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Using the WHO Labour Care Guide

for a positive childbirth experience

Acknowledgments

Using the LCG for a positive childbirth experience

Facilitator Flip Chart

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For the facilitator

How to facilitate training

1 Before the training

- Plan for the training with leadership and local organizations well in advance.
- Review the *WHO Labour Care Guide (LCG) User's Manual*, the 2018 *Recommendations for intrapartum care for a positive childbirth experience*, and the MOMENTUM Country and Global Leadership (MCGL) *Key Points for Considering Adoption of the Who Labour Care Guide: Policy Brief*.
  - Compare local parameters for alert signs and protocols for managing them with those in the WHO LCG User's Manual and plan for adaptation as needed.
  - Review Annex 5 in the WHO LCG User's Manual - *Basic equipment and supplies for intrapartum care*. Visit the labour and delivery rooms to assess availability of necessary equipment and supplies, capacity to accommodate a birth companion, barriers to maintaining privacy/confidentiality. Begin plans with managers to ensure ability to implement the WHO LCG.
- Recommend that providers complete the course on *Essential care during labour and birth* before completing the course on the WHO LCG. Evaluate the capacity of providers to assess the WHO LCG parameters and make a plan to reinforce capacity as needed.
- Review service delivery data and documentation practices with facility management to assess strengths and gaps.

2 Arrange materials and equipment and put up the Action Plan

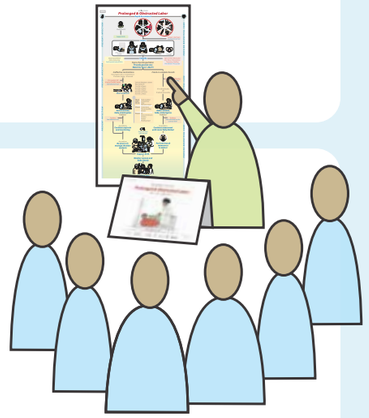
- Ensure you have the following learning materials for each participant:
  - Participant Characteristics – 1 for each participant
  - WHO LCG – at least 3 copies for each participant
  - 1 black and red pen, 1 pencil and eraser for each participant
  - WHO *LCG User's Manual* – 1 for each participant
  - *Key Points for Considering Adoption of the Who Labour Care Guide: Policy Brief* – 1 for each facilitator and managers at the facility
  - Participant Worksheets – 1 for each participant
  - Post-course assessment – 1 for each participant
  - Course Evaluation – 1 for each participant
  - Confidence Assessment – 1 for each participant
- Print enough Action Plans to post 2-3 in the training room, and 2-3 for the labour/delivery room in each participant's facility.

3 Welcome participants

- Welcome participants.
- Introduce facilitators and give participants the opportunity to introduce themselves, if they don't already know each other.
- Ask participants to complete the "Participant characteristics" form and review the submissions.

4 Introduce the module and learning objectives

- Hand out and introduce the learning materials.
- Review objectives:
  - Identify for whom, when, and where the WHO LCG can be used
  - Recognize the principal elements and sections of the WHO LCG
  - Competently and confidently assess all parameters in the WHO LCG
  - Correctly fill out the WHO LCG
  - Identify alert values and actions to take
  - Make a plan of care with the woman and her companion
  - Identify additional resources that are available



5 Engage participants

- Follow the content outlined in the FlipChart.
- As you teach, point out where you are in the *WHO LCG User's Manual* and on the WHO LCG and Action Plan.
- Always emphasize respectful care, good communication, and shared decision-making.
- As you explain and demonstrate, involve participants by inviting discussion.
- Use the "Discuss" questions to identify local problems and find local solutions to achieve the best care possible.

6 Evaluate participants

- Use the post-course assessment to check knowledge and ability to correctly complete the WHO LCG. Let participants know they may refer to the WHO LCG User's Manual / Quick Guide to fill in the LCG correctly, make assessments, and respond to alert signs appropriately.
- Correct and review the completed LCGs with participants. Ask participants if there are any questions or need for clarification. Enter data into the Excel file.
- Pass out the Course Evaluation and Confidence Assessment. Enter data into the Excel file.

7 After the training

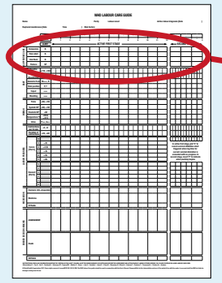
- Plan for mentorship following the training.
- Work with participants and facility managers to plan changes that will improve care during labour and childbirth in the facility and facilitate implementation of the LCG.
- Identify 2 providers at each health centre/3 providers at each hospital to serve as peer practice coordinators and facilitate low-dose-high-frequency activities after training.
- Plan for ongoing audits of LCGs and quality improvement activities.

For the facilitator

How to use the learning materials

WHO Labour Care Guide (LCG)

Refer to each section in the WHO LCG when using the other materials.

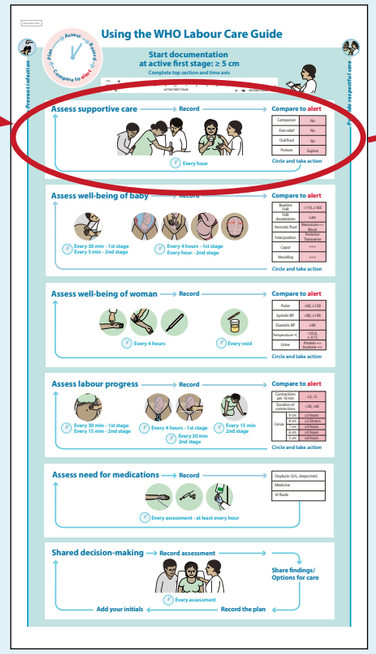


WHO LCG User's Manual

Refer to the User's Manual for guidance on how to complete each section of the LCG, identify alert values, and manage identified problems.

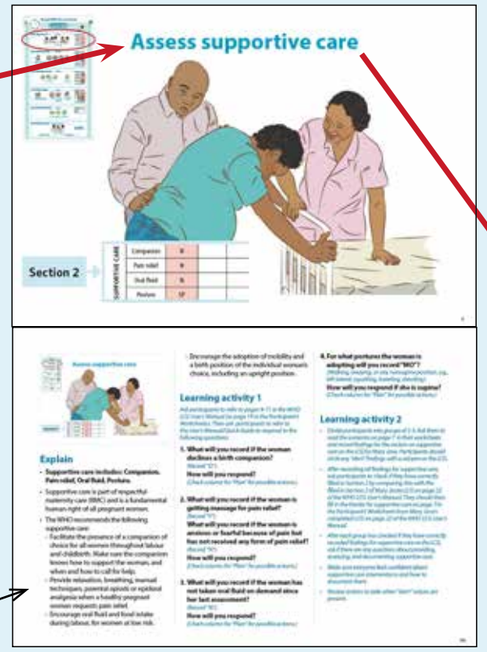
Action Plan

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



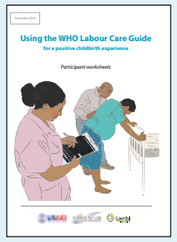
Flipchart

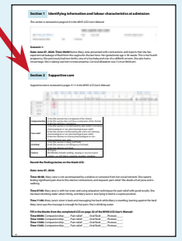
Use illustrations and text to teach how to complete the WHO LCG. Make sure that a plan is made to reinforce skills based on providers' capacity.



Worksheets

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





Additional resources

IMPAC Managing Complications of Pregnancy and Childbirth>

WHO recommendations Intrapartum care of a positive childbirth experience>

IMPAC Pregnancy, Childbirth, Postpartum, and Newborn Care>

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 blue 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 section of the WHO LCG 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.

You can make a difference

Explain

Start with a story.
Story 1: Say to participants, ***"Close your eyes and imagine you are on duty and take over care for a woman who has been in labour for 12 hours. You see that the labour monitoring tool has been incompletely filled out. You find she is dehydrated, lying on her back, is alone, and there is fetal distress. You call a senior provider who decides she needs an emergency cesarean birth. But it is too late for the baby." Pause. "The baby is stillborn."***
Pause again to allow the participants to reflect.

