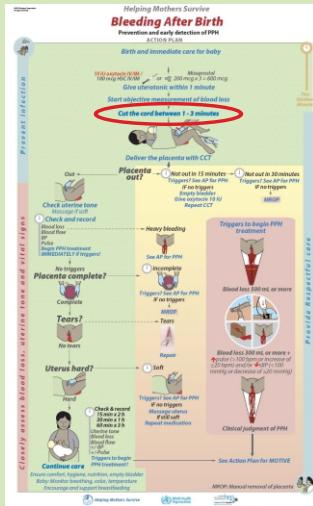
Women should be regularly monitored for early warning signs of excessive blood loss (e.g. tachycardia or hypotension).

Discuss

1. Does your facility currently use objective measurement of blood loss?
2. How do you measure blood loss?
3. What would be the challenges to using calibrated drapes?
4. What alternatives can you think of?

Knowledge check

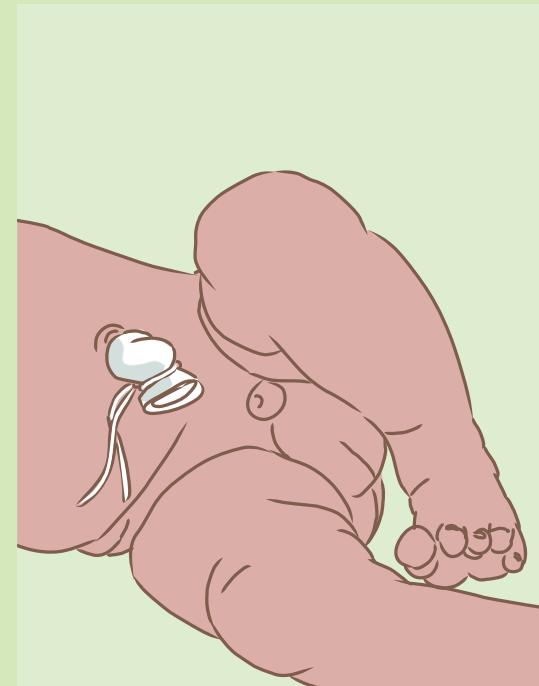
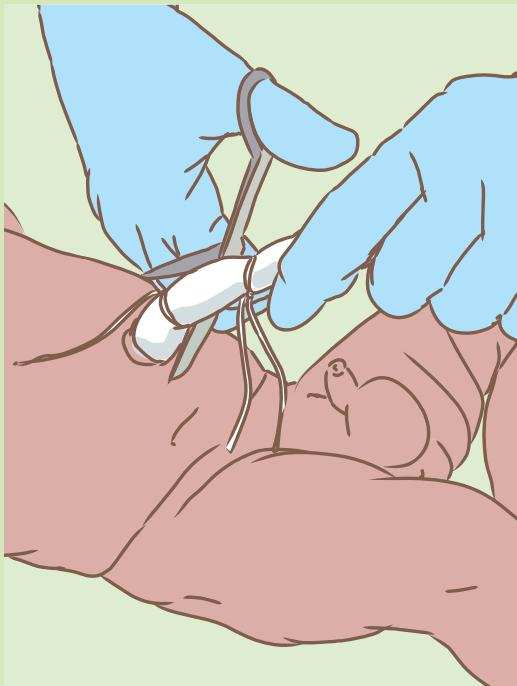
Why is objective measurement of blood loss preferred?
Because visually estimating blood loss often delays diagnosis of PPH



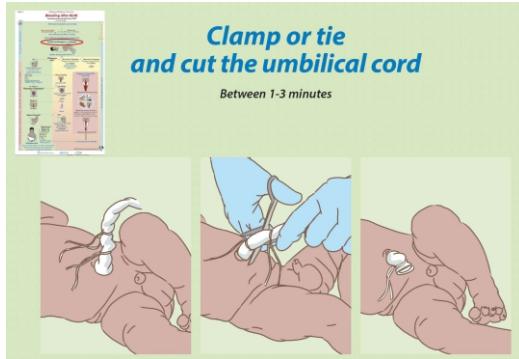
MODULE 8

Clamp or tie and cut the umbilical cord

Between 1-3 minutes



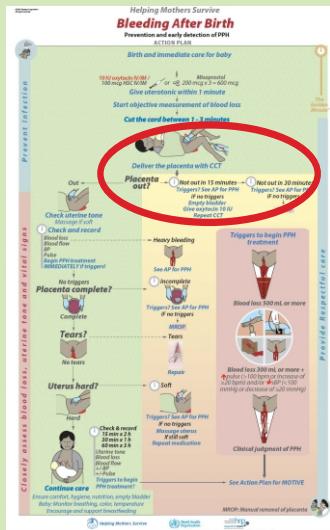
Explain



Timing of cutting the cord depends on the condition of both woman and baby. It is recommended to cut the cord between 1 and 3 minutes after birth if both are doing well. Waiting at least one minute will also make sure the baby gets enough red blood cells from the placenta to prevent anemia. This also allows time for the uterotonic given to prevent bleeding.

- If the woman is bleeding heavily or if the baby is not breathing well, cut the cord sooner and call for help.
- Cleanliness is important to prevent infection of the cord. Double glove before birth so that one pair may be removed before you cut the cord. All supplies should be sterile or disinfected.

- To cut the cord place 2 clamps or ties around the cord. Place the first clamp or tie around the cord about 2 finger-breadths from the baby's abdomen. Place another clamp or tie about 5 finger-breadths from the abdomen.
- Before cutting the cord, remove your first pair of gloves if doubled gloved, or change gloves.
- When cutting the cord, be sure to shield your face from blood splashing by covering the scissor with a thin piece of sterile gauze before cutting.



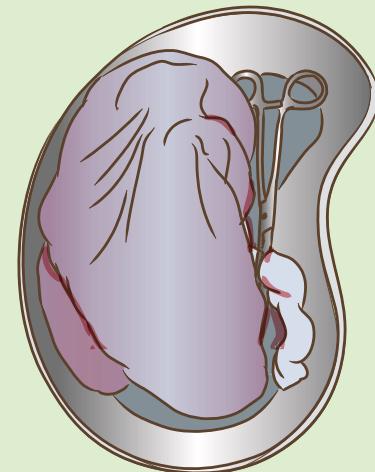
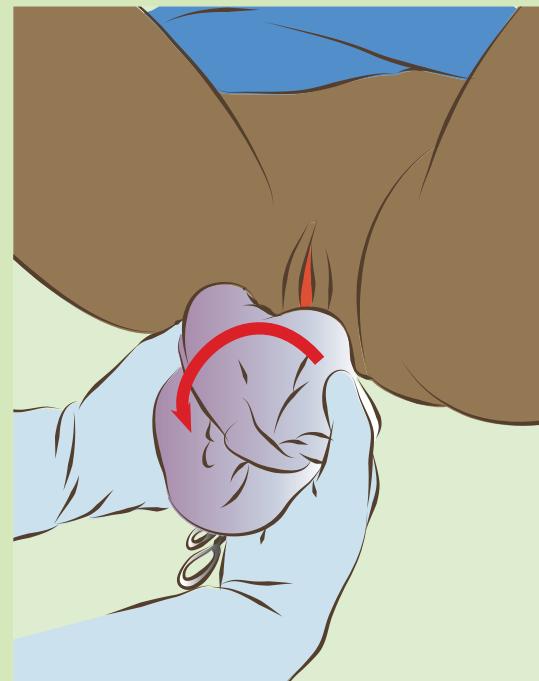
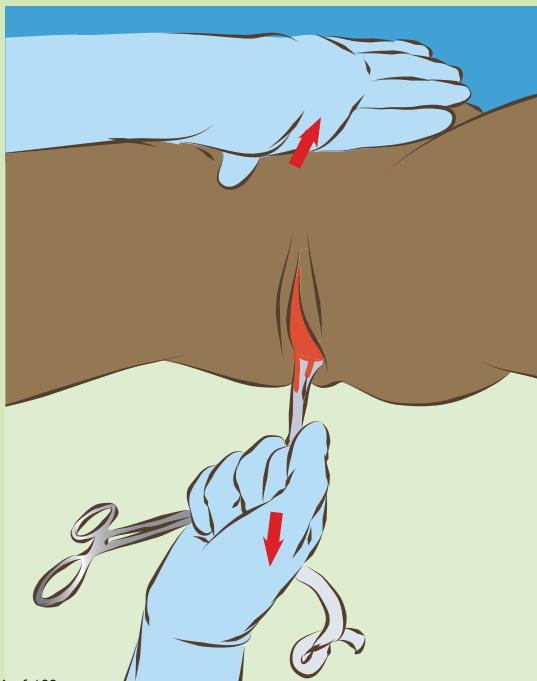
MODULE 9

Preventing PPH Deliver the placenta with CCT

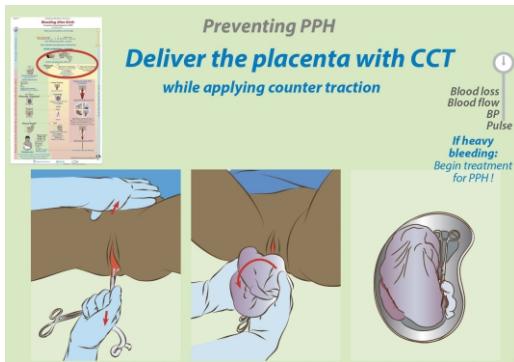


Blood loss
Blood flow
BP Pulse

**If heavy
bleeding:**
Begin treatment
for PPH!



Explain



The placenta should be delivered within 10 minutes after uterotonic is given..

Performing **controlled cord traction** to deliver the placenta is the second step of active management of the third stage of labor and should only be done by skilled birth attendants.

- Controlled cord traction can speed delivery of the placenta, however, if not done properly, it can be harmful.
- **Controlled cord traction must be gentle and done only during contractions.**
- Always stabilize the uterus when providing controlled cord traction
- Never pull too hard on the cord or if you feel resistance as this can tear the cord or invert the uterus.
- Tissue left inside the uterus can cause hemorrhage and infection.

Explain how to safely provide controlled cord traction.

- Clamp cord close to perineum and wait for contraction.
 - During contraction, pull the cord gently downward and provide **counter-traction to stabilize the uterus**. Do not pull suddenly or in other directions.
 - Release traction between contractions.
- Explain how to safely deliver the placenta.**
- When the placenta is visible at the opening of the vagina, gently pull the cord upward to guide the placenta out.
 - As the placenta delivers, hold it with both hands and gently turn the placenta as it delivers. Gentle twisting of the placenta as it delivers helps keep the membranes from tearing.

If the **woman will arrive in your care after she delivered** elsewhere and has a retained placenta or PPH. In these cases, you will need to care for her based on her signs and symptoms and what you learn about any care she has received.

NOTE: The woman will need additional treatment or manual removal of the placenta if:

- the placenta is not out after 30 minutes
- the placenta is incomplete

To manage a placenta that has not delivered in 15 minutes AND there is no sign of PPH:

- **Encourage the woman to empty her bladder.** Only catheterize the bladder if the bladder is distended and she is unable to void on her own.
- If the placenta still does not deliver, **repeat 10 units of oxytocin**.
- **DO NOT repeat** misoprostol or HSC for retained placenta.
- **Do NOT give** ergometrine or oxytocin and ergometrine fixed dose combination.
- **Continue controlled cord traction.** It may take several more contractions for the placenta to deliver.

Knowledge check

Why should you never pull on the placenta or cord when resistance is felt?

Because you might tear the cord off or pull the uterus out.

When is it safe to touch the placenta to remove it?

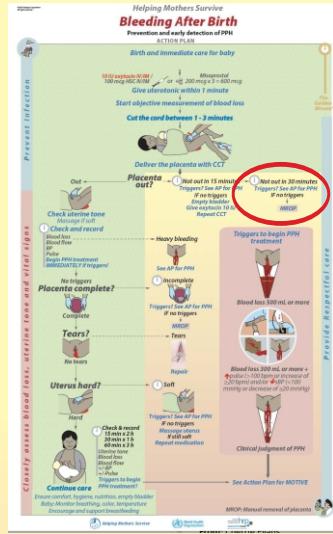
When it is visible at the opening of the birth canal

How does turning the placenta reduce the risk of leaving tissue behind?

It helps it form a rope with the membranes, which is stronger and less likely to leave pieces behind.

When do you place a blood collection device?

After giving the uterotonic for AMSTL.



MODULE 10

If placenta is not out in 30 minutes - Check for heavy bleeding

Perform manual removal of placenta

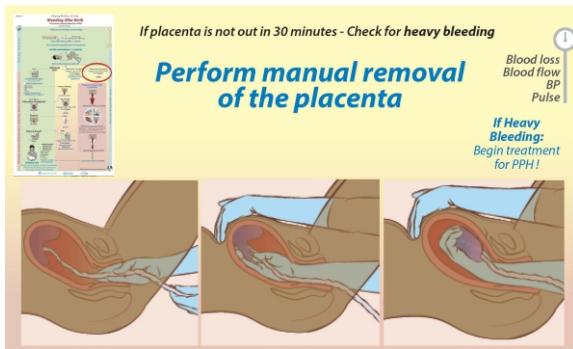


*Blood loss
Blood flow
BP
Pulse*

**If Heavy
Bleeding:
Begin treatment
for PPH !**



Explain



If the placenta has not delivered by 30 minutes:

- **Initiate manual removal of placenta (MROP).**
- **Check for heavy bleeding and record** on the blood loss monitoring chart: Blood loss and flow, BP, and pulse.
- **Anytime before 30 minutes, if there is heavy bleeding, begin treatment for PPH immediately, and initiate manual removal of the placenta!!**

This will be further discussed later.

Advanced Care Note

- If learners have additional training and authorization to provide more advanced care, they should act within their scope of practice. This may include manual removal of the placenta or retained pieces.
- If manual removal is done, the woman will require antibiotics to reduce the risk of infection.
- Manual removal should **NEVER** be attempted without proper training and authorization.

Discuss

Ask,

1. **"How long after birth of the newborn do you consider the placenta retained? 15 minutes? 30 minutes? 60 minutes?"**

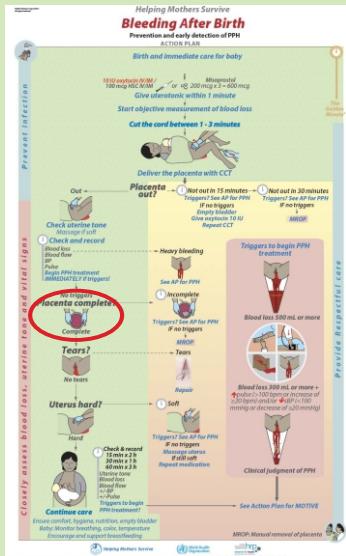
At 15 minutes we initiate another dose of oxytocin, ensure the bladder is empty and continue CCT. In Nigeria, at 30 minutes we initiate MROP

2. **"How do you manage a retained placenta?"** MROP

Knowledge check

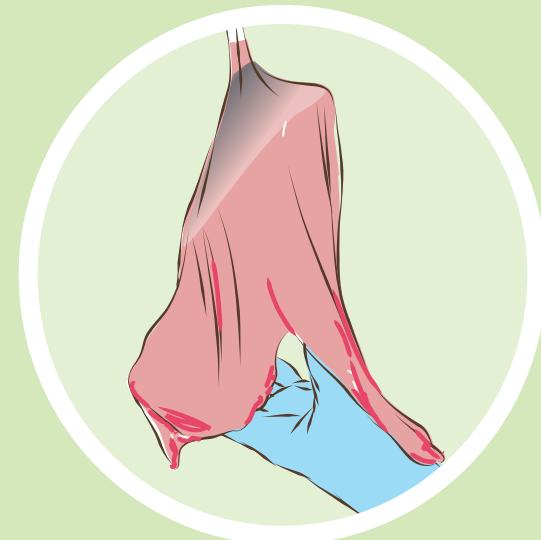
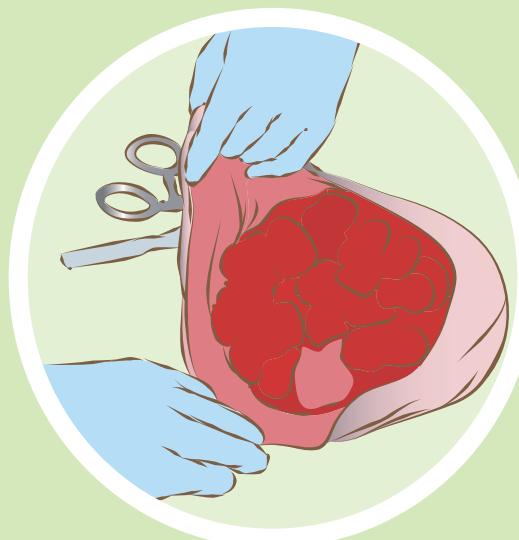
Why should a provider call for additional help?
To help you manage problems that are outside your scope of practice

When should providers begin thinking about getting additional help?
As soon as any problem arises that they cannot manage on their own

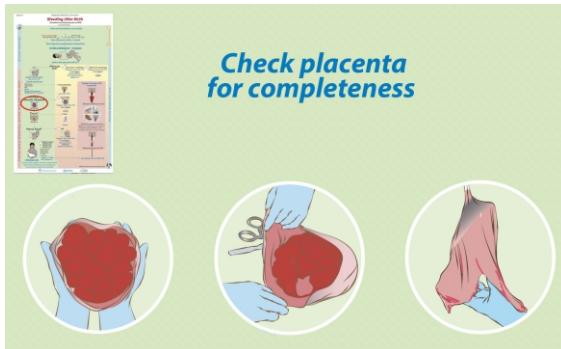


MODULE 11

Check placenta for completeness



Explain



If there is no heavy bleeding when checking uterine tone, blood loss, blood flow, BP, and pulse after delivery of the placenta:

- Check the placenta and membranes for completeness.
- Careful inspection of the placenta will alert you to lobes or fragments that may remain in the uterus.
- Any tissue left inside the woman can cause hemorrhage and infection.

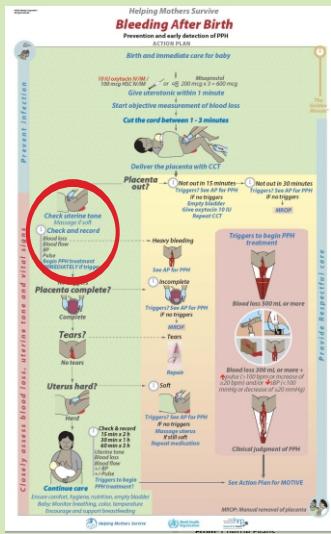
Demonstrate

Demonstrate and explain how to check the placenta for completeness.

- Look at both sides of the placenta.
- Hold the placenta in your hand with the maternal side up. Cup the placenta in your hands to see if the lobes fit together and none are missing.
- Hold the placenta upside down by the cord and hold out the membranes to recreate the sac. Look at the membranes to be sure large pieces are not missing.

Knowledge check

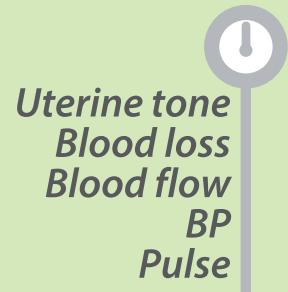
If a piece of the placenta stays in the uterus, why does the woman bleed more?
The uterus cannot contract to squeeze the blood vessels and stop the bleeding.



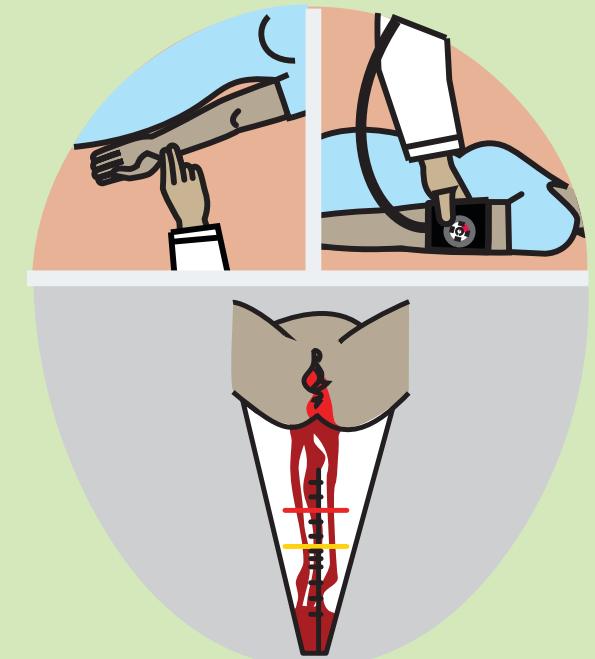
MODULE 12

When placenta is out - Check for heavy bleeding

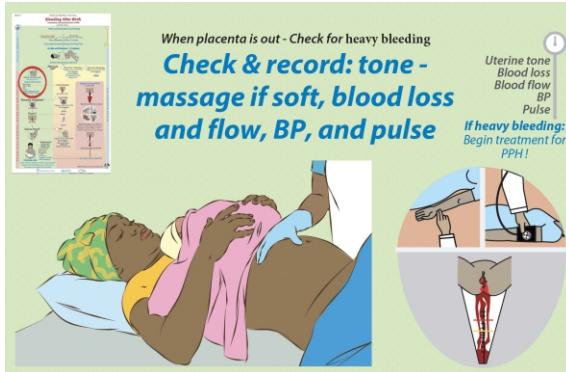
**Check & record: tone -
massage if soft, blood loss
and flow, BP, and pulse**



**If heavy bleeding:
Begin treatment for
PPH!**



Explain



Immediately after the placenta has delivered, **check and record** on the blood loss monitoring chart:

1. **Uterine tone** - The final step to prevent PPH. Massage the uterus if it is soft. Uterine tone can change quickly. Check the uterus every 15 minutes for the first two hours after birth.

Explain how to assess the uterus for tone and massage if soft.

- A hard uterus feels like your forehead and does not need massage. A soft uterus feels like the tip of your nose and needs massage.
 - If the uterus is soft, massage the uterus.
- Immediately postpartum, the uterus should be firm at mid line, and approximately level or below the umbilicus.

- If the uterus rises above the umbilicus, it could mean clots are forming inside. Massage the uterus to remove the clots.
 - If the fundus is displaced from midline, it could mean the bladder is full. If her bladder is distended, help her to empty her bladder; catheterize only if she is unable to void.
 - Assure NO urine is allowed in the drape
2. **Blood loss and blood flow** as you check uterine tone.

Sweep blood and clots into the funnel of the drape or other tool for accurate measurement.

3. **BP and pulse**

If there is heavy bleeding, immediately call for help and begin the treatment for PPH!!

We will discuss this later today.

- Teach the woman :
 - How to check the uterus and massage it if it feels soft or if she feels she is bleeding too much.
 - To call a provider if the uterus is soft or if she feels her bleeding has increased.

Discuss

1. "Is it common practice in your facility to check and record uterine tone, blood loss and flow, BP, and pulse immediately after the placenta has delivered?"

2. "What can you do to make sure all women are assessed for heavy bleeding to begin the treatment for PPH immediately after delivery of the placenta?"

Knowledge check

Why is it important to keep checking the tone of the uterus?

If the uterus is soft, it is not contracted and the woman will bleed. Massage it to make it contract.

True or False - Once the uterus contracts or gets hard, it will always stay hard.

False - A uterus can lose tone and begin to bleed.

What are some reasons why a uterus might not contract?

There may be retained tissue or the woman's bladder may be full.

What kind of bleeding after birth is dangerous?

