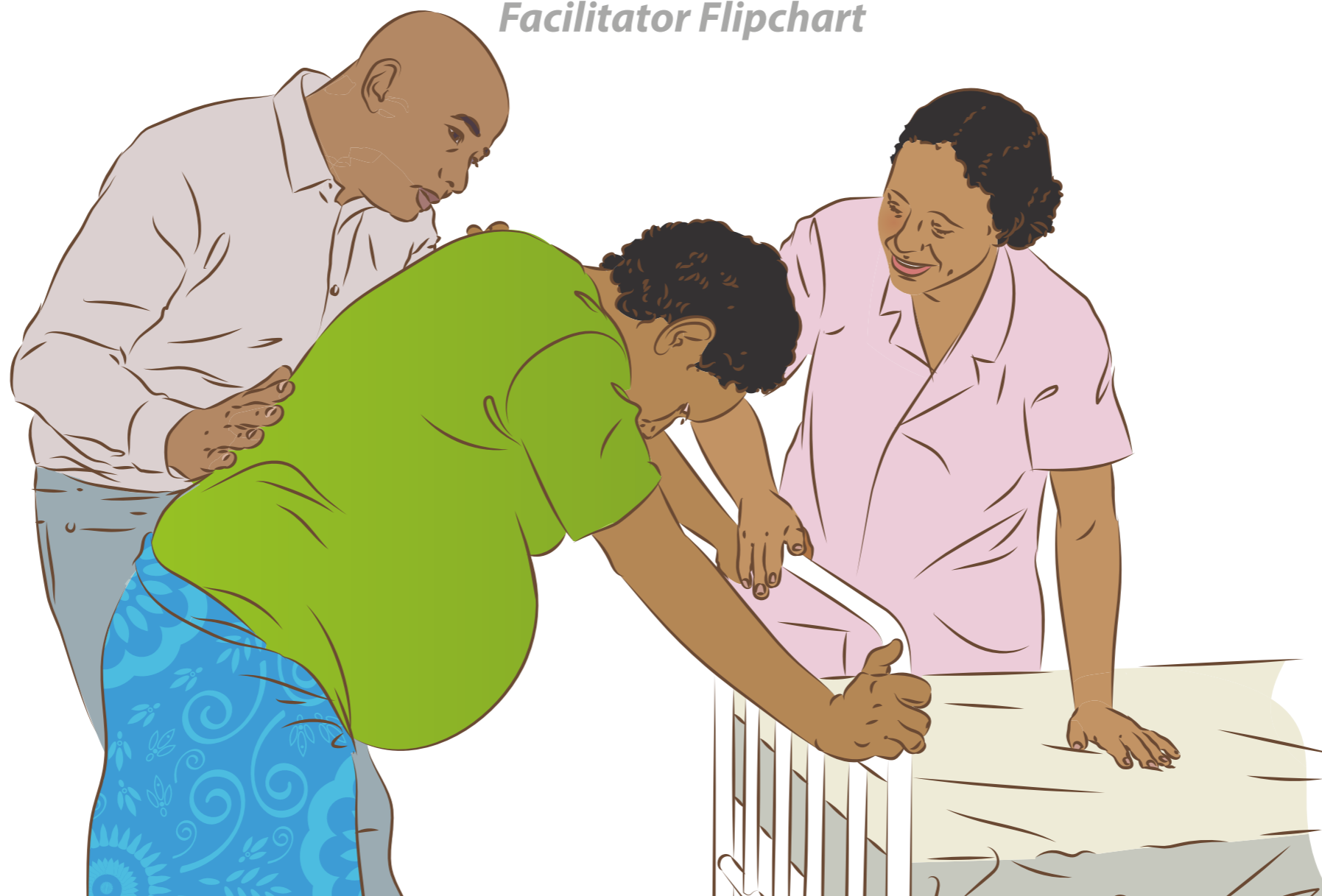


Using Labour Care Guide for preterm labour to document intrapartum care

Facilitator Flipchart

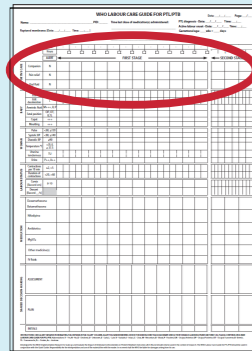


For the facilitator

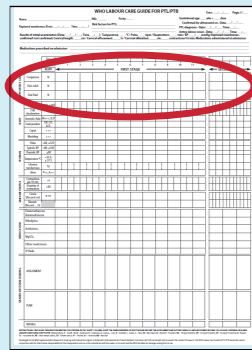
How to use the learning materials

Labour Care Guide (LCG) for Preterm Labour (PTL)

Refer to each section of the LCG for PTL when using the other materials.



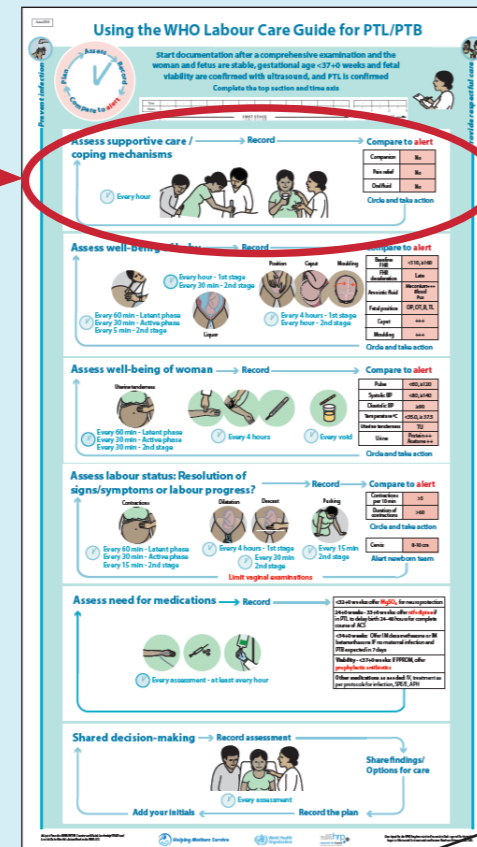
First page



Additional page(s)

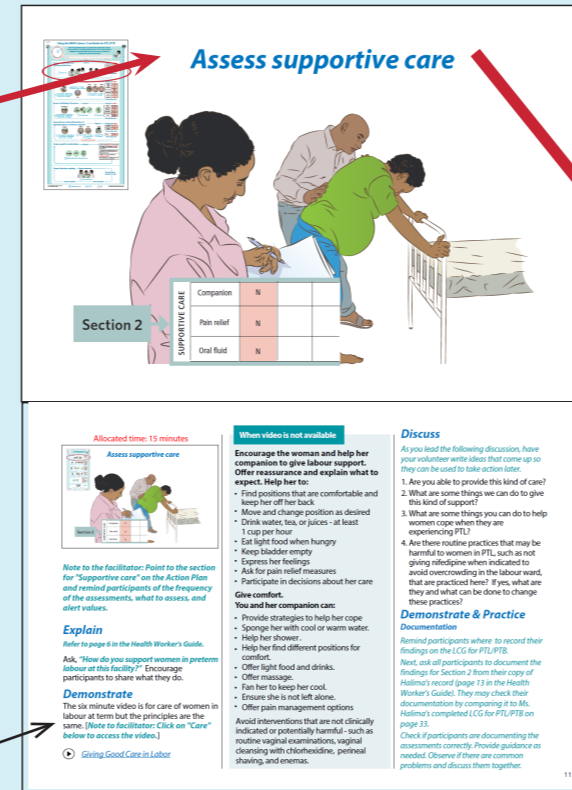
Action Plan

When introducing a section, ask a participant to point out where you are on the Action Plan.



Flipchart

Use illustrations and text to teach how to complete the LCG for PTL and care for and monitor women in PTL.

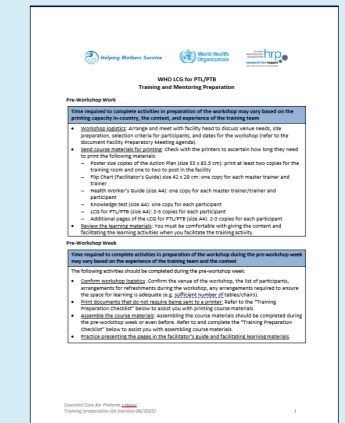


Provider Guide

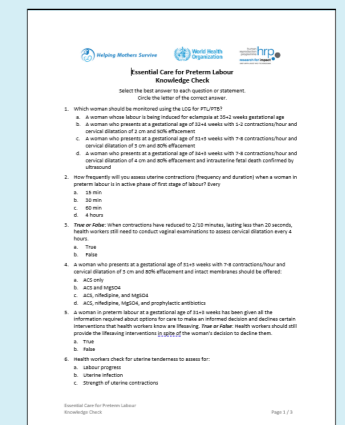
Contains a Quick Guide to assist with completing the LCG for PTL, essential information, and learning activities.



Additional resources



Training and Mentoring Preparation



Pre- and Post-Tests

Explain

Explain: "Need to know" information to cover during this session. Involve participants by asking questions.

As you teach, always emphasize respectful care, good communication and shared decision-making.

The *small italic text* are notes to guide you during the training.

Discuss

Use the "Discuss" questions to identify local problems and find local solutions.

Ask the questions and facilitate discussion. If responses are suggested, give participants a chance to respond before explaining. Honour providers' experiences by encouraging them to share. Explore what is actually being done in their facility (Is this what you do now? Why or why not?). Identify ways to overcome barriers and put new skills into practice. Ask for a volunteer to note down any changes that need to be made at the facility.

Learning activities

For each learning activity, allot enough time for participants to respond, for discussion, and for questions.

Practice

For each section of the LCG for PTL that is reviewed, allot enough time for participants to complete the exercises, for you to check their documentation and for questions/discussion.

Knowledge check

Use the "Knowledge Checks" to provide an opportunity to review and reinforce information learned.

Training Preparation

1. Prepare the venue

Arrange and meet with facility head and confirm dates for training. Ensure all relevant staff participants have been invited. Ensure your transportation to training site is arranged (if needed).

2. Prepare yourself

Review the five sections of the Flip Chart pages:

- **Explain**—Key points that you will explain to the learner.
- **Discuss**—Questions that will provoke discussion among the participants about the local context of care. These questions will also help participants identify changes to improve care.
- **Recording actions to improve care on a flipchart**—After discussion, ask a volunteer to record the actions developed by participants to improve care. These actions will be used by the facility after the training activity..
- **Learning activity**—Opportunities for participants to review the Quick Guide and respond to questions.
- **Practice**—Guidance about how learners should complete each section of the LCG for PTL.
- **Knowledge questions**—Ask the questions and give participants a chance to answer.

Familiarize yourself with exercises and evaluations in the Flip Chart:

- Exercises provide practice to complete the LCG for PTL. Facilitator directions are included with each exercise.

Review the Provider Guide (PG):

- Familiarize yourself content so you can refer participants to content in the Provider Guide. Each page on the Flipbook provides reference pages in PG Guide

Familiarize yourself with protocols, guidelines, and common practices nationally or in the facility that differ from those recommended in this program:

- These might include:
 - where women in PTL are monitored
 - how women in PTL are monitored
 - monitoring tools used during latent and active phases of first stage and second stage
 - monitoring tools used on the antenatal ward.

The decision to teach something that differs from recommendations in this programme should be agreed upon in advance with the course director in consultation with the health authority.

3. Prepare the participants (optional)

The participants can be given the PG in advance of the course and asked to read it.

4. Print the course materials

Refer to the "Training Preparation Checklist" to assist you with decisions about the number of materials to print.

Posters

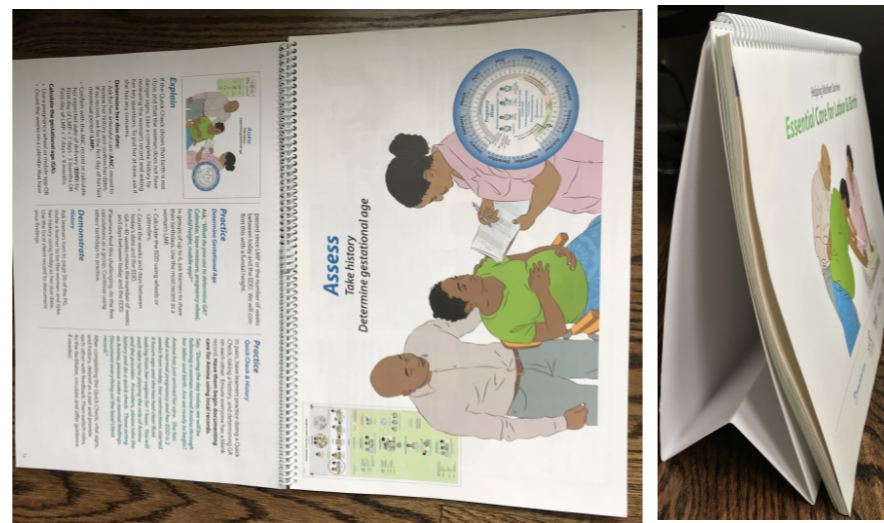
Print poster size copies of the **Action Plan** to post on the wall so that they can be easily seen by all participants and you can easily refer to them.

Print at least two for the training room and one to two to post in the facility..

Flipchart (Facilitator's Guide) - Size 42x29 cm

Each facilitator will need a Flipchart. The Flipchart should have a stand (see the photo below) so that you can place it where participants can see the title page and you can read the facilitator's notes. The Flipchart has two types of pages: 1) Pages i, ii, iii have instructions for the facilitator, 2) Pages with a number (such as 2) are the title page that should face the participant and 3) Pages with a number and a letter (such as 2b) have facilitator notes and should face you.

Print the Flipchart as below. Ask the printers to first print one copy to verify that printing has been correctly done; once you are satisfied that they have been printed correctly, print the number you need.



Facilitator notes

Title page

PG Guide - Size A4

Print one Provider Guide for each facilitator and each participant.

LCG for PTL - Size A3

Print 3 copies for each participant and additional copies to keep in the labour ward to monitor women in PTL after the training activity.

Additional pages of the LCG for PTL - Size A4

Print 3 copies for each participant and additional copies to keep in the labour ward to monitor women in PTL after the training activity.

Additional documents to print

- Sign-in sheet.
- One copy of the pre- and post-tests per participant.
- One confidence assessment per participant.
- One course evaluation form per participant.
- One course completion certificate per participant.

5. Procure/Assemble required equipment and supplies

For each participant:

- 1 red pen, 1 black pen, 1 pencil, 1 eraser.
- 1 notebook.

Other

- Blank flip chart paper and stand; different coloured markers
- Prepared flip chart pages:
 - (1) Welcome.
 - (2) Expectations and norms.
 - (3) Actions to improve care for women in preterm labour.
- Tape or putty to hang job aids and the Action Plan.
- Examples of monitoring tools from participants' facility.
- Key to correct the post-test.

Advice for Course Facilitators

1. Assemble the course materials

Assemble all educational materials and supplies to facilitate practice and exercises.

2. Prepare the space for learning

Arrange the classroom space so that all learners can easily see the Flipchart and refer to the poster-sized Action Plan. If possible, arrange seating in a circle.



Prepare the 3 flip chart pages: (1) Welcome; (2) Expectations and norms; (3) Actions to improve care for women in preterm labour.

3. Educational Advice

Using the Flipchart

Each step in the Action Plan is presented on the Facilitator's Flipchart. The front is viewed by the learner. The back is viewed by the facilitator. It is organized into three steps to help the facilitator support learning:

- 1. Explain** - essential information is printed on the facilitator's page. Encourage learners to participate actively and share their experiences. Do not simply "lecture" the participants – use questions and other techniques to involve participants as you explain the text on the Flipchart.
- 2. Discuss** to identify barriers and find solutions for incorporating knowledge and skills into practice. Ask participants what they have learned and what they would change in their practice. The discussion can also highlight important local practices.
Ask for a volunteer to note any improvements to be made on the paper flip chart - this should be used to help improve conditions in the facility.