Say, ***"Open your eyes. How do you feel? Have you known of women who have had poor outcomes because of poor care or women afraid to advocate for themselves because they are afraid of being treated poorly?"***
Allow for a response and continue with the next story.
Story 2: Say, ***"Imagine a woman comes to the labour ward. You welcome her, smile, and invite her and her companion to come into the labour ward. You assess her regularly, carefully document her care, compare findings with "normal" findings, quickly identify a problem, and communicate carefully with the woman and her companion. You act quickly to help. The woman gives birth safely and feels empowered by her experience. She and her baby are happy and healthy."***

Pause, then ask, ***"Now how do you feel? Would anyone like to share?"***

Thank participants and say, ***"Each of us can make a difference! Today we are going to learn how to use the WHO LCG to ensure women have a positive childbirth experience and providers can give the best possible care. Let us get started."***

Share the overall and specific objectives with participants and ask if they have any quesions.

Overall course objective
By the end of this course, participants will be able to competently complete the WHO LCG, interpret findings, and develop a plan of care with women and their companions.

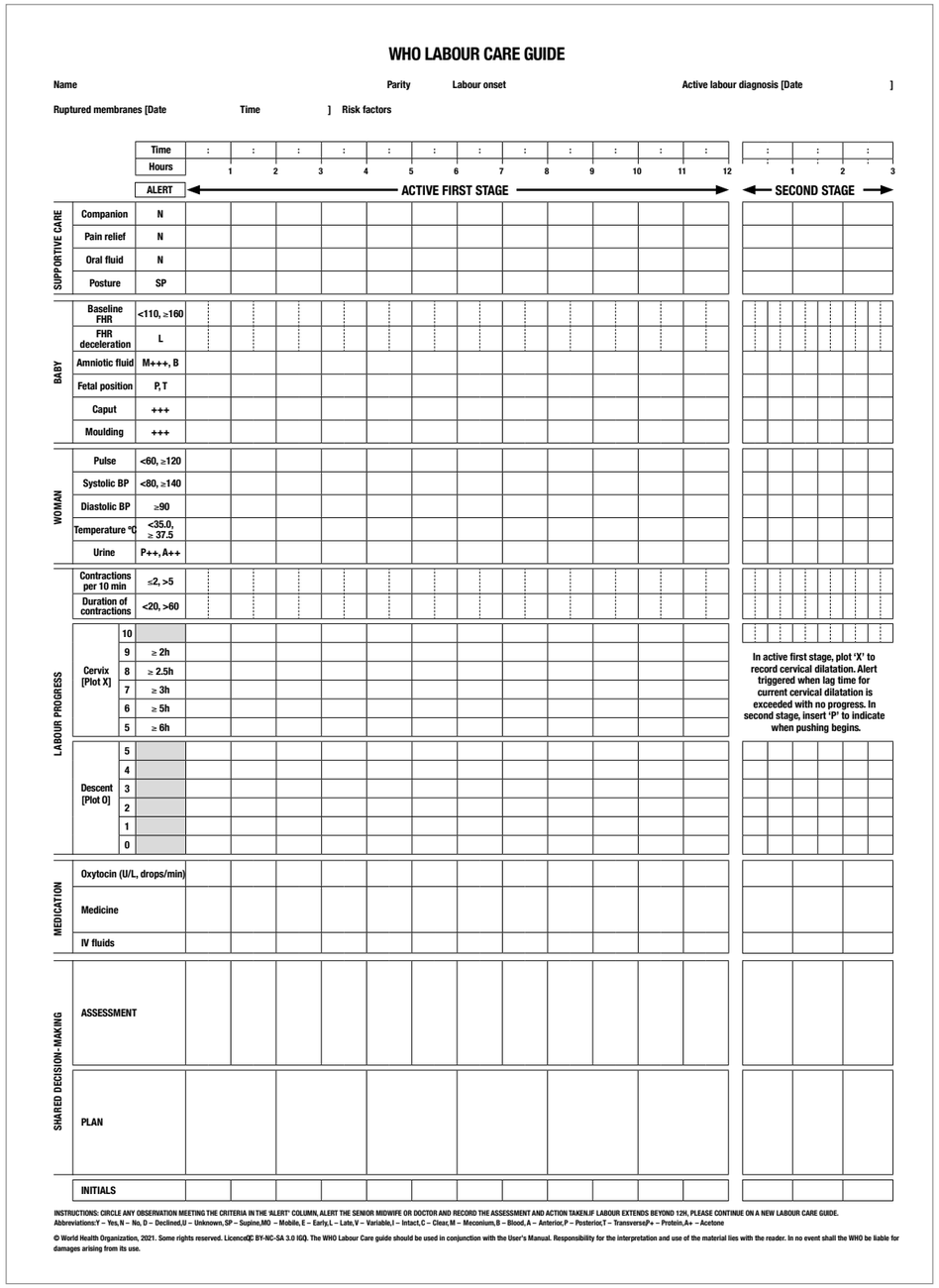
Specific course objectives
- List the principal aims of the LCG.
- Identify for whom, when, and where the Labour Care Guide (LCG) can be used
- Recognize the principal elements and sections of the LCG
- Competently and confidently assess all parameters in the LCG
- Correctly fill out the LCG
- Competently use the reference thresholds (alert signs) to trigger reflection and specific action(s).
- Make an assessment based on findings from the evaluation
- Make a plan of care with the woman and her companion
- Identify additional resources that are available

Learning materials

- WHO LCG
- WHO LCG User's Manual
- Key Points for Considering Adoption of the Who Labour Care Guide: Policy Brief
- FlipChart for facilitators to guide the training activity
- Participant Worksheets to use for completing the LCG as each section is discussed and additional job aids to assist with assessment
- Action Plan for using the WHO LCG

Overview of the WHO Labour Care Guide

Why? For whom? When? Where?



WHO LABOUR CARE GUIDE

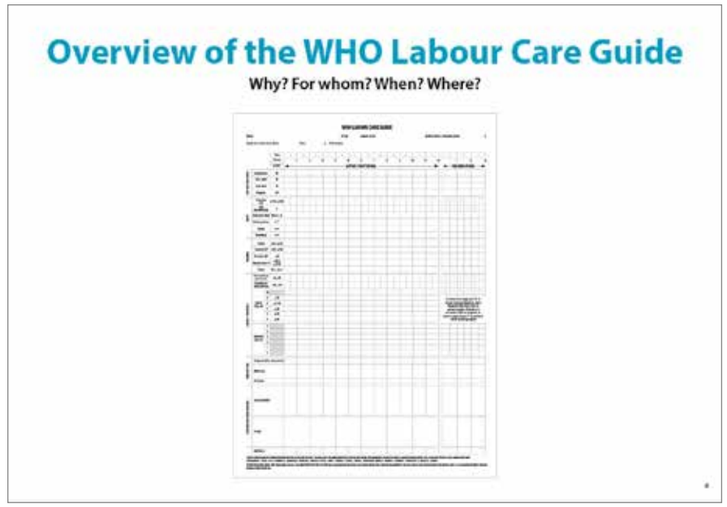
Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N																
	Pain relief	N																
	Oral fluid	N																
	Posture	SP																
BABY	Baseline FHR	<110, ≥160																
	FHR deceleration	L																
	Amniotic fluid	M+++, B																
	Fetal position	P, T																
	Caput	+++																
	Moulding	+++																
WOMAN	Pulse	<60, ≥120																
	Systolic BP	<80, ≥140																
	Diastolic BP	≥90																
	Temperature °C	<35.0, ≥ 37.5																
	Urine	P++, A++																
LABOUR PROGRESS	Contractions per 10 min	≤2, >5																
	Duration of contractions	<20, >60																
	Cervix [Plot X]	10																
		9	≥ 2h															
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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.
Abbreviations:Y – Yes,N – No, D – Declined,U – Unknown,SP – Supine,MO – Mobile, E – Early,L – Late,V – Variable,I – Intact,C – Clear,M – Meconium,B – Blood,A – Anterior,P – Posterior,T – Transverse,P+ – Protein,A+ – Acetone



Explain

Labour Care Guide

Why?