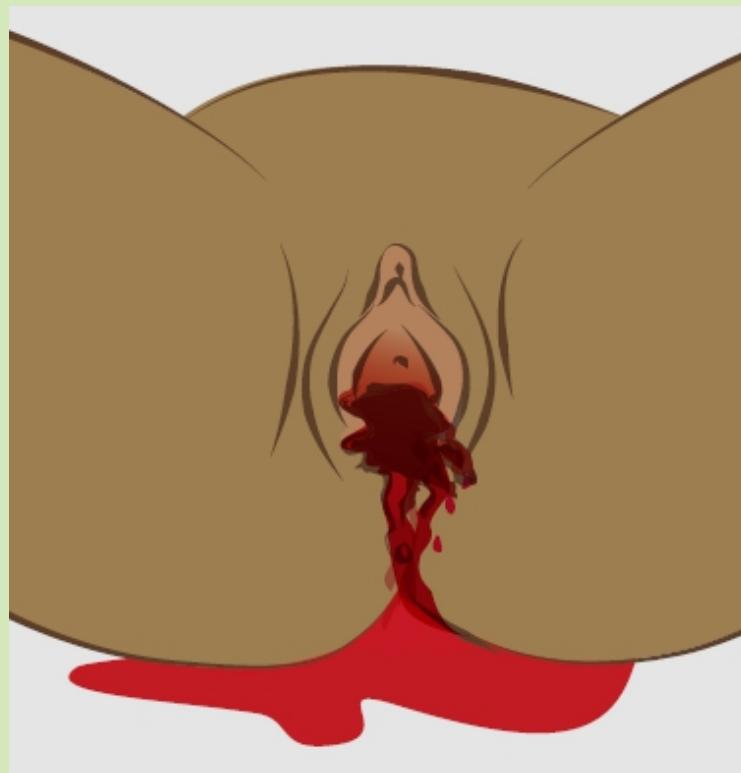
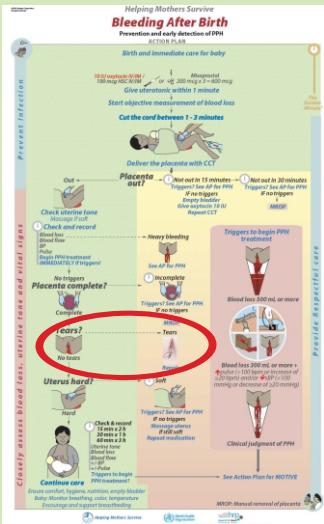
A large gush that will not stop OR a constant small or heavy stream that will not stop OR large clots.

Why should the provider check and re-check the woman often?

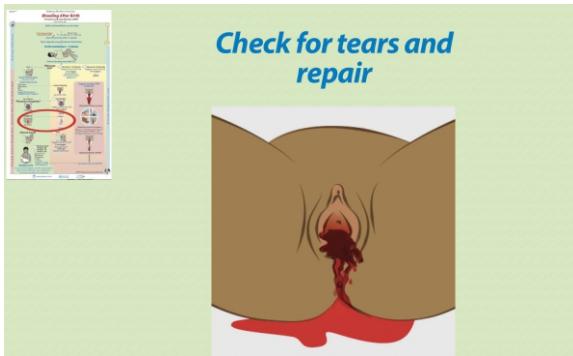
The uterus could get soft at any time, or bleeding that was normal could become heavy.

MODULE 13

Check for tears and repair



Explain



Lacerations or tears are another cause of bleeding after birth.

A woman who has had female genital cutting or an episiotomy is at increased risk for bleeding from tears.

Remember! A woman can have significant vaginal tears without having tears of the perineum.

If the woman is bleeding more than normal, the uterus is firm, and the placenta is complete, tears are likely even if they cannot be seen.

If you are not able to assess for genital tears, immediately **consult a senior provider**.

To check for tears:

- Explain to the woman what you are about to do and obtain her oral consent.
- Ensure good lighting.
- Before checking for tears, you may need to remove clots from the vagina and cervix as you massage the uterus. This may decrease active bleeding and improve your ability to see tears.
- Gently wipe away blood so you can see tears.
- Assess the extent of the trauma including all the structures involved, the apex of the injury and any bleeding.
- Decide on how to respond based on amount of bleeding and extent of the trauma (follow local protocols).

To manage tears:

If you are not able to repair tears:

- Apply firm, steady pressure to tears that are bleeding with a clean or sterile cloth to slow bleeding.
- Continue to apply pressure to tears until the bleeding stops, you are able to suture or **she is receiving advanced care**.
- Do not remove soaked cloths, but add additional cloths on top and **seek advanced care** if you cannot do the repair.

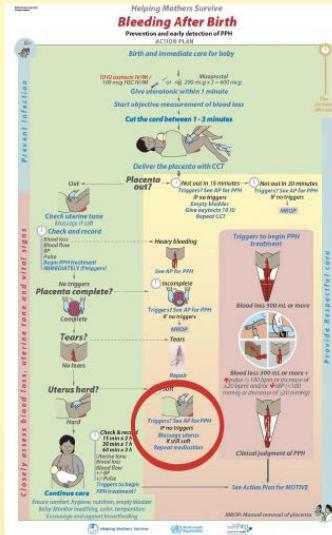
If you are able to repair tears, now is the time to do so. If she has tears that are not within your scope of practice to repair, seek advanced care.

If you think the woman is bleeding too much, call for help, and immediately begin the treatment bundle for PPH!!

We will review management of PPH shortly.

Advanced Care Note

Learners should act within their scope of practice- this includes repairing lacerations.



MODULE 14

*If placenta is out and uterus is soft,
and no heavy bleeding*

Massage uterus

If still soft

Repeat medication



Uterine tone
Blood loss
Blood flow
BP
Pulse

***If heavy
bleeding:
Begin treatment
for PPH!***



Explain



A soft uterus is the #1 cause of PPH.

If the uterus is soft:

- **Check for heavy bleeding to begin the treatment bundle for PPH and record on the blood loss monitoring chart: Uterine tone, blood loss and flow, BP, and pulse.**
- **If there is heavy bleeding, begin the treatment bundle for PPH immediately!!**

If there is no heavy bleeding:

- **Massage the uterus until it contracts or for at least one minute.** Massage can expel blood clots which will help the uterus contract.
- **Do not insert hand into the uterus to expel clots.** Watch the bleeding while you massage to see if it slows as the uterus contracts.

- Feel if the bladder is full. If it is full and she cannot pass urine on her own, catheterize the bladder following facility protocol.
- After the bladder is empty, recheck uterine tone and massage again if soft.

If the uterus does not contract with massage and emptying a distended bladder, act fast to prevent PPH!

- Give a treatment dose of oxytocin or misoprostol to manage atony: 10 units oxytocin IM or IV **OR** 800 mcg misoprostol orally, rectally or under the tongue
- **Do NOT give heat stable carbetocin to treat atony or PPH.**
- Continue assessing uterine tone and bleeding to see if the uterotonic and massage are working.

If you think the woman is bleeding too much and/or not responding to treatment for atony, call for help, and begin treatment for PPH immediately!!

Discuss

1. **"If you find a woman is bleeding from a uterus that will not contract, what medication do you use at your facility?"**
2. **"Do you have drugs other than oxytocin and misoprostol?"**

Knowledge check

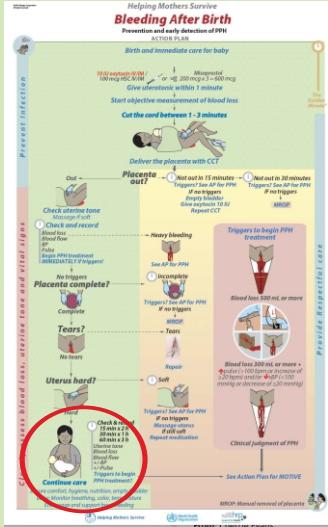
What drug should you NEVER repeat? Heat Stable Carbetocin

Why is it important to keep checking the woman's uterus and bleeding?
Her uterus may get soft at any time and she may begin to bleed heavily.

MODULE 15

If bleeding is normal and uterus is hard - Check for heavy bleeding

Continue care for the woman and baby

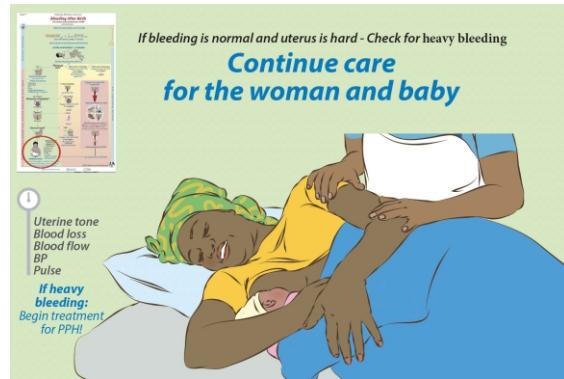


Uterine tone
Blood loss
Blood flow
BP
Pulse

If heavy
bleeding:
Begin treatment
for PPH!



Explain



As you continue care for the woman and her baby, keep them skin-to-skin to keep the baby warm. Start breastfeeding as soon as the baby is ready within the first hour after birth.

- Routine care means continued monitoring of both woman and baby. Check and re-check them both **every 15 minutes for the first 2 hours, then every 30 min for the next 4 hours.**
- Check uterine tone, blood loss and flow, BP, and pulse of the woman.
- Check the baby's color, temperature, breathing and cord.
- **If there is heavy bleeding, begin treatment for PPH immediately!**

- Encourage the woman to keep her bladder empty. A full bladder can keep a uterus from contracting.
- If the woman is not bleeding at one hour after the placenta delivers, you can remove the blood collection device or drape. If she is actively bleeding, keep the device in place until bleeding has stopped.
- Women and babies should remain in facilities for 24 hours following a normal vaginal birth so they can be monitored.
- If there is heavy bleeding, begin treatment for PPH immediately

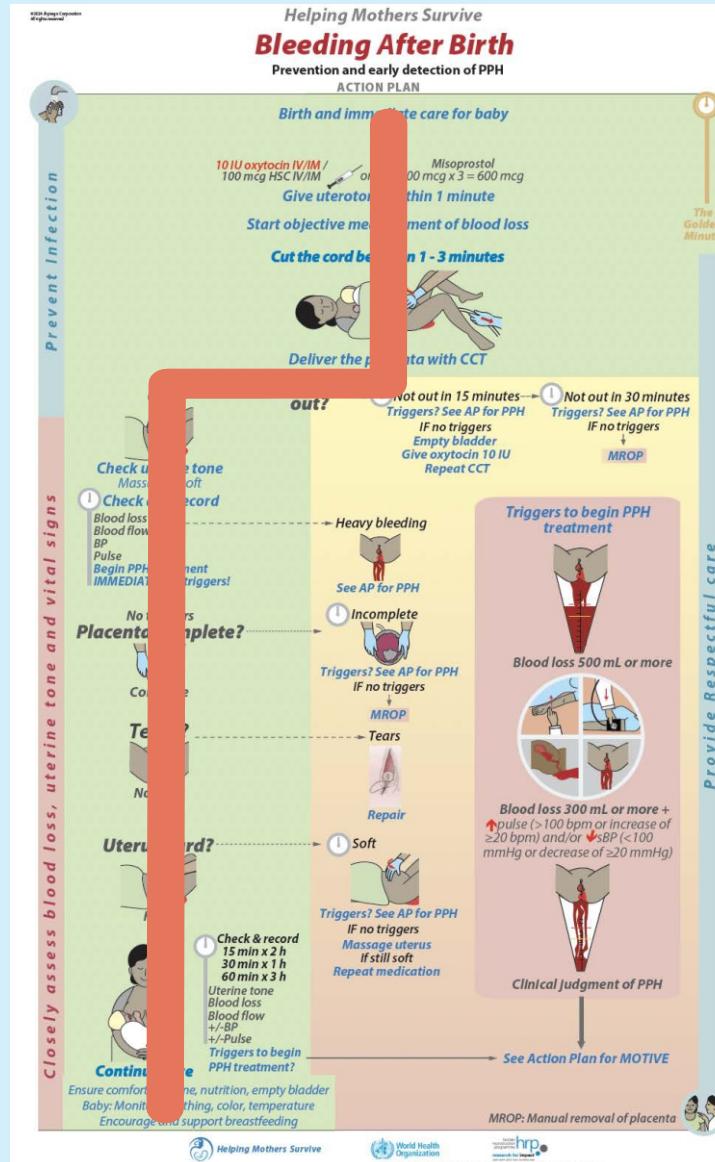
Demonstrate

With a volunteer wearing the birthing simulator, demonstrate the steps to prevent PPH and immediate newborn care.

- Deliver baby onto mother's stomach
- Dry baby thoroughly and assess for crying or breathing; cover with a dry cloth. Resuscitate as needed.
- Check for second baby; if none, proceed with third stage care while continuing to observe baby
- Give a uterotonic drug to the woman within one minute of birth of the last baby.
- Start objective measurement of blood loss.
- Before cutting the cord, remove first pair of gloves if double gloved or change gloves and clamp and cut the cord between 1-3 minutes after birth
- Perform controlled cord traction during contractions
- Feel the uterus once the placenta delivers and massage if soft
- Check and record blood loss, blood flow, BP, and pulse on the blood loss monitoring chart
- Check placenta for completeness
- Check for and repair tears
- Continue to closely observe the woman and baby and provide routine care

LEARNING ACTIVITIES

*How much is too much?
Assessing blood loss
and Preventing PPH*



LEARNING ACTIVITIES

***How much is too much?
Assessing blood loss
Preventing PPH***

Explain

- Visual estimation of blood loss is difficult.
- Decision making should be guided based on both blood loss AND the woman's vital signs.
- All women are at risk for life-threatening bleeding.
- Dangerous bleeding can be:
 - a slow, constant trickle OR
 - a heavy flow OR
 - a large gush OR
 - large blood clots expelled

Exercise 1

Blood estimation exercise

The purpose of this activity is to demonstrate how hard it is to accurately estimate blood loss.

Prep:

Set up four stations showing different amounts of blood and label them A, B, C, D:

- A. White towel or culturally appropriate cloth - 600 cc
 - B. Gauze bandage - 100 cc
 - C. Liquid in a basin - 300 cc
 - D. Blood clot (use red fruit jam)– 500 cc
- Release learners for a short break to walk by stations and write their estimates of blood loss at each station.
- When they come back together, discuss their estimates. Show the differences among the group and discuss how easy it can be to underestimate. **This is why we use objective measurement of blood loss.**

Exercise 2

Routine third stage practice

Prep:

- Divide learners to six learners to one facilitator and simulator.
- 1 learner wearing the simulator
- Simulator with baby delivered on the abdomen, cord still attached.

- Have first learner demonstrate normal care from the moment of birth to routine care.
- Guide the learner as necessary using the Action Plan and give feedback.
- Have each learner practice this same scenario while the facilitator gives feedback.
- Have the other learners trace what is happening on the Action Plan.
- **REMEMBER-HSC and Ergometrine**
 - DO NOT Repeat doses
 - DO NOT use for induction or labor augmentation
- Ask: "**Can we repeat HSC if needed?**"- No, it is a single dose for PPH prevention.
- Ask: "**What about Ergometrine?**"- It is single dose as well. If used to prevent a PPH, you cannot use it to treat PPH.
- Ask: "**Can HSC or Ergometrine be used to augment labor?**"- NO, they could cause a uterine rupture and death!

MODULE 16

Main causes of bleeding after birth

P T



T



P R



T P G

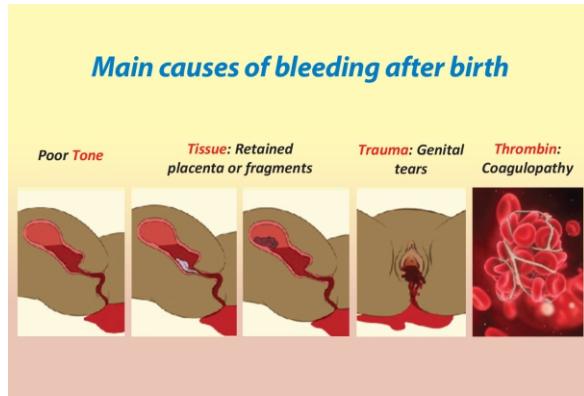


TR



P

Explain



All women are at risk for life-threatening bleeding. To prevent morbidity and death from PPH, the most important actions providers can take are to **prevent PPH**, **detect PPH early** through careful monitoring, and **begin treatment for PPH immediately**.

Dangerous bleeding can be:

- a slow, constant trickle OR
- a heavy flow OR
- a large gush OR
- large blood clots

Respond quickly!

The main causes of bleeding are:

- **Tone:** uterine atony is the most common cause of PPH. Atony accounts for 8 out of 10 cases of PPH.
- If the uterus does not contract, blood continues to flow into the uterus. Every woman is at risk for atonic uterus.
- We must monitor women closely because even a uterus that was contracted can then become atonic. Causes include:
 - A full bladder
 - **Anything in or distending the uterus:** During pregnancy/labor: large baby, polyhydramnios, multiple pregnancy, or fibroids. After birth: retained placenta, membranes, or placental fragments.
 - **Anything exhausting the uterus:** prolonged labors, multiparity
- **Tissue:** retained tissue or invasive placenta can allow blood to flow into the uterus. If a piece of the placenta or membranes is left behind, the uterus may not contract and the woman may bleed or get an infection.
- **Trauma:** laceration, hematoma, uterine inversion, uterine rupture
 - Episiotomies can increase the risk of tearing; they should not be done routinely.

- Female genital cutting also increases the likelihood of tearing.
- **Thrombin:** coagulopathy
 - Women with severe pre-eclampsia or eclampsia may have disseminated intravascular coagulopathy.
 - Some women may have history of clotting disorders.
 - Women who have PPH could develop a coagulopathy.

Knowledge check

Who is at risk for bleeding?

All women

What are the four causes of bleeding after birth?

Poor uterine tone, retained tissue, tears, thrombin

If a woman is bleeding too much, what is the first thing you should check?

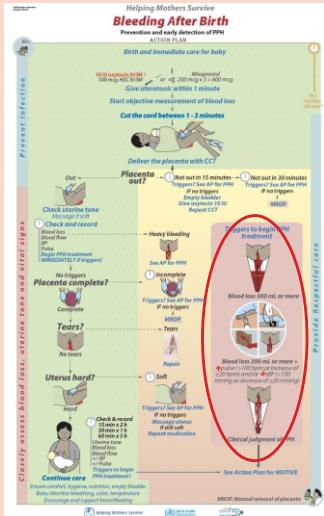
Check to see if the uterus is contracted.

Why is it important to check the placenta and membranes?

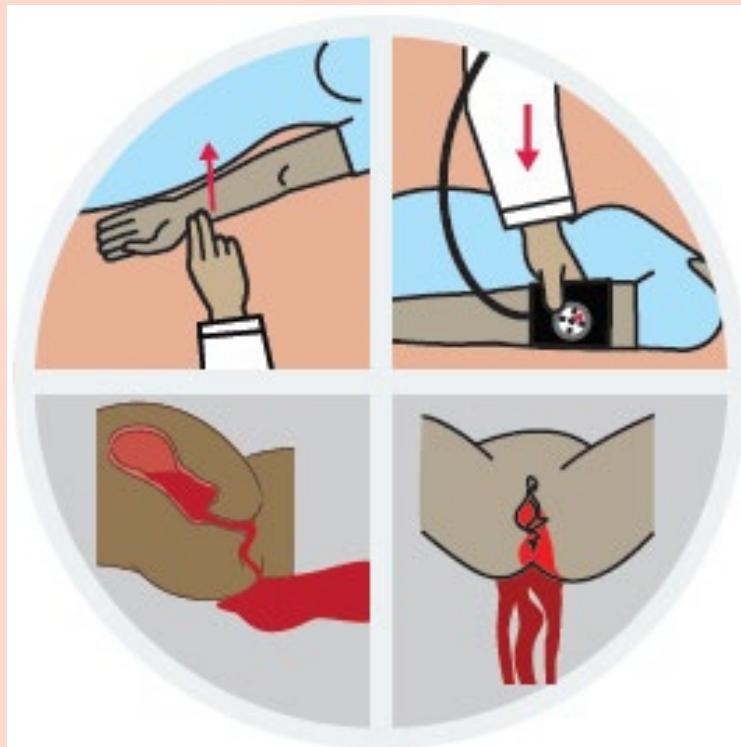
To be sure there are no pieces left inside the uterus which can prevent the uterus from contracting and may cause heavy bleeding

MODULE 17

3 Triggers to begin the WHO 1st response bundle for PPH (MOTIVE)



PB



L

PB



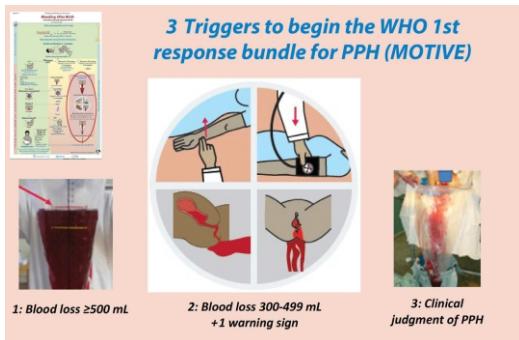
L

PC

PPH

e.g Increasing pulse rate
Decreasing systolic BP

Explain



From this point on we will refer to Triggers. Make sure you know them!

Facilitation note: As you describe the triggers, be sure to point to the Action Plan.

To save lives, the most important action is to detect PPH early and then **ACT QUICKLY TO BEGIN PPH TREATMENT** as soon as PPH is diagnosed!

Remember:

- A woman with anemia could drop her blood pressure or become tachycardic with very little blood loss.
- You should always use a calibrated drape or other calibrated device for objective measurement of blood loss that avoids spillage, ensures the woman's comfort, and that the provider can see in real-time the amount of blood loss.

There are three ways that will alert you to diagnose PPH and “trigger” the treatment bundle for PPH:

1. The first way to diagnose PPH and “trigger” the treatment bundle for PPH is if **500 mL or more of blood has been lost.**

This is the definition of PPH following vaginal birth. Regardless of a woman's vital signs or the rate of blood flow, if the blood loss reaches 500 mL, begin treatment for PPH!

2. A second way to diagnose PPH and “trigger” the treatment bundle for PPH is if **300 mL of blood has been lost AND you note one or more of the following:**

- Atonic uterus
- Heavy blood flow OR large blood clots expelled OR constant trickle of blood
- Severe anemia
- Changes in vital signs
 - Increasing pulse rate (>100 bpm or an increase of >20 bpm)
 - Decreasing systolic BP (<100 mmHg or a decrease of >20 mmHg)

3. The final way to diagnose a PPH is with **clinical judgment**. If you suspect PPH for any reason, “trigger” the treatment bundle for PPH. Clinical judgment is very important!

Some signs that might alert you to PPH could be:

- Atonic uterus
 - Heavy blood flow OR large blood clots expelled OR constant trickle of blood"
- Changes in vital signs:
 - Increasing pulse rate (>100 bpm or an increase of >20 bpm)
 - Decreasing systolic BP (<100 mmHg or a decrease of >20 mmHg)
 - Concern that the woman is at high risk for PPH (previous PPH, anemia, twins, prolonged labor, pre-eclampsia, breech, infection, retained placenta and others) may make you trigger the treatment bundle sooner.

NOTE: Begin treatment for PPH as soon as your clinical judgment makes you suspect PPH rather than waiting and risking that the woman loses more blood and goes into shock.

Discuss

Ask, "**Are there any challenges you might face when deciding when to “trigger” treatment for PPH?**"

Ask, "**How will you manage triggers if you do not have an objective measurement tool such as a calibrated drape for quantitative blood loss?**"

MODULE 18

DETECT AND TREAT PPH EARLY

E



M



O



T



IV



E



Early detection

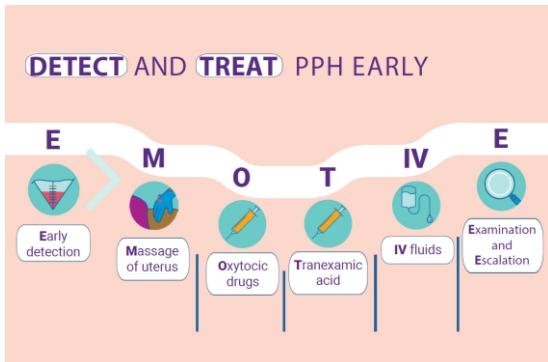
Massage of uterus

Oxytocic drugs

Tranexamic acid

IV fluids

Examination and Escalation



Facilitation note: Point to each letter of the circle on the front of this page as you say what it stands for. Do not discuss each item. You will do this later.