3. Facilitate practice. Ask participants to work in groups of 2-3 with different cadres represented in each small group. Instructions for completing the LCG for PTL are on pages 1-12 of the PG. Give clear instructions for activities that are printed in the Flipchart including allotted times.

(1) Ask participants to refer to the relevant page in the PG to understand how to record findings for each section on the LCG for PTL. (2) Next, ask all participants to document the findings for each section from their copy of Halima's record in the PG.

(3) They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Move around the room and check if participants are documenting the assessments correctly. Provide guidance as needed.

Observe if there are common problems and discuss them together.

Presenting materials

- Ask participants to refer to corresponding pages in the PG and show where you are on the Action Plan at the start of each Flipchart page. The corresponding pages in the PG are written on the Facilitator's page in the Flipchart.
- Use a timekeeper to stick to the session timings on the training agenda to make sure you don't go over the time allocated.
- Text in italics** either provides you with a prompt of what to say or ask OR information on how to conduct a learning activity.
- For learning activities, **answers are provided in blue text.**

Engage the learners

Encourage learners to participate actively and share their experiences. Some of the classroom time will be spent on group discussion. Ask participants to reflect on their own practice first and then facilitate a discussion on what they have learned and concrete actions to take to improve care for women in PTL.

When practicing completion of the LCG for PTL, provide positive feedback and then offer constructive suggestions for improvement. Be respectful and positive when correcting mistakes.

5. Evaluate knowledge

Describe to learners how they will be evaluated. At the beginning of the course, ask each learner to complete the pre-test. This gives learners a heads up on content to be covered and provides trainers with a heads up on content areas to pay particular attention to.

At the end of the course, ask each learner to complete the post-test. Each learner should receive a score of at least 80% on the post-test to get a certificate.

Correct responses to knowledge questions on the Pre-/Post-Test can be found on page 22 in this Flipchart. The document with the key for correcting questions 16-20 on the post-test can be found in the folder "Pre- and Post-Tests".

Protect participants' privacy on results: At the beginning of the course, write numbers on a small piece of paper (if there are 6 participants, write numbers 1-6), have participants randomly pick a piece of paper with a number, write their name on the paper with the number and give it back to you. Participants should write this number on the pre- and post-tests - you will have the participant's name associated with the number to record results.

If a participant does not achieve a score of at least 80% on the post-test, review results with the participants, clarify any problems and give the participant a chance to re-take the post-test.

6. Evaluate the training activity

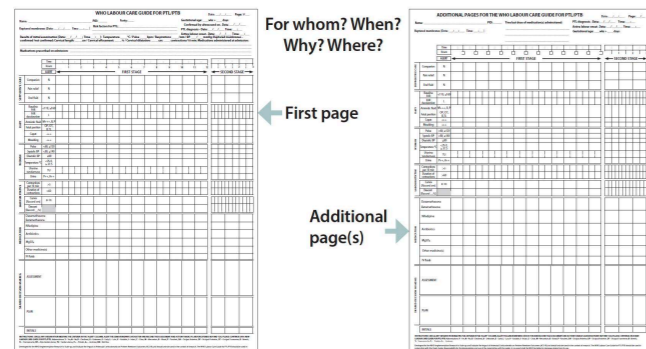
At the end of the course, ask each learner to complete the "Course Evaluation" and "Confidence Assessment" forms. Emphasize to participants that their feedback is extremely important to continue to improve the course materials and how the training activity is carried out.

Compile results from the forms and include them in the final training report. Provide recommendations based on the feedback.

7. Provide course completion certificates

Provide course completion certificates to all participants who received at least 80% on the post-course knowledge check.

WHO Labour Care Guide for Preterm Labour



Explain

Labour Care Guide (LCG) for preterm labour (PTL):

Who is it for?

Women in PTL with confirmed gestational age (GA) less than 37+0 weeks.

When do we use it?

Once PTL has been established starting at ≥ 3 cm. Start using it even if in latent phase OR 2nd stage!

Why do we use it?

To ensure good labour monitoring by comparing assessments to alert values to:

- Identify and manage complications quickly.
- Ensure compassionate support for the woman in labour.
- Ensure medications such as antenatal corticosteroids (ACS) and magnesium sulfate ($MgSO_4$) are being given per protocol.

- Identify and manage side effects of medications.
- Help you know when to alert the neonatal team when birth is close.
- Improve documentation.
- Ensure continuity of care between health workers.

Where?

The LCG for PTL is designed for use where women can receive comprehensive obstetric care at all times, including access to safe caesarean, and their preterm newborns can receive care in a neonatal unit with ventilation support available.

Why are there two pages?

The interventions we give a woman in PTL may slow or stop contractions, which is what we want if it is safe for her to continue her pregnancy. This extra time allows the interventions to improve newborn outcomes to work. Because of this, she may need longer monitoring and the second page allows you to document this longer time period and track interventions over time.

Discuss

1. What barriers exist to documenting care for women in PTL?

Ask for a volunteer to note down any solutions identified.

Labour Care Guide for Preterm Labour

For whom? When?
Why? Where?

← First page

Additional page(s) →

LABOUR CARE GUIDE FOR PRETERM LABOUR (PTL) Date: ___/___/___ Page: 1/___

Name: _____ PID: _____ Parity: _____ Gestational age: ___ wks + ___ days
Confirmed by ultrasound on - Date: ___/___/___

Ruptured membranes [Date: ___/___/___ Time: ___:___] Risk factors for PTL: _____ PTL diagnosis - Date: ___/___/___ Time: _____

Results of initial examination [Date: ___/___/___ Time: ___:___]: Temperature ___ °C / Pulse ___ bpm / Respirations ___ /min / BP ___ / ___ mmHg; Ruptured membranes - confirmed (not confirmed); Cervical length: ___ cm / Cervical effacement: ___ % / Cervical dilatation: ___ cm; contractions/10 min; Medications administered at admission: _____

Medications prescribed on admission: _____

	Time	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
ALERT ← FIRST STAGE → SECOND STAGE →																
SUPPORTIVE CARE	Companion	N														
	Pain relief	N														
	Oral fluid	N														
BABY	Baseline FHR	<110, ≥160														
	FHR deceleration	L														
	Amniotic fluid	M+++ , B, P														
	Fetal position	OP, OT, B, TL														
	Caput	+++														
WOMAN	Moulding	+++														
	Pulse	<60, ≥120														
	Systolic BP	<80, ≥140														
	Diastolic BP	≥90														
	Temperature °C	<35.0, ≥37.5														
LABOUR STATUS	Uterine tenderness	TU														
	Urine	P++, A++														
	Contractions per 10 min	>5														
MEDICATION	Duration of contractions	>60														
	Cervix [Record cm]	8-10														
	Descent [Record ___/___]															
	Dexamethasone															
	Betamethasone															
SHARED DECISION-MAKING	Nifedipine															
	Antibiotics															
	MgSO ₄															
	Other medicine(s)															
	IV fluids															
ASSESSMENT																
PLAN																
INITIALS																

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE FOR PTL/PTB. Abbreviations: Y=Yes, N=No, D=Declined, U=Unknown, E=Early, L=Late, V=Variable, I=Intact, C=Clear, M=Mecorium, B=Blood, P=Placental, OA=Occiput Anterior, OP=Occiput Posterior, OT=Occiput Transverse, B=Breech, TL=Transverse lie, NT=Non-tender uterus, TU=Tender uterus, P=Protein, A=Acetone, ND=Not Due

Developed for the WHO Implementation Research to Scale-up and Evaluate the Impact of Antenatal Corticosteroids on Preterm Newborn Outcomes (ACS-IB) and should only be used in the context of research. The Labour Care Guide for PTL should be used in conjunction with the Quick Guide. Responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO be liable for damages arising from its use.

ADDITIONAL PAGES FOR THE LABOUR CARE GUIDE FOR PTL Date: ___/___/___ Page: ___/___

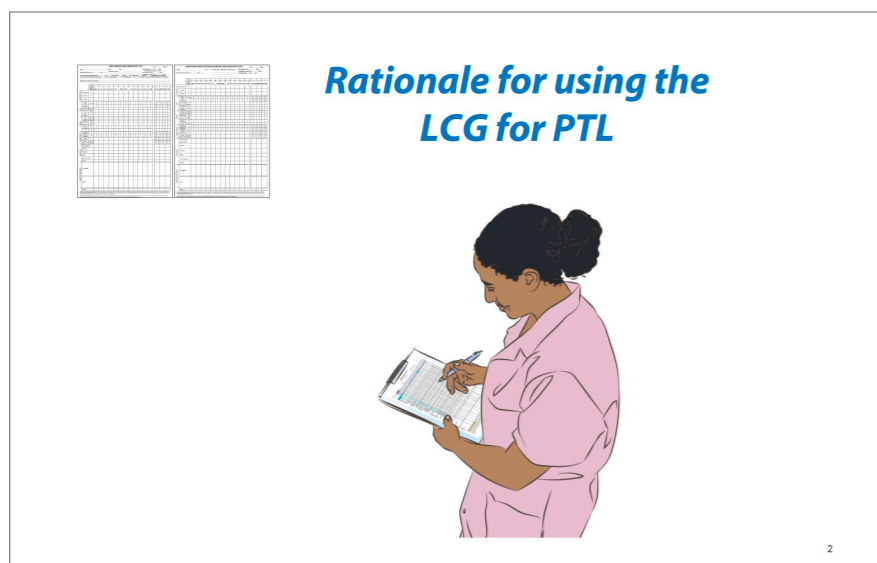
Name: _____ PID: _____ Time last dose of medication(s) administered: _____ PTL diagnosis - Date: ___/___/___ Time: ___:___

Ruptured membranes [Date: ___/___/___ Time: ___:___] Gestational age: ___ wks + ___ days

	Time	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
ALERT ← FIRST STAGE → SECOND STAGE →																
SUPPORTIVE CARE	Companion	N														
	Pain relief	N														
	Oral fluid	N														
BABY	Baseline FHR	<110, ≥160														
	FHR deceleration	L														
	Amniotic fluid	M+++ , B, P														
	Fetal position	OP, OT, B, TL														
	Caput	+++														
WOMAN	Moulding	+++														
	Pulse	<60, ≥120														
	Systolic BP	<80, ≥140														
	Diastolic BP	≥90														
	Temperature °C	<35.0, ≥37.5														
LABOUR STATUS	Uterine tenderness	TU														
	Urine	P++, A++														
	Contractions per 10 min	>5														
MEDICATION	Duration of contractions	>60														
	Cervix [Record cm]	8-10														
	Descent [Record ___/___]															
	Dexamethasone															
	Betamethasone															
SHARED DECISION-MAKING	Nifedipine															
	Antibiotics															
	MgSO ₄															
	Other medicine(s)															
	IV fluids															
ASSESSMENT																
PLAN																
INITIALS																

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE FOR PTL/PTB. Abbreviations: Y=Yes, N=No, D=Declined, U=Unknown, E=Early, L=Late, V=Variable, I=Intact, C=Clear, M=Mecorium, B=Blood, P=Placental, OA=Occiput Anterior, OP=Occiput Posterior, OT=Occiput Transverse, B=Breech, TL=Transverse lie, NT=Non-tender uterus, TU=Tender uterus, P=Protein, A=Acetone, ND=Not Due

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Explain

- The reason we use LCG for PTL is to help you document care specific to women in PTL. For example, there are alert values specific to PTL such as uterine tenderness, presentation, number and duration of contractions, and cervical dilatation that are different from alert values for women in labour at term.
- Using LCG for PTL will help you monitor labour status so you can see if contractions are decreasing or have stopped to allow interventions to work when appropriate.
- And it will help you monitor her labour as she progresses toward birth.

- If care is documented using other labour monitoring tools instead of the LCG for PTL, the right care may not be given. For example:
 - you may not recognize that care and monitoring should be different for the woman in PTL than for the woman in term labour
 - appropriate interventions (ACS, MgSO₄, nifedipine, prophylactic antibiotics) may either not be given at all or the course may not be completed per protocol
 - other documentation tools, such as the LCG for term pregnancies may prompt you to respond to alert values that are not appropriate for women in PTL, possibly resulting in inappropriate interventions to speed up labour
 - health workers may not monitor parameters specific to women in PTL that are crucial to outcomes.
- If labour has stopped, a woman can be monitored on the antenatal ward and you can use your regular monitoring tools to document care. When labour restarts, use additional pages of the LCG for PTL to continue.

Discuss

How can you ensure that all women in PTL are monitored using the LCG for PTL? *Encourage answers below. Ask for a volunteer to note down any solutions.*

- Train all maternity health workers on how to monitor women in PTL and use the LCG for PTL for documentation.
- Ensure adequate numbers of the LCG for PTL and additional pages of the LCG for PTL are available.
- Communicate with colleagues working in the labour ward and those working in the antenatal ward to ensure ongoing monitoring and care of women in cases where labour has resolved.
- Periodically audit completed LCGs for PTL to check what care women received and how it was documented.

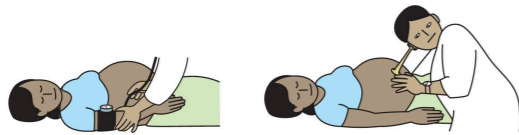
Rationale for using the LCG for PTL

The image shows two pages of the WHO Labour Case Guide for PTL/PTB. The left page is the main form, titled 'WHO LABOUR CASE GUIDE FOR PTL/PTB', and includes sections for 'FIRST STAGE' and 'SECOND STAGE'. The right page is titled 'ADDITIONAL PAGES FOR THE WHO LABOUR CASE GUIDE FOR PTL/PTB' and contains a grid for recording data over time, with columns for 'FIRST STAGE' and 'SECOND STAGE'.



Recap of Risk of PTB course:

Diagnose PTL, ensure the right facility, offer medications per protocol, provide intrapartum care and document



Explain

In the Risk of PTB course, we covered how to assess and manage a woman who presents with high risk of preterm birth. As a brief refresher:

Remember, you will:

- Ensure the woman and fetus are stable and manage complications.
- Do a comprehensive assessment: general, abdominal, ultrasound, speculum, laboratory and potentially digital vaginal but only after speculum examination.

Ask: When will you diagnose PTL and begin the LCG for PTL?

- GA is < 37+0 weeks **and**
- At least 6 uterine contractions/hr **and**
- At least one of the following:
 - cervical dilation ≥ 3 cm **or**
 - effacement $\geq 75\%$.

If in PTL, confirm:

- Gestational age, fetal viability, and fetal presentation using ultrasound.
- Status of membranes.
- Absence of maternal infection.
- Medical or obstetric conditions that require management.

Ensure the right facility

The woman should be transferred to the referral hospital if:

- GA cannot be confirmed.
- She is <34 weeks and you do not have the ability to provide advanced care for a preterm newborn.

Ask: What are the medications you might give to improve newborn outcomes and at what GA?

- ACS (dexamethasone or betamethasone) for fetal lung maturity only if the GA is <34+0 weeks.
- Tocolytics (nifedipine) to slow labor and allow the steroids to work if the GA is <34+0 weeks.
- Antibiotics for PPROM to help prevent infection if GA <37+0 weeks.
- MgSO₄ for fetal neuroprotection if the GA is <32+0 weeks.

Offer other medications as needed:

IV fluids, treatment per protocol for identified infection, SPE/E, APH, unstable hypertension, and others as needed.

If diagnosed in PTL, provide intrapartum care and monitoring:

- Pay special attention to signs of infection and non-reassuring fetal and maternal status.
- Begin the LCG even if she is in second stage of labour.
- Provide timely referral if caesarean birth is indicated and the facility does not have 24/7 CS ability.
- Alert the neonatal team to prepare for PTB.