- To improve quality of care during birth, facilitate effective implementation of the WHO 2018 Intrapartum Care recommendations, and promote a shift to improving the experience of childbirth, WHO developed the LCG and an User's Manual/Quick Guide.
- To guide monitoring and documentation of the well-being of women and babies and the progress of labour.
- To guide health personnel to offer supportive care throughout labour to ensure a positive childbirth experience.
- To assist health personnel to promptly identify and address emerging complications, by providing reference thresholds for labour observations that are intended to trigger reflection and action(s) if an abnormal observation is identified.
- To prevent unnecessary use of interventions in labour.
- To ensure continuity of care between providers and prevent medication errors.
- To support audit and quality improvement.

For whom?

- The LCG has been designed for the care of women and their babies during labour and birth, regardless of their risk status.
- The LCG was primarily designed for the care of women with low-risk pregnancies. ***High-risk women may require additional and specialized monitoring and care.***

When?

- Documentation on the LCG should be initiated when the woman enters the active phase of the first stage of labour ***(5 cm or more cervical dilatation)***, regardless of her parity and membrane status.
- Although the LCG should not be initiated during the latend phase, the woman and her baby should be monitored and receive care and support.
- Once initiated, the LCG will support continuous monitoring through the active phase of first stage of labor and the second stage of labour.

Where?

The LCG can be used at all levels of care in health facilities, although the plan of care will vary depending on the level of care provided at the facility.

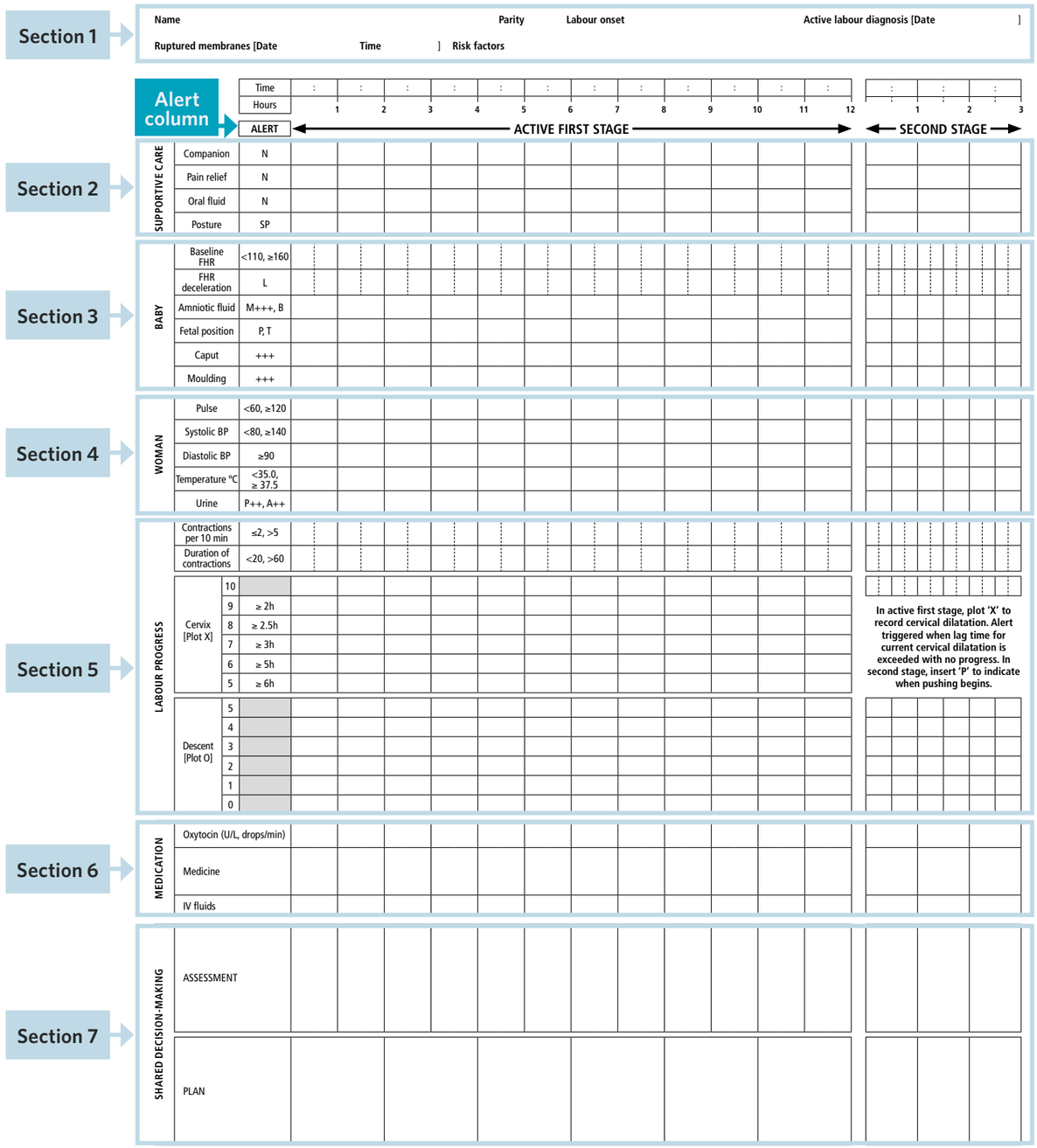
Discuss

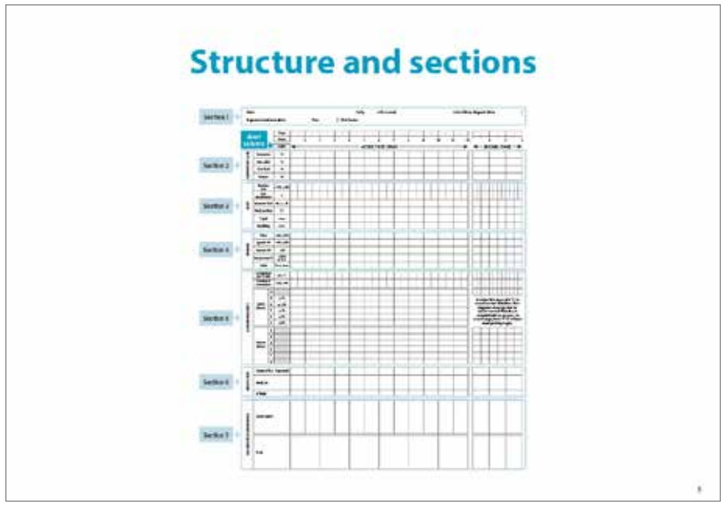
Ask the following questions and facilitate a discussion:

1. **What do feel you are doing well when caring for women in labour and giving birth?**
2. **In what areas do you feel you can improve care to ensure women get the care they need without getting unnecessary interventions?**
   Facilitate a discussion on how to improve care. Ask for a volunteer to note down any solutions identified to improve how care is provided. Review the results of the "Participant characteristics" form and ask:
3. **What are the main reasons a labour monitoring tool is not used regularly?**
4. **How can you improve the use of a labour monitoring tool?**
   Facilitate a discussion on how to improve care. , Note barriers and solutions for later inclusion in the facility quality improvement action plans.

Ask a volunteer to note barriers to monitoring women and using a labour monitoring tool per protocols and include solutions in the facility's action plan.

Structure and sections





Ask participants to refer to their copy of the LCG. After you read the title of a section, ask participants to list the parameters to assess for that section.

Explain

- Careful documentation of parameters and comparison to alert values assists providers to make decisions about labour management based on the status of a woman and her baby and whether or not labour is progressing normally.
- **Section 1:**
  Identifying information and labour characteristics at admission:
  Name; known obstetric, medical and social risk factors, labour admission characteristics that may impact outcomes and should be considered when planning for care and labour management.
- **Section 2: Supportive care**
  Interventions that optimise quality of care: labour companionship, pharmacological and non-pharmacological pain relief, oral fluid, and maternal posture
- **Section 3: Well-being of the baby**
  Parameters to monitor the well-being of the baby: baseline fetal heart rate (FHR) and decelerations in FHR, amniotic fluid, fetal position, moulding, and caput succedaneum.
- **Section 4: Well-being of the woman**
  Parameters to monitor the well-being of the woman: pulse, blood pressure, temperature and acetonuria/proteinuria.
- **Section 5: Labour progress**
  Intermittent monitoring of labour progression parameters - frequency and duration of contractions, cervical dilatation and descent of the baby's head.
- **Section 6: Medication**
  All types of medication used during labour: oxytocin use and dose, name of the medication and dose, name of IV fluids and perfusion rate.
- **Section 7: Shared decision-making**
  Assessment based on findings and plan of care based on continuous communication and informed consent. The provider must place initials under it.