Explain

Say, **"So far we have discussed prevention and early detection of PPH and care for a woman when bleeding is normal. Now let us talk about how to treat PPH."**

Many deaths from PPH can be prevented with prompt recognition and proper treatment. The mnemonic "E-MOTIVE" will help providers remember Early detection and the five interventions in the WHO 1st response treatment bundle for PPH. You likely already do most or all of these things.

The difference in the 1st response bundle for PPH is that providers should aim to perform ALL the interventions within 15 minutes as your first response **for every woman with PPH**, regardless of any improvement after any of the interventions.

Point and say, **"We will describe each component in detail later. The first "E" is for early detection, then comes the treatment bundle which includes":**

Early detection - this depends on accurate and early identification of women with PPH.

- Place the calibrated drape or other measurement tool right after the birth of the baby. Ensure the uterotonic medication is given within one minute.
- Closely monitor uterine tone, blood loss, blood flow, BP, and pulse to quickly identify and begin the treatment bundle for PPH.

Massage the uterus until uterus has contracted or for one minute to address atony.

Oxytocic drugs (uterotonic drugs) to stimulate contractions.

Tranexamic acid (TXA) which is an antifibrinolytic drug that has been shown to reduce death from PPH.

IV fluids in addition to the oxytocin infusion and IV TXA should be given if clinically indicated for resuscitation.

Examine to find the cause of bleeding.

Check:

- the bladder to see if it is distended
- the perineum and vagina for tears
- for clots to evacuate (the height of the fundus and clots in the vagina)
- the placenta and membranes for completeness

Escalate! if needed. Escalate if:

- Bleeding does not stop after first response
OR
- You are unable to identify the cause of bleeding
OR
- You are unable to manage the cause of bleeding

The concept of a bundle was developed to help providers more reliably deliver the best possible care to save lives.

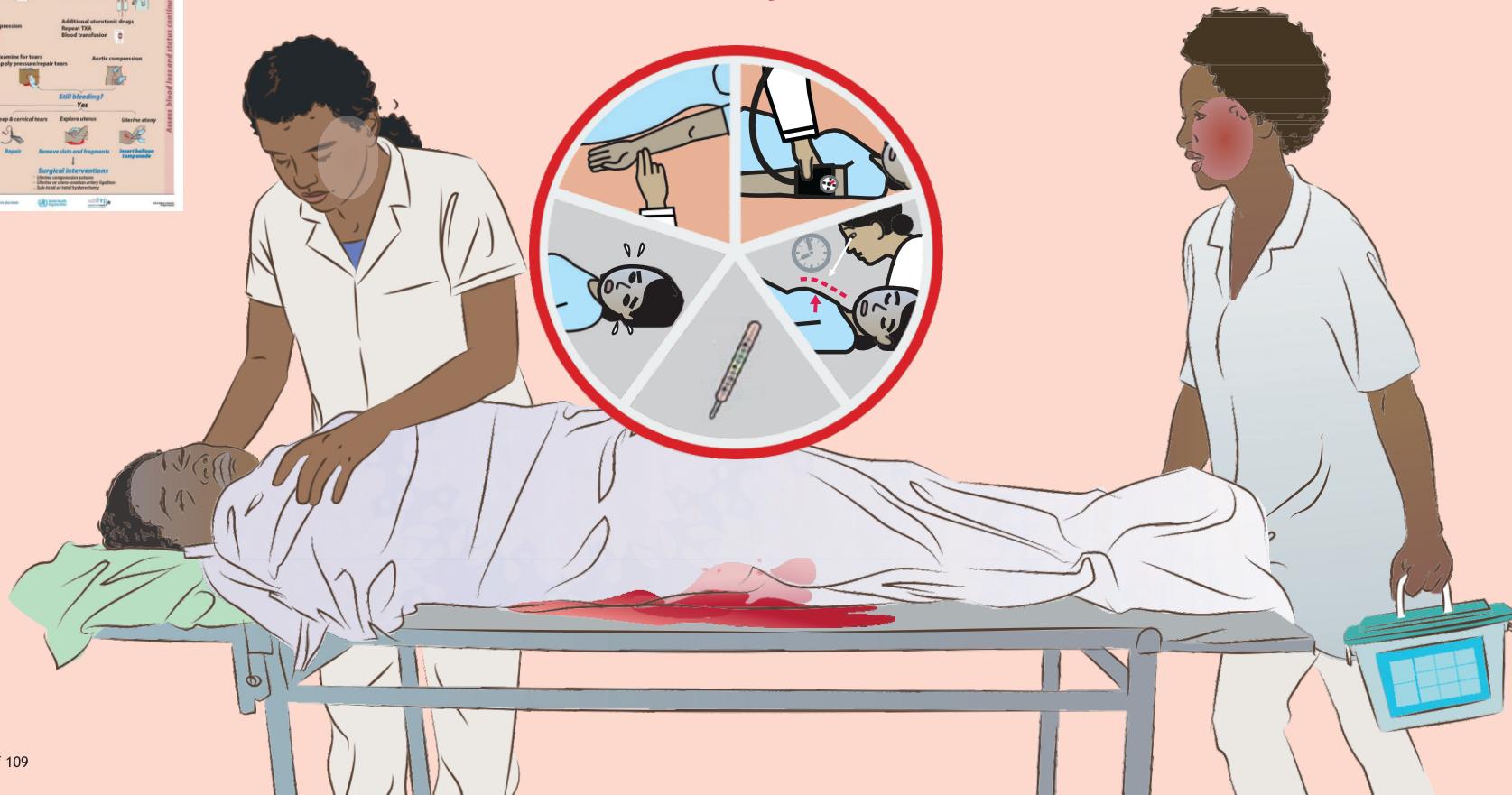
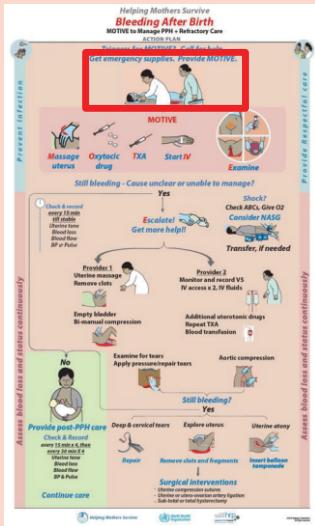
All components of a bundle are given in the shortest possible time, without waiting for a response to individual interventions.

The mnemonic "MOTIVE" helps providers remember the five interventions but should not be considered the recommended order in which the interventions must be given.

MODULE 19

If any trigger is observed, treat PPH !

*Call for help
Call for the emergency trolley
or Carry case*



Explain



E- early detection is the first step and it begins with you. Begin the treatment bundle for PPH once a trigger has been identified:

- 500mL or more of blood loss
- 300mL or more of blood loss + one additional concerning sign
- Your clinical judgment that she is having PPH

A provider may need to begin the treatment bundle for PPH :

- Immediately after birth
- Any time in the postpartum period
- For a woman who was brought to you after giving birth at home or in another facility.

Regardless of how she came to you, **shout for help, call for the emergency trolley, do a rapid assessment and prepare to begin the treatment bundle for PPH.**

Any time a woman has been diagnosed with PPH, check BP and pulse and watch closely for signs of shock:

- **Fast or weak pulse of 100 beats per minute or more**
OR
- **Low blood pressure with systolic BP less than 100 mmHg**

Also check the woman's general condition, level of consciousness, presence of anxiety and/or confusion, blood loss and flow, color, and temperature of skin.

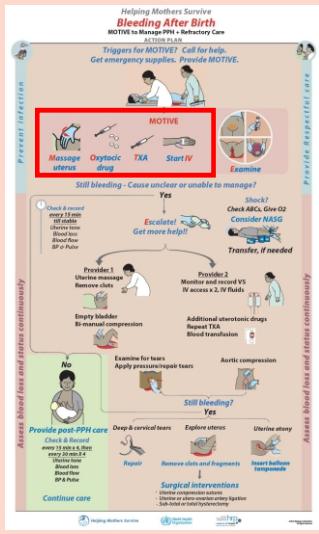
A woman with shock may also have:

- Rapid breathing - over 30 breaths per minute or more
- Pale skin, especially around the inner eyelids, mouth, or palms
- Sweating, or cold and clammy skin
- Changes in mental state: anxiety, confusion, or unconsciousness
- Scanty urine output - less than 30 ml per hour

Continuously assess for shock and communicate with the woman - check and record on the blood loss monitoring chart: uterine tone, BP, pulse, and blood loss and blood flow at least every 15 minutes until she is stable.

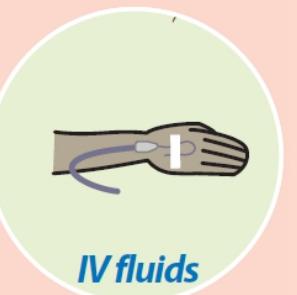
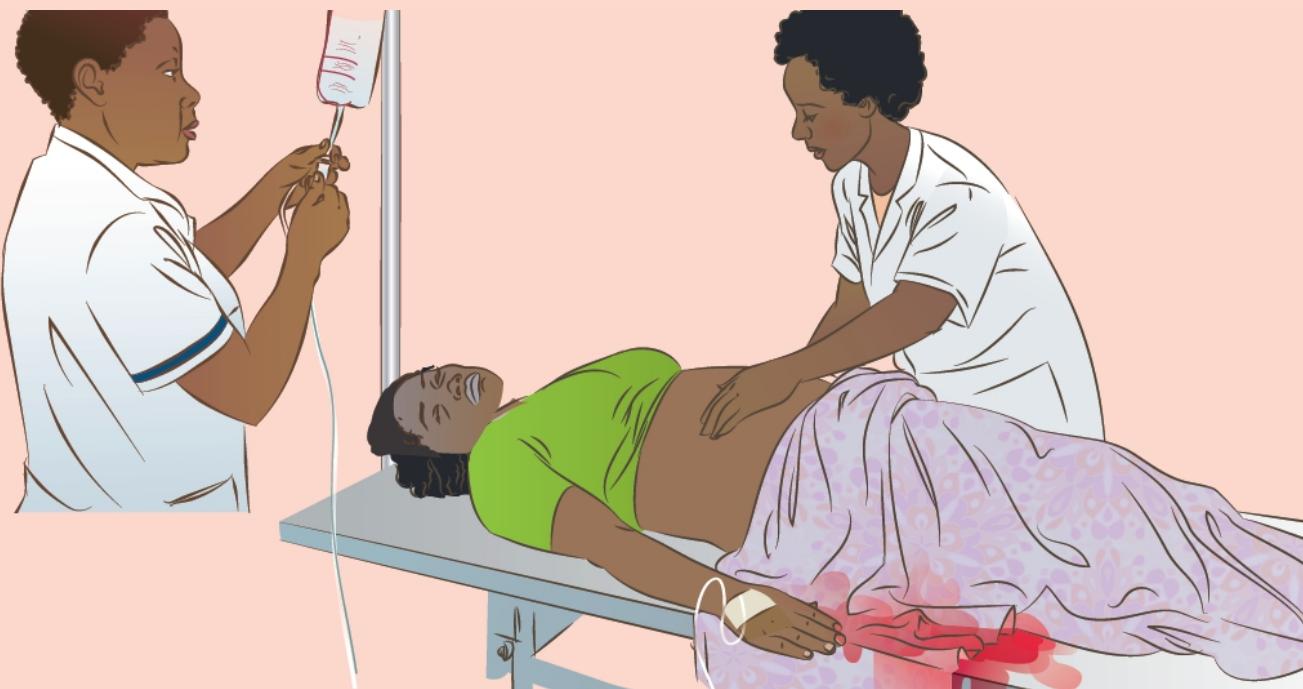
IV fluids in addition to the oxytocin infusion and IV TXA should be given if clinically indicated for resuscitation / shock and will require a second IV access.

Say, "**Let's take a "quick pulse". Can everyone look at the second hand on your watch or clock? Count your heart beat at your neck or wrist for 10 seconds. Take this number and multiply by 10 for the quick pulse rate.**"



MODULE 20

Start 1st response bundle for PPH



Explain



Facilitation note: As you explain each component, point to the Action Plan.

Now we will review and practice the interventions of the WHO 1st response or MOTIVE bundle for PPH. Remember, once PPH is diagnosed give all interventions in the bundle as quickly as possible until they have all been done. Aim to complete the bundle in **15 minutes or less**.

Unlike when we use a sequential approach, we will do all of the interventions, even if the woman starts improving after you have performed one or two of the interventions. This is very important. PPH and shock are life-threatening emergencies. **Act fast!** Teamwork is essential to manage emergencies and save lives.

Team members can perform several tasks at once as directed by the team leader. If you are alone, you will need to perform all the actions as quickly as possible. on your own.

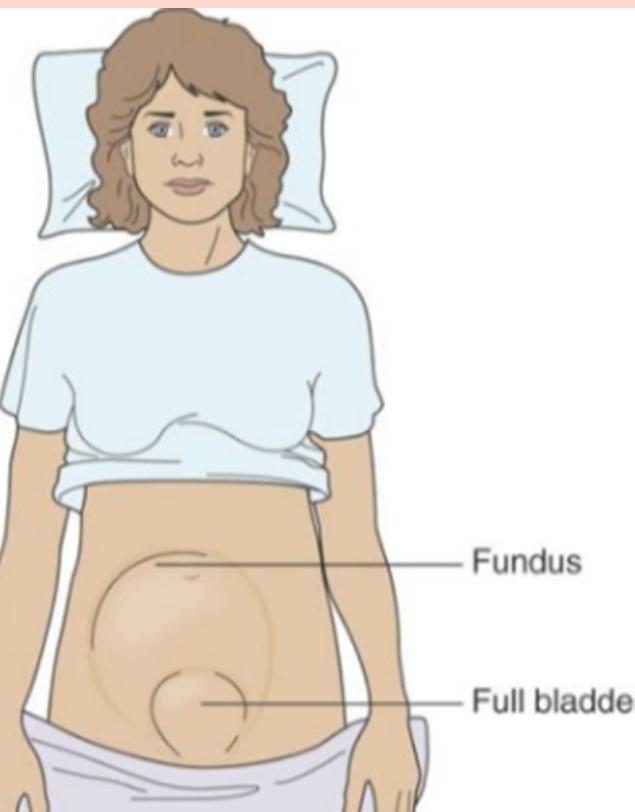
Start the 1st response treatment bundle for PPH regardless of the cause of PPH:

- Check ABCs. Ensure the airway is open and woman is breathing. If not breathing or in cardiac arrest, **start resuscitation**. If breathing, start oxygen at 6-8L/minute.
- Check the woman's vital signs at least every 15 minutes.
- **Massage the uterus to help it contract and to expel blood and clots. While doing massage, check if the bladder looks or feels distended.**
When you are providing care alone, if you have given massage for 1 minute, quickly move to giving a uterotonic.
Infuse 10 IU Oxytocin in 500 mL over 10 minutes, or as fast as possible.
If you cannot start an IV right away, give oxytocin 10 IU by IM injection or 800 mcg of misoprostol oral, sublingually or rectally or other appropriate uterotonic as available.
- **Give 1g TXA in 10 mL (or 1g diluted in 200mL crystalloid) by IV over 10 minutes. Faster administration can cause hypotension. TXA can be given in the same line where oxytocin is being infused but should not be mixed in the same IV bag**
• Give a second dose of TXA 1g IV over 10 minutes if: bleeding continues 30 minutes after the first dose OR bleeding restarts within 24 hours of completing the first dose
- If an **IV** is not in place, start at least one IV using an 18-gauge cannula or the largest available.
- Before infusing fluids, collect blood for hemoglobin and cross-match if you can readily do this. Getting the blood samples should not prevent or delay giving the MOTIVE interventions.
- Consider a second IV line for additional IV crystalloid fluids (NS or RL) depending on clinical condition and local protocols.
- **When the first 500mL with 10 IU oxytocin has infused, add 20 IU oxytocin to 1L of crystalloid fluids (NS or LR) and infuse over 4 hours (+/- misoprostol 800mcg PO/PR/SL if used).**

Do not begin TXA if the birth was more than 3 hours ago.

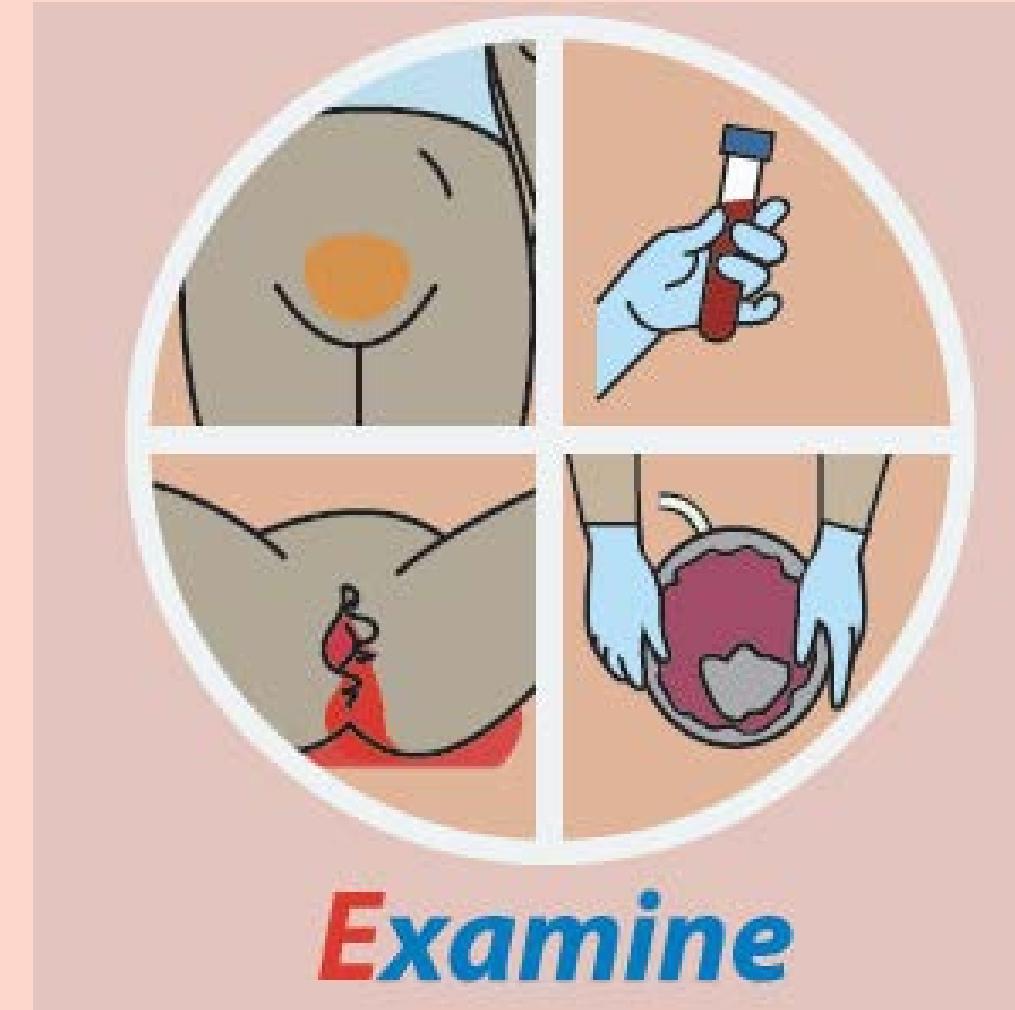
- **Do NOT give TXA to women with a contraindication to antifibrinolytic drugs.** This includes a known thromboembolic event during any pregnancy, labor, or birth, renal failure, history of convulsions or hypersensitivity to TXA.
- Adverse events are rare, but could include nausea, diarrhea, or deep vein thrombosis (DVT).

Document the type of IV fluids and rate, oxytocic drug(s) and dose, and TXA dose.

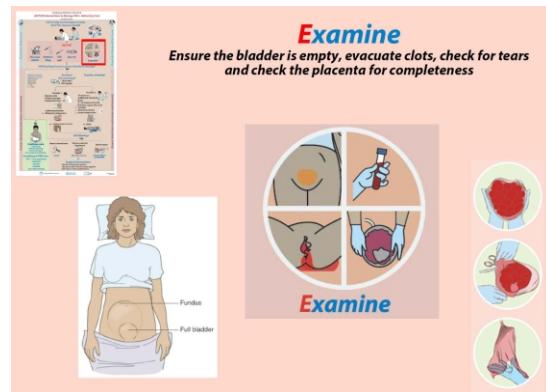


Examine

Ensure the bladder is empty, evacuate clots, check for tears and check the placenta for completeness



Explain



The last "E" in MOTIVE is for examination. Once you have delivered the bundle, do a thorough examination to be sure you identify and address all causes of bleeding.

- **Check uterine fundal height and evacuate any clots.**
- **Feel the bladder to assess if it is distended:**
 - If the woman's bladder is distended and she cannot void on a bedpan OR if she is bleeding heavily OR this is part of your practice for treating PPH, catheterize the bladder. Follow local protocols.
 - Monitor urinary output and ensure the bladder remains empty.

- **Check for genital and cervical tears:**

- Check for and remove any clots in the vagina.
- If a tear is identified as the source of bleeding, it must be repaired.
- If there is a cervical laceration and you cannot repair it, refer.
- If you do not identify any lacerations, continue with other examinations.

- **Recheck the placenta for completeness:**

- Careful inspection of the placenta will alert you to membranes, placental lobes or placental fragments that may remain in the uterus.

Once you have implemented all of the steps of the 1st response treatment bundle for PPH and have done a complete examination to ensure all causes of PPH have been identified, take any further steps to manage the cause as needed. Document in the client record what you have done and record blood loss and vital signs on the blood loss monitoring form.

Advanced Care Note

- If you are trained and it is within your scope of practice, provide additional care per local protocols.
- If continued treatment is beyond your scope of practice, seek advanced care immediately!

Knowledge check

What is the dose and route for administering TXA for treatment of PPH?

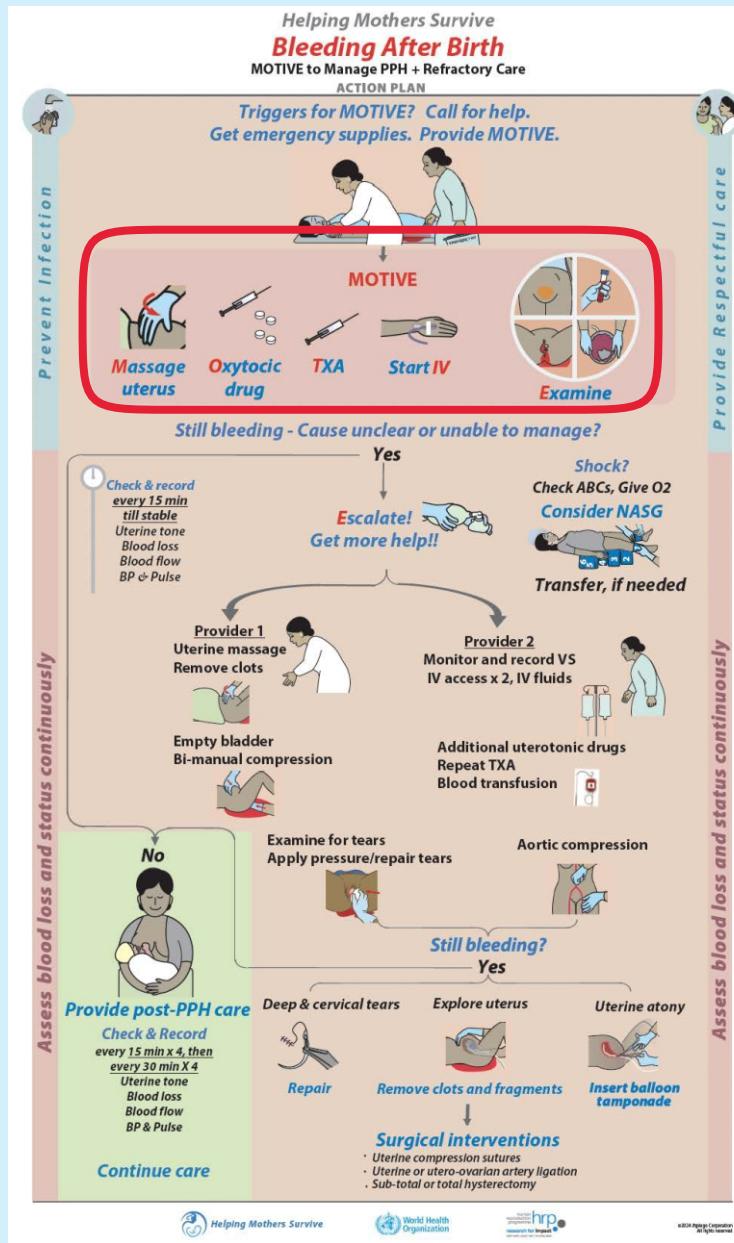
1g TXA in 10 mL (or 1g diluted in 200mL crystalloid) by IV over 10 minutes.