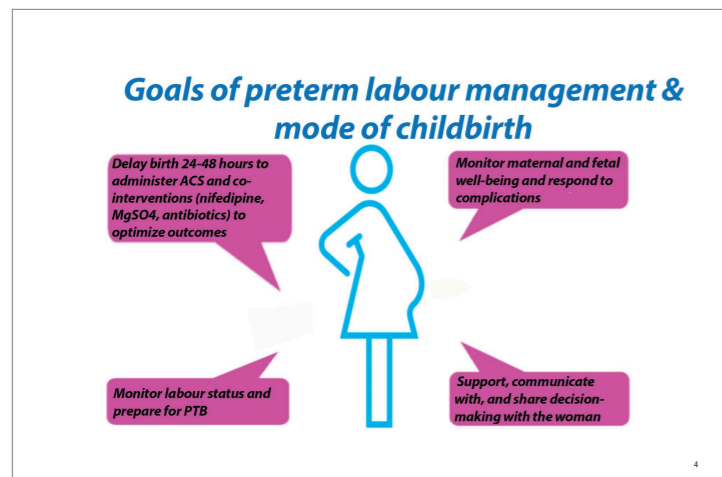
Remember, sometimes it is not safe to prolong the pregnancy. Ask: When is it not safe?

- Eclampsia.
- Worsening pre-eclampsia.
- Uncontrolled severe hypertension.
- Maternal haemorrhage.
- Chorioamnionitis.
- Fetal demise.
- Non-reassuring maternal and/or fetal status.

Recap of Risk of PTB course:

Diagnose PTL, ensure the right facility, offer medications per protocol, provide intrapartum care and document





Explain

The overall goals of managing PTL are to:

- Delay birth 24-48 hours to administer ACS and co-interventions (nifedipine, MgSO₄, antibiotics) to optimize outcomes if it is safe to continue the pregnancy.
- Delay birth until the woman can reach the referral hospital.
- Monitor maternal and fetal well-being using the LCG for PTL and respond to complications.
- Monitor labour status and prepare for PTB.
- Provide supportive care.
- Communicate with, and share decision-making with the woman and companion.

The LCG for PTL will guide care decisions

- It is crucial that assessments are accurate and findings are correctly documented. If health workers are not confident in their assessments, they should seek help from more senior providers.
- If health workers document findings they have not assessed or are not able to assess accurately, the right care may not be given.
- Be sure to adapt the frequency of monitoring based on interpretation of your assessments. If you have concern about the progress of labour or the well-being of the woman and her baby, increase the frequency of your assessments.
- Care should not be based on findings from individual observations alone, but rather on your overall assessment of the woman and her baby.

Malpresentations and malpositions are more common preterm. Assessment, including with ultrasound, should be done if suspected or labour is progressing slowly.

Decide on mode of childbirth

Preterm labour alone is not an indication for caesarean delivery. If the fetus is viable, decisions about mode of childbirth are very similar to those for term births. A notable exception: vacuum assisted birth should not be done if the GA is <34 +0 weeks or the estimated fetal weight is <2500 g.

When transverse lie is the ONLY indication for a caesarean birth, it is important to wait until birth is imminent because:

- If safe to do so, we want to delay birth to allow interventions time to improve newborn outcomes.
- Presentation might change as labour progresses.
- Signs and symptoms of labour may resolve.

Discuss

How can you ensure that the mode of childbirth is carefully decided with the woman rather than providing routine caesarean births for all women in PTL?

- Train all maternity health workers, including obstetricians, on indications for caesarean birth.
- Careful and consistent monitoring of maternal and fetal well-being to inform decisions about mode of childbirth.
- Promote shared decision-making even for making decisions on the mode of childbirth.

Goals of preterm labour management & mode of childbirth

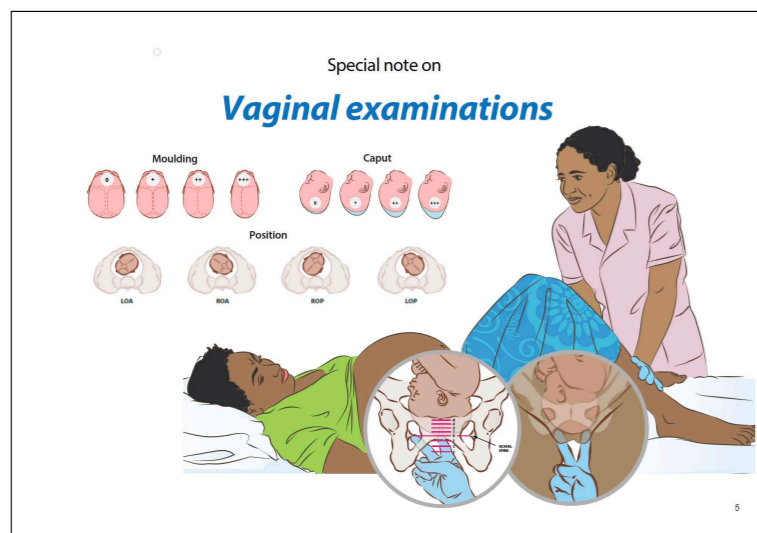
Delay birth 24-48 hours to administer ACS and co-interventions (nifedipine, MgSO₄, antibiotics) to optimize outcomes

Monitor labour status and prepare for PTB



Monitor maternal and fetal well-being and respond to complications

Support, communicate with and share decision-making with the woman



Explain

Vaginal examinations (VEs) help determine cervical dilatation and effacement, caput, and moulding, fetal position, descent, and characteristics of amniotic fluid if membranes are ruptured, but they should be done judiciously.

Best practices for VEs during PTL:

- First, do NOT perform VEs if the woman is bleeding OR there is suspected or confirmed placenta praevia.
- Do a sterile speculum examination first to assess the status of membranes, cervical length and dilatation.

- VEs increase the risk of infection and:
 - should only be done if labour is established, birth is imminent, or if it will change your management
 - should not be done more than every 4 hours without a good reason
 - should be limited or avoided if membranes are ruptured.
- If the woman is receiving nifedipine, do not perform VEs unless there are indications there are regular uterine contractions OR contractions have restarted after stopping OR contractions increase in frequency and duration OR birth is imminent.

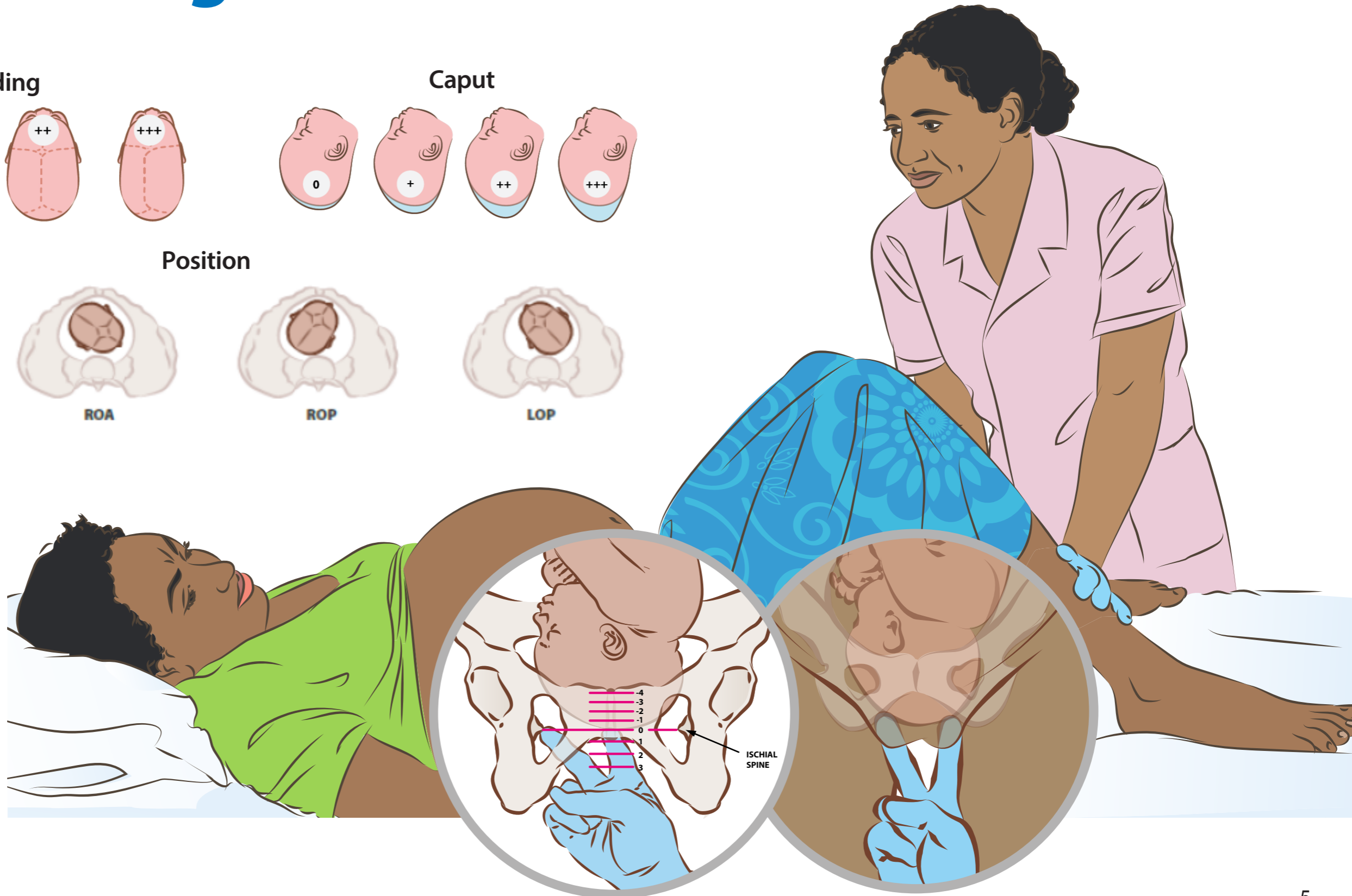
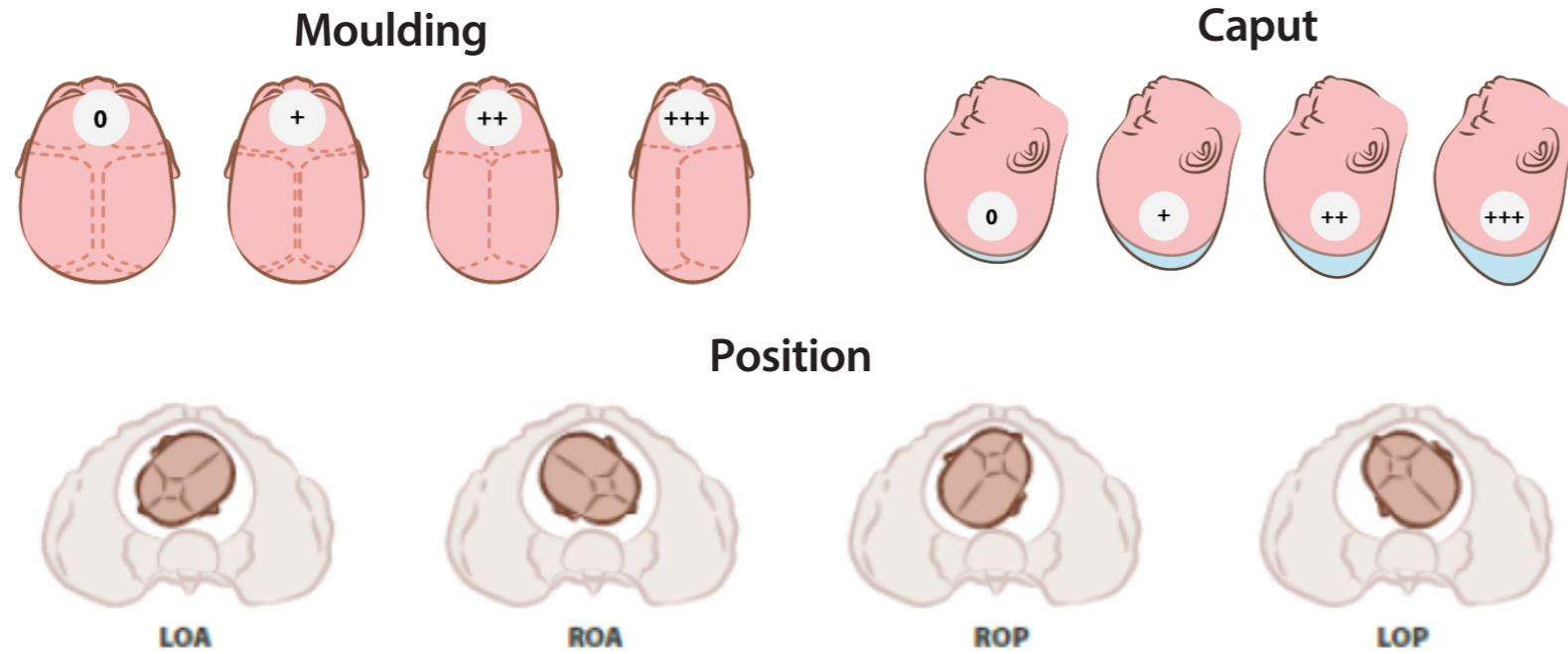
Best practices for VEs for all women:

- Communicate and be respectful.
- Obtain consent.
- Ask the woman to empty her bladder.
- Ensure privacy.
- Do not do a VE during a contraction. Stop the VE if she has a contraction.
- Wash hands, put on clean examination gloves, and use clean technique to wash the labia with water. Look for lesions, bleeding, discharge, amniotic fluid.
- Remove and dispose of clean gloves, wash hands and put on sterile gloves.
- Ask her to relax her legs. Never force her legs apart.
- To avoid multiple VEs, make all assessments at the same time: cervical dilatation and effacement, caput, moulding, fetal position, descent and characteristics of amniotic fluid.
- Watch how the woman is coping during the VE and respond appropriately.
- Inform the woman of findings and record on the LCG for PTL.

REMEMBER: Vaginal loss can be assessed WITHOUT performing a VE.

Special note on

Vaginal examinations



Frequency of monitoring and recording	
<p>Latent 1st stage of labour: ≥3cm but <5cm</p> <p>Every hour Fetal heart rate Contractions Uterine tenderness Companion, pain relief, oral fluid Liquor Medication</p> <p>4 hours Pulse, BP, temp Position, fetal descent (abdominally) Cervix, only if needed for care</p>	<p>Active 1st stage of labour: ≥5cm</p> <p>Every 30 minutes Fetal heart rate Contractions Uterine tenderness</p> <p>1 hour Companion, pain relief, oral fluid Liquor Medication</p> <p>4 hours BP, pulse, temperature Position Fetal descent Cervix, only if needed</p>
<p>If labour stops, move to antenatal ward and check:</p> <p>Every 4 hours Fetal heart rate Contractions Uterine tenderness Companion, pain relief, oral fluid Liquor Medication</p>	<p>2nd stage of labour: 10cm</p> <p>Every 5 minutes Fetal heart rate</p> <p>15 minutes Contractions</p> <p>30 minutes Uterine tenderness Fetal descent Liquor</p> <p>1 hour Companion, pain relief, oral fluid Position, caput, moulding Bladder empty Medication</p> <p>4 hours BP, pulse, temperature</p> <p>Every void in labour Protein & acetone</p>

Explain

The frequency of monitoring a woman in PTL, with the exception of vaginal examinations, is the same as for women in term labour and will vary based on whether the woman is in latent or active phase of first stage or in second stage of labour.

The frequency of monitoring will decrease if labour is resolving because the woman is receiving nifedipine or treatment for an underlying cause of PTL such as infection.

Ask

Point to the box on the left front of this page and ask a participant, "During latent 1st stage of labour, what will you assess every hour? Every 4 hours?" When they are done ask another participant the same about active labour and so on. Follow along by reviewing the columns to the right.