Explain

- For all parameters:
  - there is a horizontal time axis for documentation of the time of observation
  - there is a a column with alert vaues to determine any deviation from normal observations that require action.

Ask participants to refer to their copy of the LCG and identify:

- *Section to record assessments during active first stage of labour*
- *Section to record assessments during second stage of labour*
- *Time axis*
- *Alert column*

Discuss

Ask the following question and facilitate a discussion:

- **What big differences do you notice in the columns of the LCG and the labour monitoring tool you are now using for active phase of first stage?**
  Give participants a chance to respond. Adapt your response based on the labour monitoring tool used in the facility.

  In the LCG: Second stage of labour, "Alert" column, baseline FHR/decelerations/caput/fetal position/ supportive care, assessment and plan, provider's initials.

Reference thresholds – Alert values

Circle any observation meeting the criteria in the "Alert column"

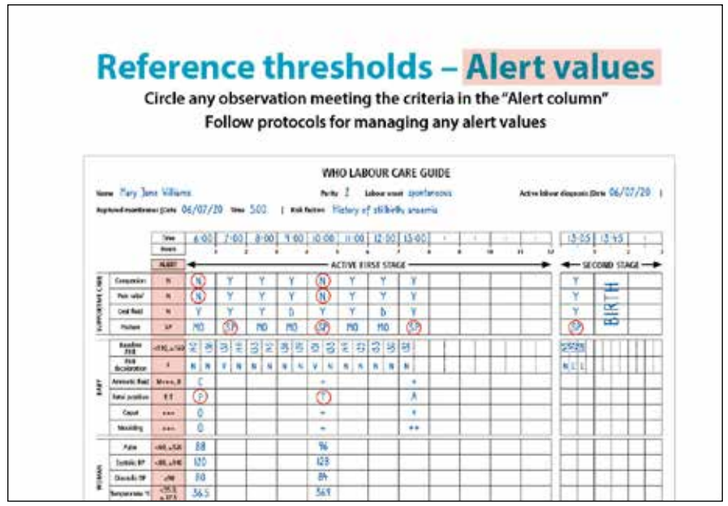
Follow protocols for managing any alert values

WHO LABOUR CARE GUIDE

Name Mary Jane Williams **Parity** 2 **Labour onset** spontaneous **Active labour diagnosis [Date** 06/07/20]

Ruptured membranes [Date 06/07/20 **Time** 5:00] **Risk factors** History of stillbirth; anaemia

			Time	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	:	:	:	:	13:05	13:45	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
		ALERT		← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N		(N)	Y	Y	Y	(N)	Y	Y	Y					Y		
	Pain relief	N		(N)	Y	Y	Y	(N)	Y	Y	Y					Y		
	Oral fluid	N		Y	Y	Y	D	Y	Y	D	Y					Y	BIRTH	
	Posture	SP		MO	(SP)	MO	MO	(SP)	MO	MO	(SP)					(SP)		
BABY	Baseline FHR	<110, ≥160		140 136	132 148	133 145	138 128	151 133	149 125	153 130	132					145 128 118		
	FHR deceleration	L		N N	V N	N N	N N	V N	N N	N N	N					N E E		
	Amniotic fluid	M+++, B		C				+			+							
	Fetal position	P, T		(P)				(T)			A							
	Caput	+++		0				+			+							
	Moulding	+++		0				+			++							
WOMAN	Pulse	<60, ≥120		88				96										
	Systolic BP	<80, ≥140		120				128										
	Diastolic BP	≥90		80				84										
	Temperature °C	<35.0, ≥ 37.5		36.5				36.9										
	Urine	P++, A++		-/-				-/-										



Explain

- Unlike the partograph, the WHO LCG includes an "Alert" column that presents thresholds for abnormal labour observations that require further assessment and action by the healthcare provider.
- Alert values are based on WHO guidance and expert consensus, and are meant to be used as early-warning signals. However, reference alert values should be adapted in accordance with local guidelines and should not replace the expert clinical judgement of a care provider.
- If labour observations do not meet any of the criteria in the "Alert" column, labour progression should be regarded as normal, and no medical intervention is warranted.
- The parameters to assess during the first and second stage of labour provide information on the woman's and baby's well-being and progress of labour. Therefore, assessment and documentation of ALL parameters should be accurate.
- Understanding normal values should reduce unnecessary interventions; while identifying the presence of an alert value should improve taking timely action, including for non-clinical interventions.
- Whenever you find an "alert" value, circle the recorded assessment. This should help to highlight those observations that require special attention. Follow protocols for managing the alert values.

Learning activity

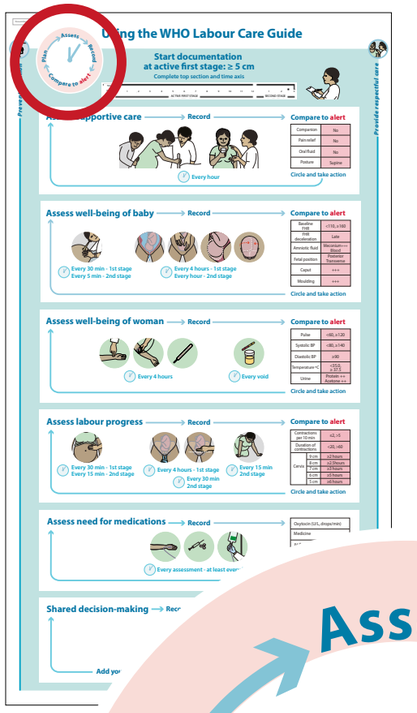
Ask participants to find the table in the WHO Labour Care Guide: Quick Guide in the Participant's Worksheets and identify "alert values" and actions for the parameters below:

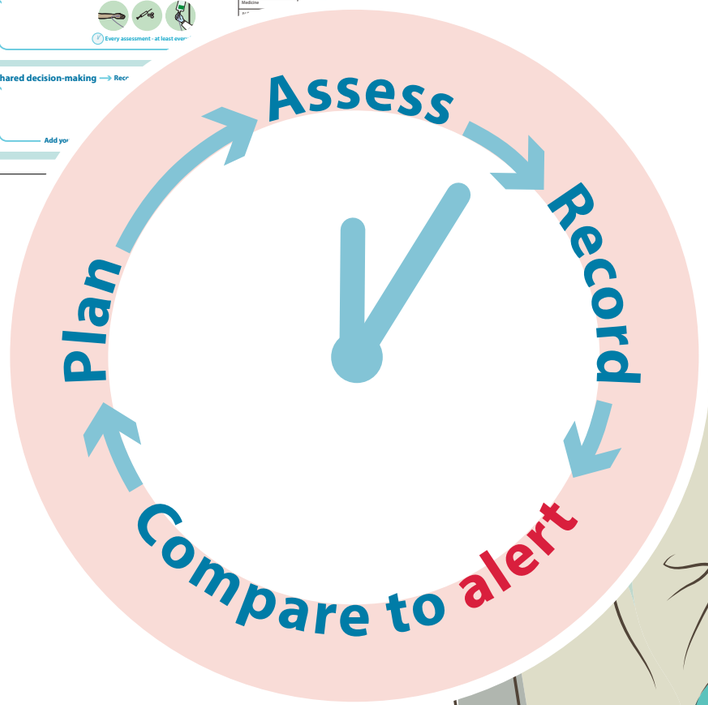
- Section 2: Supportive care – Posture (page 20)
- Section 3: Care of the baby - FHR deceleration (page 21)
- Section 3: Care of the baby - absent FHR (page 21)
- Section 4: Care of the woman – Urine (page 23)
- Section 5: Labour progress – Contractions (page 24)