When should you administer a second dose of TXA?

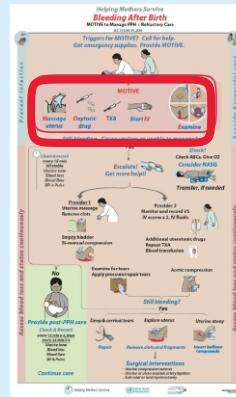
*Give a second dose of TXA 1g IV over 10 minutes if
1) Bleeding continues 30 minutes after the first dose OR 2) Bleeding restarts within 24 hours of completing the first dose.*

Demonstration

E-MOTIVE



Demonstration
E-MOTIVE



Demonstrate

Prep:

- Have **1st volunteer** wear the simulator with the blood collection drape/tool in place. Explain to them how to open and close the blood tank and make the uterus relax and contract.
- Tell the volunteer you will signal when to open the blood tank to moderate flow and keep the uterus soft.
- Have 500mL of blood in the drape
- Have a **2nd volunteer** act as the assistant.
- You need this Flipchart page to be visible to read your parts.
- Observers should be ready to provide feedback after the simulation.

Say, "**Now let us take the case of Ms. R. and give the 1st response bundle. May I have a volunteer?**" Take a moment to prepare.

Speak to the volunteer wearing the simulator and the participants to say, "**Let me remind everyone of the case. You are Ms. R and I assisted the birth of your baby with no problems about 30 minutes**

Page 55 of 109

ago. I gave you 10 IU of oxytocin IM within 1 minute of birth and your placenta delivered quickly without problems. However, 30 minutes later, I see you are bleeding heavily (500 mL in the drape). There is no IV in place. I took your vital signs just now and they are: Pulse-88 bpm, Blood pressure-118/68 mmHg, Respirations-22 breaths/minute. I called for Sister to get the emergency trolley and I gave the report using SBAR to my fellow midwife."

- Quietly signal to the **1st volunteer** to open the blood tank to medium.

Begin massaging the uterus and say to the woman, "**You are bleeding too much and I need to give you some medications and start an IV to help you stop bleeding.**"

Say to your **assistant**, "**We need begin the 1st response bundle. Sister, please put 10 IU oxytocin into 500 mL of crystalloid fluids and start the IV infusion. If possible, please collect blood for hemoglobin and crossmatch. Please infuse the oxytocin IV drip as rapidly as possible. I will prepare the TXA.**" Your **assistant** should pretend to inject 10 IU mock oxytocin into 500 mL of IV fluid while you prepare mock TXA (1g TXA in 10 mL). Demonstrate slow IV administration at 1 mL/minute. While you are still injecting, whisper to the volunteer to turn off the bleeding and say aloud, "**Sister, while I give the TXA over 10 minutes, please examine Ms. R.**"

Your assisstant will now:

- Massage the uterus again while checking the bladder and looking at the bleeding and say, "**Your uterus is firm and your bladder is empty.**"

- Check fundal height and vagina for clots to evacuate. Say, "**Uterine fundus is midline at the umbilicus and there are no clots in the vagina.**"
- Check the placenta and say, "**Your placenta is complete.**"
- Say, "**Sister, is the oxytocin IV infusion running as fast as possible?**" One of you will confirm that it is.
- Tell the woman you will look for any lacerations and demonstrate doing so.

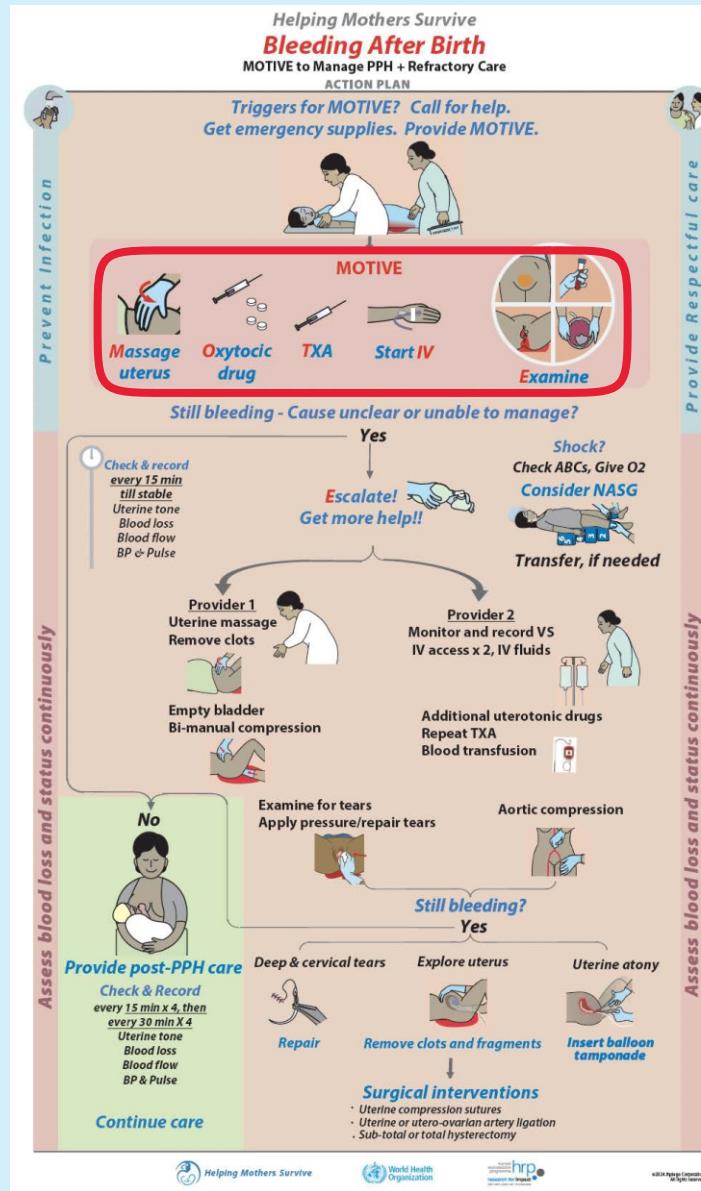
Allow you and your assistant to finish the tasks and then say, "**The TXA dose is complete. The entire bundle has been given. I can feel that her uterus is contracted and her bleeding has stopped. At this point let us recheck her vital signs and document in the woman's record**" As facilitator, check BP and other vital signs and document all findings.

Debrief

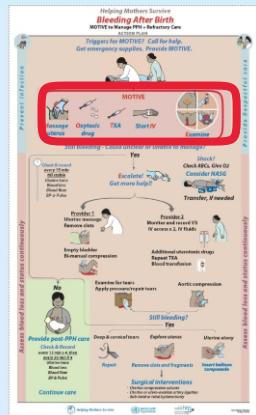
When finished, debrief with observers. Ask, "**Why did I trigger the 1st response bundle?**" Because she was bleeding heavily (lost 500 mL of blood). Say, "**When the bleeding stopped, did I stop giving TXA or giving the rest of the bundle?**" No. Ask an observer to evaluate your performance and that of the team by pointing to each step on the Action Plan. Then invite comments from others:

1. What went well?
2. Is there anything we should do differently next time?
3. How was this different than what you usually do? What was different and why?

EXERCISE: E-MOTIVE



**EXERCISE:
E-MOTIVE**



Break into small groups of 6 or fewer. Ensure providers have the PG open to page 5 for SBAR and remind them to look at the Action Plan for E-MOTIVE steps. Ask for two volunteers in each small group. Others observe.

Practice – Case #1:

Prep:

- Facilitator wears the simulator with blood flow opened to medium at the start.
- Have 350mL in the drape to begin.
- Have 1 volunteer be the provider
- Have a 2nd volunteer be the assistant.
- Give results of assessments only if the learners do the assessment.

Each facilitator says, **"I am Ms. S. You assisted the birth of my second baby with no problems 20 minutes ago. I received 10 IU of oxytocin IM within 1 minute the birth. My placenta delivered without problems. I called you now because I am bleeding heavily and passing large clots. I do not have an IV in place. Please take care of me."**

Providers should:

- Make an assessment
- Trigger E-MOTIVE.
- Call for a helper to bring the emergency trolley.
- Use SBAR to communicate and assign tasks.

Case practice guidance

- If the learner looks at the drape/assesses the soaked cloths, ask, **"How much blood has she lost?"** Note there may be more than 350 mL by this time.
- Vital signs:
 - Pulse: 112 bpm
 - Blood pressure: 98/64 mmHg
 - Respiration: 22 breaths per minute
 - Blood is flowing steadily

Learners should call for help and begin E-MOTIVE. They should:

- Call for the emergency trolley
- Massage the uterus (Case#1 keep it soft until oxytocin is started; Case#2 uterus firm throughout)
- Check bladder when massaging the uterus (bladder is empty)
- Put 10 IU oxytocin into a 500 mL.
- Start an IV
 - Before infusing fluids, collect blood for labs.
 - Begin infusing the IV with oxytocin over 10 minutes (as rapidly as possible). (Both cases, as facilitator, stop the bleeding here).
- Give 1g tranexamic acid in 10 mL IV over 10 minutes. (Case #1 as facilitator, make the uterus firm here)
- Check fundal height and evacuate clots from the vagina and cervix.
- Check for vaginal and perineal tears (Case #1 no tears; Case #2 deep vaginal tear)

- Check placenta for completeness (complete in both cases)

Practice – Case #2:

Prep:

- Facilitator wears the simulator, blood flow on high.
- 500+ mL blood loss in drape
- Have 1 volunteer as the provider, no assistant.
- Use the case practice guidance with the new case parameters, then debrief.

Say, **"Ms. A, a 32 y/o P3 gave birth 45 minutes ago. During monitoring, you note that she appears to be bleeding slowly. Her uterus is firm. BP 112/62, pulse 98 bpm, respirations 24 breaths per minute, temperature 37.5°C. BP was 136/72 and pulse was 72 bpm immediately after birth."**

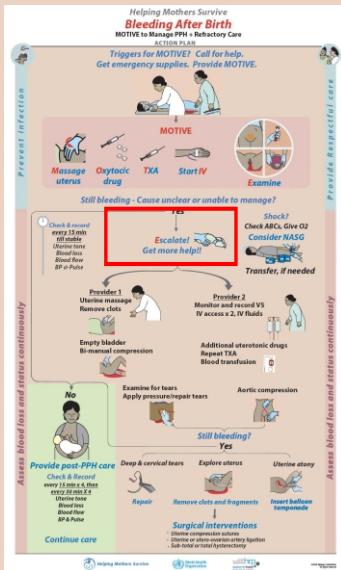
Debrief

When finished, debrief with observers. Ask, **"What was the diagnosis and cause? Why did you trigger E-MOTIVE?"**

(Case #1: >300 mL blood loss with pulse >100 and sBP <100. Case #2: > 500mL blood loss)

>Ask the provider and assistant to evaluate their performance and then invite comments from others:

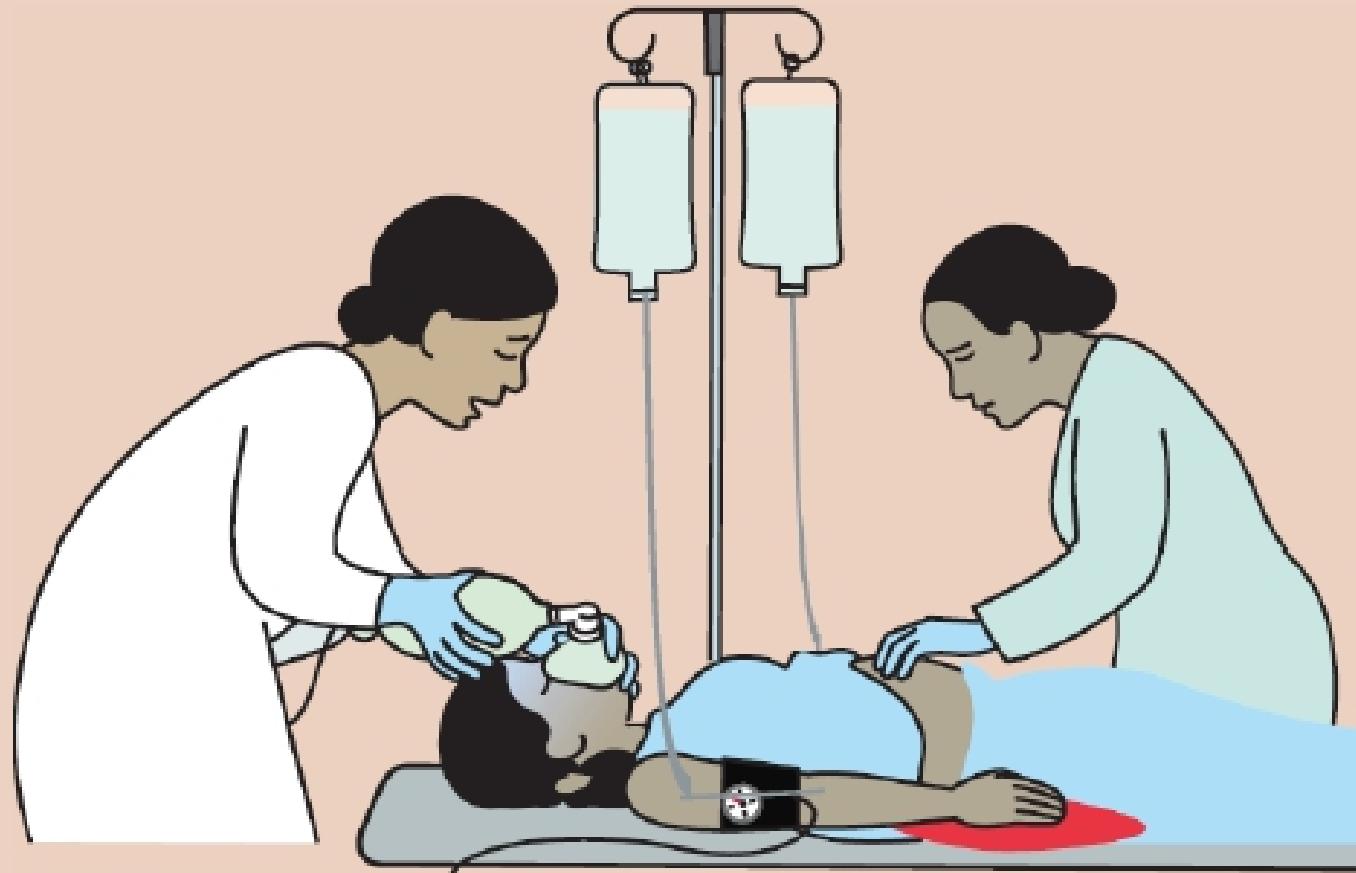
1. What went well?
2. Ask them to point to each step in E-MOTIVE to describe what was done and why.
3. Is there anything you would do differently next time?
4. How this was different than what you usually do? What was different and why? (Case #1 bleeding stopped before TXA was given but we still gave it. Provide constructive feedback if needed.



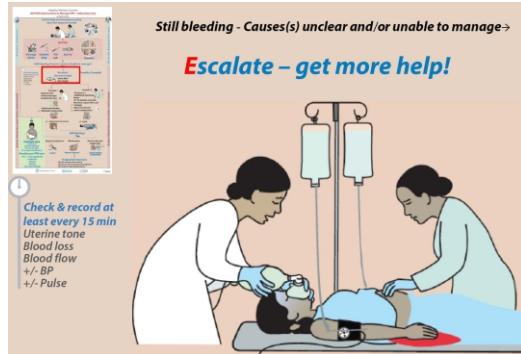
MODULE 22

Still bleeding - Cause unclear or unable to manage

Escalate – get more help!



Explain



The last **E** in MOTIVE also stands for escalate. You need to ESCALATE immediately if:

- You have delivered all elements of the bundle and the woman is still bleeding
- OR
- You have delivered all elements of the bundle, were unable to identify or manage the cause OR the woman is still bleeding

Call for additional help!! Make a decision quickly if you need to transport the woman if what she needs is beyond the scope of what is available at your facility.

Escalate care to the most senior doctor on site, or consultant responsible for labour ward that is on call, with urgent request to attend the woman. But CONTINUE treatment while waiting.

This is a life-threatening emergency. **Act fast!** Teamwork is essential to manage PPH and save lives.

When team members arrive:

- Communicate with team members using the S-B-A-R communication
- Assign a team leader, usually the most senior provider
- The team leader should assign tasks to team members. Team members can perform several tasks at once as directed by the team leader.
- Make sure that someone is assigned to record findings (uterine tone, blood loss and flow, BP, pulse) and interventions.
- Used closed loop communication

Start emergency management:

- Check ABCs. Ensure the airway is open and the woman is breathing.
- If not breathing or in cardiac arrest, start resuscitation.
- If breathing, start oxygen at 6-8L/ minute.

Escalate response immediately and DO NOT WAIT for bundle to be completed if:

1. There is brisk, uncontrollable bleeding
2. Objective blood loss is $> 1000\text{ml}$ in calibrated drape
3. If the patient has become hypotensive or collapsed
4. Extensive genital tract trauma, including 3rd or 4th degree tear with bleeding. Suture lacerations by skilled provider without delay!
5. Uterine inversion
Retained placenta with increased bleeding (MROP by skilled provider without delay!)

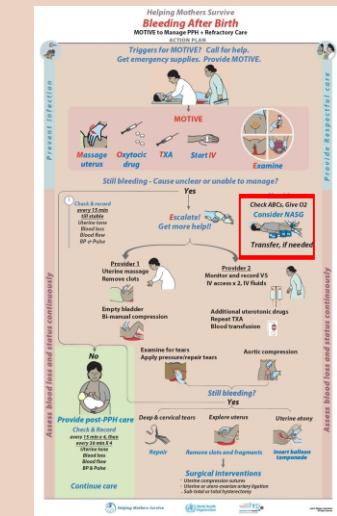
Advanced Care Note

Prepare to transfer immediately If the woman's care is beyond the scope of care offered in your facility. Continue to provide care while awaiting transport.

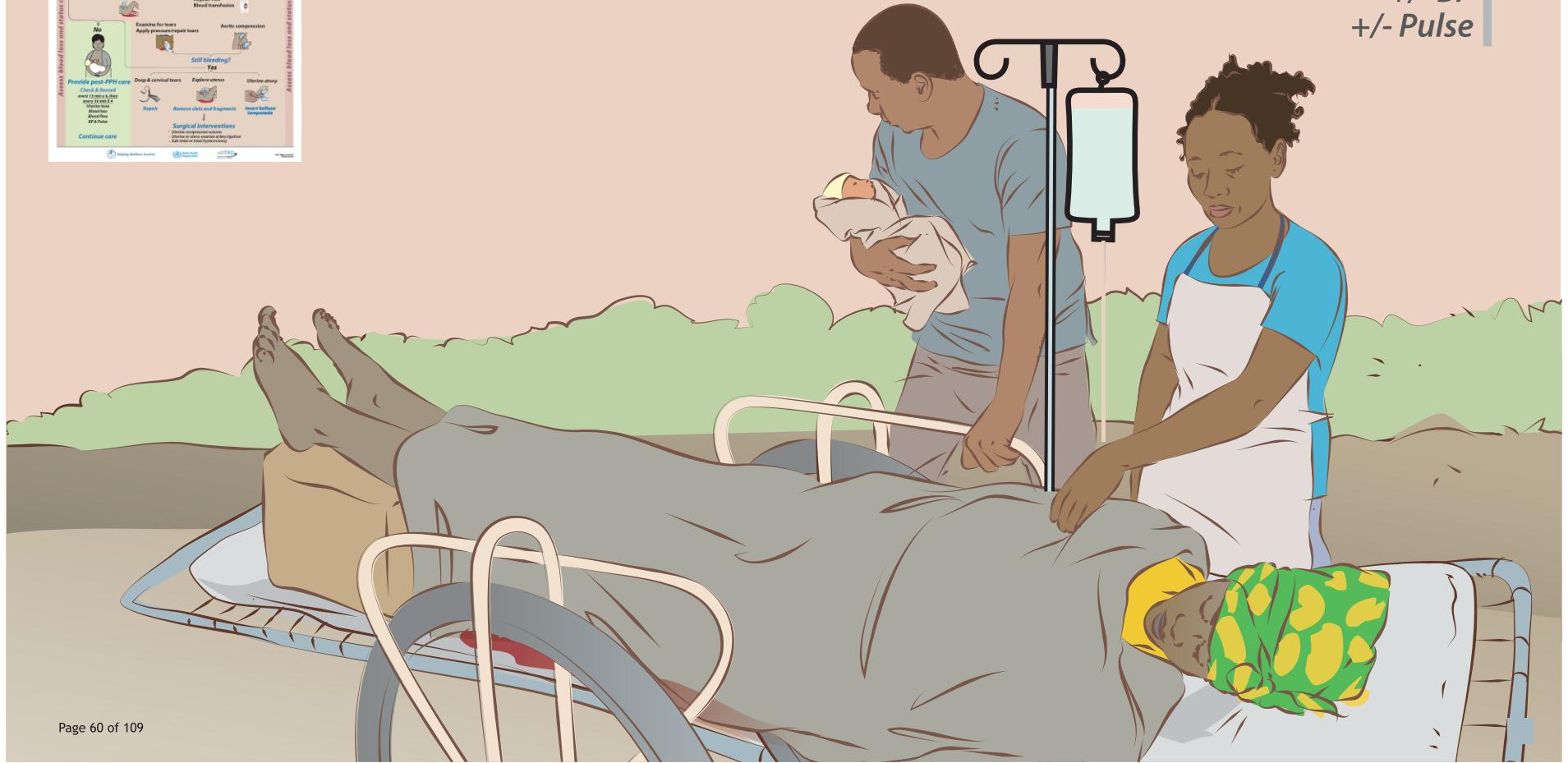
Use Non-pneumatic Anti Shock Garment (NASG). This will be further discussed shortly

MODULE 23

Transfer, if needed



Check & record at least every 15 min
Uterine tone **Blood loss**
Blood flow **+/- BP**
+/- Pulse



Explain



If a woman needs referral to another facility, knowing who can provide this care and how to reach them quickly will save lives.

Contact information for advanced care and providers and who to call for transport when needed should be clearly posted.

It is better to transport the woman while she is stable than to wait until it is an emergency!!

Act fast! If the woman continues to bleed, she may go into shock and die. A delay in getting care is one of the most common reasons women die from PPH.

- Immediately prepare for referral!
 - Transport the woman and her baby together.
 - Notify the referral facility of the transfer.
 - Use S-B-A-R to communicate with the referral provider.
 - Write the referral note.