Monitoring frequencies

Assess during latent 1st stage of labour:

- Every hour:
 - fetal heart rate
 - contractions
 - uterine tenderness.
 - companion, pain relief, oral fluid
 - liquor.
- Every 4 hours:
 - pulse, BP, temperature
 - position, fetal descent (abdominally)
 - vaginal examination for cervix, caput, moulding, only if needed to manage care

Assess during active 1st stage of labour:

- Every 30 minutes:
 - fetal heart rate
 - contractions
 - uterine tenderness.
- Every hour:
 - companion, pain relief, oral fluid
 - liquor
 - medications.
- Every 4 hours:
 - pulse, BP, temperature
 - position, fetal descent (abdominally)
 - vaginal examination for cervix, caput, moulding, only if needed to manage care

Assess during 2nd stage of labour:

- Every 5 minutes:
 - fetal heart rate.
- Every 15 minutes:
 - contractions
 - pushing efforts.
- Every 30 minutes:
 - uterine tenderness
 - fetal descent
 - liquor.
- Every hour:
 - companion, pain relief, oral fluid
 - position, caput, moulding
 - bladder empty
 - medications.
- Every 4 hours:
 - pulse, BP, temperature.

Each void in labour: proteinuria, acetonuria

If contractions have stopped or if the woman is having two contractions or less in 10 minutes lasting less than 20 seconds, monitor the woman **on the antenatal ward:**

- Every 4 hours:
 - fetal heart rate
 - contractions
 - uterine tenderness.
 - companion, pain relief, oral fluid
 - liquor.
- Every 8 hours: Maternal vital signs.
- Daily: bowel activity.

Frequency of monitoring and recording

Latent 1st stage of labour: $\geq 3\text{cm}$ but $< 5\text{cm}$

Every hour Fetal heart rate
 Contractions
 Uterine tenderness
 Companion, pain relief, oral fluid
 Liquor
 Medication

4 hours BP, pulse, temp
 Position, fetal descent (abdominally)
 Cervix, only if needed for care

Active 1st stage of labour: $\geq 5\text{cm}$

Every 30 minutes Fetal heart rate
 Contractions
 Uterine tenderness

1 hour Companion, pain relief, oral fluid
 Liquor
 Medication

4 hours BP, pulse, temperature
 Position
 Fetal descent
 Cervix, only if needed

2nd stage of labour: 10cm

Every 5 minutes Fetal heart rate

15 minutes Contractions

30 minutes Uterine tenderness
 Fetal descent
 Liquor

1 hour Companion, pain relief, oral fluid
 Position, caput, moulding
 Bladder empty
 Medication

4 hours BP, pulse, temperature

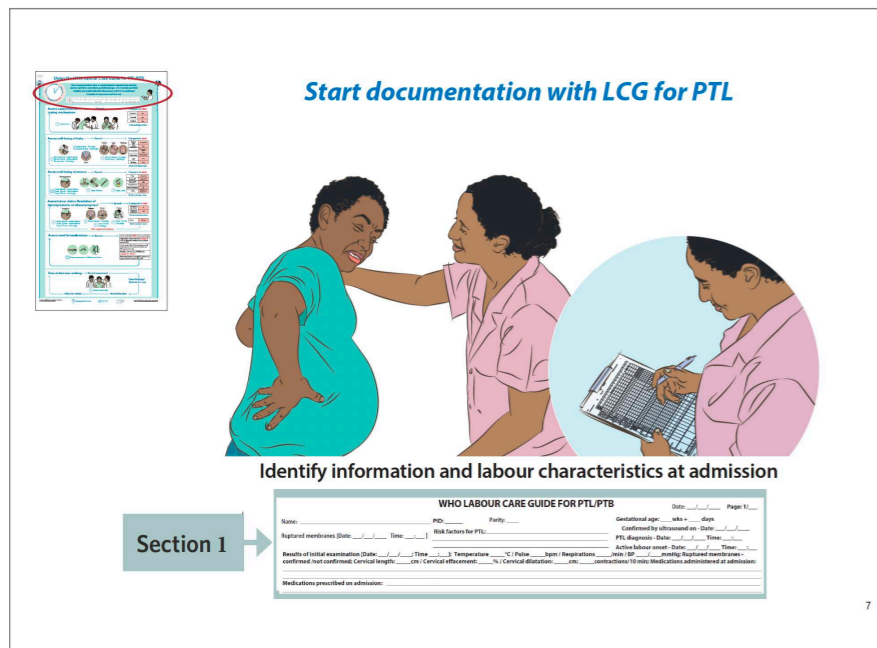
If labour stops, move to antenatal ward and check:

Every 4 hours Fetal heart rate
 Contractions
 Uterine tenderness
 Companion, pain relief, oral fluid
 Liquor
 Medication

Every 8 hours
 Pulse, BP, temp, respirations

Daily
 Bowel activity

Every void in labour Protein & acetone



Explain

Facilitation note: Point to the top section of the LCG on the Action Plan and ask participants to turn to page 4 and 5 of the PG as they look at their copy of the LCG.

This section of the Provider Guide will help you understand how to record your assessments as we work through the case of Halima.

Starting at the top of the LCG for PTL, you will see the woman's identifying characteristics, GA, admission vital signs, risk for PTB, medications given. In the top row of the table, you will need to fill in the time axis based on her admission time.

Note that some information, such as date and time of ruptured membranes and date and time of onset of active labour, will need to be completed as those events happen.

Correctly completing this section helps determine care of the woman and will ensure that treatments that were started on admission will be continued in a timely manner.

Remember, if documentation is not accurate or incomplete, the right care may not be given and changes in status may be missed.

- Close monitoring is essential to assess maternal and fetal well-being, and labour status.
- The neonatal team should be informed on admission so they can plan to be present at the birth.

Ask

Ask participants to refer to pages 4-5 in the PG and the first page of the LCG for PTL and ask:

1. What date for the ultrasound confirming gestational age will you record? *The date it was done.*
2. What are some risk factors for PTL that you may record? *Refer to list on page 4.*
3. How will you complete the section on PTL diagnosis? *20 April 2025, midnight because she is 5cm and actively contracting.*
4. What parts of the examination on admission will you record? *Refer to list.*

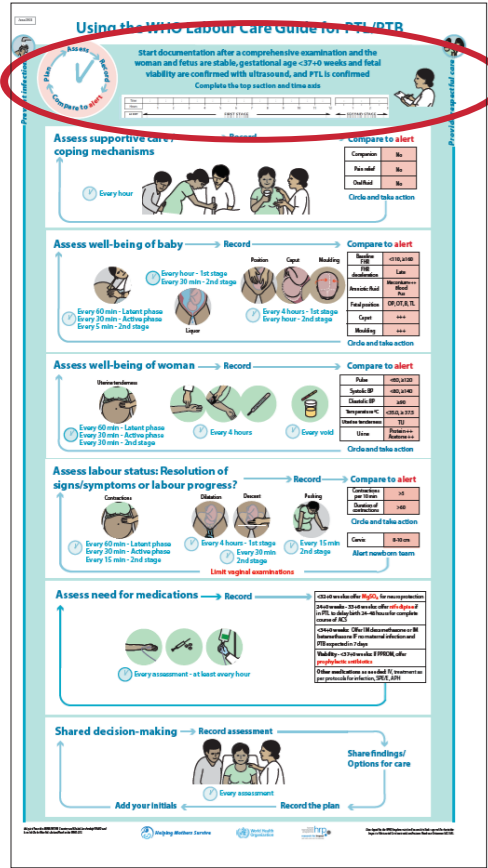
Practice

Ask participants to document the findings for Section 1 from Halima's record on pages 13-14 in the PG. Have them refer to pages 4-5 in the PG to help them. Ensure they fill in the time of day in the first row of the table.

They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Check if participants are documenting the findings correctly. Provide guidance as needed. Observe if there are common problems and discuss them together.

Start documentation with LCG for PTL



Identify information and labour characteristics at admission

Section 1

WHO LABOUR CARE GUIDE FOR PTL/PTB Date: ___/___/___ Page: 1/___

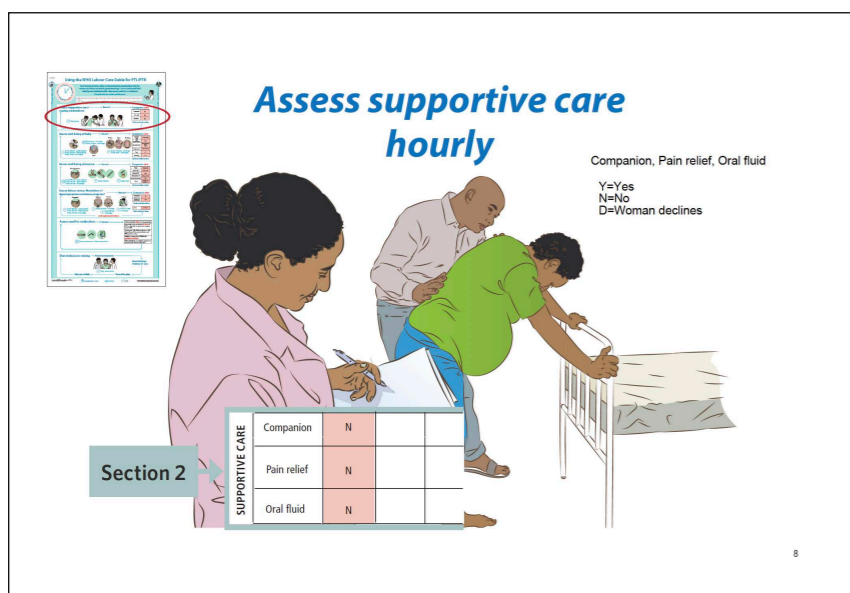
Name: _____ PID: _____ Parity: _____ Gestational age: ___ wks + ___ days

Ruptured membranes [Date: ___/___/___ Time: ___:___] Risk factors for PTL: _____ Confirmed by ultrasound on - Date: ___/___/___

Active labour onset - Date: ___/___/___ Time: ___:___

Results of initial examination [Date: ___/___/___; Time: ___:___]: Temperature ___°C / Pulse ___ bpm / Respirations ___/min / BP ___/___ mmHg; Ruptured membranes - confirmed /not confirmed; Cervical length: ___ cm / Cervical effacement: ___% / Cervical dilatation: ___ cm; ___ contractions/10 min; Medications administered at admission: _____

Medications prescribed on admission: _____



Facilitation note: Point to the section for "Supportive care" on the Action Plan and show the "assess supportive care, record, compare and act" circle around section 2. Point out the frequency and the alert value. Ask participants to refer to page 6 in the PG.

Explain

A woman should have a companion of her choice, pain relief measures if she needs them and fluids to drink if she wants. You will mark Y for yes, N for no, and D for declined. The alert value is N and should be circled in red.

Ask, **"How do you support women in preterm labour at this facility?"** Encourage participants to share what they do.

Demonstrate

This video is for care of women in labour at term but the principles are the same. Facilitator, click on "Care" below to access the video.



[Giving Good Care in Labor](#)

When video is not available, Explain:

Encourage the woman and help her companion to support her. Offer reassurance and explain what to expect. Help her to:

- Find positions that are comfortable and keep her off her back.
- Move and change position as desired.
- Drink water, tea, or juices - at least 1 cup per hour.
- Eat light food when hungry.
- Keep bladder empty.
- Express her feelings.
- Ask for pain relief measures.
- Participate in decisions about her care.

Give comfort.

You and her companion can:

- Offer strategies to help her cope.
- Sponge her with cool or warm water.
- Help her shower.
- Help her find different positions for comfort.
- Offer light food and drinks.
- Offer massage.
- Fan her to keep her cool.
- Ensure she is not left alone.
- Offer pain relief options.

Avoid interventions that are not clinically indicated or potentially harmful - such as routine vaginal examinations, vaginal cleansing with chlorhexidine, perineal shaving, and enemas.

Discuss

Have a volunteer write ideas that come up during discussion to act on later.

1. Are you able to provide this kind of care?
2. What are some things we can do to give this kind of support?
3. Are there routine practices that may be harmful to women in PTL such as not giving nifedipine when indicated or rupturing membranes to speed birth and avoid overcrowding in the labour ward? If yes, what are they and what can be done to change these practices?

Practice

*Ask participants to document findings for Section 2 from Halima's record on page 14 in the PG from 06:00 through birth at 15:35. Have them refer to page 6 in the PG to help them. **Remind them to circle alert values in red pen.***

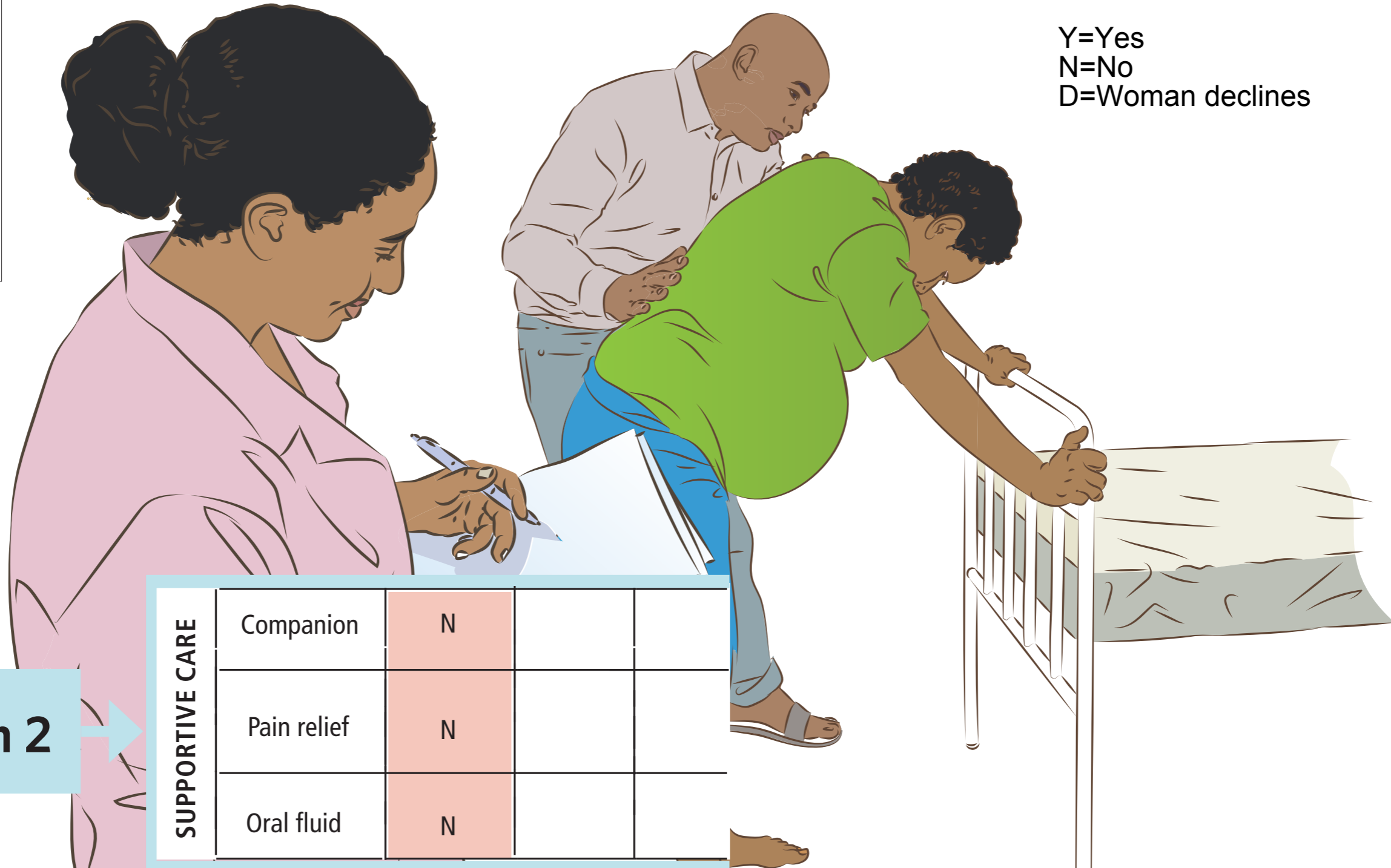
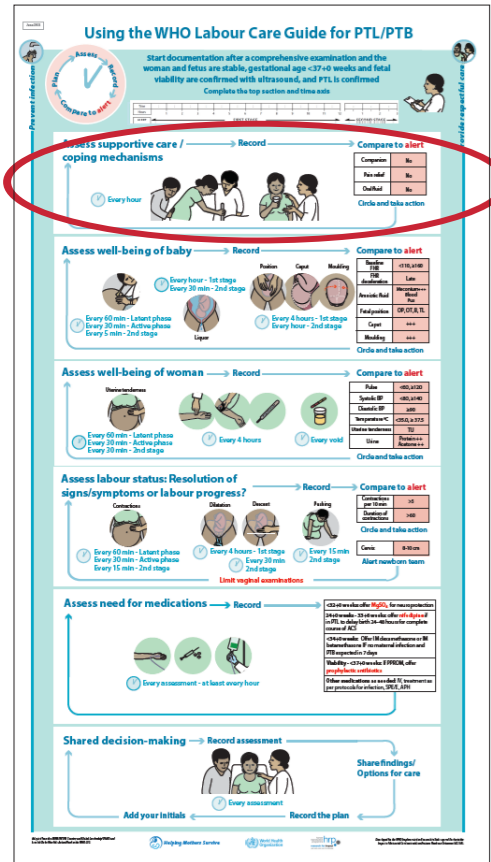
They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Check if participants are documenting the assessments correctly. Provide guidance as needed. Observe if there are common problems and discuss them together.