Discuss

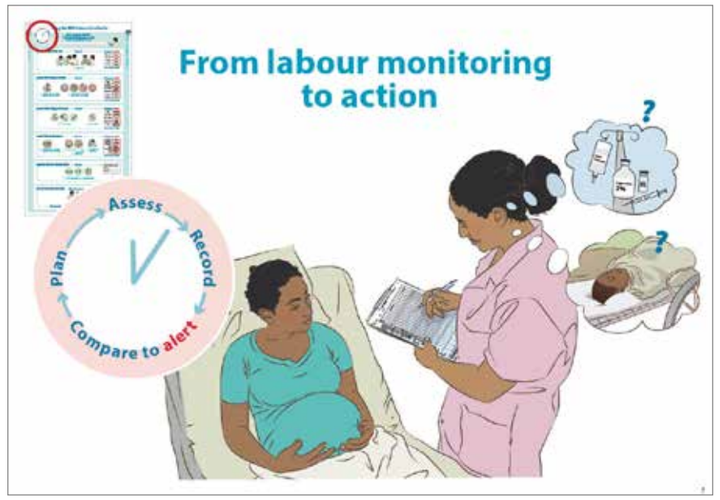
Ask the following question and facilitate a discussion:

1. **Some of the skills to assess the parameters may be new or need refreshing, this may need practice and mentorship to achieve competence. What can you do when you do not feel confident or competent to assess a parameter while at the woman's bedside?**
   Suggestions: ask a more senior provider for assistance and feedback, organize on-the-job training and mentorship for your team, set up skills training corners in the facility for individual or peer-to-peer practice.
2. **What can you do when you do not know how to correctly complete the labour care guide?**
   Suggestions: ask a more senior provider for help, refer to the WHO LCG User's Manual or Quick Guide in the Participant worksheets.





From labour monitoring to action



Explain

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

Point to the yellow circle on the front page and explain the steps.

Each time you **assess** or check the woman, fetus, and labour progress 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.

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

Ask participants to refer to page 4 in the Participant's Worksheets and ask a participant to read the bullets describing the steps to take when assessing the woman, baby, and labour progress and making a plan of care. Provide any clarification needed.

Planned care must consider findings from your assessment, the woman's personal attributes and choices. When assessment is not accurate or providers feel pressured to document findings they did not actually assess, changes in the woman's or fetus' status may be missed and quality of care may be compromised.

Discuss

Ask the following questions and facilitate a discussion:

1. **What questions must you ask yourself when you compare findings to alert values?**

Give participants a chance to respond. Then provide the following responses:

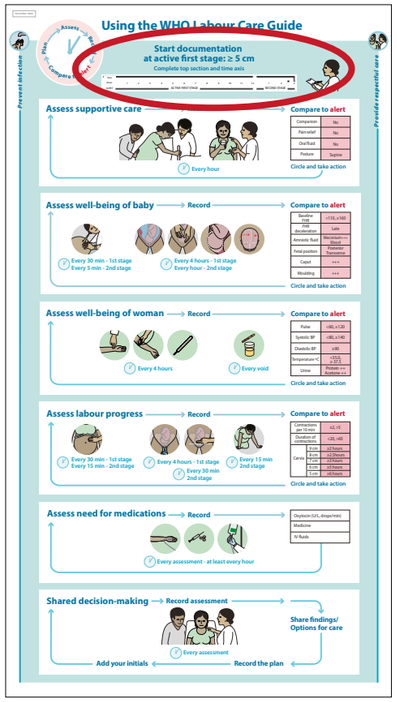
While recording findings, compare findings to alert values to decide:

- **Supportive care**: Is the woman receiving the supportive care she needs? If not, how should care be improved?
- **Care of the baby**: Are there signs of fetal distress or signs of obstructed labour / cephalopelvic disproportion? If so what is the most likely cause? What are options for care?
- **Care of the woman**: Are there maternal alert values? If so, what is the most likely diagnosis? What are options for care?
- **Labour progress**: Is labour progress normal? If not, what is the most likely cause? What are options for care?

2. **Do you regularly use the process of "Assessing the woman, fetus, and labour progress -> Recording your findings -> Comparing to alert values -> and then developing a care plan with the woman and her companion based on findings and options for care"?**
   If not, why not?
   Facilitate a discussion on how to ensure that ALL providers use this process when providing care to women in labour and giving birth.

   Ask for a volunteer to note down any solutions identified to improve how findings are used to improve care and respond in a timely fashion when an "alert" value is identified.

3. **A blank cell suggests the parameter was not assessed. What should you document when you were unable to assess a parameter?**
   Suggestion: Decide as a team how to document inability to assess a parameter, contact a senor provider as soon as one is available to assist you to assess the parameter.



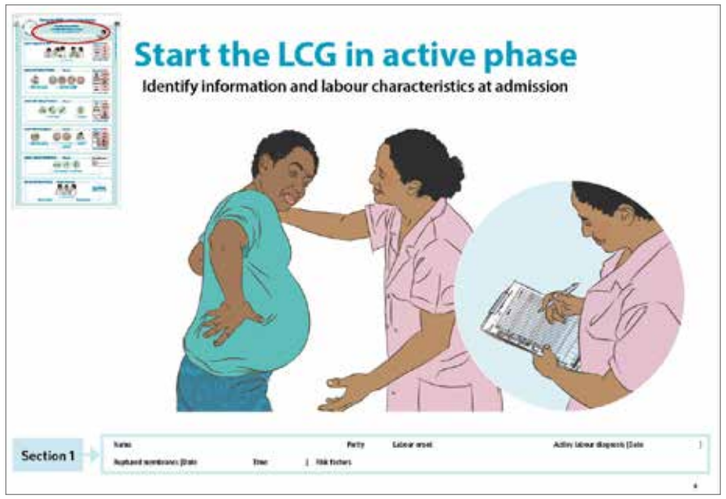
Start the LCG in active phase

Identify information and labour characteristics at admission

Section 1

Name **Parity** **Labour onset** **Active labour diagnosis [Date** **]**

Ruptured membranes [Date **Time** **]** **Risk factors**



Explain

- Section 1 is for documenting the woman's name and labour admission characteristics that are important for labour management: parity, mode of labour onset, date of active labour diagnosis, date and time of rupture of membranes, and risk factors.
- This section should be completed **when active labour diagnosis is confirmed (cervical dilatation ≥ 5cm).**
- Correctly completing Section 1 is extremely important because it provides the context for care of the woman and should determine if the woman should be cared for by a different type of provider or at a different level of care, if monitoring needs to be modified, etc

Learning activity 1

Ask participants to refer to pages 8-9 in the WHO LCG User's Manual (or page 19 in the Participant's Worksheets). Then ask participants to refer to the User's Manual/Quick Guide to respond to the following questions:

1. **How will you complete the section on labour onset?**
2. **What will you record in the section on active labour diagnosis?**
3. **What will you record if rupture of membranes is confirmed and the woman cannot report the date and/or time, and there is no documentation in the medical record?**
4. **What obstetric risk factors with implications for care provision and potential outcome of labour management will you record?**
5. **What medical, risk factors with implications for care provision and potential outcome of labour management will you record?**
6. **What social risk factors with implications for care provision and potential outcome of labour management will you record?**

Learning activity 2

Divide participants into groups of 2-3. Ask them to read the scenario on page 8 in their worksheets and fill in the LCG. Participants should circle any "alert" findings with a red pen on the LCG.

Ask participants to check if they have correctly filled in Section 1 based on the scenario by comparing this with the filled in Section 1 of Mary Jan'es LCG on page 22 of the WHO LCG User's Manual.