- NEVER leave the woman alone. Always keep the woman and her baby together and keep them warm.
- Continue the IV infusion:
 - Maintenance dose of 20 IU IV oxytocin diluted in 1000mL NS/RL over 4 hours IV
 - Additional crystalloid fluids by separate IV line if clinically indicated for resuscitation
- Ensure the woman has received the first dose of 1g TXA in 10 mL over 10 minutes **only if within the first three hours of birth. Give a second dose of TXA if bleeding continues 30 minutes after the first dose OR if bleeding restarts within 24 hours.**
- Minimize bleeding until the woman reaches the referral facility:
 - Use an indwelling catheter to keep the bladder empty. If she has bleeding tears that you are not able to repair: Apply firm, steady pressure with a clean or sterile cloth until the bleeding stops or she is receiving advanced care.
 - Continue to massage the uterus until well contracted.
 - Use bimanual or aortic compression, as needed, until the bleeding stops or she is receiving advanced care.
 - If trained and authorized to do so, manually remove the placenta.
- Continue to monitor and record uterine tone, blood flow and loss, BP, and pulse.

Place the NASG before transport. The NASG should stay on during all procedures and surgery until the source of bleeding is found and corrected, no matter how long this takes.

NASG does not treat PPH, but adds time to seek treatment. If being used at this facility, we will cover NASG shortly.

Advanced Care Note

If learners have additional training and authorization to provide more advanced care, they should do so prior or during transport.

Knowledge check

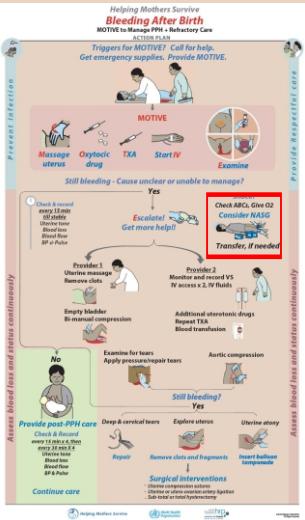
What should be included in a transport plan?
Call ahead if possible. Have a provider go with the woman if possible. Keep the woman and her baby together.

Prior to transportation, what steps should have been tried to stop bleeding?
Repeat medication, massage, and bimanual compression.

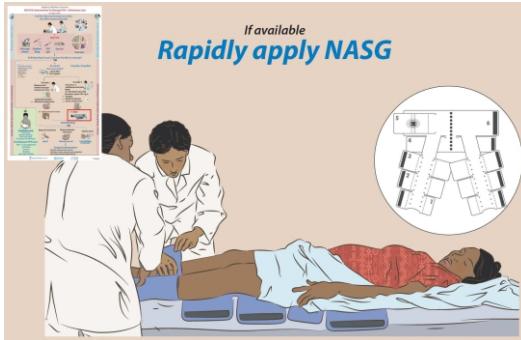
Module 24

If available

Rapidly apply NASG



Explain



Before training day, determine if the non-pneumatic anti-shock garment (NASG) is available at this facility. If it is, check the protocol for timing of use. If NASG is not available, skip this page.

The NASG is a wrap that applies pressure to the lower body and abdomen. It forces blood to the heart, lungs, and brain to stabilize a woman in shock.

After the NASG is on, women can receive treatments, be transported, and survive delays in receiving blood and surgery.

NASG does not treat PPH, but adds time to seek treatment.

The NASG should stay on during all procedures and surgery until the source of bleeding is found and corrected, no matter how long this takes.

Always wear gloves when applying, removing, and cleaning the NASG!

Demonstrate & Practice

Show video  [Using an anti-shock \(9:15min\)](#). If you cannot show videos, invite a learner to demonstrate using the steps below.

To apply:

- As you explain what you are doing and why, place the woman on the laid out NASG - top of NASG is at lowest rib and pressure ball at the level of umbilicus.
 - Close each segment pair beginning at ankles and ending with 6th segment using 1 OR 2 people. Use as much strength as possible, while ensuring the woman can breathe normally.
 - To ensure proper fit, place 1-2 fingers under the top of each closed segment. Pull up on fabric and let go. If no snapping sound, tighten segment.
- Monitor for shortness of breath and decreased urine output. These are signs that the NASG may be too tight. If either occur, loosen 5th & 6th segments.

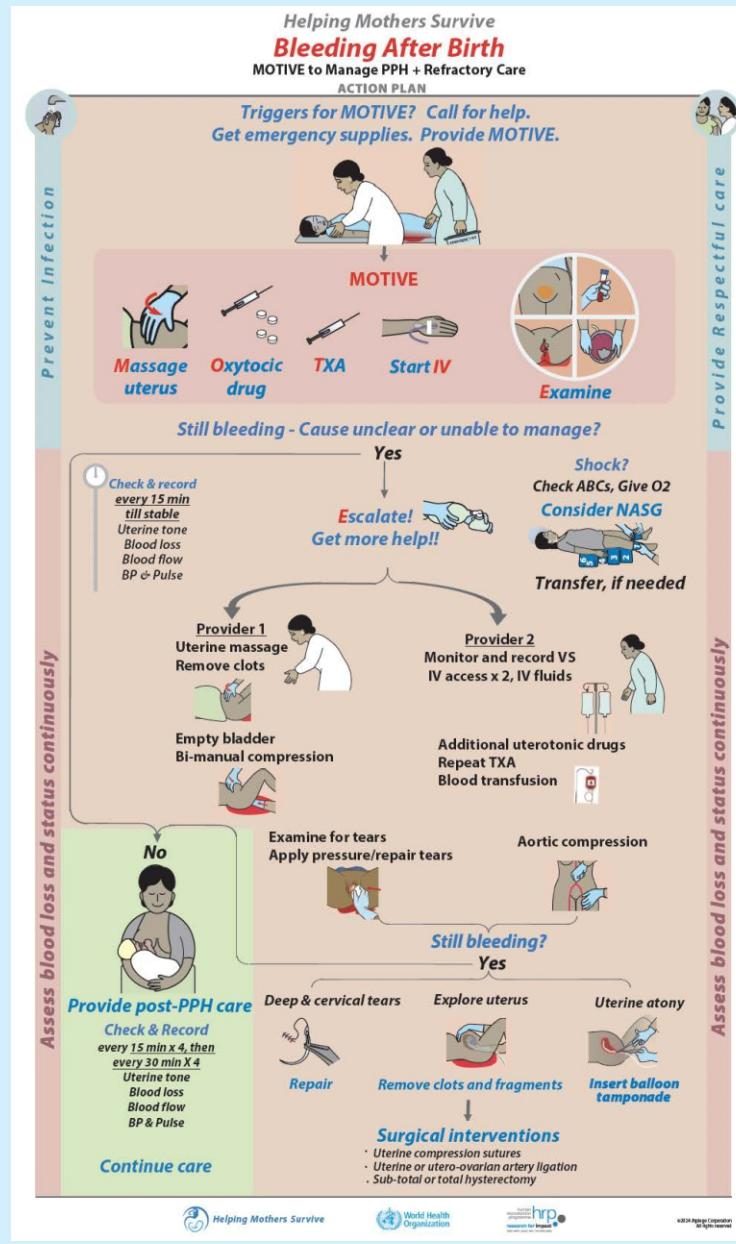
To remove:

Confirm pulse and BP immediately before beginning removal of NASG. Remove NASG if all the following are true **for at least 2 hours:**

- Pulse is 100 bpm or less.
- Systolic BP (sBP) is 100 mmHg or greater.
- Bleeding reduced to normal postpartum rate.
- Keep IV fluids running.
- Begin at ankle segments. Open both segments, wait 15 minutes, retake BP and pulse.
- If pulse does not increase more than 20 beats per minute and sBP does not decrease more than 20 mmHg, continue opening each segment pair, waiting 15 minutes and checking vital signs before opening next segment.
- If at any time BP or pulse change more than outlined above, rapidly re close the NASG starting with the last segment that was opened and continue from top to bottom. Look for the source of bleeding.

LEARNING ACTIVITIES

NASG



LEARNING ACTIVITIES

NASG

Facilitation note

After demonstration, if NASG will be used at this facility, have all learners practice application and removal using the checklist on this page. When done discuss with learners:

1. How to incorporate NASG into PPH management protocols.
2. Identify facility focal person responsible for training staff on cleaning and storage, NASG transport and maintenance to/from referral/referring facilities, and orienting new providers to NASG protocol.

Checklist

To apply:

- Explain what you are doing and why
- Place woman on open, laid out NASG
- Close each segment pair beginning at ankles and ending with 6th segment
- Check proper fit (with snapping sound) for each segment
- Monitor for shortness of breath and decreased urine output.

To remove:

- Remove NASG if for at least 2 hrs: pulse is 100 bpm or less, sBP is 100 or greater, bleeding at expected rate.
- Open ankle segments
- Wait 15 mins, retake BP and pulse.
- If pulse does not increase more than 20 beats per minute and sBP does not decrease more than 20 mmHg, continue opening each segment pair, waiting 15 minutes and checking vitals before opening next segment.

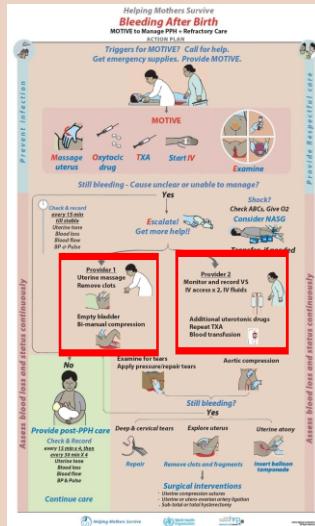
Usage tips for NASG

- All segments should be applied using as much strength as possible. But don't apply abdominal segments so tightly that woman cannot breathe.
- Two people can more rapidly apply the NASG, but only one person should apply segments 4, 5, & 6 to avoid making it too tight.
- During application, try to leave the knees exposed so they can bend.
- If a woman is short and the NASG extends beyond her feet, fold segment "1" into segment "2" and proceed as above beginning with segment "2"
- If woman is not conscious, roll her on her side and place a folded NASG so the top is level with her lowest rib and the dotted line is along her spine. Roll her over on her back and then to the other side so you can pull the garment flat. Roll her onto her back and proceed to apply the NASG.
- Because the NASG stretches, you can reach under the segment to check uterine tone and provide massage.
- The NASG can be left in place while any vaginal procedure is done. If a woman is short, segment 4 can be removed until procedure is complete.
- NASG can be left in place during surgery but segments 4, 5, & 6 should be removed just before skin incision. These segments should be replaced immediately after surgery.
- For toileting, a woman can use a bedpan after segment 4 is slid up along her back and out of the way. When she is finished, slide segment 4 back in place.

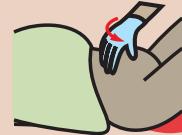
MODULE 25

Get more help!!

Assign roles for immediate care



Uterine massage
Remove clots



Empty bladder
Bimanual compression

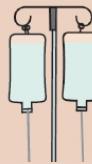


Check & record at least every 15 min

Uterine tone
Blood loss
Blood flow
BP
Pulse



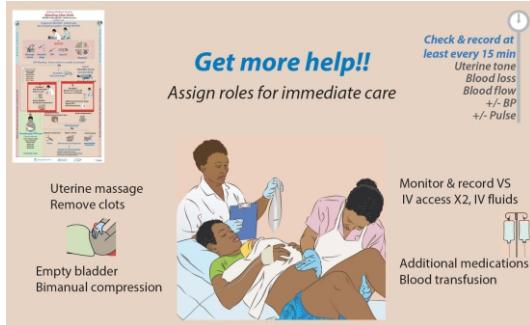
Monitor & record VS
IV access X2, IV fluids



Additional medications
Blood transfusion



Explain



Facilitator: Explain the importance of **clear roles and communication** as the situation becomes more urgent and complicated. Remember to demonstrate and use closed loop communication.

Care must NOT be delayed while help is coming. As help arrives, assign roles. Ideally you have at least 2 providers; one providing medications, placing IVs, collecting vital signs, while the other provider stays vigilant at the perineum, providing hands on treatment. The most senior provider will lead the team and clinical decision making.

Continue to monitor and record uterine tone, blood flow and loss, BP, and pulse.

Provider 1:

This is the provider who most likely assisted the birth so is already there. She will be responsible for assessing bleeding, uterine tone and report any response to medication. In addition she will:

- **Massage the uterus:** Anytime the uterus feels soft, and after assessing and removing any clots, the uterus should be massaged. Communicate with the woman what you are doing, and why. Let her know that it will hurt so she is ready.
- **Remove clots:** Clots, placental fragments, or amniotic sac that remains in the uterus be removed manually. If present will prevent uterus from contracting.
- **Empty the bladder:** A full bladder prevents the uterus from contracting. Catheterizing the bladder will help the uterus contract.
- **Bimanual Compression:** With bimanual compression you squeeze the uterus, which compresses the vessels in the uterus, decreasing blood flow. This may express clots. We will review compression techniques later.

Provider 2: The first person to arrive to help will manage the medications

• Monitor and record VS

• Place a second IV line:

This provides access for crystalloid fluids and additional medications from the 1st IV line.

• Provide additional uterotonic drugs

- Maintenance dose of oxytocin 20 IU in 1000cc saline over 4 hours.
- Misoprostol 800 mcg PO, PR or SL
- If >30 minutes since first does of TXA, repeat TXA 1 gm IV.
- **Do NOT give** another dose of HSC.

• **Blood transfusion.** If a woman is severely anemic (hemoglobin below 7 g/dl or hematocrit below 20%), arrange a transfusion as soon as the need is identified, and resources are available.

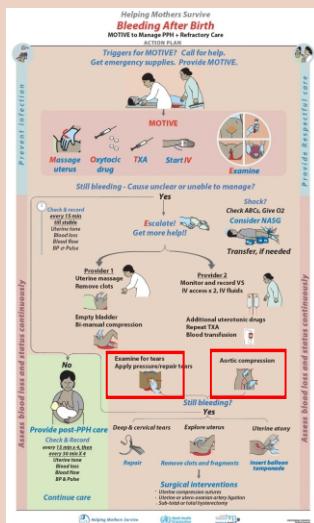
Knowledge check

What medications can you repeat?

TXA (if 30 min from first dose Oxytocin and misoprostol)

Prior to transportation, what steps should have been tried to stop bleeding?

Repeat medication, massage, bimanual compression, and apply NASG if available.



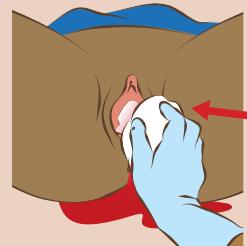
MODULE 26

Assign roles for additional care, as needed

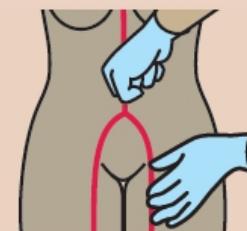
Check & record at least every 15 min

Uterine tone
Blood loss
Blood flow
BP
Pulse

Examine for tears
Apply pressure/repair tears



Aortic compression



Explain



Coordinating care and good communication are vital, especially during an emergency. Every team member needs to remember to communicate what they are doing and any effect it may have on care others are providing. Closed loop communication confirms everyone understands.

Additionally communicate with the woman. Tell her what you are doing and why.

Escalated care continues....

Act fast! If the woman continues to bleed, she may go into shock and die. A delay in getting the right care is one of the most common reasons women die from PPH.

Provider 1:

- **Examine for tears:** While assessing for bleeding, examine the perineum and vagina for bleeding tears.
- **Apply pressure/repair tears:** If tears were identified and you cannot repair them immediately, apply pressure to all bleeding areas. Otherwise, repair.

Ongoing: Assess uterine tone and monitor blood loss

Provider 2:

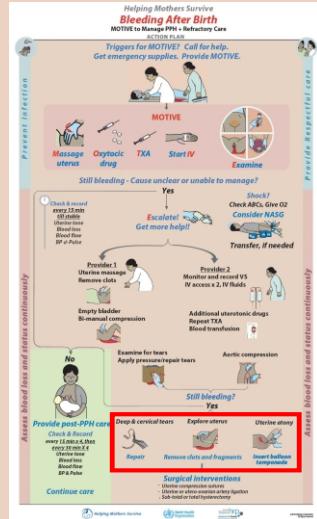
- **Consider Aortic compression** When bleeding continues, you can limit blood flow to the uterus by compressing the aorta. This can also support blood flow to the brain by diverting it from the lower parts of the body. We will review compression techniques later.

Remember! Continue to **monitor and record** uterine tone, blood flow and loss, BP, and pulse **every 15 min while unstable.**

Knowledge check

What should be included in a transport plan?
Call ahead if possible. Have a provider go with the woman if possible. Keep the woman and her baby together.

Prior to transportation, what steps should have been tried to stop bleeding?
Repeat medication, massage, and bimanual compression NASG if available.



MODULE 27

Still bleeding

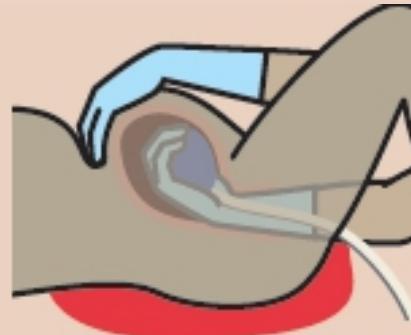
Check & record at least every 15 min
 Uterine tone
 Blood loss
 Blood flow
 BP
 Pulse

Deep tears & cervical lacerations



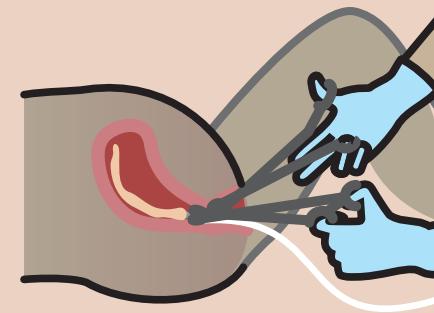
Repair

Remove placental fragments & clots



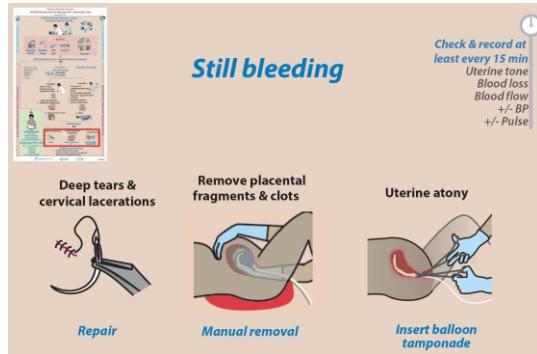
Manual removal

Uterine atony



Insert balloon tamponade

Explain



By now you have completed the bundle, called for help, assigned tasks, given extra doses of medications, repaired lacerations within the scope of the team, massaged the uterus, done bimanual compression and manual removal of the placenta if required.

NASG should be placed on the woman.

If the woman continues to bleed, we need to continue to search for causes and explore other options to arrest the bleeding.

Assess the abdomen for other causes such as uterine rupture

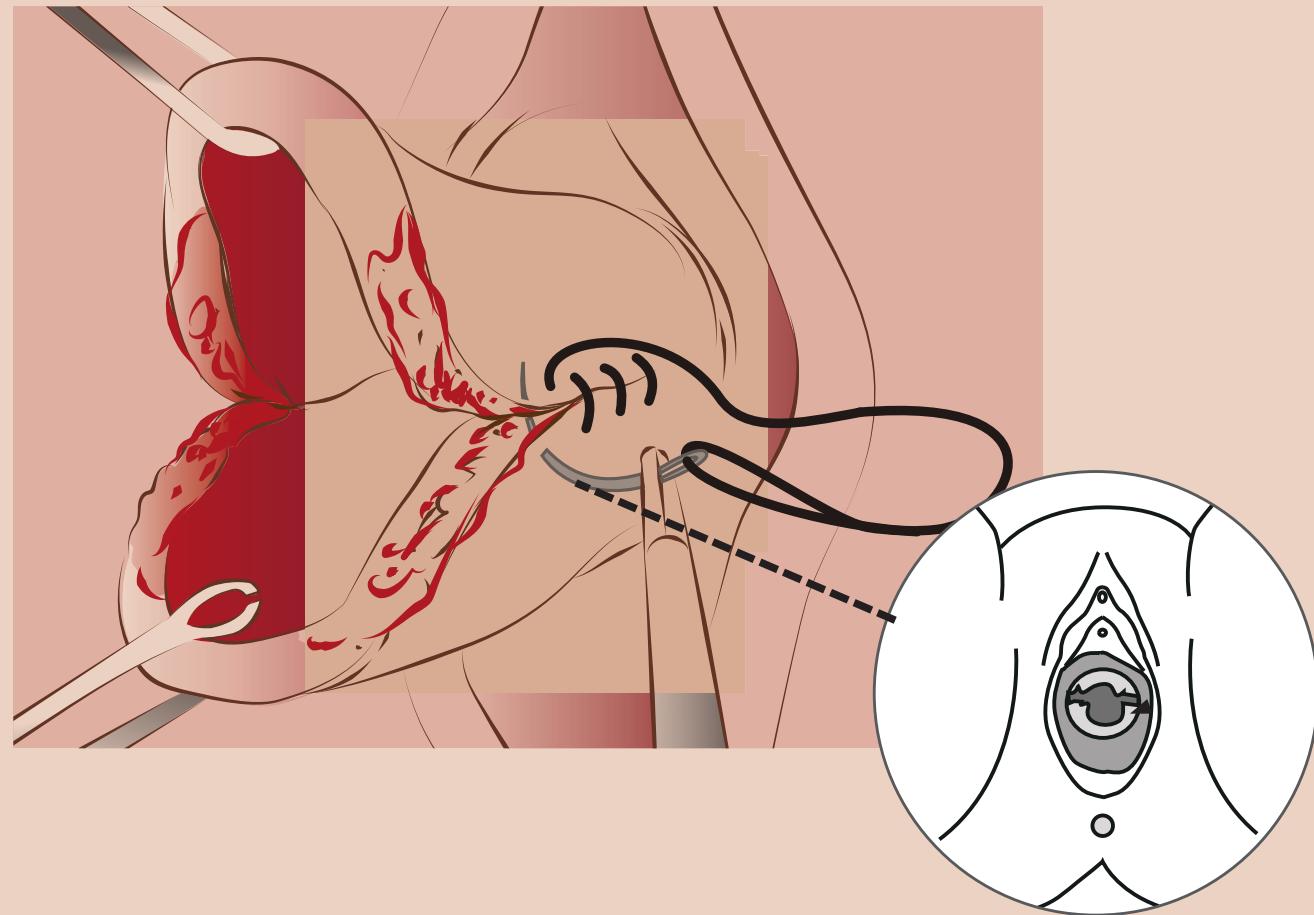
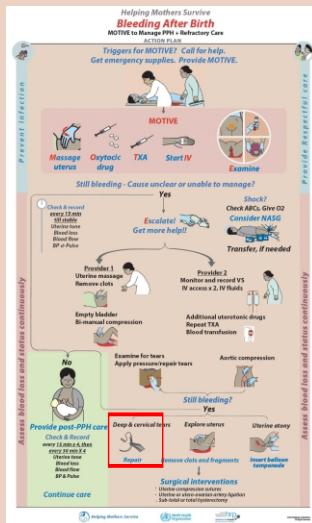
- **Repair lacerations:** Reevaluate for lacerations. Although you did this earlier, deep vaginal lacerations and cervical lacerations can easily be missed. They can also cause serious bleeding.
- **Manual removal of placenta, fragments and clots.** Anything in the uterus can prevent it from contracting to squeeze blood vessels that are bleeding. Assuring nothing is retained in the uterus is also necessary prior placing a balloon tamponade. We will review manual removal shortly.
- **Insert balloon tamponade** This is done to compress blood vessels from the inside of the uterus.

Knowledge check

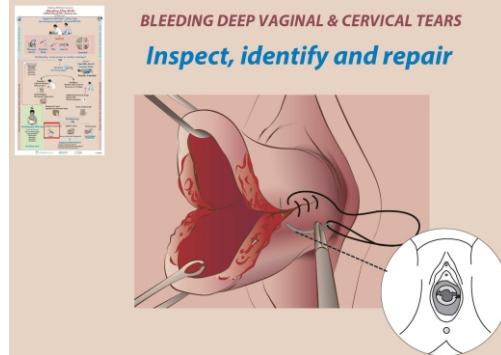
Why are we considering further lacerations and what is in the uterus again?? Because if she is still bleeding, we need to continue to seek other causes, including those we may have missed- (i.e. a cervical laceration, clots or placental fragments in the uterus etc)

MODULE 28

BLEEDING DEEP VAGINAL & CERVICAL TEARS *Inspect, identify and repair*



Explain



Tears that cause PPH are most often deep vaginal or cervical tears. Only tears that are large and continue to bleed need to be repaired.