Assess supportive care hourly

Companion, Pain relief, Oral fluid

Y=Yes
N=No
D=Woman declines



SUPPORTIVE CARE	Companion	N		
	Pain relief	N		
	Oral fluid	N		

Section 2

Assess well-being of the baby
Fetal heart rate and decelerations

Section 3

Baseline FHR	<110, ≥160
FHR deceleration	L
Amniotic fluid	M++, B, P
Fetal position	OP, OT, B, TL
Caput	+++
Moulding	+++

N = No decelerations
E = Early decelerations
L = Late decelerations
V = Variable decelerations

Facilitation note: Point to the section for "Well-being of the baby" on the Action Plan and front page of this Flipchart as you explain.

Explain

Assess the well-being of the baby to help you identify problems early, including:

- Signs of worsening fetal status.
- Umbilical cord compression.
- Cord prolapse which is more common in PTL due to malpresentations.

Check the fetal heart

A normal fetal heart rate (110-159 bpm) may slow during a contraction but usually recovers to normal as soon as the uterus relaxes.

Very slow FHR (<110 bpm) in the absence of contractions or persisting after contractions may be a sign of fetal distress.

A rapid fetal heart rate (≥ 160 bpm) may be due to maternal fever, drugs causing rapid maternal heart rate, hypertension or infection.

It is reassuring if FHR is normal and there are no decelerations. However, an abnormal FHR with or without decelerations does not always indicate that hypoxia or acidosis is present.

Check FHR for a full minute during a contraction and for 30-60 seconds after the contraction ends to decide:

1. When the FHR begins to decrease in relation to the contraction.
2. When the FHR returns to baseline in relation to the contraction.

Fetal heart rate decelerations:

- **Early decelerations:** The FHR drops below baseline at the start of a contraction, reaches the lowest point at the peak of the contraction, and then returns to baseline after the peak of a contraction.
- **Variable decelerations:** The timing of drops in FHR and return to baseline in relation to the contraction is variable. Variable decelerations are classified as severe when they last more than 60 seconds, fall below 70 beats/min, or have a drop of 60 beats/ min below the baseline.

- **Late decelerations:** The FHR drops below baseline usually after the peak of a contraction. These decelerations are associated with hypoxemia.

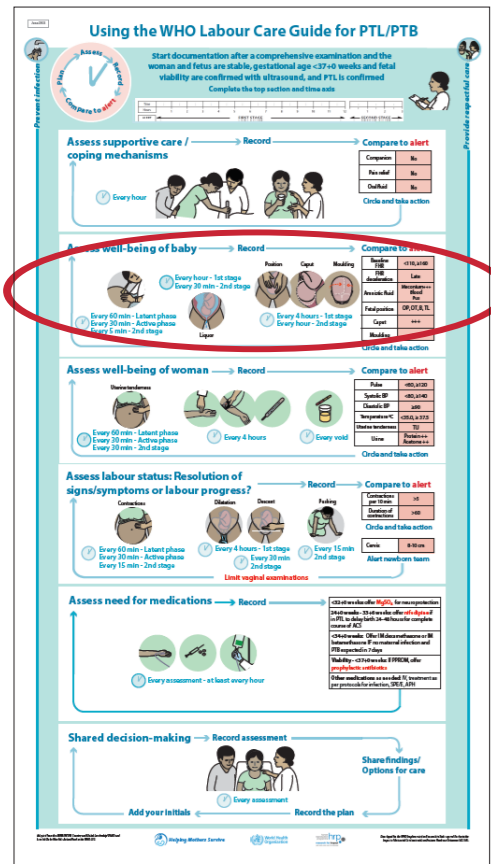
Discuss

Have a volunteer write ideas that come during discussion to act on later.

1. Can you monitor the fetus this closely? If not, why and how can you improve monitoring?
2. How long do you typically listen to the fetal heart rate? (*Remind that it should be for one full minute.*)
3. Do you assess decelerations using intermittent auscultation? If not, what can you do to begin listening for decelerations?

Assess well-being of the baby

Fetal heart rate and decelerations



N = No decelerations
 E = Early decelerations
 L = Late decelerations
 V = Variable decelerations

Section 3

BABY	Baseline FHR	<110, ≥160	
	FHR deceleration	L	
	Amniotic fluid	M+++ , B, P	
	Fetal position	OP, OT, B, TL	
	Caput	+++	
	Moulding	+++	



Assess well-being of the baby

Amniotic fluid

I = Intact membranes
 C = Clear fluid
 M = Meconium-stained fluid +, ++, +++
 B = Blood-stained fluid
 P = Purulent discharge

Position

A = Occiput anterior positions
 P = Occiput posterior positions
 T = Occiput transverse positions
 B = Breech
 TL = Transverse lie

Caput

0 + ++ +++

Moulding

0 + ++ +++

Baseline FHR	<110, ≥160
FHR deceleration	L
Amniotic fluid	M++, B, P
Fetal position	OP, OT, B, TL
Caput	+++
Moulding	+++

Section 3

Facilitation note: Point to the section for "Well-being of the baby" on the Action Plan and front page of this Flipchart as you explain.

Explain

Assess the well-being of the baby by checking:

Amniotic Fluid

Note and document status of the membranes. Record time of rupture or leaking membranes and note the color and character of the fluid. On the LCG for PTL you will mark:

- I = intact.
- C = ruptured and clear.
- M = meconium – use +, ++, +++ to denote very light, medium, thick.
- B = blood stained – be sure to note new-onset, worsening or bright red vaginal bleeding.
- P = purulent.

Fetal presentation and position

Assess presentation and position by gentle abdominal examination and confirm when performing vaginal examination to assess other clinical parameters.

Caput

Caput is diffuse swelling of the scalp when it is compressed against the dilating cervix or pelvic bones. It is graded from 0 to +++ based on severity. When performing vaginal examination to assess other clinical parameters, evaluate the presence of caput. Alert value = +++

Moulding

Pressure on the fetal head during labour can cause the bones of the skull to overlap. It is graded from:

- 0 = none – bones are separated.
- + = sutures are touching.
- ++ = sutures overlap but are reducible.
- +++ = sutures overlap but cannot be reduced.

Severe moulding +++ coupled with poor progress of active labour may indicate obstructed labour. When performing vaginal examination to assess other clinical parameters, evaluate the presence of moulding. Alert value = +++.

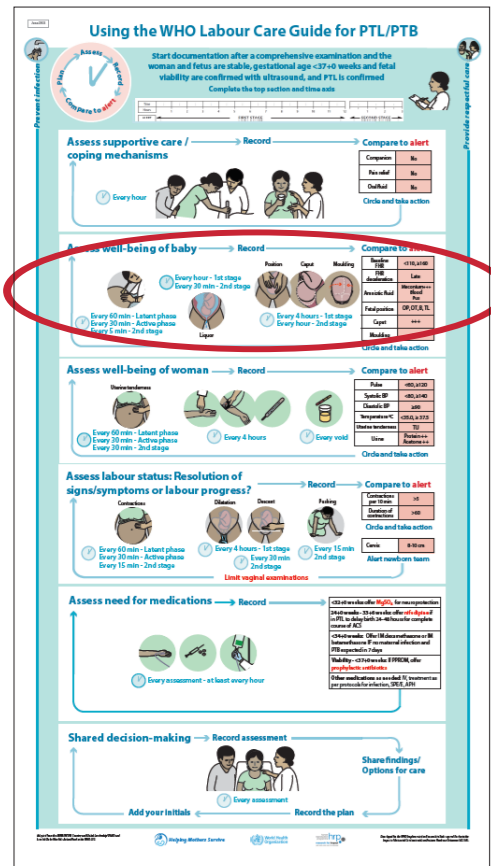
Practice

Ask participants to document findings for Section 3 from Halima's record on page 14 in the PG from 06:00 through birth at 15:35. Have them refer to pages 7-8 in the PG to help them. **Remind them to circle alert values in red pen.**

They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Check if participants are documenting correctly. Observe if there are common problems and discuss them together.

Assess well-being of the baby



Amniotic fluid

- I = Intact membranes
- C = Clear fluid
- M = Meconium-stained fluid +, ++, +++
- B = Blood-stained fluid
- P = Purulent discharge



Position

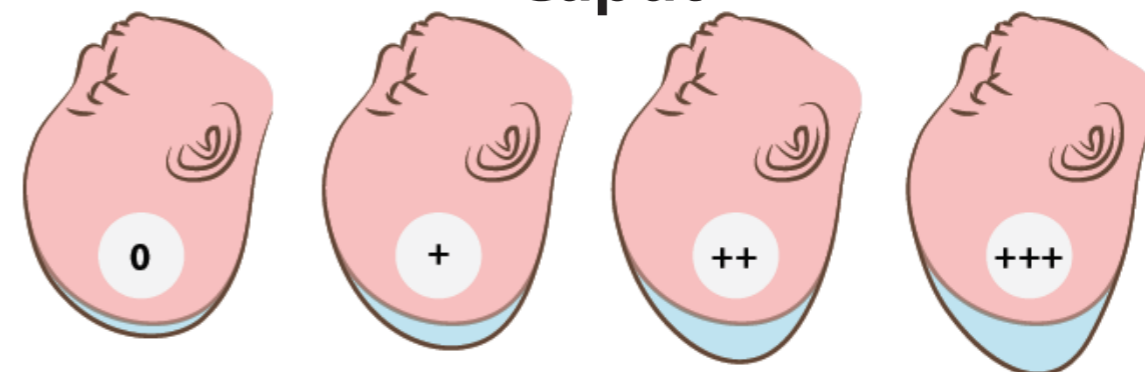
- A = Occiput anterior positions
- P = Occiput posterior positions
- T = Occiput transverse positions
- B = Breech
- TL = Transverse lie



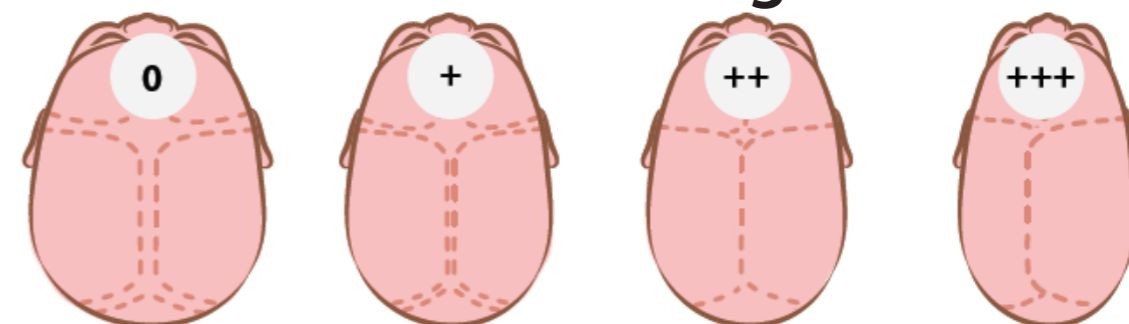
Section 3

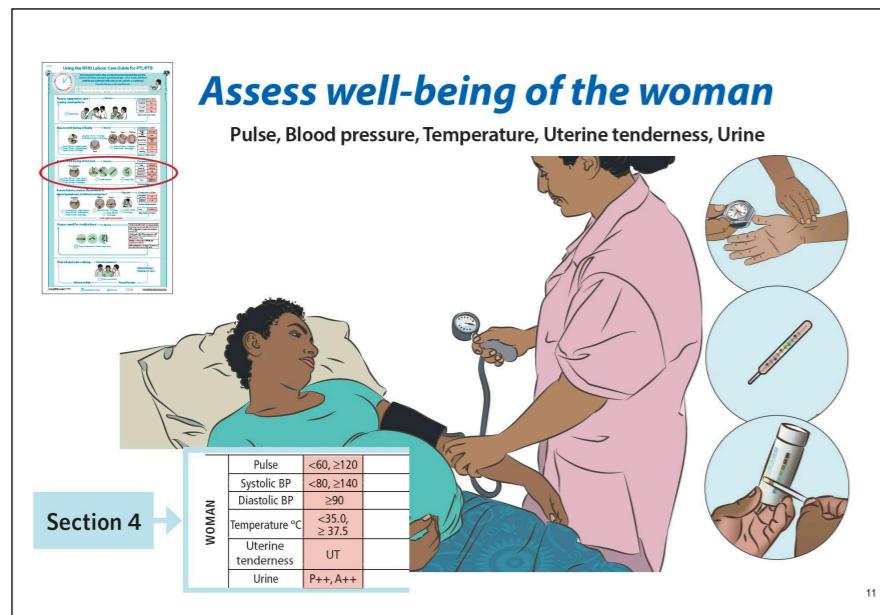
BABY	Baseline FHR	<110, ≥160	
	FHR deceleration	L	
	Amniotic fluid	M+++, B, P	
	Fetal position	OP, OT, B, TL	
	Caput	+++	
	Moulding	+++	

Caput



Moulding





Explain

Assess the well-being of the woman to identify problems early, including:

- Signs of chorioamnionitis such as maternal fever with uterine tenderness, maternal or fetal tachycardia, purulent vaginal discharge.
- Side effects of medications.
- Effectiveness of ongoing treatments.
- Worsening maternal condition.

Note: If a woman is on nifedipine for PTL and she develops signs of chorioamnionitis, discontinue nifedipine and ACS.

Normal findings:

- Temperature: >35.0 °C and ≤ 37.5 °C.
- BP: systolic BP 80–139 mmHg/diastolic BP 60–89 mmHg.
- Pulse: 60 -119 beats per minute.
- Uterine tenderness: None.
- Proteinuria: $<++$
- Acetonuria: $<++$

Ask

What are signs that the woman has chorioamnionitis?

Temperature >38 °C, tender uterus, maternal or fetal tachycardia, foul-smelling/purulent vaginal discharge.