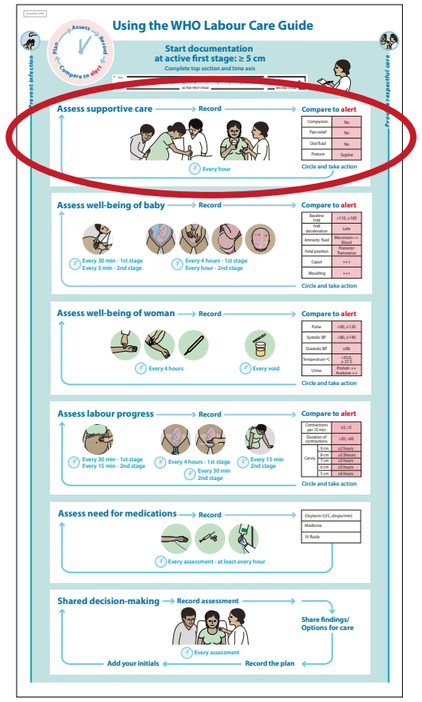
Discuss

After each group has checked if they have correctly completed the LCG, ask:

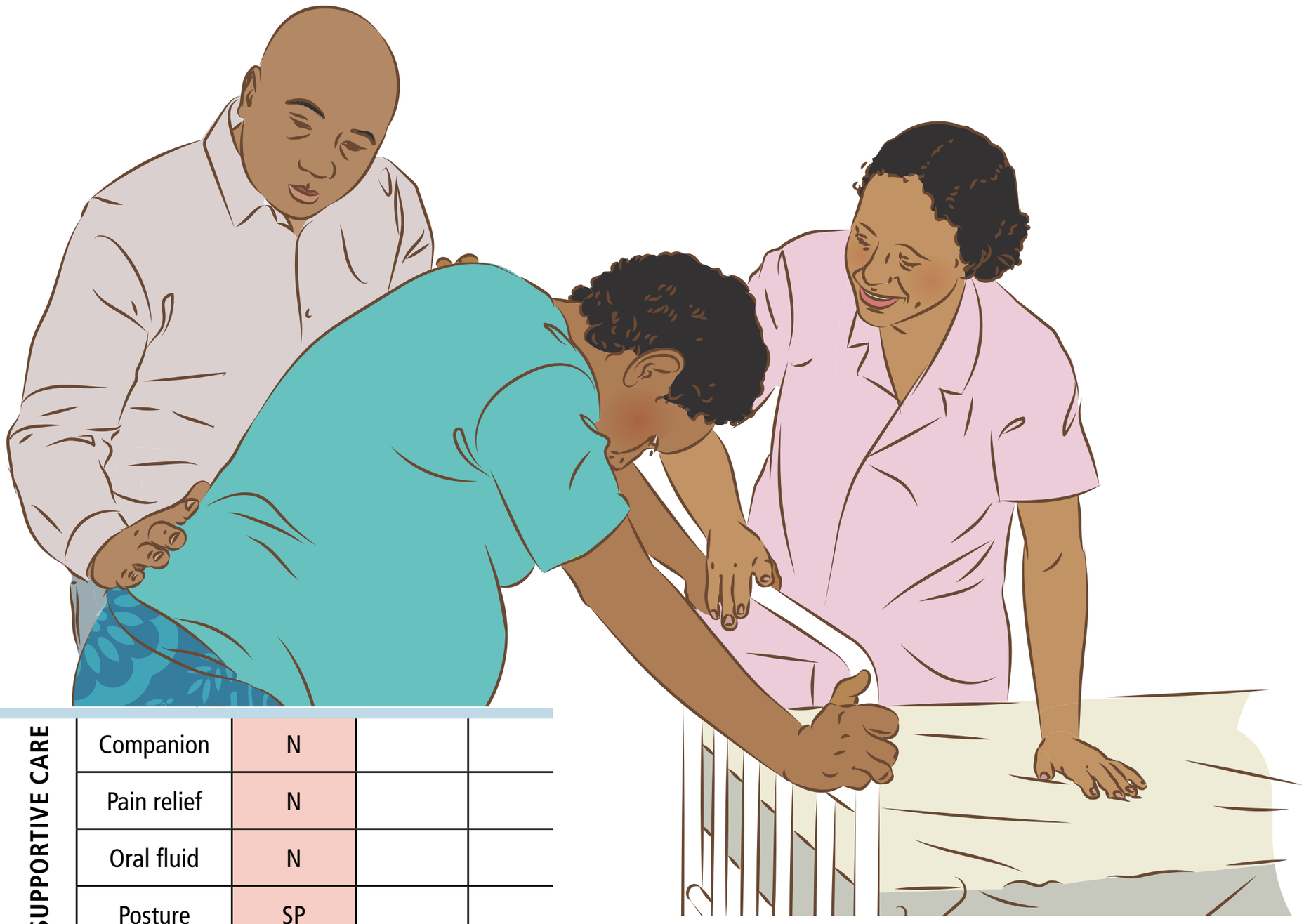
1. **Are women in your facility currently being assessed for risk factors when they enter active phase of first stage of labour?**
2. **How hard will it be for you to ensure that in your facility women are consistently assessed for risk factors and decisions made based on the presence/absence of them?**

Facilitate a discussion on how to ensure that ALL providers assess for risk factors when a woman enters active phase and make care decisions based on their presence/absence.

Ask for a volunteer to note down any solutions identified to improve making a careful assessment of risk factors and making care decisions based on them.



Assess supportive care



Section 2

SUPPORTIVE CARE	Companion	N		
	Pain relief	N		
	Oral fluid	N		
	Posture	SP		

Explain

- **Supportive care includes: Companion, Pain relief, Oral fluid, Posture.**
- Supportive care is part of respectful maternity care (RMC) and is a fundamental human right of all pregnant women.
- The WHO recommends the following supportive care:
  - Facilitate the presence of a companion of choice for all women. Make sure the companion knows how to support and when and how to call for help.
  - Provide relaxation, breathing, manual techniques, parental opiods or epidural analgesia when a healthy pregnant woman requests pain relief.
  - Encourage oral fluid and food intake during labour for women assessed at low risk for complications.
  - Encourage the adoption of mobility and a birth position of the individual woman's choice, including an upright position.

Learning activity 1

Ask participants to refer to pages 9-11 in the WHO LCG User's Manual (or page 20 in the Participant's Worksheets). Then ask participants to refer to the User's Manual/Quick Guide to respond to the following questions:

What will you record if the woman declines a birth companion?
(Record "D").
How will you respond?
(Check column for "Plan" for possible actions.)

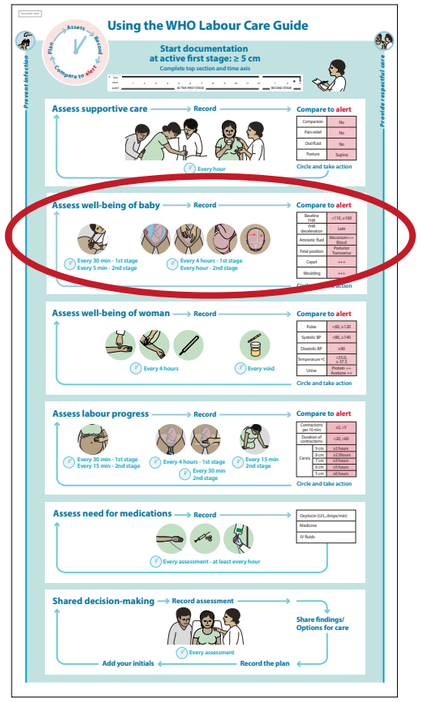
1. **What will you record if the woman is getting massage for pain relief?**
   (Record "Y").
   What will you record if the woman is anxious or fearful because of pain but has not received any form of pain relief?
   (Record "N").
   How will you respond?
   (Check column for "Plan" for possible actions.)

Note: if using a blood collection tool e.g. a calibrated drape, place it immediately after administering a uterotonic for management of third stage of labour, but before the placenta is born.

2. **What will you record if the woman has not taken oral fluid on demand since her last assessment?**
   (Record "N").
   How will you respond?
   (Check column for "Plan" for possible actions.)
3. **For what postures the woman is adopting will you record "MO"?**
   (Walking, swaying, or any nonsupine position, e.g., left lateral, squatting, kneeling, standing).
   How will you respond if she is supine?
   (Check column for "Plan" for possible actions.)