Bleeding from a tear may be slow, heavy, or spurting from an artery. If repair does not stop bleeding, surgery may be required.

Seek advanced care!

Demonstrate

To identify deep vaginal tears

- Ensure privacy and good lighting.
- Tell the woman what you are doing.
- Ensure bladder is empty or catheterize. Give IV pethidine and diazepam, or ketamine, if tears are high and extensive. Do not give if woman is in shock.

- Wash hands. Put on sterile gloves.
- Clean perineum, vulva, and vagina with antiseptic solution.
- Separate the labia and examine periurethral area, perineum, and vaginal opening. Wrap fingers in gauze and press on the back wall of the vagina to expose the entire sulcus.
- Press against the vaginal wall and move gauze-wrapped fingers up the side.
- Repeat on other side. Move up the vaginal wall to the cervix.

To repair deep vaginal tears

- Draw 10 ml of 0.5% lignocaine into syringe.
- Insert the needle from the bottom to the apex on one side of the tear.
- Withdraw plunger to ensure needle is not in a blood vessel, then inject medication as needle is withdrawn. then repeat on other side of the tear.
- Wait 2 minutes for effect. Place continuous 2-0 vicryl suture to repair the entire length of the tear, starting 1 cm beyond the apex.
- Repair in 2 layers if tear is deep– consider interrupted to **close deep space first**, then re-approximate vaginal tissue.
- Avoid suturing down into rectum.
- Review wound care and hygiene.

To identify cervical tears:

- Have an assistant apply fundal pressure to help visualize the cervix.
- Use sponge forceps to grasp cervix at 12 o'clock position and another to grasp cervix at 3 o'clock. Inspect between the forceps for any tears.
- Then move the first forceps to 6 o'clock and inspect the area between the forceps again. Continue rotating forceps and inspecting in this manner until full cervix is inspected and tears are identified.

To repair cervical tears:

- After identifying cervical tear, put both forceps in one hand.
- Use size 0 vicryl suture.
- Place first suture above the tear. Close tear with continuous suture

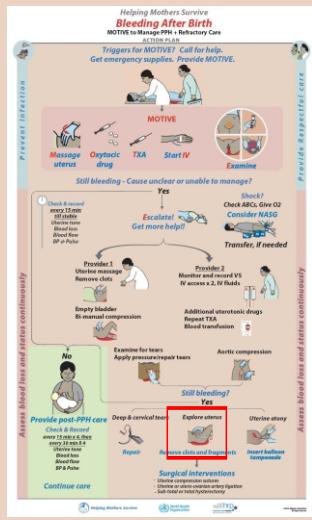
If possible, show video ▶ [Cervical tears](#) (5 min).

If video is not available, demonstrate repair.

Cervical tears often occur at 3 and 9 o'clock using a clock as the reference for the cervix

Facilitation note

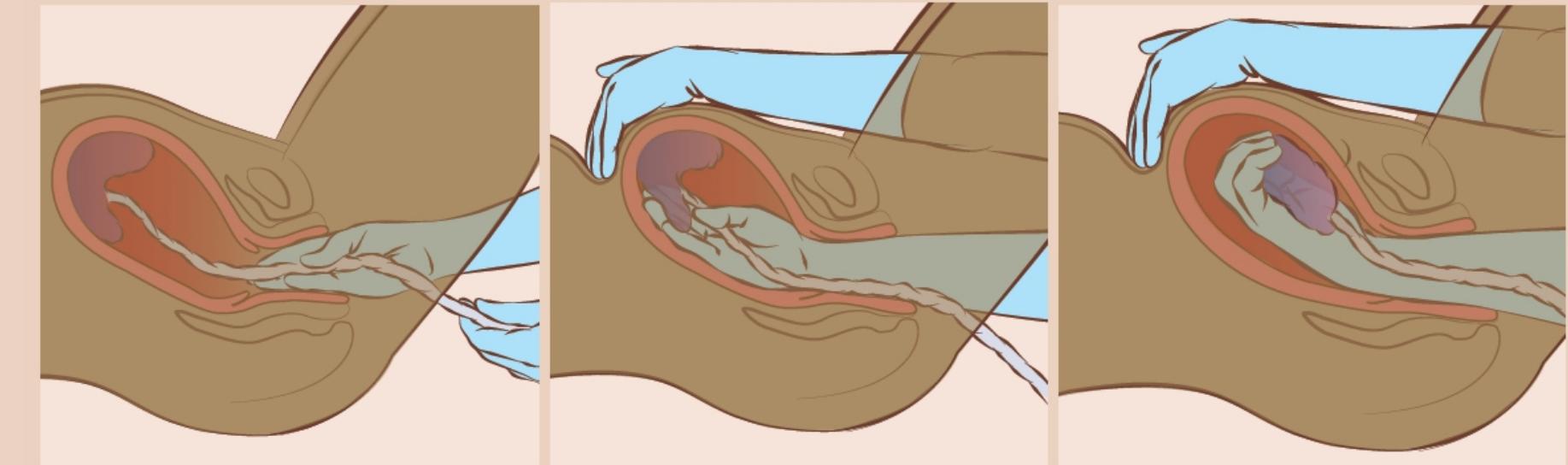
You can make simulators out of foam blocks or towels for practising repair of tears. Watch video or demonstrate then have learners practice. Circulate to give guidance. Tell learners that practicing this skill will be part of ongoing practise after training day so they will want to learn how to create their own simulators.



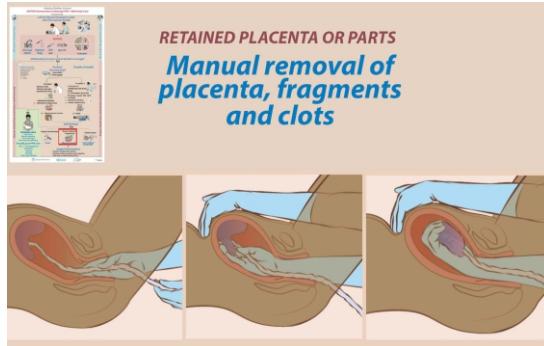
MODULE 29

RETAINED PLACENTA OR PARTS

Manual removal of placenta, fragments and clots



Explain



Retained placenta, fragments, bits of amniotic sac and clots can cause bleeding and infection. The uterus cannot contract if it contains the placenta, fragments, or clots.

Because atony is the most common cause of PPH, it is important to check the fundus often and consider an intrauterine sweep for clots, or placental fragments.

- If the placenta is not delivered in 30 minutes OR if the placenta is not complete OR if bleeding is heavy at any time before delivery of the placenta, remove the placenta and fragments manually. **Do not delay!**
- If you are unable to remove the placenta or parts of it remain in the uterus, surgery may be required. **Seek advanced care!**

Demonstrate

If possible, show video ▶ [Manual removal of the placenta](#) (5 min).

If video is not available, demonstrate manual removal of placenta using the simulator:

- Ensure privacy. Explain what you will do and why.
- Ask the woman to void or catheterize her bladder.
- Secure IV access if not already in place.
- Depending on local preference and clinical situation, you may use Diazepam, pethidine or ketamine to premedicate. Or take to the operating theater and use general anesthesia
- Give a single dose of antibiotics: either ampicillin/clavulanic acid IV or cefazolin IV.
- Put on personal protective equipment, wash hands, and put on long, elbow length, sterile gloves.
- Hold umbilical cord with a clamp (if placenta is retained). Gently pull, using the cord to guide your other hand into uterus.
- Form the hand into a cone and insert it into the uterus by following the cord to locate the placenta. Identify the rough surface behind the placenta and carefully separate it from the uterine wall by smoothly sweeping fingers back and forth.

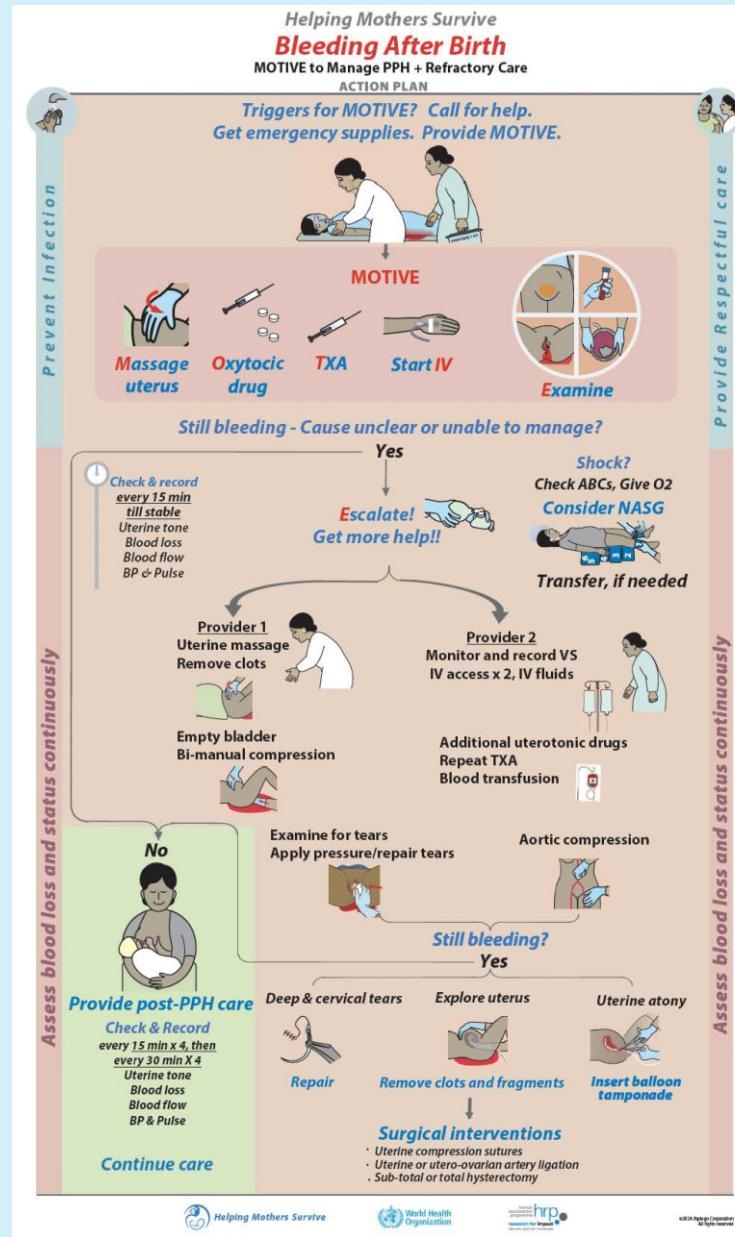
- After confirming total separation of placenta, withdraw your hand bringing the placenta with it. With your other hand, provide counter-traction to the uterus abdominally.
- Examine placenta for completeness.
- If assessing for fragments or clots, follow the procedure. You can use a sterile gauze wrapped around your fingers to wipe the interior of the uterus. Often a clot is lodged in the cervix. Gently pull all clots and debris out.
- Check uterine tone. Massage if soft.
- Give Oxytocin 20 IU IV in 1 L normal saline over 4 hours.
- Monitor bleeding, take vital signs, and ensure that the uterus is well-contracted (assess every 15 minutes for two hours, and then every 30 minutes for the next 4 hours).

Practice

Have all supplies ready in advance. If video was not available, begin practice with a learner holding the placenta in one hand. Demonstrate how to use the cord as a guide into the uterus and how to feel for the edge of the placenta. Show how to begin separating it with the side of your fingers and hand. Then prepare a simulator of the uterus with placenta in place. Have learners take turns practicing.

EXERCISE:

Practice



Exercise: Practice

In groups of 6 or fewer, practice care for PPH. Ensure providers have the PG open to page 5 or SBAR and tell them to look at the Action Plan to remind them of E-MOTIVE triggers and steps. Ask for two new volunteers. Others will observe.

Practice – Case #3

Prep:

- Facilitators wear the simulator with the blood tank open to medium flow at the start.
- Have 1 volunteer be the provider
- Have 2nd volunteer be the assistant
- Have 500mL in the drape.
- Keep the uterus firm throughout.
- Give results of assessments only if the learners do the assessment.
- Observers should be ready to provide feedback after the simulation.

Say, **"I am Ms. C, and am 18 y/o. You assisted the birth of my first baby with no problems 15 minutes ago. I received 10 IU of oxytocin IM within 1 minute after birth. You delivered my placenta without problems. You have come to check on me. I do not have an IV line in place. Please take care of me."**

Providers should make an assessment and trigger E-MOTIVE. They should call for a helper to bring the emergency trolley. They should use SBAR to communicate and assign tasks.

Case practice guidance

IF the learner looks at the drape/soiled cloths, ask, "How much blood is there?" Note there may be more than 500mL at this time.

- Vital signs: Pulse: 92 bpm, Blood pressure: 118/62 mmHg, Respiration: 22 breaths per minute, level of consciousness: Alert, Blood is flowing steadily

Learners should call for help and begin E-MOTIVE:

- Call for the emergency trolley to be brought to the bedside
- Check the uterus (**keep it firm**)
- Check the bladder (**bladder is empty**)
- Put 10 IU oxytocin in 500 mL IV fluids
- Start an IV infusion
 - Before infusing fluids, collect blood for hemoglobin, immediate cross-match.
 - Begin infusing the IV with oxytocin over 10 minutes (as rapidly as possible). (**As facilitator, keep bleeding going**).
- Give 1g tranexamic acid in 10 mL IV over 10 minutes.
- Palpate the abdomen to check fundal height and evacuate clots from the vagina and cervix.
- Check for vaginal, cervical, and perineal tears. (As facilitator, say, **"You do not see any"**)
- Check placenta for completeness (As facilitator, say, **"It is complete"**)

As facilitator, keep the bleeding going and ask, **"Has the 1st response bundle worked?" (No).** Ask, **"What will you do next?" (Escalate! – call for advanced care/consultant)**

Practice – Case #4

Prep:

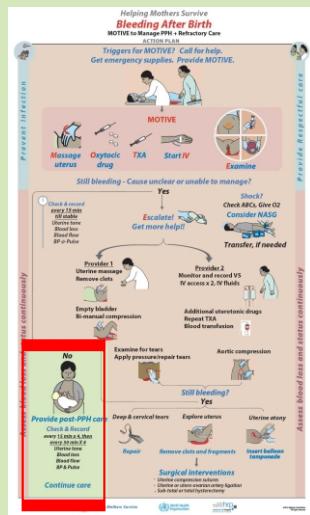
- Facilitators wear the simulator will blood flow on full.
- Have 500 mL in the drape
- Repeat with a new pair of learners using the following case while
- Use the case practice guidance with the new case parameters and debrief:

Say, **"Ms. A, a 32 y/o G5P5 gave birth 45 minutes ago. Her placenta was retained and you did a manual removal because she was bleeding. She has an IV line in place, she has lost 500 mL of blood. Her uterus is soft. BP 110/62, pulse 112 bpm, respirations 24 breaths per minute."** (As facilitator, do not stop the bleeding.)

Debrief

When finished, debrief with the team. Ask, "Why did you trigger E-MOTIVE?" (Case #3: >500 blood lost. Case #4: >500mL blood lost AND pulse >100). Ask the provider and assistant to evaluate their performance and then invite comments from others:

- What went well?
- Ask them to point to each step in E-MOTIVE to describe what was done.
- Is there anything you would do differently next time?

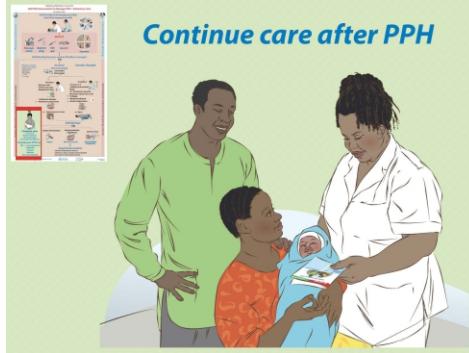


MODULE 30

Continue care after PPH



Explain



A woman who has experienced PPH needs close monitoring and special care to recover and to support breastfeeding.

A woman recovering from PPH must be monitored closely until she is stable:

- Maintain supplemental oxygen at 6-8 L/minute.
- Closely monitor her condition: assess and document uterine tone, bleeding, and take vital signs every 15 minutes until she stabilizes. Then every 30 min for the next 4 hours.

Once she is stable

- Adjust IV infusion rate to 1 L in 6 hours and increase Per Oral hydration.
- Begin decreasing oxygen per local protocol.
- Perform laboratory tests including repeat hemoglobin or hematocrit.
- Slowly increase physical activity

To decide if she can return home

- The woman's vital signs, urine output, and mental state must return to normal.
- She must be able to walk around without dizziness and care for herself and her baby.
- If the woman had manual removal of her placenta, fragments OR bi manual compression or insertion of UBT, observe closely for infection.
- Continue or begin antibiotics per local protocol and do not discharge if she has symptoms of infection.

Additional discharge instructions after PPH

- A woman who has experienced PPH and her family should be counseled about her **need for rest and good nutrition** as she recovers. Teach her warning signs of anemia, increased bleeding, infection, and to seek care if she experiences these.
- If hemoglobin was less than 7 g/dl: she should have been given a blood transfusion immediately.
- At discharge continue with supplements: either ferrous sulfate 200 mg or ferrous fumarate 300 mg and folic acid tablets, 5 mg once daily for 9 months.

- If hemoglobin is 7-11 g/dl: Give ferrous sulfate 200mg or ferrous fumarate 300mg by mouth plus folic acid 5 mg by mouth once daily for 6 months.
- Provide all other routine care instructions and postpartum family planning counseling.
- Encourage NSAIDS (or acetaminophen if allergic) for pain relief
- Have her follow up for care in 48 hours, 10 days and again in 6 weeks.

If the woman has tears

- Teach the woman to gently wash perineum at least twice a day (always after bowel movements), change pad frequently, and wash hands after self-care.

Debriefing Woman and Family

- Review what happened, counsel for next pregnancy, recommend facility birth .
- A PPH is traumatic for the woman and family. Offer trauma counseling.

Debriefing Staff

All staff involved should be debriefed and offer support to process and review the experience in a supportive, non-judgmental environment

Facilitation note

Request two learner volunteers – one to play the provider, and one to play a woman recovering from PPH and shock. Request that the provider determine if the woman is stable enough to go home, and, if she is, the provider should role-play all necessary care and counseling.

Exercise Preparing for “LDHF” Taking Action!

LDHF

Ongoing practice and quality improvement activities Taking Action with S.M.A.R.T. Goals

Specific

The Emergency Trolley is regularly checked and ready to deliver the 1st bundle at every birth

Measurable

A fully stocked Emergency Trolley is available at 100% of births

Achievable

We have staff who will be assigned to check that the Emergency Trolley has all supplies and drugs that are not expired every day or week

Relevant

A well-stocked Emergency Trolley will ensure we can deliver the 1st response bundle when needed

Time limited

We can begin this today!

EXERCISE	
Preparing for "LDHF"	
Taking Action!	
LDHF	
Ongoing practice and quality improvement activities	
Taking Action with S.M.A.R.T. Goals	
Specific	The PPH Emergency Trolley is regularly checked and ready to deliver the "first response" bundle at every birth
Measurable	A fully stocked PPH Emergency Trolley is available at 100% of births
Achievable	We have staff who will be assigned to check that the PPH Emergency Trolley has all supplies and drugs that are not expired every day or week
Relevant	A well-stocked PPH Emergency Trolley will ensure we can deliver the "first response" bundle when needed
Time limited	We can begin this today!

Ask, **"What is LDHF? Does anybody know?"**

Say, **"LDHF means, 'low-dose, high-frequency'. It is an approach to training where we do small amounts of learning and practice at our facilities and with our colleagues to make it easier to use what we have learned."**

Have providers turn to page **61** of the Provider's Guide so they can see the skills practice and quality improvement activities they will do after today. These activities will be coordinated by Practice Coordinators who will work with maternity staff and help each other do the activities.

All staff who care for women on the labor ward should be included in these sessions even if they were not part of the training today.

Taking Action!

Say, "Now it is time to talk about taking action to prevent PPH and the 1st response bundle of care as our first response to PPH."

Discuss

Ask,

- 1. "Is there anything about using HSC to prevent a PPH that will be difficult?"**
- 2. "Is there anything we learned about the 1st response bundle that will be easy to do? Is there anything that may be hard to do?"**
 - a. "What about knowing when to trigger the 1st response bundle?"**
 - b. "What about changing from sequential care to use of the entire bundle for all PPH cases?"**
 - c. Anything else?"**
- 3. "Can we have our volunteer read the list of items that came up during discussions today which they wrote down."**

Based on the discussion above, ask them to come up with 2 - 3 SMART goals to answer the question, "What do we need to prevent a PPH with HSC and the 1st response bundle from today onward?"

Ask, **"Has anyone heard of SMART goals? Based on our discussion, can we create SMART goals to make these changes?"**

Give SMART examples below:

Example 1

- Specific** – The emergency trolley is ready to deliver the 1st response bundle at every birth.
- Measurable** - A fully stocked emergency trolley is available at 100% of births.
- Achievable** - We have staff who will be assigned to ensure the emergency trolley has all supplies and drugs that are not expired every day or week.
- Relevant** – A well-stocked emergency trolley will ensure we can deliver the 1st response bundle when needed.
- Time limited** – We can begin this today!

If needed, give a second example. Have groups of 4-6 to create goals based on the list of items that came up during training. Give them 15 minutes then have the groups share their goals. Point out that the first LDHF exercise is putting their plans into action.

Example 2 – if needed

- Specific** – We will begin the 1st response bundle with any of the triggers.
- Measurable** – 1st response bundle is implemented at 100% of PPH cases meeting the triggers.
- Achievable** - All staff on the labor ward are now or will shortly be trained in the 1st response bundle.
- Relevant** – Triggering the 1st response bundle can save lives.
- Time limited** – We can begin this today!

MODULE 31

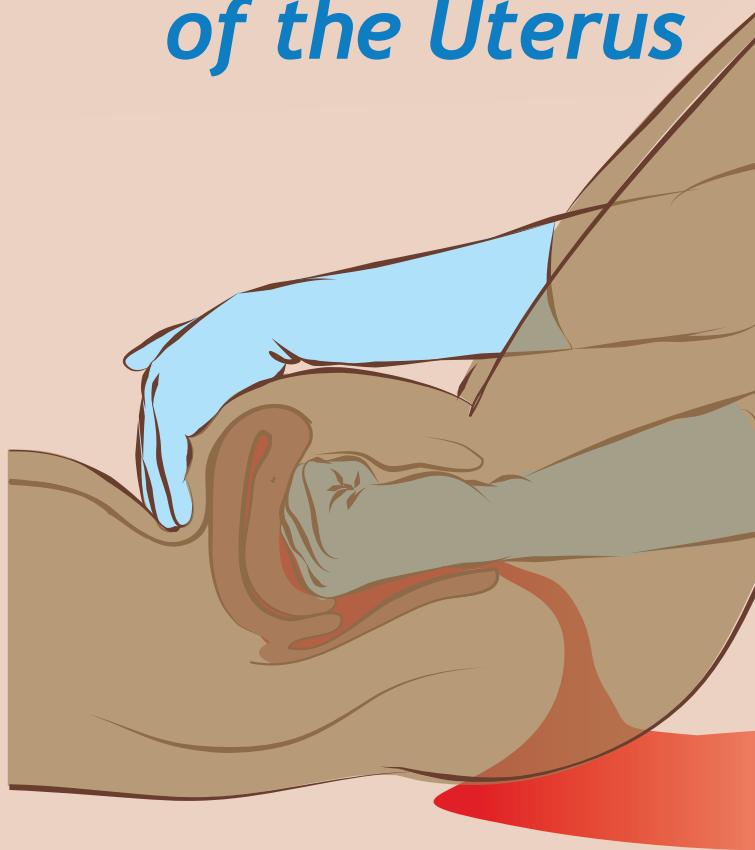
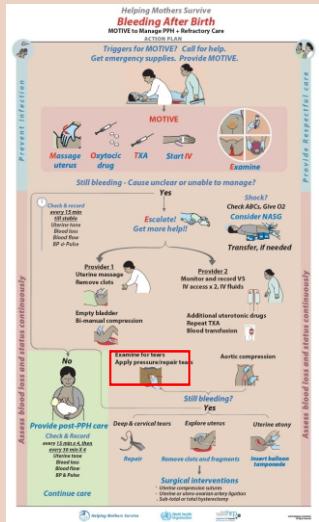
Resources

- Bi-manual compression of the uterus
- Aortic compression
- Uterine Balloon Tamponade (UBT)
- Surgical interventions

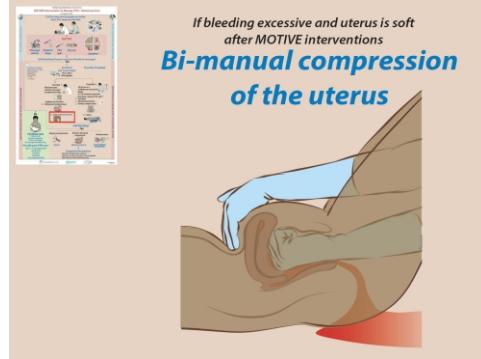
MODULE 32

If bleeding is excessive and uterus is soft after MOTIVE interventions

Bi-manual compression of the Uterus



Explain



If the uterus does not contract after emptying a full bladder, massage, repeating a uterotonic, and performing the MOTIVE interventions, squeezing the uterus between your hands (or bimanual uterine compression) may help stop the bleeding. Act fast - she needs advanced care!