Practice

Ask participants to document findings for Section 4 from Halima's record on page 14 in the PG from 06:00 through birth at 15:35. Have them refer to page 9 in the PG to help them. **Remind them to circle alert values in red pen.**

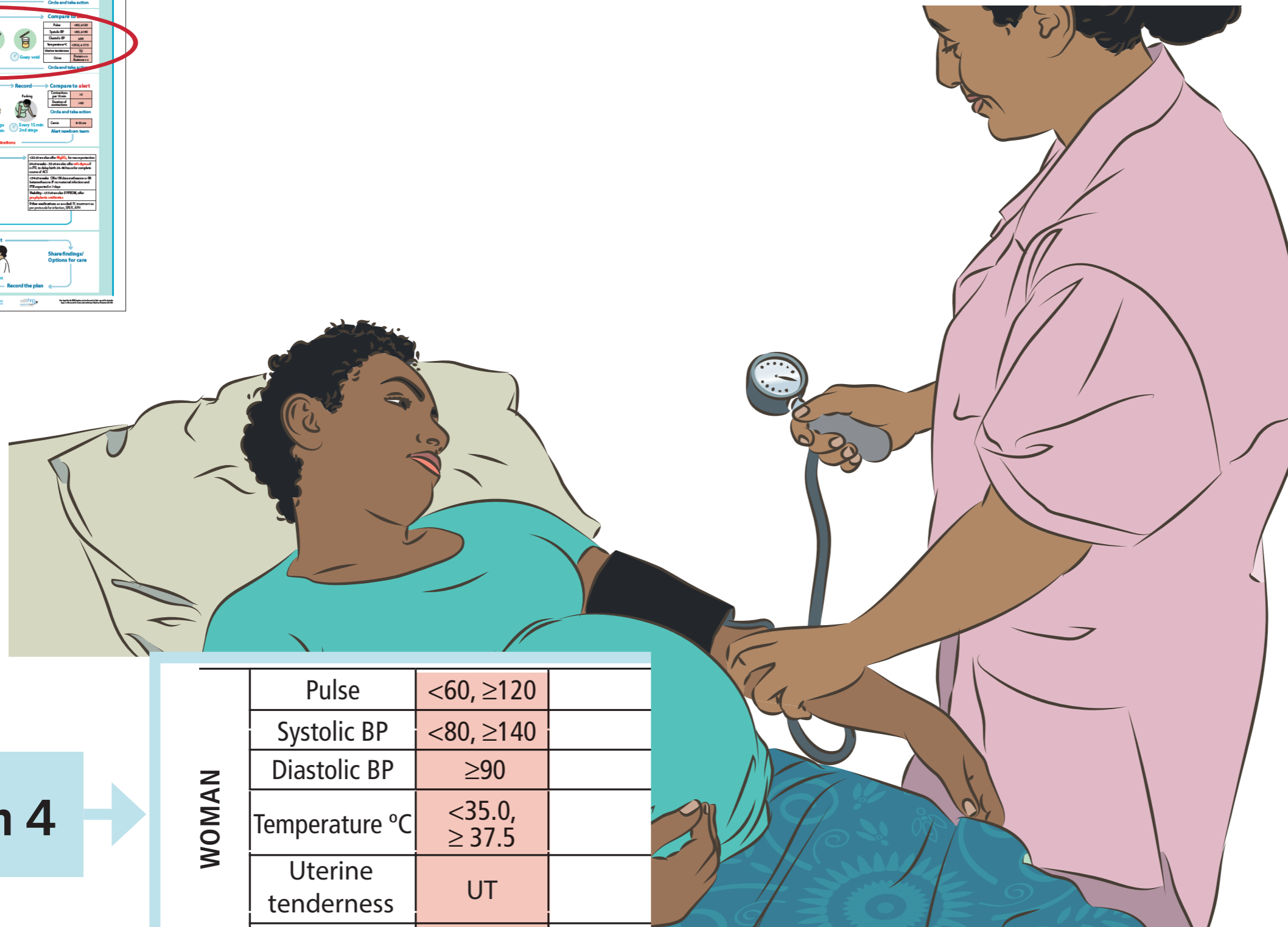
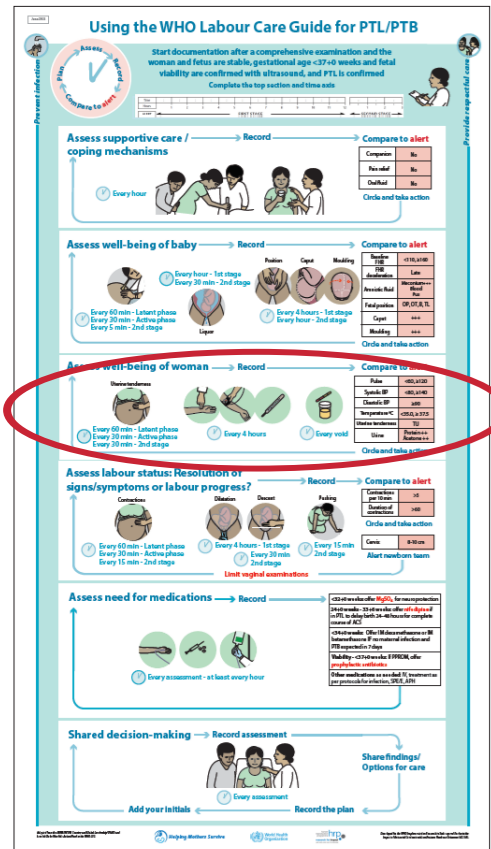
They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Check if participants are documenting the assessments correctly. Provide guidance as needed. Observe if there are common problems and discuss them together.

Review actions to take for alert values.

Assess well-being of the woman

Pulse, Blood pressure, Temperature, Uterine tenderness, Urine



Section 4

WOMAN	Pulse	<60, ≥120
	Systolic BP	<80, ≥140
	Diastolic BP	≥90
	Temperature °C	<35.0, ≥37.5
	Uterine tenderness	UT
	Urine	P++, A++

Assess labour status

Contractions

Cervical dilatation

Descent

LABOUR STATUS	Contractions per 10 min	>5	
	Duration of contractions	>60	
	Cervix (Record cm)	8-10	
	Descent (Record ___/5)		

Section 5

12

Explain

Assess labour status

Assess how many contractions the woman is having in 10 minutes and how many seconds they last:

- Every 60 minutes during latent first stage.
- Every 30 minutes during active first stage.
- At least every 15 minutes during second stage.

Act fast! Provide emergency care and alert a senior health worker if the woman has:

- Abdominal pain that comes on suddenly or lasts between contractions. This may be placental abruption or uterine rupture, especially if there is vaginal bleeding.

- Any contraction longer than 60 seconds OR if there are more than five contractions in 10 minutes OR the uterus does not relax between contractions. These are signs of obstructed labour or hyperstimulation.

If contractions stop or are two or fewer in 10 minutes lasting <20 seconds:

- Consult with a senior health worker to decide if the woman should be cared for in the antenatal ward and follow protocols.

Assess dilatation and cervical effacement

Remember: Do not perform digital VEs unless the woman is having ≥ 3 contractions in 10 minutes, each lasting ≥ 20 seconds.

Assess descent

Place fingers above the symphysis pubis to see how many fingers fit between the pubic bone and the base of the fetal head.

- 5/5: Entire head is above the pubic bone -not engaged.
- 4/5: Head is slightly below the pelvic brim but still high.
- 3/5: Head is entering the brim.
- 2/5: Engaged—the head is firmly in the pelvis.
- 1/5: Only the occiput is felt above the symphysis.
- 0/5: Head is not palpable abdominally; fully engaged/descended.

When cervical dilatation reaches 8-10 cm:

- Alert the neonatal team to prepare to receive and care for a preterm newborn.

Practice

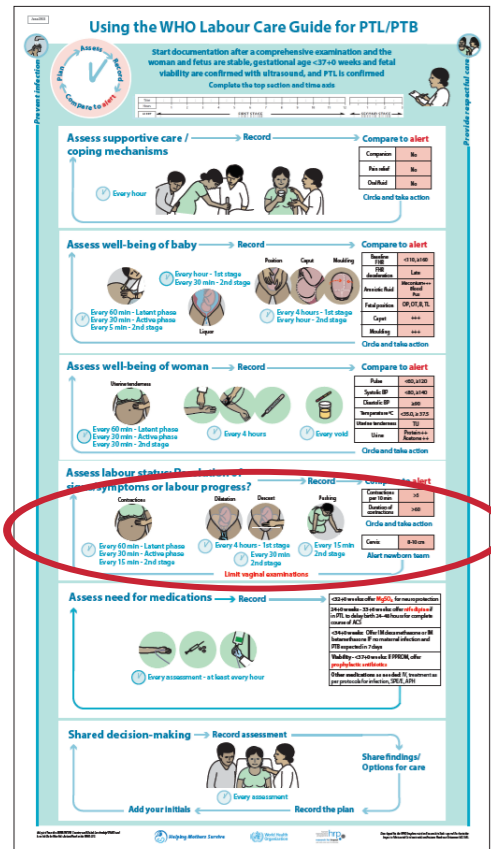
Ask participants to document findings for Section 5 from Halima's record on page 16 in the PG. Have them refer to page 10 in the PG to help them. **Remind them to circle alert values in red pen.**

They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Check if participants are documenting the assessments correctly. Provide guidance as needed. Observe if there are common problems and discuss them together.

Review actions to take for alert values.

Assess labour status



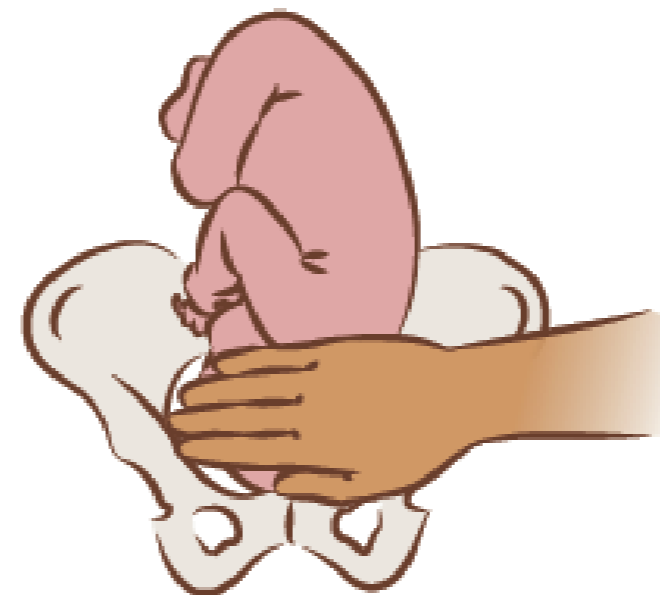
Contractions



Cervical dilatation



Descent



Section 5

LABOUR STATUS	Contractions per 10 min	>5		
	Duration of contractions	>60		
	Cervix [Record cm]	8-10		
	Descent [Record ___/5]			

Medication
ACS, Nifedipine, Antibiotics, MgSO₄, Other medicines, IV fluids

Section 6

MEDICATION	
Dexamethasone	
Betamethasone	
Nifedipine	
Antibiotics	
MgSO ₄	
Other medicine(s)	
IV fluids	

Explain

Check the woman's medication status

This section will help you remember which medications to give and provides a place to record them. This includes the medications to improve preterm newborn outcomes and any other medications or IV fluids.

- For each medication:
 - if she is not receiving it, mark "N" for no
 - if she was offered but declined, mark "D"
 - if it is not due, mark "ND" for not due
 - if given, record time, dose, and route.
- Carefully follow recommendations for use:
 - indications and contraindications
 - dose and route
 - frequency.

Ask

Ask participants to refer to page 11 in the PG and ask:

1. What will you record if you administered dexamethasone at 09:15? Circle dexamethasone in the medication list and record "09:15 - 6mg IM" in the 09:00 cell
2. What will you record if the woman is NOT receiving any IV fluids at 14:00? Record "N" in the cell for IV fluids at 14:00.
3. What will you record if the woman is receiving IV MgSO₄ at 13:00? Record "1g/h IV MgSO₄" in the cell for MgSO₄ at 13:00.

Learning activity

Divide participants into groups of 2-3. Ask them to review medication orders for Halima on page 13 of the PG, review assessments on the LCG for PTL and assess if she needs any medications or an IV infusion.

Give participants a chance to respond. Then explain:

- She was prescribed dexamethasone, nifedipine, and MgSO₄ and will need continuing doses.
- Maternal status is reassuring and she had no danger signs on admission.

- Liquor is clear, her uterus is nontender, and her temperature is normal, so there are no signs of chorioamnionitis.
- There is meconium 1+ but this is a normal finding with breech.
- FHR is within normal limits but there are early decelerations in second stage.

Practice

Ask participants to document findings for Section 6 from Halima's record on page 16 in the PG. Have them refer to page 11 in the PG to help them. **Remind them to circle alert values in red pen.**

They may check their documentation by comparing it to Ms. Halima's completed LCG for PTL on page 34.

Check if participants are documenting the medications correctly. Provide guidance as needed. Observe if there are common problems and discuss them together.

Medication

ACS, Nifedipine, Antibiotics, MgSO₄, Other medicines, IV fluids

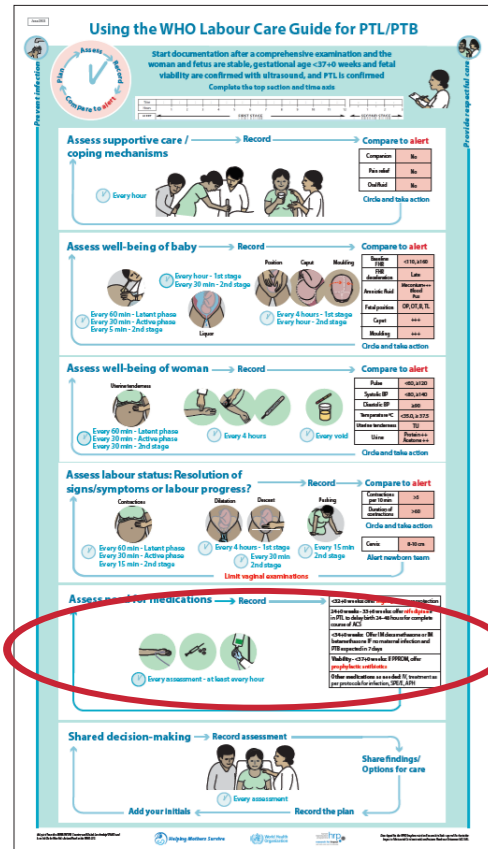
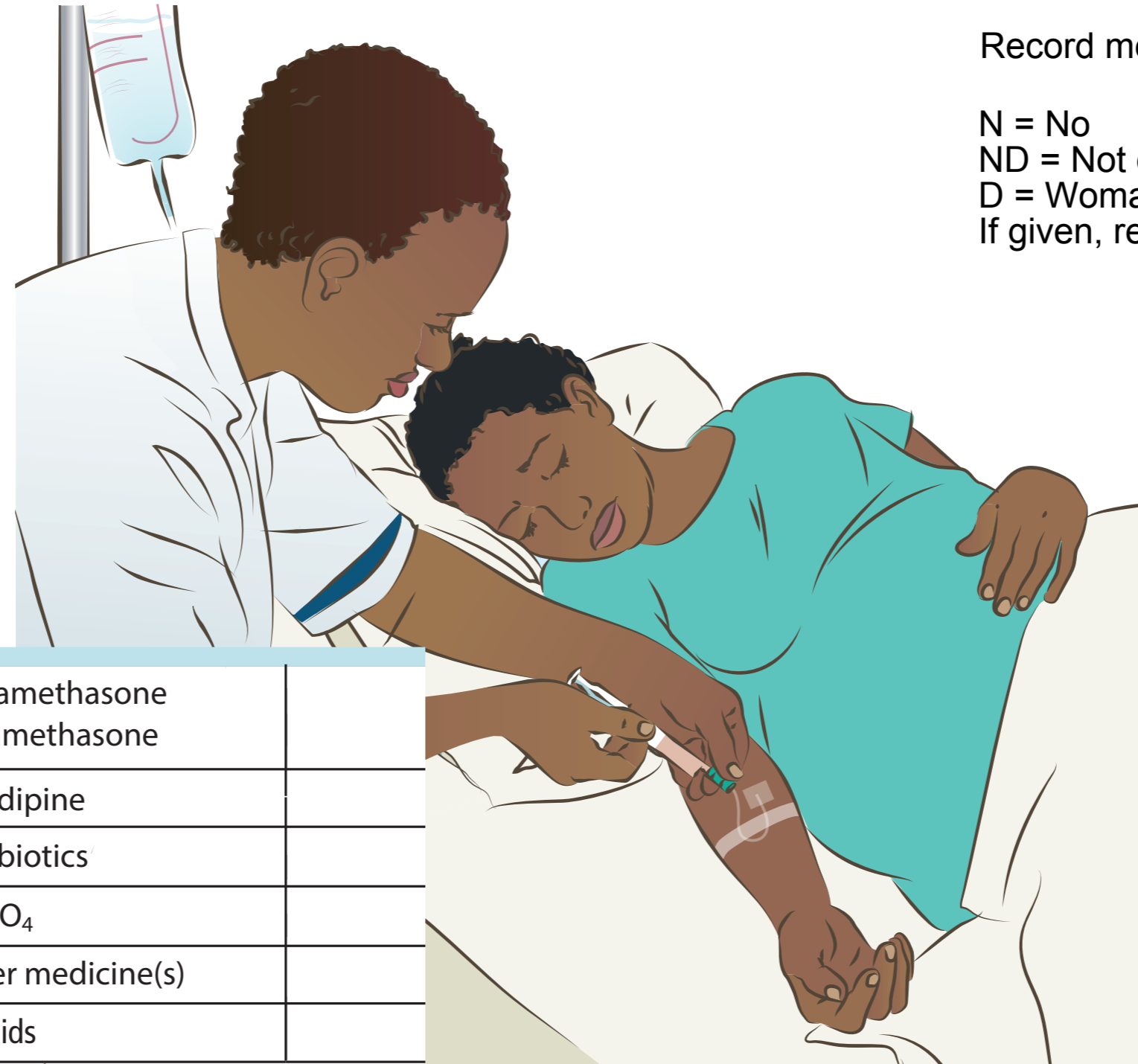
Record medication