Learning activity 2

- *Divide participants into groups of 2-3 and read the scenarios on page 8 of the worksheets. Then record and circle with a red pen any "alert" findings for the supportive care section of the LCG for Mary Jane.*
- *Then ask participants to check their recordings in Section 2 by comparing this with the filled in section 2 on page 22 of the WHO LCG User's Manual.*
- *Now ask participants to fill in the blanks for supportive care on page 8 in the Participant's Worksheets.*
- *When finished ask if there are any questions about providing, assessing and documenting supportive care.*
- *Make sure all participants feel confident and know how to document supportive care.*
- *Review the actions that should be taken when "alert" values are present.*

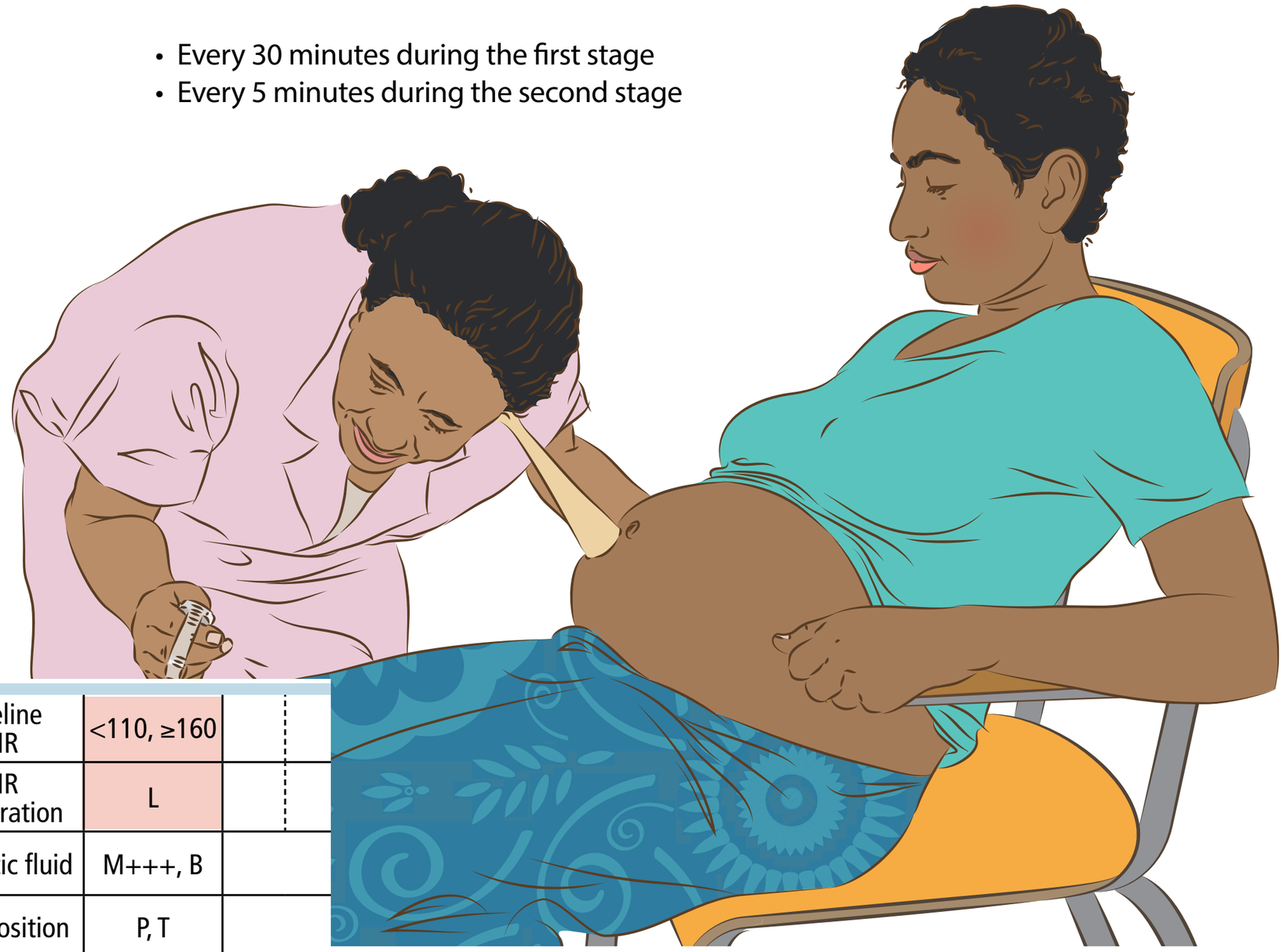


N= No decelerations
E = Early decelerations
L = Late decelerations
V = Variable decelerations

Assess well-being of baby

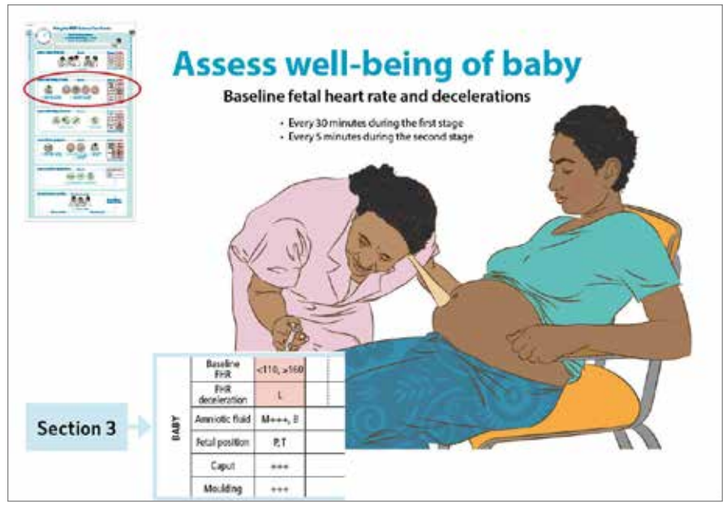
Baseline fetal heart rate and decelerations

- Every 30 minutes during the first stage
- Every 5 minutes during the second stage



Section 3

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



Review and discuss question 7 of the Participant characteristics. Make a plan to reinforce competency if needed.

Refer to pages 11-14 in the WHO LCG User's Manual (or pages 21-22 in the Participant's Worksheets).

Ask participants to refer to page 9 in the articipant's Worksheets.

Explain

- **Assess FHR every 30 minutes during the first stage and every 5 minutes during the second stage of labour.**
  Normal FHR: <110 and ≥160 bpm.
- Record the baseline FHR (as a single counted number of beats in 1 minute). For the second stage, record the most clinically significant value within the 15-minute time frame.
- Intermittent auscultation of the fetal heart rate with either a Doppler ultrasound or Pinard stethoscope is recommended for healthy pregnant women.
- A normal FHR may slow during a contraction but usually recovers to normal as soon as the uterus relaxes.
  - A very slow fetal heart rate (<100 bpm) in the absence of contractions or persisting after contractions is suggestive of fetal distress.
- A rapid fetal heart rate (≥160 bpm) may be a response to maternal fever, drugs causing rapid maternal heart rate (e.g. terbutaline or ritodrine), hypertension or amnionitis.
  - In the absence of a rapid maternal heart rate, a rapid FHR should also be considered a sign of fetal distress
- **To identify decelerations, check FHR for a full minute during a contraction and for 30-60 seconds after the contraction ends to decide** when the FHR begins to decrease and returns to baseline in relation to the contraction.
- **Record**
  N = No decelerations
  E = Early decelerations
  L = Late decelerations
  V = Variable decelerations

Learning activity

Ask participants to refer to page 9 in the Participant's Worksheets to respond to the following questions:

1. **How will you identify an early deceleration?**
2. **How will you identify a late deceleration?**
3. **How will you identify variable decelerations?**
4. **What will you do if FHR is <110 or ≥160, or if late decelerations or a single prolonged deceleration are present?**
   - ask the woman to turn on her left side
   - then perform a prolonged auscultation
   - alert a senior care provider and follow clinical guidelines.