You do not need to wait until the woman is in shock to compress the uterus.

Compression may buy time to allow the medication to work until the woman can receive advanced care.

Do NOT do vaginal packing. Placing packing into the vagina after birth can restrict optimal assessment of blood loss and cause an infection.

Demonstrate & Practice

Show video ▶ [2:40 one compression](#) min) If you cannot show video:

Explain and demonstrate bimanual compression of the uterus

- Shout for help!
- Continue the IV infusion with oxytocin.
- This is a painful but life-saving measure: it is important to tell the woman what you are about to do and why and that it will hurt.
- Care must be taken to clean hands thoroughly and wear sterile gloves.
- Quickly but thoroughly wash hands and put on sterile, long, elbow length gloves or improvise to use regular gloves to make elbow length gloves.
- Insert a flattened hand in the upper vagina and make a fist against the upper part of the vagina and the uterus. Put the other hand on the abdomen at the fundus.
- Compress the uterus between your two hands for at least 5 minutes OR until the bleeding stops and the uterus is firm OR advanced care is available (e.g. uterine balloon tamponade [UBT], surgical intervention).

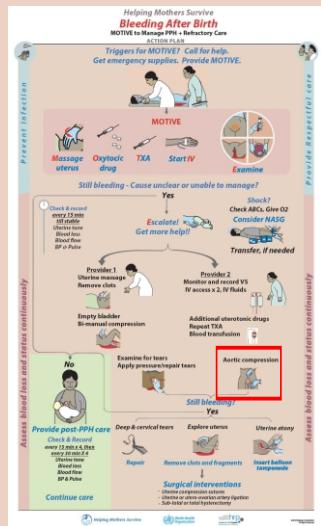
Women who need bimanual compression of the uterus have already lost a lot of blood and are more likely to bleed again. They need to be watched even more closely and for longer than women who have not bled this much. If your facility cannot supply blood transfusion or advanced care, the woman must be transferred.

Have participants practice bimanual uterine compression. As facilitator, wear the simulator with the baby and placenta delivered. Tighten the cervix ribbon. Have learners turn to page 36 of the PG as they practice. Offer supportive feedback.

Knowledge check

Why must a woman who has received bimanual uterine compression be sent to an advanced care facility? Because she has lost too much blood, may bleed again and she may need a blood transfusion

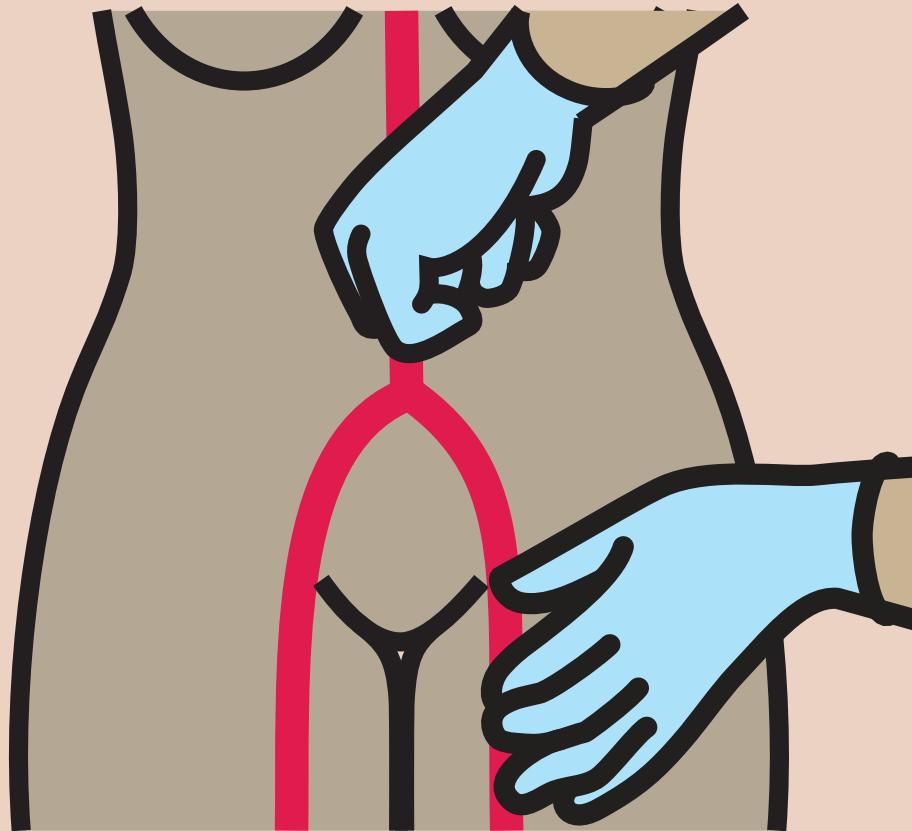
What steps should be done to stop bleeding before uterine compression?
Call for help, massage the uterus, be sure the bladder is empty, and repeat medication.



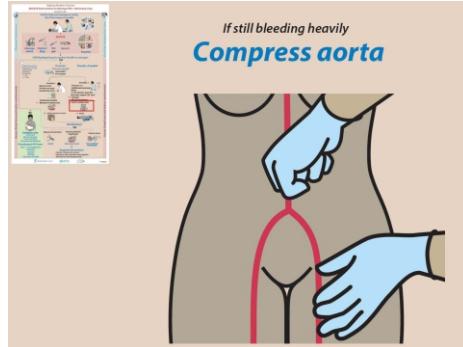
MODULE 33

If still bleeding heavily

Aortic Compression



Explain



Teach aortic compression alone as a temporizing measure when a setting does not meet requirements for inserting uterine balloon tamponade (UBT).

If heavy bleeding and atony persist despite massage, uterotronics, TXA, and bimanual compression, compress the aorta as a temporizing measure until appropriate care is available.

Maintain compression until bleeding is controlled or alternative measures (e.g., intrauterine balloon tamponade, surgical intervention) can be taken.

Demonstrate

Use a postpartum uterus model OR an empty 500 mL water bottle.

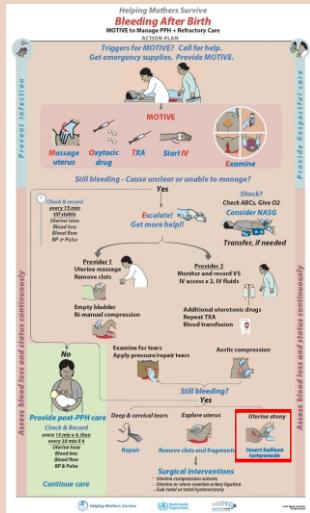
If possible, show videos ► [Aortic compression](#) (2:50 min)

If no video, demonstrate aortic compression:

- Ensure privacy.
- Continue the IV infusion with oxytocin.
- If you have not done so already, give a second dose of Tranexamic acid 1g IV over 10 minutes if: bleeding continues 30 minutes after the first dose OR bleeding restarts within 24 hours of completing the first dose.
- Ensure the woman is on a firm surface. A soft mattress may not be firm enough.
- Tell woman what you will do and why.
- Apply downward pressure with a fist on the abdominal aorta through the abdominal wall. Compress just above and to the left of the umbilicus.
- With the other hand, palpate the femoral pulse to check effectiveness of compression.
 - If the pulse is palpable during compression, the pressure exerted by the fist is inadequate.
 - If the femoral pulse is not palpable, the pressure exerted is adequate.
- Maintain compression until bleeding is controlled or alternative measures can be taken.

Practice

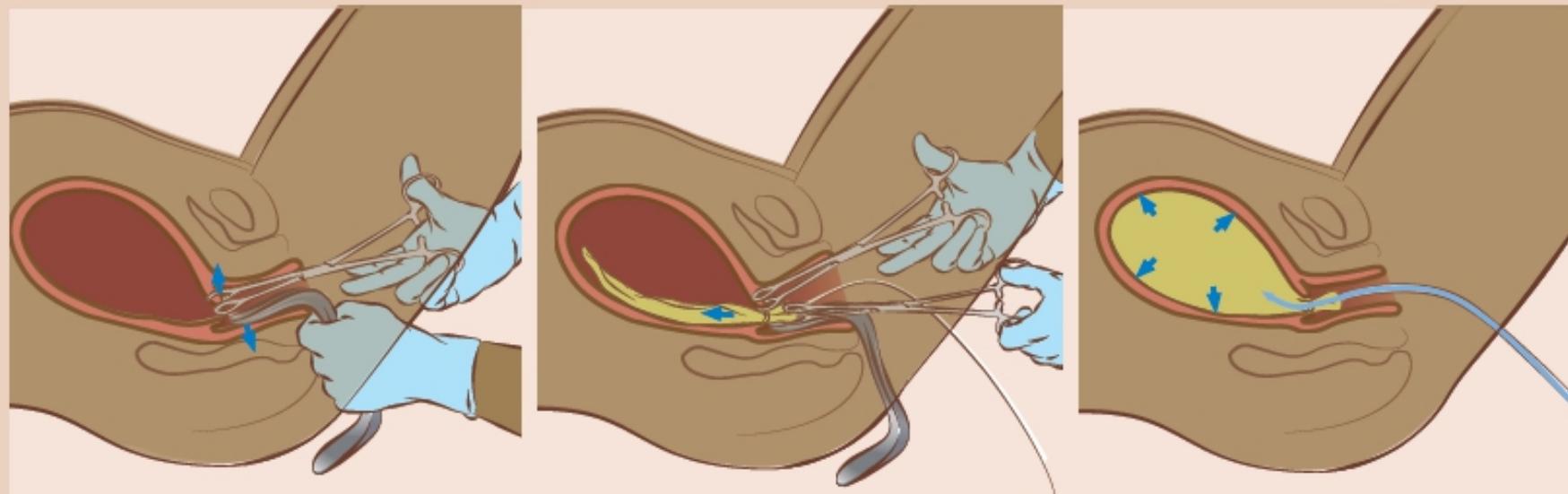
Ask learners to practice bimanual and aortic compression. Circulate and provide coaching as needed.



MODULE 34

If still bleeding heavily

Insert uterine balloon tamponade



Explain



Only teach uterine balloon tamponade (UBT) if its use is within local guidance and standards of care and meets WHO recommendations to only use UBT in settings with immediate access to surgery and blood and where first line treatment includes uterotronics, TXA and IV fluids. If these conditions are not met, UBT should not be taught or used.

If heavy bleeding and atony persist despite massage, uterotronics, TXA, and bimanual compression, insert a UBT. When referral is needed, UBT can be placed before transfer. Supplies for UBT should be kept in a PPH emergency kit.

Before UBT insertion, ensure no retained placental pieces or bleeding lacerations.

If using bimanual uterine compression to stop bleeding while an intrauterine balloon tamponade is prepared, you will need to switch to aortic compression immediately before the balloon is inserted to minimize blood loss.

If no video, demonstrate assembly and insertion:

- Place foley catheter into condom and tie with suture. Do not inflate catheter balloon.
- Ensure privacy. Tell woman what you will do and why.
- Administer a single dose of antibiotics: ampicillin with Clavulanic acid 625mg IV OR 1 g cefazolin IV.
- Ensure empty bladder.
- Put on personal protective equipment, wash hands, and put on sterile gloves.
- Expose cervix with Sims speculum and hold with forceps. Insert UBT through cervix and high, up to the uterine fundus.
- Connect catheter to IV giving set and IV bag. Inflate condom with IV solution (300-500 mL) until bleeding stops.
- Hold and tie the catheter to retain fluid.

Once UBT is in place, continue to monitor for any ongoing blood loss. If bleeding is not controlled within 15 minutes, seek surgical care immediately!

Record insertion time and amount of fluid used and monitor the woman closely. Keep UBT in uterus for 12-24 hours once bleeding is controlled and woman is stable.

To remove UBT:

- Once stable for at least 12 hours, deflate UBT by 200 ml every hour. Reinflate if bleeding re-starts.
- After removal, monitor closely for 6 hours. Record BP, pulse, urine output, pallor, amount of bleeding and check tone: every 15 minutes for the first 2 hours; then every 30 minutes for the next 2 hours; then every hour for the next 2 hours.

Demonstrate & Practice

Turn to Provider's Guide [page 88](#) for supplies needed for UBT practice.

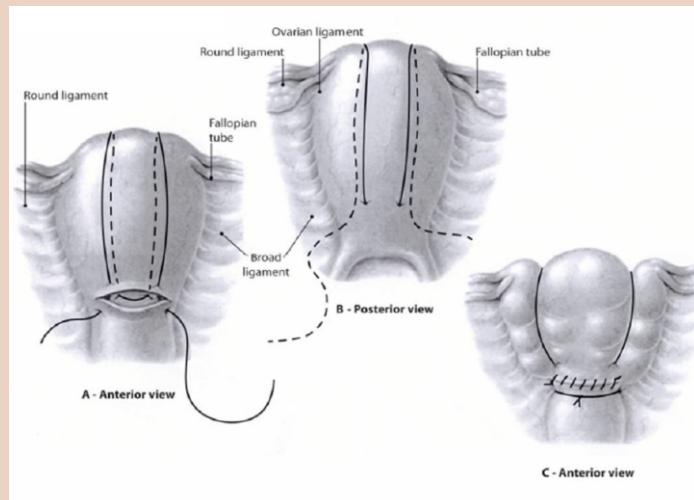
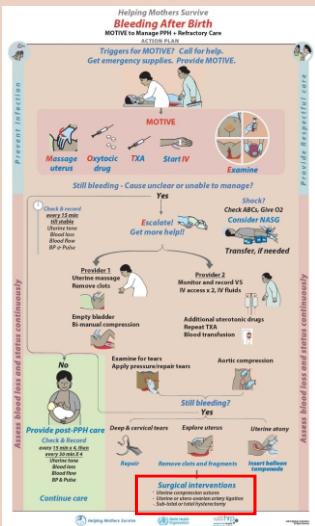
Use a postpartum uterus model OR an empty 500 mL water bottle.

If possible, show videos ▶ [Aortic compression](#) (2:50 min) and ▶ [UBT](#) (6 min).

Have learners practice in pairs performing assembly and insertion of UBT. Walk among the pairs and provide supportive guidance.

MODULE 36

Surgical interventions for uterine atony

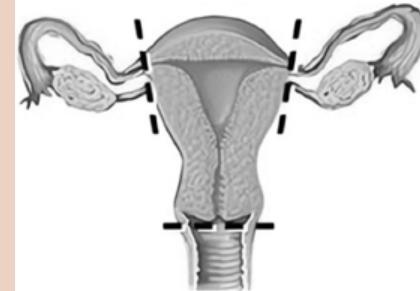
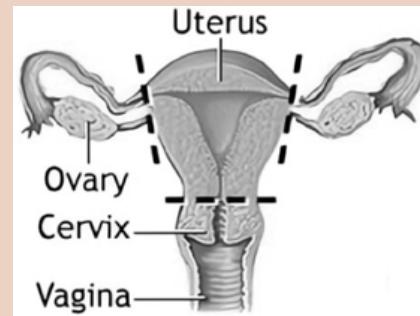


Uterine compression sutures



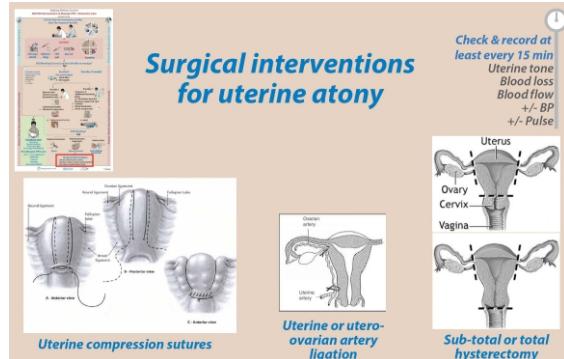
Uterine or utero-ovarian artery ligation

Check & record at least every 15 min
Uterine tone
Blood loss
Blood flow
 $+/-$ **BP**
 $+/-$ **Pulse**



Sub-total or total hysterectomy

Explain



Surgical interventions for uterine atony are required when other methods fail. **They are crucial to effectively manage refractory PPH and prevent death.**

Surgical interventions, like all prior interventions, attempt to address the underlying causes of PPH directly to provide an immediate halt to bleeding and save the woman's life.

Uterine compression sutures

Sutures are placed around the uterus to compress the uterus and reduce bleeding from the blood vessels. This helps stabilize the uterus and prevents further blood loss.

Uterine or uteroovarian artery ligation

The surgeon ties off or seals the uterine or uteroovarian arteries, which are major blood vessels supplying the uterus and ovaries. Restricting blood flow to these vessels helps reduce bleeding and stabilize the woman's condition.

Sub-total or total hysterectomy

If other surgical interventions fail, the uterus is partially or completely removed to stop the bleeding. This may be necessary if all other methods to control bleeding have failed or if there are complications such as uterine rupture. While sub-total hysterectomy removes only a portion of the uterus, total hysterectomy removes the entire uterus, effectively stopping further bleeding from the source.

Failure to initiate a hysterectomy early when indicated can lead to death!

Discuss

1. What surgical interventions do you use for PPH in your facility?

Contributors

Prevention, early detection, and treatment of PPH



Helping Mothers Survive

Helping Mothers Survive
Prevention, early detection, and treatment of PPH
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The ***Prevention, early detection, and treatment of PPH*** module was adapted from the ***Bleeding after Birth Complete 3.0*** module developed by the ***Helping Mothers Survive*** program. This adaptation was created in response to new WHO recommendations and research around interventions to improve survival and reduce morbidity and mortality due to PPH.

Acknowledgments



Helping Mothers Survive Bleeding after Birth Complete

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Jhpiego is an international, nonprofit health organization affiliated with Johns Hopkins University. For more than 40 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidenced-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

The Helping Mothers Survive Bleeding after Birth Complete module was conceived and developed by a team in the Technical Leadership Office of Jhpiego and uses the module design created for Helping Babies Breathe (HBB), a module developed by the American Academy of Pediatrics. The module was further expanded in 2023 to include early detection of PPH and the WHO 1st response bundle for PPH from the E-MOTIVE trial conducted by University of Birmingham and partners.

This adaptation was led by Susheela Engelbrecht.

We express our sincere gratitude to our partners and colleagues around the world who work with us to reduce the incidence of the leading cause of maternal death, postpartum hemorrhage. We would like to give special thanks to those who provided guidance in the development of these materials, the International Confederation of Midwives (ICM), the International Federation of Gynecology and Obstetrics (FIGO), the United Nations Population Fund (UNFPA), the World Health Organization (WHO), the Maternal and Child Survival Program (MCSP), and the American Academy of Pediatrics (AAP).



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Jhpiego is an international, nonprofit health organization affiliated with The Johns Hopkins University. For 40 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen health care services for women and their families.



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OSCE 1: 300 mL + worrying signs

Read the following guidelines to learners at the start of the OSCE:

- The purpose of this activity is to assess your ability to make clinical decisions while providing care to a client in a simulated environment.
- For this station assume you are in a Facility where you have all equipment and supplies necessary for a normal vaginal birth and for basic emergency management.
- I will provide all the essential information at the start of this OSCE station.
- Ask me to clarify any questions prior to beginning. Once the OSCE has started, I will only provide information about the results of any assessment you do.
- From the start of the OSCE, you will have 7 minutes to complete each station.
- **Even though I am the examiner, I will be acting as a woman who has just given birth. Talk to and care for me exactly as you would to a woman you are caring for in a clinical situation.**
- **You are alone** and will need to conduct all steps in the process without assistant.
- Be explicit in verbalizing your clinical findings and subsequent decisions.
- If you give a medication, you must state what you are giving, the dose, the route, and why you are giving it.

Instructions for the Examiner:

- Read above information to the learner.
- Wear the birthing simulator with the drape unfolded and 300mL in the drape.
- Reduce the amount of blood to 350ml in between each learner
- When the OSCE begins have the blood flowing rapidly. Slow the bleeding after TXA has been administered.
- Observe only; do not intervene during the learner's demonstration.
- In the checklist, you will see *instructions to you in italics*. Follow these instructions.
- Learners must complete each action within each step in order to receive credit for accurately completing that step. The order of the steps is not important; it is important that all interventions are performed.
- Do NOT give information for assessments they do not make.
- Hold feedback until the end of the assessment for all learners.
- Give half a mark for partial answer

Read the following to the learner: "I gave birth 30 minutes ago without complications. You gave me 10 IU oxytocin IM for prophylaxis within 1 minute of birth and my placenta was delivered without problems. You have just done a routine check and found my uterus is soft and I am bleeding. My pulse is 110 bpm, BP is 96/68 mmHg, Respiration is 18 breaths per minute. **I have an IV line.** Show me how you will respond."

Pass score is 9/12

Participant name or ID# _____ Date _____

OSCE 1: 300 mL + worrying signs

	OSCE ITEMS ***Note that checklist is for assessment only, instructions/information to the learner are in italics***	Performed to standard	
		Yes	No
	<i>Throughout the OSCE, evaluate respectful care. Observe the learner's communication with the woman. Learners should be respectful, supportive, tell you what they are doing and why. You will score respectful care at the end.</i>	<i>Check appropriate box for each item</i>	
1.1	Examines bleeding and amount of blood loss in the drape.		
1.2	Massages the uterus.		
1.3	<i>Ask, "What is happening to me?" Correct response, "You are bleeding too much."</i>		
1.4	Checks the bladder. <i>IF the learner checks the bladder, say, "The bladder is not distended".</i>		
1.5	Puts oxytocin 10 IU in 500 mL OR 20 IU in 1L of NS or RL if 500 mL bags not available		
1.6	Changes the IV bag and infuses the IV with oxytocin as rapidly as possible <i>IF they don't mention infusion rate, ask, "How rapidly will you infuse the IV?" correct answer, "Over 10 minutes OR As rapidly as possible"</i>		
1.7	Prepares 1g TXA in 10 mL and inserts it into IV line. <i>IF they prepare TXA, stop the bleeding and ask, "How will you inject TXA?" Correct answer, over 10 minutes. Say, "10 minutes is up and the injection is complete."</i>		
1.8	Rechecks the uterus <i>Have the uterus contracted.</i>		
1.9	Checks for tears <i>If the learner checks, say, "There are no perineal or vaginal tears".</i>		
1.10	Checks the placenta <i>If the learner checks the placenta, say, "The placenta is complete".</i>		
1.11	Ask: "What is the most likely cause of PPH?" Response: "Tone – uterine atony".		
1.12	Ensured privacy and confidentiality. Provided respectful care and good communication. Told you what was to happen and why, and informed you of the findings.		