N = No

ND = Not due

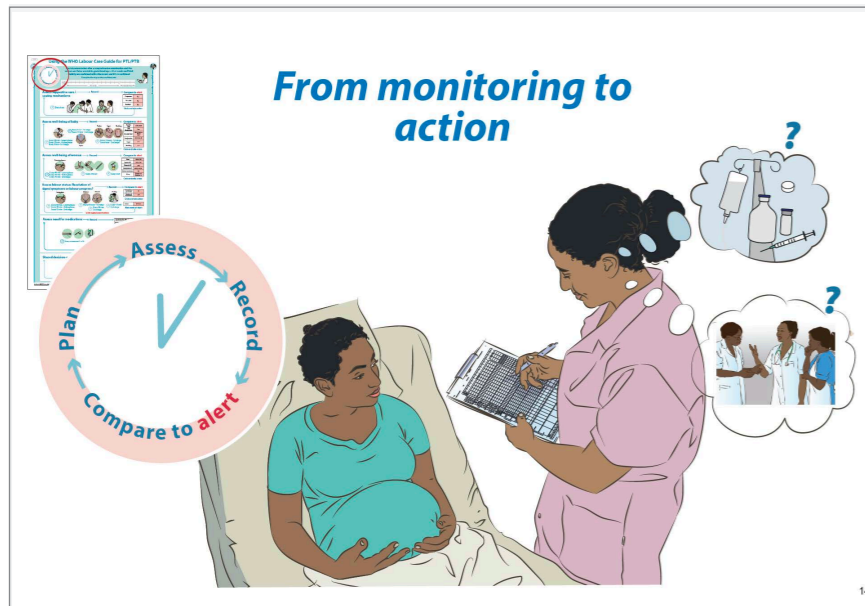
D = Woman declines

If given, record dose, route & time



Section 6

MEDICATION	Dexamethasone	
	Betamethasone	
	Nifedipine	
	Antibiotics	
	MgSO ₄	
	Other medicine(s)	
IV fluids		



Explain

While caring for a woman in PTL, you must actively make decisions to quickly manage problems and improve outcomes.

Facilitation note: Point to the circle on the front page and Action Plan and explain the steps.

Each time you **assess** or check the woman, fetus, and labour status you will need to **record** your findings, **compare to alert values**, and then develop a care **plan** based on findings, your assessment, and shared decisions with the woman.

Your plan will take into account findings from the assessment, goals for labour management, and the woman's choices.

After implementing the plan, re-start the **Assess** → **Record** → **Compare** to alert values → **Plan** cycle.

Ask

Ask participants to refer to the Quick Guide on page 6-11 of the Provider Guide to consider options for care in the following scenarios: **What action(s) will you take when you find the following?**

- **Supportive care:** The woman is anxious, expressing feelings of guilt and fear that medications might harm her baby. *Offer a companion, let her voice her concerns.*
- **Well-being of baby:** At 34+3 weeks GA, cervix 4 cm, 80% effaced, with 3 contractions/10 min lasting 40 seconds, FHR is 180 bpm with late decelerations and there is foul-smelling discharge. *Turn to left side, call senior provider, prolonged auscultation, assess further.*
- **Well-being of woman:** On admission a woman at 32 weeks GA had normal vital signs. 3 hours after admission, her BP =102/58, pulse=102 bpm, temp =38.5 °C. *Call senior provider, follow protocols.*
- **Labour status:** At 34+3 weeks GA, 4 cm cervical dilatation, 80% effacement, with 3 contractions/10 min lasting 40 seconds. She received nifedipine and ACS. 4 hours later, cervix is still 4 cm dilated and she has 0-1 contractions/ 10 minutes lasting 30 seconds. *Call senior provider to consider moving to antenatal ward.*
- **Medications:** The same woman above received ACS and modified release nifedipine at 08:00. It is now 12:00. What medications should she be offered? *Depending on contractions, nifedipine 20 mg and paracetamol if complaint of headache.*

Discuss

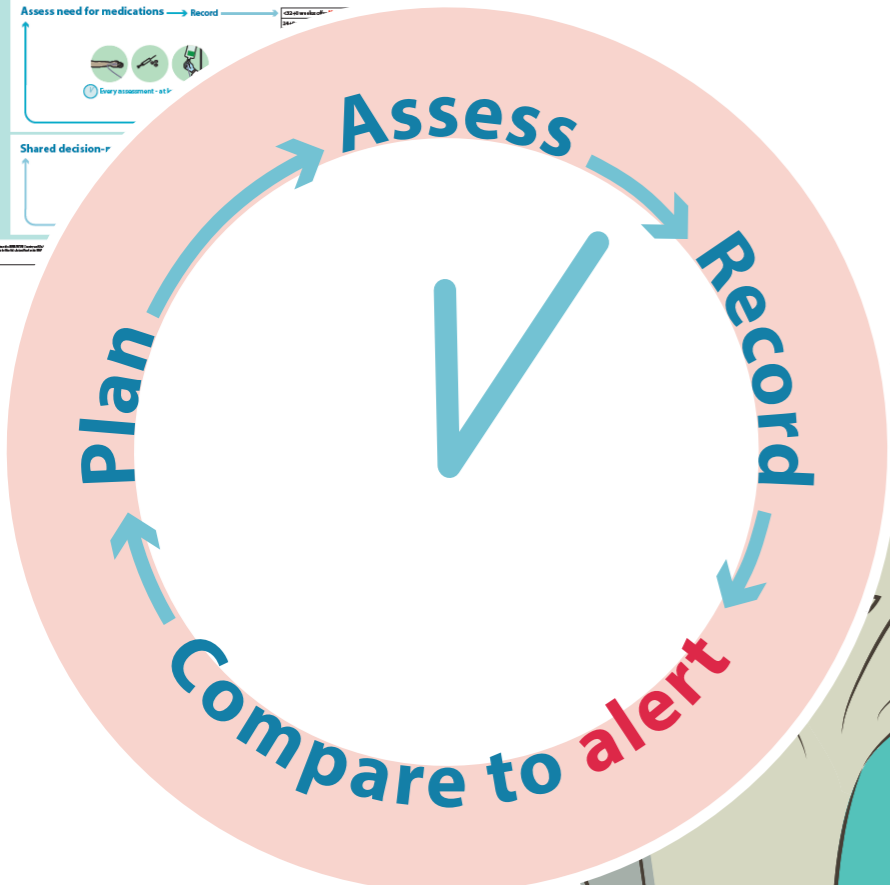
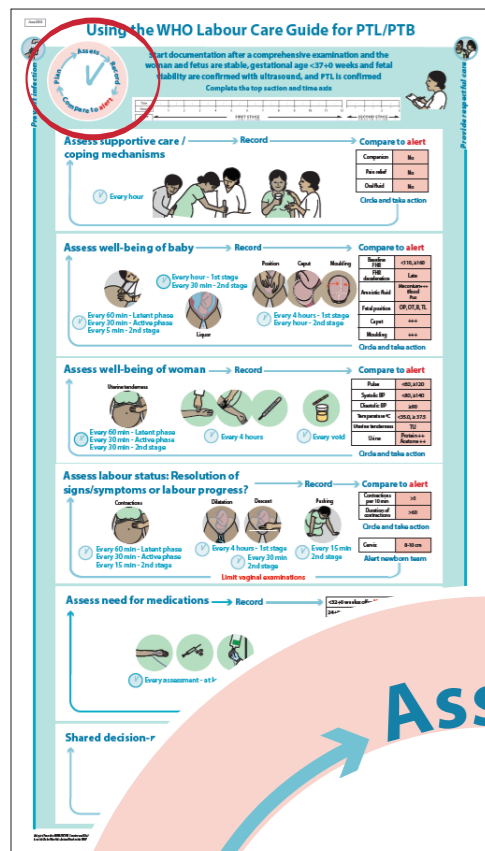
1. Have you used the Access, Record, Compare to alerts, Plan cycle to monitor a woman and develop a care plan with her and her companion? If not, how can you begin this practice?

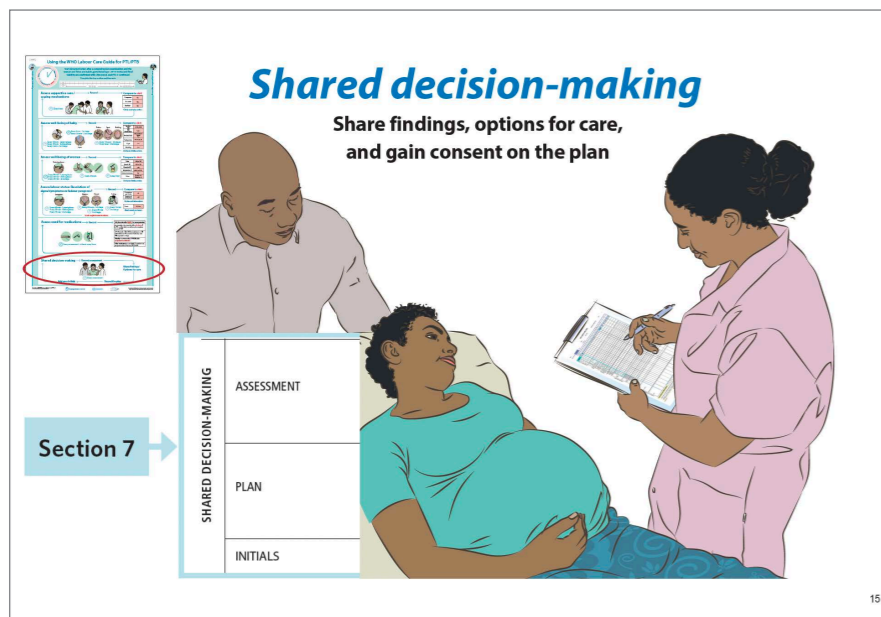
Ask for a volunteer to note down solutions to use this cycle to improve care and respond quickly when an "alert" value is identified.

2. When a cell is left blank at a time an assessment should be conducted, it appears that no effort was made to conduct the assessment. What will you document when you are either unable to assess a parameter or are not confident in your assessment and no senior health worker is available to assist you with the assessment? *Agree on how to document. For example, place a "-" in the cell to indicate you knew the assessment should have been conducted but you were unable to and no one was available to assist you with the assessment.*

If you were unable to do an assessment due to time constraints, do it as soon as you are able and record at the time you performed it. Contact a senior health worker as soon as one is available to assist you with assessing a parameter you are not able to assess.

From monitoring to action





Explain

Shared decision-making increases patient satisfaction and adherence to treatment. Shared decision-making is a collaborative process where health workers on the perinatal team and patients work together to make decisions that are both evidence-based and aligned with the women's values and preferences. This can help ensure a woman receives the best, individualized care.

- To enable shared decision-making:
 - ensure good communication between health workers and women in labour
 - take into consideration a woman's values, preferences, fears and concerns.

- use appropriate language, and culturally appropriate terminology
- consider language, health literacy, education level and understanding of the process of pregnancy and birth
- explain in clear, simple terms findings of assessments and their implications
- explain all care options, including benefits and risks for the woman and the baby
- give plenty of time for the woman to ask questions
- come to agreement on the plan of care and obtain informed consent.
- Involve the woman, family and health workers on the perinatal team who are involved in care of the woman and preterm newborn in shared decision making.
 - for the woman, this includes the obstetrician, midwife, nurses
 - for the preterm newborn, this includes NICU staff, neonatologists, paediatricians, nurses.
- On section 7 of the LCG for PTL, every hour record your assessment and the plan as agreed on with the woman.
 - assessment examples include maternal infection, PTL resolving, fetal distress, etc

- plan examples include alerting the neonatal team when she is first admitted in PTL, starting antibiotics if you diagnose an infection, consulting a senior doctor for a complication you have diagnosed or transfer to the antenatal ward if labour is resolving.

Demonstrate and Practice

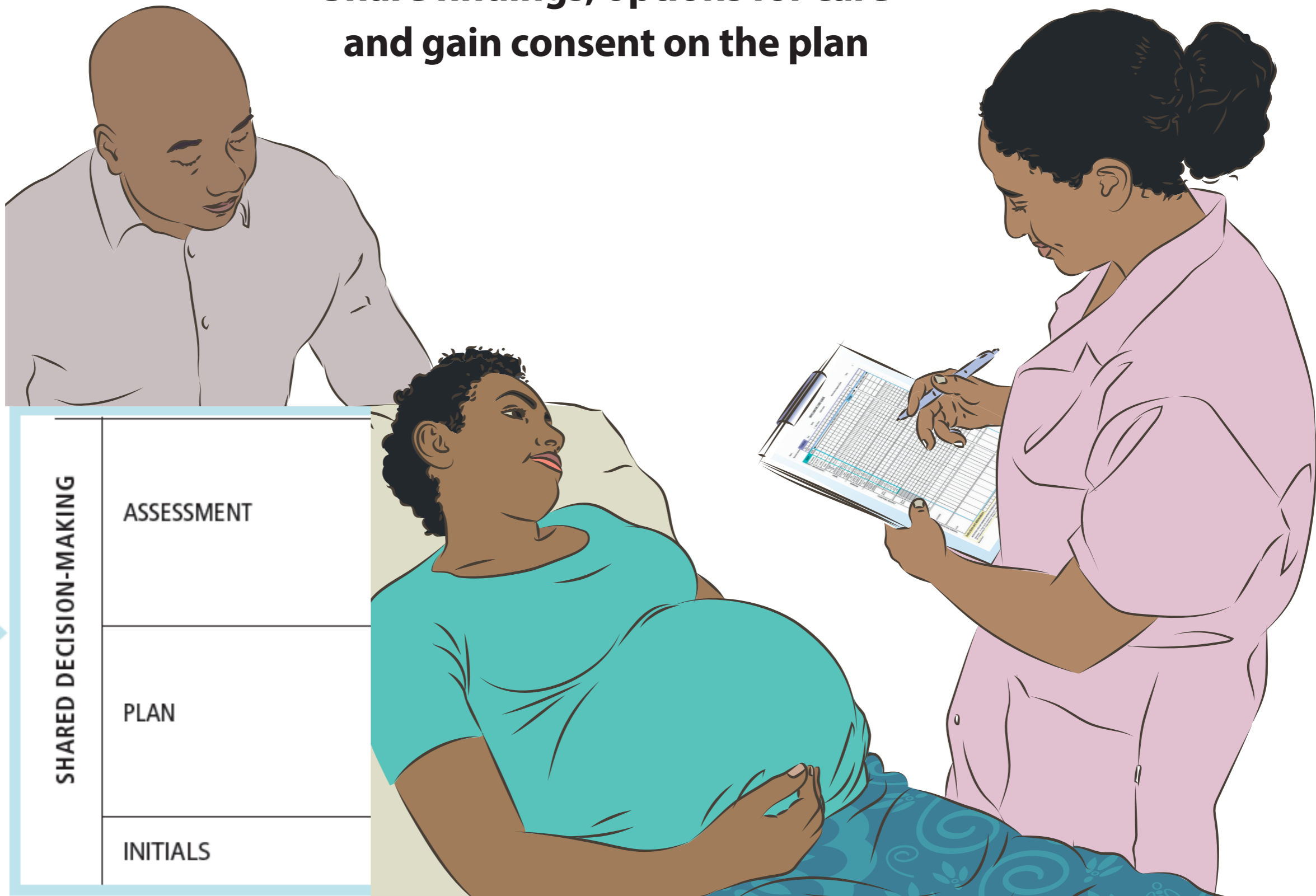
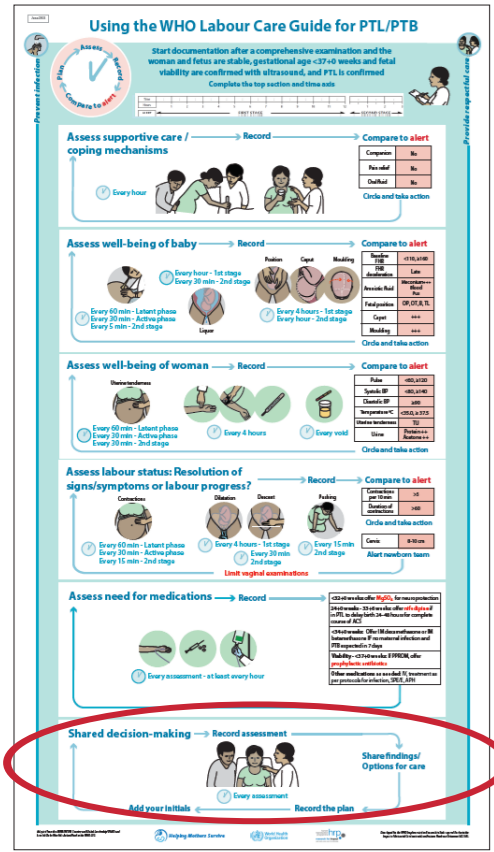
Divide participants into pairs. Ask one to be the health worker and the other to be Halima. Ask them to review each hour of Halima's LCG, write their assessment of each hour in section 7, then role play the discussion of the assessment and options for care for that hour. Have them record a plan of care for every hour. Demonstrate the first hour's assessment, shared decision-making and plan with a volunteer acting as Halima. Tell them to refer to page 11 in the PG to help them.

Remind them to initial the LCG. Have them check their documentation by comparing it to Halima's completed LCG for PTL on page 34.

After each group has checked if they have correctly completed the LCG for PTL, ask if there are any questions about using the LCG for PTL.

Shared decision-making

Share findings, options for care and gain consent on the plan



Section 7 →

SHARED DECISION-MAKING	ASSESSMENT
	PLAN
	INITIALS

EXERCISE: Ms. Beena

Instructions

Divide participants into groups of 2-3. Ask them to review Ms. Beena's LCG for PTL on page 25 in the PG and respond to the questions on page 24 in the PG. Give participants 10 minutes to respond to questions, then facilitate a discussion about responses. Answers are below and on page 35 in the PG.

1. What is your general impression about care provided? Was Ms. Beena monitored per protocol? If not, how should she have been monitored?

She was not monitored per protocol. In active phase of first stage of labour, labour status and the well-being of the woman and baby should have been monitored:

- Half-hourly - Fetal heart rate / decelerations, uterine contractions / tenderness
- Hourly - Companion, pain relief, oral fluid, vaginal loss (bleeding / foul-smelling discharge / liquor)
- 4 hourly - Maternal vital signs, descent, fetal position (by abdominal examination). *vaginal exam only if needed to manage care.*
- Each void - Proteinuria, acetonuria

When Ms. Beena was in second stage of labour, health workers should have monitored labour status and the well-being of the woman and baby as follows:

- Every 5 minutes - Fetal heart rate / decelerations [*record the most clinically significant value within the 15-minute time frame*].
- Every 15 minutes - Uterine. contractions, pushing efforts.
- Half-hourly - Uterine tenderness, vaginal loss (bleeding / foul-smelling discharge / liquor), descent.
- Hourly - Companion, pain relief, oral fluid, fetal position, caput, moulding.
- 4 hourly - Maternal vital signs.
- Each void - Proteinuria, acetonuria.

2. What is your general impression about documentation on the LCG? How could documentation be improved?

- Documentation was incomplete.
- Alert signs and the type of ACS were circled correctly, documentation of parameters assessed were correctly documented.
- Assessments at 18:30 and 19:30 during first stage were not documented. No assessment during second stage was recorded.
- There was no plan of care at 19:30 and during second stage.
- Documentation for second stage should have started at 21:15.

3. Were all the appropriate interventions to improve a preterm newborn's outcomes offered? If not, what other options should health workers have offered Ms. Beena?

- Ms. Beena presented at 31+3 weeks pregnant and should have been offered an ACS, MgSO₄, and nifedipine. If PPRM was diagnosed, then she should have also received a prophylactic antibiotic.

3. Do you agree with the assessments made? If not, what assessments would you record for Ms. Beena?

- Assessments were sporadic. From the few parameters recorded, it does not appear that Ms. Beena or her baby had any problems.
- It is difficult to know because documentation was incomplete.

3. Do you agree with the care plan recorded? How could you improve the care provided to Ms. Beena?

- It is difficult to know because documentation was incomplete.
- The neonatal team should have been alerted when she was admitted in active labour.

EXERCISE

Ms. Beena

LABOUR CARE GUIDE FOR PRETERM LABOUR (PTL)

Date: ___/___/___ Page: 1/___

Name: _____ PID: _____ Parity: _____ Gestational age: ___ wks + ___ days
 Ruptured membranes [Date: ___/___/___ Time: ___:___] Risk factors for PTL: _____ Confirmed by ultrasound on - Date: ___/___/___
 PTL diagnosis - Date: ___/___/___ Time: _____

Results of initial examination [Date: ___/___/___ Time: ___:___]: Temperature ___°C / Pulse ___bpm / Respirations ___/min / BP ___/___mmHg; Ruptured membranes - confirmed /not confirmed; Cervical length: ___cm / Cervical effacement: ___% / Cervical dilatation: ___cm; ___ contractions/10 min; Medications administered at admission: _____

Medications prescribed on admission: _____

		Time	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
		Hours	FIRST STAGE												SECOND STAGE		
		ALERT															
SUPPORTIVE CARE	Companion	N															
	Pain relief	N															
	Oral fluid	N															
BABY	Baseline FHR	<110, ≥160															
	FHR deceleration	L															
	Amniotic fluid	M+++, B, P															
	Fetal position	OP, OT, B, TL															
	Caput	+++															
	Moulding	+++															
WOMAN	Pulse	<60, ≥120															
	Systolic BP	<80, ≥140															
	Diastolic BP	≥90															
	Temperature °C	<35.0, ≥37.5															
	Uterine tenderness	TU															
Urine	P+, A++																
LABOUR STATUS	Contractions per 10 min	>5															
	Duration of contractions	>60															
	Cervix [Record cm]	8-10															
Descent [Record ___/5]																	
MEDICATION	Dexamethasone																
	Betamethasone																
	Nifedipine																
	Antibiotics																
	MgSO ₄																
	Other medicine(s)																
SHARED DECISION-MAKING	IV fluids																
	ASSESSMENT																
	PLAN																
	INITIALS																

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE FOR PTL/PTB. Abbreviations: Y - Yes, N - No, D - Declined, U - Unknown, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, B - Blood, P - Purulent, OA - Occiput Anterior, OP - Occiput Posterior, OT - Occiput Transverse, B - Breech, TL - Transverse lie, NT - Non-tender uterus, TU - Tender uterus, P+ - Protein, A+ - Acetone, ND - Not Due

Developed for the WHO Implementation Research to Scale up and Evaluate the Impact of Antenatal Corticosteroids on Preterm/Neonatal Outcomes (ACS-IR) and should only be used in the context of research. The Labour Care Guide for PTL should be used in conjunction with the Quick Guide. Responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO be liable for damages arising from its use.

EXERCISE: Ms. Etsub

Explain

While learning to use the LCG for PTL to document care, we filled in Halima's record horizontally, section by section. This was for learning purposes only. When we provide care, we will be filling in the columns vertically every 30 minutes. Let us practice this now with Ms. Etsub.

Instructions

Divide participants into groups of 2-3. Ask them to use information about Ms. Etsub on pages 26-32 in the PG to complete her LCG for PTL.

Read the case: "Ms. Etsub arrives in latent phase, her labour is effectively stopped for some time, and she then goes into active labour. You will need to use three monitoring tools:

- 1) The first page of the LCG for PTL.
- 2) Monitoring tools used at the facility for women hospitalized on the antenatal ward.
- 3) Additional pages of the LCG for PTL when labour restarts.

Pay special attention to the monitoring frequency for each parameter. Be sure to make an assessment and plan of care for each hour based on findings. You will have 45 minutes.

Circulate among the participants to assist them with completing the LCG for PTL. When they are done, they may check their LCGs for PTL by comparing them to Ms. Etsub's completed LCGs for PTL on pages 36-37 in the PG.

Discuss

1. What did you find positive about using the LCG for PTL to care for women with PTL?
2. What did you find challenging about completing the LCG for PTL?
3. Are there any areas that you want further training on?
4. What do you feel may be some challenges to using the LCG for PTL? What are some solutions to these challenges?

Review actions to improve care for women in PTL recorded by your volunteer on the flip chart. Facilitate a discussion on how to implement the actions in the facility.

EXERCISE
Ms. Etsub



Using Labour Care Guide for preterm labour to document intrapartum care

Pre- and Post-Test

Select the best answer to each question or statement. Circle the letter of the correct answer.

1. Which woman should be monitored using the Labour Care Guide for preterm labour and birth (LCG) for PTL?

- a. A woman whose labour is being induced for eclampsia at 35+2 weeks gestational age
- b. A woman who presents at a gestational age of 32+4 weeks with 1-2 contractions/hour and cervical dilatation of 2 cm and 50% effacement
- c. A woman who presents at a gestational age of 31+3 weeks with 7-8 contractions/hour and cervical dilatation of 3 cm and 80% effacement
- d. A woman who presents at a gestational age of 34+3 weeks with 7-8 contractions/hour and cervical dilatation of 4 cm and 80% effacement and intrauterine fetal death confirmed by ultrasound

2. A woman presents in second stage at a gestational age of 35 +2 weeks. This is her second pregnancy, she has no risk factors for PTL and no identified complications in this pregnancy or current labour. You will monitor and care for her using:

- a. The facility's tool for monitoring second stage
- b. The WHO Labour Care Guide
- c. The WHO Labour Care Guide for preterm labour and birth

3. True or False: When contractions have reduced to 2/10 minutes, lasting less than 20 seconds, health workers still need to conduct vaginal examinations to assess cervical dilatation every 4 hours.

- a. True
- b. False

4. A woman who presents at a gestational age of 31+3 weeks with 7-8 contractions/hour and cervical dilatation of 3 cm and 80% effacement and intact membranes should be offered which medications, if no contraindications exist:

- a. ACS only
- b. ACS and MgSO₄
- c. ACS, nifedipine, and MgSO₄
- d. ACS, nifedipine, MgSO₄, and prophylactic antibiotics

5. A woman in preterm labour at a gestational age of 31+3 weeks has been given all the information required about options for care to make an informed decision and declines certain interventions that health workers know are lifesaving. True or False: Health workers should still provide the lifesaving interventions in spite of the woman's decision to decline them.

- a. True
- b. False

6. Health workers check for uterine tenderness to assess for:

- a. Labour progress
- b. Uterine infection
- c. Strength of uterine contractions

7. The single most effective way to prevent infection is:

- a. Decontaminating and reprocessing reusable medical equipment/devices
- b. Cleaning all surfaces with detergent and water between clients
- c. Wearing gloves
- d. Performing hand hygiene

8. True or False: When giving information about her situation to a woman in preterm labour, it is better not to be completely honest as this might increase the woman's stress level.

- a. True
- b. False

9. Which of the following interventions IS RECOMMENDED when caring for women in preterm labour:

- a. routine 4-hourly vaginal examinations to assess labour status
- b. vaginal cleansing with chlorhexidine prior to vaginal examinations to prevent infection
- c. continuous fetal monitoring
- d. assistance with showering to improve comfort

10. In early decelerations:

- a. The time the FHR lowers below baseline is variable
- b. The FHR lowers below baseline usually after the peak of a contraction
- c. The FHR lowers below baseline usually at the start of a contraction

11. In cases of spontaneous preterm labour when there are no contraindications to nifedipine, nifedipine should be offered when gestational age is between 24+0 weeks - 33+6 weeks

- a. ONLY to women with intact membranes
- b. ONLY to women whose cervical dilatation is less than 5cm
- c. ONLY when there are adequate staff to monitor the woman on the antenatal ward
- d. To all women who provide informed consent

12. When wearing gloves, you should practice hand hygiene:

- a. ONLY before putting on gloves
- b. After removing gloves ONLY IF you had contact with bodily fluids
- c. ONLY after removing gloves whether or not you had contact with bodily fluids
- d. ALWAYS before putting on and taking off gloves

13. Which of the following statements is TRUE about performing vaginal examinations when monitoring a woman in preterm labour?

- a. Vaginal examinations should be routinely performed at least every 4 hours until labour stops or she gives birth.
- b. Once preterm labour is diagnosed, vaginal examinations should only be performed when she indicates she has the urge to push.
- c. Vaginal examinations should only be performed when they can provide critical information to manage the woman's care.
- d. Vaginal examinations should not be performed on women in preterm labour.

14. How frequently will you assess vaginal loss (bleeding / foul-smelling discharge / liquor) when a woman in preterm labour is in latent phase of first stage of labour? Every

- a. 15 minutes
- b. 30 minutes
- c. 60 minutes
- d. 4 hours

15. Which of the following statements is TRUE about using the LCG for PTL/?

- a. The LCG for PTL should only be used in Referral hospitals
- b. The LCG for PTL should only be started once cervical dilatation has reached 5 cm
- c. The LCG for PTL can be started on women diagnosed in preterm labour in lower facilities who are being transferred to a higher level facility
- d. The LCG for PTL should be used on ALL women in preterm labour, even for those women who have a condition that makes it unsafe to prolong the pregnancy

Knowledge Check: Answer Key

1. c; 2. c; 3. b; 4. c; 5. b; 6. b; 7. d; 8. b; 9. d; 10. c; 11. d; 12. d; 13. c; 14. c; 15. a

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Related Training Modules

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Contributors

Using Labour Care Guide for preterm labour to document intrapartum care

Facilitator Flip Chart

The **Using Labour Care Guide for preterm labour to document intrapartum care** module was adapted from:

- The **Essential Care for Labour & Birth** module developed by the **Helping Mothers Survive programme and**
- The **Using the WHO Labour Care Guide for a positive childbirth experience** module developed by the MOMENTUM Country and Global Leadership/USAID and Laerdal Global health programmes.

This adaptation was created to accompany training on care for threatened preterm birth for the purpose of the WHO ACS-IR trial. The Labour Care Guide for PTL aims to improve intrapartum care for women experiencing preterm labour and maternal and newborn outcomes.

Using Labour Care Guide for preterm labour to document intrapartum care Facilitator Flip Chart

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