Score _____ /12 Pass score is 9/12 Pass / Fail (circle one)

OSCE 2: 500 mL + no worrying signs

Read the following guidelines to learners:

- The purpose of this activity is to assess your ability to make clinical decisions while providing care to a client in a simulated environment.
- For this station assume you are in a facility where you have all equipment and supplies necessary for a normal vaginal birth and for basic emergency management.
- I will provide all the essential information at the start of this OSCE station.
- Ask me to clarify any questions prior to beginning. Once the process has started, I will only provide information about the results of any assessment you do.
- From the start, you will have 7 minutes to complete the station.
- **Talk to and care for the woman in front of you exactly as you would in real life. Even though I am both the examiner and acting as the woman in labor, please speak to me as if I am the woman.**
- **You can call one assistant to assist you, if needed.**
- Be explicit in verbalizing your clinical findings, asking for assistance, and subsequent decisions.
- If you give a medication, you must state what you are giving, the dose, the route, and why you are giving it.

Instructions for the Examiner

- Read above information to the learner.
- Ask for a volunteer to “assist” the provider doing the OSCE. Tell volunteer they are NOT being tested but only to help if asked. Instruct the volunteer to only complete interventions requested by the examinee.
- Wear the birthing simulator with the drape unfolded with between 500 mL and 550 mL of blood in the drape. Use the placenta with a cotyledon missing. When the OSCE begins have the blood flowing and do not stop during the OSCE.
- Keep uterus soft for the entire OSCE.
- Observe only; do not intervene during the learner’s demonstration.
- In the checklist, you will see ***instructions to you in italics***. Follow these instructions.
- For each step, the learners must either complete the action or ask the assistant to complete the action to receive full credit for accurately completing that step. The order of the steps is not important; it is important that all interventions are performed.
- Give half credit for partially completed steps
- Do NOT give information for assessments they do not make.
- Hold feedback until the end of the assessment for all learners.

Read the following to the learner: “I gave birth 15 minutes ago. During a routine check you found my pulse 92 b/m, BP 114/62 mmHg, respirations 20 breaths per minute. I do not have an IV line. Your colleague is with you in the room. Show me how you will respond.”

Pass score is **11/14**

Participant name or ID# _____ Date _____

OSCE 2: 500 mL + no worrying signs

	OSCE ITEMS ***Note that checklist is for assessment only, instructions/information to the learner are in italics*** <i>Throughout the OSCE, evaluate respectful care. Observe the learner's communication with the woman. Learners should be respectful, supportive, tell you what they are doing and why. You will score respectful care at the end.</i>	Performed to standard	
		Yes	No
1.1	Checks bleeding and amount of blood loss in the drape. <i>Keep bleeding steady.</i> Ask, "What is happening to me?" Correct response, "You are bleeding too much."		
1.2	Calls for help! (<i>Assistant is available</i>)		
1.3	Massages the uterus <i>Keep the uterus soft.</i>		
1.4	Checks the bladder. If the learner checks the bladder, say, " <i>The bladder is empty</i> ".		
1.5	Communicates with the assistant using S-B-A-R. <i>Note: This should be brief and provide important information about blood loss, uterine tone, Vital Signs, and what has already been done – uterine massage and checking the bladder.</i>		
1.6	Asks the assistant OR Starts the IV		
1.7	Asks the assistant OR Puts oxytocin 10 IU in 500 mL OR 20 IU in 1L of NS or RL if 500 mL bags is not available		
1.8	Asks the assistant OR infuses the IV with oxytocin as rapidly as possible <i>IF they don't say the rate, ask, "How rapidly will you infuse the IV?" correct answer, "Over 10 minutes" or "As rapidly as possible"</i>		
1.9	Asks the assistant OR Administers 1g TXA in 10 mL <i>IF they prepare TXA, ask, "How will you inject TXA?" Correct answer, over 10 minutes. Say, "10 minutes is up and the injection is complete." Slow the bleeding slightly after TXA has been administered but keep the blood flowing.</i>		
1.10	Asks the assistant OR Rechecks the uterus <i>Have the uterus soft.</i>		
1.11	Asks the assistant OR Checks for tears If the learner checks, say, " <i>There are no tears</i> ".		
1.12	Asks the assistant OR Checks the placenta If the learner checks the placenta, say, " <i>The placenta is incomplete</i> ". OR " <i>You can see it is incomplete</i> "		
1.13	Identifies that all interventions of the MOTIVE bundle have been performed, but she is still bleeding and escalates her care to manage atony and incomplete placenta. <i>If not stated, ask: "What is the most likely cause of PPH?" Response: "Tissue – incomplete placenta and uterine atony".</i>		
1.14	Ensured privacy and confidentiality. Provided respectful care and good communication. Told you what was to happen and why, and informed you of the findings. Worked well with the assistant.		

Score _____ /12

Pass score is 9/12

Pass / Fail (circle one)

Helping Mothers Survive Bleeding after Birth Complete Day 2

OSCE 3: Atony

Guidelines to be read to participants:

- For this station assume you are in a rural health care facility with no surgical or bloodtransfusion capacity. You have all equipment and supplies necessary for a normal vaginal birth and basic emergency management.
- All essential information will be provided to you at the start of this OSCE station.
- Ask me to clarify any questions prior to beginning. Once the OSCE has started, I will only provide information about the results of any assessment you do.
- You will have 5 minutes to complete this station.
- Even though I am the examiner, I will be acting as a woman who has just given birth. Talk to and care for me exactly as you would to a woman you are caring for in a clinical situation.
- Be explicit in verbalizing your clinical thinking and subsequent decisions.
- If you give a medication, you must state what you are giving, the dose, the route, and why you are giving it.

Instructions for the examiner:

- Read above information to the learner.
- Start with birth simulator with the baby delivered and the placenta removed. Once time has begun, open the blood tank to full flow.
- Observe only; do not intervene in demonstration of the participant.
- In the checklist, you will see *instructions to you in italics*. Follow these instructions.
- Learners must complete each action within each step in order to receive credit for accurately completing that step. The order of the steps is not important; it is important that all interventions are performed.
- Do NOT give information for assessments they do not make.
- Hold feedback until the end of the assessment for all learners.
- Give half a mark for partial answer

Read the following to the learner: "You delivered my baby 10 minutes ago. I have a history of **severe anemia** and had an uneventful labour and birth. You gave me 10 IU oxytocin IM within 1 minute of delivery. Now you have just delivered my placenta. What will you do next?"

Key

Pass score for Atony = 12 /15

Helping Mothers Survive: Bleeding after Birth Complete OSCE 3: Atony

Participant name or ID# _____ Date _____

	Checklist of skills OSCE ITEMS ***Note that checklist is for assessment only, instructions/information to the learner are in italics ***	<u>Yes</u> Performed to standard	<u>No</u> Did NOT perform to standard
	<i>Throughout the OSCE, evaluate respectful care. Observe the learner's communication with the woman. Learners should be respectful, supportive, tell you what they are doing and why. You will score respectful care at the end.</i>	<i>Check appropriate box for each item</i>	
3.1	Massages the uterus		
3.2	Checks the woman's bleeding (<i>keep simulator bleeding on full flow</i>)		
3.3	Gives a treatment dose of medication telling what dose, route and why (<i>mark correct if 10 IU Oxytocin IM OR 800mcg misoprostol orally or sublingual</i>)		
3.4	Re-checks the uterus and bleeding (<i>keep simulator bleeding on full flow</i>)		
3.5	Checks bladder or catheterizes bladder (<i>say, "bladder is empty"</i>)		
3.6	Inspects the placenta for any missing pieces (<i>say "the placenta is complete" keep bleeding heavy</i>)		
3.7	Shouts for help! (<i>here or earlier</i>)		
3.8	Starts IV infusion with oxytocin 20 IU in 1 L at 60 dpm, or directs another to do this. (<i>IF they say with oxytocin, ask, "At what rate?" if not given.</i>)		
3.9	Takes pulse and BP (<i>say only if measurement is taken, "pulse is 90" "BP is 112/62"</i>)		
3.10	Collects blood for 1) hemoglobin, 2) bedside clotting test and 3) grouping and cross matching (or directs another to do this). <i>If the learner says they would collect blood, ask what tests they would perform.</i>		
3.11	Give tranexamic acid 1g IV (<i>If they don't state how, ask, "How will you give this?" Give full mark only if they state it will be diluted in 10 mL of diluent and given over 10 minutes</i>)		
3.12	Washes hands or uses hand rub, puts on elbow length gloves or improvises with two pairs of gloves		
3.13	Provides bi-manual compression (<i>after 20 or 30 seconds say, it has now been 5 minutes and my bleeding has stopped</i>)		

3.14	Ask learner: "What will you do with uterotonic?" Answer: Maintain, continue IV infusion with 20 IU oxytocin in 1 L at 60 dpm over 4 hours		
3.15	Ensured privacy and confidentiality. Provided respectful care and good communication. Told you what was to happen and why, and informed you of the findings.		

Score _____/12

Pass score is 9/12

Pass / Fail (circle one)

Helping Mothers Survive Bleeding after Birth Complete 3.0

OSCE 4: Retained Placenta & Manual Removal of Placenta

Guidelines to be read to participants:

- For this station assume you are in a rural health care facility with no surgical or bloodtransfusion capacity. You have all equipment and supplies necessary for a normal vaginal birth and basic emergency management.
- All essential information will be provided to you at the start of this OSCE station.
- Ask me to clarify any questions prior to beginning. Once the OSCE has started, I will only provide information about the results of any assessment you do.
- You will have 5 minutes to complete this station.
- **Even though I am the examiner, I will be acting as a woman who has just given birth. Talk to and care for me exactly as you would to a woman you are caring for in a clinical situation.**
- Be explicit in verbalizing your clinical thinking and subsequent decisions.
- If you give a medication, you must state what you are giving, the dose, the route, and why you are giving it.

Instructions for the examiner:

- Read above information to the learner.
- Keep the placenta attached in the simulator for the entire scenario. Do not release it during the controlled cord traction.
- Observe only; do not intervene in demonstration of the participant.
- In the checklist, you will see instructions to you in *italics*. Follow these instructions.
- Learners must complete each action within each step in order to receive credit for accurately completing that step. The order of the steps is not important; it is important that all interventions are performed.
- Do NOT give information for assessments they do not make.
- Hold feedback until the end of the assessment for all learners.
- Give half a mark for partial answer
- If placenta removal is performed to standard, score 1 if not performed to standard, or not performed at all, score 0.

Read the following to the learner: "You are alone in a rural health facility. You gave 10 IU oxytocin IM within 1 minute of delivery. You provided CCT during contractions and monitored your patient's bleeding for the past 30 minutes. She remained stable, her bleeding minimal and her placenta has not delivered. What will you do next?"

Helping Mothers Survive Bleeding after Birth Complete 3.0

OSCE 4: Retained Placenta & Manual Removal of Placenta

Guidelines to be read to participants:

	OSCE ITEMS ***Note that checklist is for assessment only, instructions/information to the learner are in italics*** Note: Throughout OSCE, evaluate RMC. Observe their communication with you in your role as the woman. They should be respectful, supportive, tell you what they are doing and why. You will score this at the end.	<u>Yes</u> Performed to standard	<u>No</u> Did NOT perform to standard
		<i>Check appropriate box for each item</i>	
2.1	Repeats 10 IU IM oxytocin		
2.2	Encourages empty bladder (<i>tell learner, "bladder is empty"</i>)		
2.3	Provides controlled cord traction for each contraction (<i>Do not release placenta</i>)		
2.4	Guards uterus while providing controlled cord traction		
2.5	(<i>Say, "It has now been 1 hour since the baby was born"</i>) Identifies that the placenta may be retained		
2.6	Gives diazepam 10 mg IM		
2.7	Starts an IV line with normal saline.		
2.8	Gives appropriate antibiotics e.g ampicillin with clavulanic 625mg IV or 1 g cefazolin IV		
2.9	Washes hands or uses hand rub		
2.10	Puts on sterile elbow length gloves or improvises with two pairs of gloves		
2.11	Gently pulls the cord using it to guide her/his hand into the uterus.		
2.12	Learner describes what he/she is doing while approximating the following action using the simulator: <ul style="list-style-type: none"> Places fingers of one hand into the uterus and locate the placenta. Moves the lateral aspect of the hand back and forth in a smooth lateral motion until placenta separates from the uterine wall. 		
2.13	Provides counter-traction abdominally while removing the placenta. (<i>release placenta from simulator</i>)		
2.14	Once placenta is out, immediately checks uterine tone, and massages if soft.		

NATIONAL POSTPARTUM HEMORRHAGE TRAINING OF TRAINERS (TOT)



Venue:

Date:

BABC 3.0 Training Agenda

Day 1:

SET-UP AND WELCOME: all supplies set up and ready - 30 MINUTES BEFORE TRAINING ACTIVITY BEGINS			
Time	Session Description	Materials	Facilitators
Introduction			
08:30-9:00 Arrival 30"	<input type="checkbox"/> Welcome address <input type="checkbox"/> Brief introductions <input type="checkbox"/> Participants sign-in		
9:00-9:15 Individual Tests 15"	<input type="checkbox"/> knowledge pre-test.	Knowledge tests	
9:15-9:30 Group 15"	<input type="checkbox"/> Introduction to Bleeding after Birth training. <input type="checkbox"/> Discussion around the experience with deaths or near misses from PPH.	Participant's Guide (PG)	
9:30-9:55 Group 25"	Module 1: <input type="checkbox"/> Respectful care and communication to women and their families <input type="checkbox"/> Communicating effectively and respectfully with team members <input type="checkbox"/> Demonstration using the SBAR communication tool for Ms. R's case.	PG	
9:55-10:10 Group 15"	Module 2: Key themes: Preparing for birth and active decision making	PG	
10:10-10: 25	Tea Break		
Prevention of PPH			
10:25-10:40 Group 10"	Module 3: Actively making decision for woman and baby <input type="checkbox"/> Recognizing problems and making decision quickly and effectively for the woman and baby	PG Simulators Supplies	All

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 Champions Course Agenda

Duration	Session Description	Materials	Facilitators
10:40-11:00 Group 20"	Module 4: Prevention and early detection of PPH (AMTSL) AMTSL: <input type="checkbox"/> Immediate routine care for the woman and baby	Action Plan 1 PG Simulators Supplies	All
11:00-11:20 Group 20"	Module 5: AMTSL - Uterotonic <input type="checkbox"/> Oxytocin <input type="checkbox"/> Heat stables Carbetocin <input type="checkbox"/> Misoprostol <input type="checkbox"/> Ergometrine or Ergometrine+oxytocin	PG	
11:20-11:45 Group 25"	Module 6: AMTSL Objective Measurement of Blood Loss <input type="checkbox"/> Learning Activity: Blood estimation exercise <input type="checkbox"/> Use of Calibrated Drape	Blood stations PG	
11:45-12:00 Group 15"	Module 7: AMTSL , Clamp or tie and cut the umbilicus cord <input type="checkbox"/> Cut the cord at the right time in a manner that reduces risk of infection to the baby	PG	
12:00-12:15 Group 15"	Module 8: AMSTL Deliver the Placenta with CCT <input type="checkbox"/> Safely provide control cord traction <input type="checkbox"/> Massage the Uterus <input type="checkbox"/> Examine the placenta	Simulators PG	
12:15-12:30 Group 15"	Learning Activity: AMTSL Small group practice	Simulators Supplies	
Management of Pre-PPH bleeding			
12:30-13:00 Group 30"	Module 9: Manual Removal of Placenta <input type="checkbox"/> Identify a delayed/retained placenta and respond appropriately <input type="checkbox"/> Examining the placenta. <input type="checkbox"/> Routine monitoring and charting tone, bleeding, pulse/BP. <input type="checkbox"/> Checking for tears and repair	Action Plan 1 PG	
13:00-13: 25 Group 25"	Module 10: Check placenta for completeness <input type="checkbox"/> Check both sites of the placenta and membranes for completeness <input type="checkbox"/> Continuing assessing the uterus for tone and massaging <input type="checkbox"/> Continue monitoring of vital signs	Simulators Action Plan 1 PG	
13:25-13:40 Group 15"	Module 11: Check for Bleeding <input type="checkbox"/> Check and record tone, Massage if soft, <input type="checkbox"/> Blood loss and flow <input type="checkbox"/> Vital signs (BP and Pulse)	PG	
13:40-14:05 Stations 25"	Module 12: Check for tears and repair <input type="checkbox"/> Identify and repair tears <input type="checkbox"/> Refer if beyond scope of practice	PG	
14:05-15:00	Lunch		
15:00-15:30 Group 30"	Module 13: Soft uterus and no bleeding after delivery of placenta <input type="checkbox"/> Massage uterus <input type="checkbox"/> Repeat medication	PG	
PPH bundled care			
16:30-16:00 Group 30"	Module 14: Hard Uterus and normal bleeding <input type="checkbox"/> Continue care for woman and baby <input type="checkbox"/> Monitor for heavy bleeding	Action Plan 2 PG	

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Duration	Session Description	Materials	Facilitators
16:00-16:15 Group 15"	Module 15: Main Causes of PPH <ul style="list-style-type: none"> <input type="checkbox"/> Tone <input type="checkbox"/> Tissue <input type="checkbox"/> Trauma <input type="checkbox"/> Thrombin 	PG Action Plan 2 Simulators Supplies	
16:15-16:30 Group 15"	Module 16: Early detection; 3 Triggers to begin the WHO first response bundle for PPH (MOTIVE) <ul style="list-style-type: none"> <input type="checkbox"/> Blood loss ≥500ml <input type="checkbox"/> Blood loss 300 – 499ml + one warning sign <input type="checkbox"/> Clinical judgement of PPH 	Simulators Supplies PG	
16:30-16:45 Stations 15"	Module 17: E-MOTIVE Bundle Approach; <ul style="list-style-type: none"> <input type="checkbox"/> Early identification <input type="checkbox"/> Massage the Uterus <input type="checkbox"/> Oxytocic Drugs <input type="checkbox"/> Tranexamic Acid <input type="checkbox"/> IV Fluid <input type="checkbox"/> Examination and escalation 	Simulators Supplies	
Management of continued/refractory PPH			
16:45- 17:00 Group 15"	Module 18: Trigger PPH management <ul style="list-style-type: none"> <input type="checkbox"/> Call for Help and Emergency Trolley or Carrycase <input type="checkbox"/> Ensure coordinated team work <input type="checkbox"/> Conduct rapid assessment 	Action Plan 2 PG	
17:00-17:20 Group 20"	Module 19: First response bundle for PPH <ul style="list-style-type: none"> <input type="checkbox"/> Massage the uterus <input type="checkbox"/> Oxytocic drugs <input type="checkbox"/> Tranexamic Acid <input type="checkbox"/> IV fluids <input type="checkbox"/> Examination and escalation 	Action Plan 2 PG	
17:20-17:30 Individual 10"	Module 20: Examine for cause of PPH: <ul style="list-style-type: none"> <input type="checkbox"/> Ensure Bladder is empty <input type="checkbox"/> Evacuate clots <input type="checkbox"/> Check for tears <input type="checkbox"/> Check placenta for completion 	Simulators Supplies	
17:30-18:00	Facilitators debrief and preparation for day 2		
Day 2			
8:30-9:00 Group 30"	Signing of attendance Recap of day 1 Review of day 2 agenda		
9:00-9:15 Stations 15"	Module 21: Escalating Care <ul style="list-style-type: none"> <input type="checkbox"/> Communicate using SBAR <input type="checkbox"/> Interventions if PPH refractory to MOTIVE bundle and in spite of additional specific management 	NASGs	small group practice
9:15-9:30 Group'15"	Module 22: Seek Advanced Care; <ul style="list-style-type: none"> <input type="checkbox"/> Get help from senior provider <input type="checkbox"/> Transfer if needed <input type="checkbox"/> Keep woman and baby together <input type="checkbox"/> Continue care for mother and baby 	PG	

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Duration	Session Description	Materials	Facilitators
9:30-9:45 Group 15"	Module 23a: Get more help and assign roles for immediate care <ul style="list-style-type: none"> <input type="checkbox"/> IV access <input type="checkbox"/> Additional uterotonic <input type="checkbox"/> Remove clots <input type="checkbox"/> Massage uterus <input type="checkbox"/> Catheterize bladder <input type="checkbox"/> Examine for tears 		
9:45-10:05 Group 20"	Module 23b: Get more help and assign roles for additional care <ul style="list-style-type: none"> <input type="checkbox"/> IV fluids <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Bi-manual compression of the uterus <input type="checkbox"/> Aortic compression <input type="checkbox"/> NASG <input type="checkbox"/> Pressure to tears <input type="checkbox"/> Uterine Balloon Tamponade (UBT) 		
10:05-10:35 Group 30"	Module 24: Application and removal of NASG Learning Activity: NASG – application and removal of NASG.		
10:35-11:00 Group 25"	Tea break		
11:00-11:30	Module 25: Advanced care for Refractory Bleeding <ul style="list-style-type: none"> <input type="checkbox"/> Repair of deep tears and cervical lacerations <input type="checkbox"/> Manual removal of placental fragments and clots <input type="checkbox"/> Insertion of UBT 		
11:30-11:50 Group 20"	Module 25b: Surgical interventions for uterine atony <ul style="list-style-type: none"> <input type="checkbox"/> Uterine compression sutures <input type="checkbox"/> Utero-ovarian artery ligation <input type="checkbox"/> Sub-total or total hysterectomy 		
11:50-12:20 Group 30"	Module 26: Continue Care after PPH <ul style="list-style-type: none"> <input type="checkbox"/> Continue respectful maternal and newborn care <input type="checkbox"/> Monitoring of woman after recovering from PPH <input type="checkbox"/> Counseling including postpartum family planning <input type="checkbox"/> Support to initiate/continue breast feeding 		
12:20-12:40 Group 20"	Post knowledge test and training evaluation		
12:40- 14:40 Group 120"	OSCE one OSCE Two		
14:40-15:30	Lunch		
15:30-17:30	OSCE three OSCE four		
17:30-18:00	Certification and closing		

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 Champions Course Agenda

Acronyms

ACOG –	American College of Obstetricians and Gynecologists
aOR-	Adjusted Odd Ratio
AMTSL-	Active Management of Third Stage of Labour
APH -	Antepartum Haemorrhage
APTT -	Activated Partial Thromboplastin Time
CCT -	Control Cord Traction
DIC –	Disseminated Intravascular Coagulopathy
E-MOTIVE-	Early detection, Uterine Massage, Oxytocics, Tranexamic acid, Intravenous fluids, Examination and Escalation
EBL -	Estimated Blood Loss
FIGO -	International Federation of Gynaecology and Obstetrics
HELLP -	Haemolysis, Elevated Liver Enzymes, Low Platelets
ICM -	International Confederation of Midwives
LMICs -	Low- and Middle-Income Countries
MDGs -	Millennium Development Goals
MMEIG-	Maternal Mortality Estimation Inter-Agency Group
MMR-	Maternal Mortality Ratio
NDHS -	Nigeria Demographic and Health Survey
ICPD -	International Conference on Population and Development
INR –	International Normalized Ratio
NASG -	Non-Pneumatic Antishock Garment
OR-	Odds Ratio
PAS -	Placenta Accreta Spectrum
PPH -	Postpartum Haemorrhage
PT-	Prothrombin Time
PTTK -	Partial Thromboplastin Time with Kaolin
RCOG -	Royal College of Obstetricians and Gynaecologists
RR -	Relative Risk
RCT-	Randomised Controlled Trial
SBA -	Skilled Birth Attendant
SDGs –	Sustainable Development Goals
SOGON -	Society of Gynaecology and Obstetrics of Nigeria
UNICEF -	United Nations Children's Fund
UNFPA -	United Nations Population Fund
UNDESA -	United Nations Department of Economic and Social Affairs
WHO –	World Health Organization



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