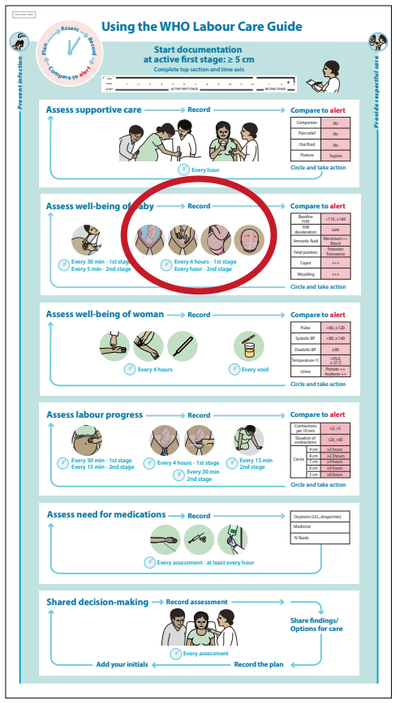
Knowledge check

How will you identify variable decelerations?

The timing of low FHR and return to baseline in relation to the contraction is variable.

How will you respond to the variable decelerations?

Continue care. However, if a single prolonged deceleration is present, ask the woman to turn on her left side, then perform a prolonged auscultation, alert a senior care provider and follow clinical guidelines.



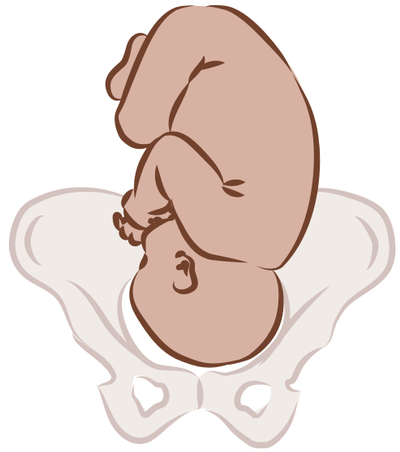
Assess well-being of baby

Amniotic fluid

I = Intact membranes
C = Clear fluid
M = Meconium-stained fluid: +, ++ and +++
B = Blood-stained fluid

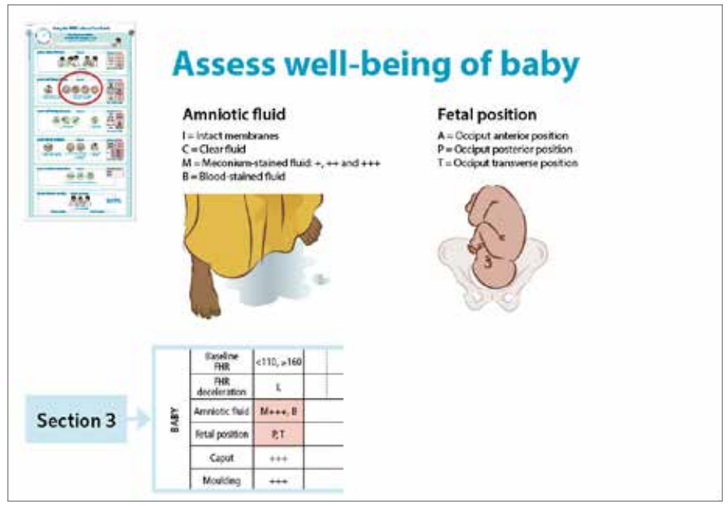
Fetal position

A = Occiput anterior position
P = Occiput posterior position
T = Occiput transverse position



Section 3

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



Review responses to question 8 of the Participant characteristics form. Ask participants if they are confident to assess fetal position. If they are not confident, make a plan to reinforce competency after this training.

Explain

Position and status of amniotic fluid should be monitored at every vaginal examination to identify risks for adverse birth outcomes.

Position

- First assess fetal presentation/position by abdominal exam. Confirm position and presentation during vaginal examination. Review findings from previous exams to compare them with your findings.
- With descent, the fetal head rotates so that the fetal occiput is anterior in the maternal pelvis. Failure of a fetal occiput transverse or posterior position to rotate to an occiput anterior position should be managed as abnormal fetal position.
- Record A = Occiput anterior position, P = Occiput posterior position, T = Occiput transverse position.
- Abnormal presentation, lie, or position can prevent labour from progressing normally. ***Alert a senior provider if any position other than OA, OP, or OT!!***
  - Only these malpositions / malpresentations have a chance of vaginal birth: occiput posterior / transverse position, chin-anterior position, complete or frank breech with a well flexed fetal head
  - **Act fast if you identify a malposition / malpresentation that will most likely require a cesarean birth!**

If available, confirm malpresentation and malposition using ultrasound.

Amniotic fluid

- If the membranes have ruptured, note the colour of the draining amniotic fluid.
  - The presence of thick meconium indicates the need for close monitoring and possible intervention for management of fetal distress.
  - Bloody amniotic fluid is common in placental abruption, placenta praevia, vasa praevia or uterine rupture.
- Record: I=Intact membranes; C=Membranes ruptured, clear fluid; M=Meconium-stained fluid: record + (non-significant), ++ (medium), and +++ (thick); B=Blood-stained meconium.
- ***If blood-stained fluid or thick meconium is present, alert a senior care provider and follow clinical guidelines!***

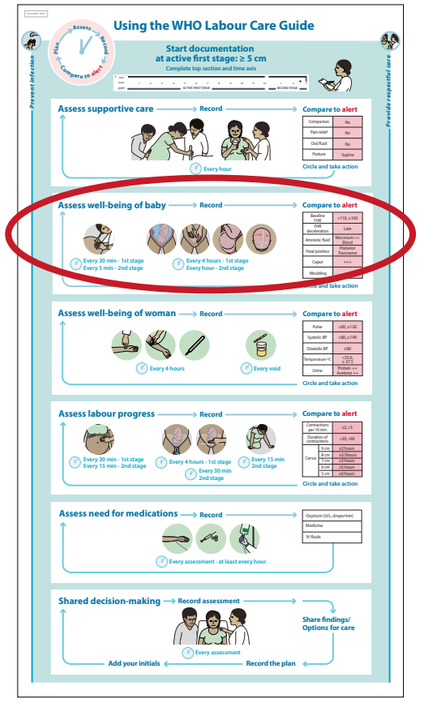
Knowledge check

How does the fetal head normally rotate with descent?

With descent, the fetal head rotates so that the fetal occiput is anterior in the maternal pelvis. Failure of a fetal occiput transverse or posterior position to rotate to an occiput anterior position should be managed as abnormal fetal position.

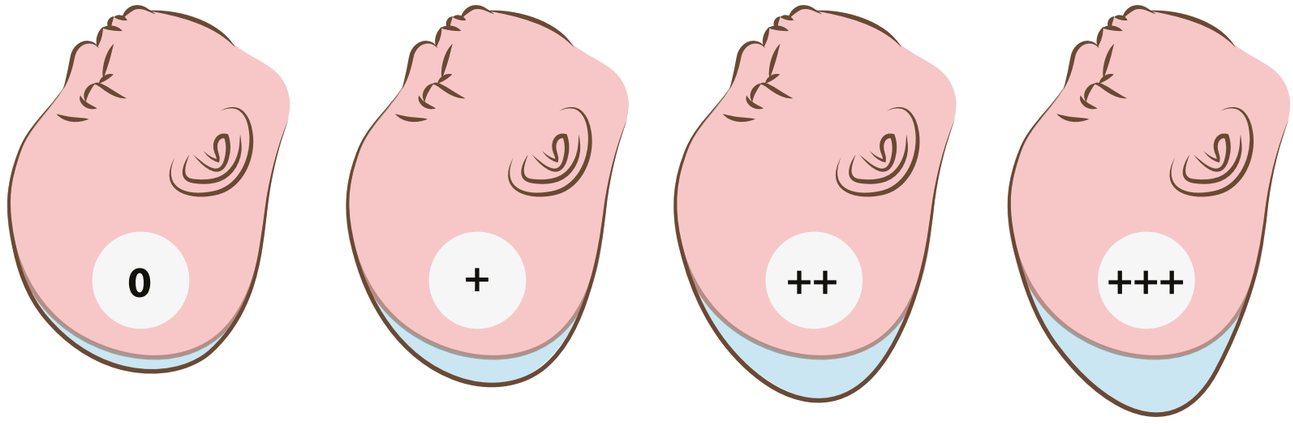
What are some causes of bloody amniotic fluid?

Bloody amniotic fluid is common in placental abruption, placenta praevia, vasa praevia or uterine rupture.

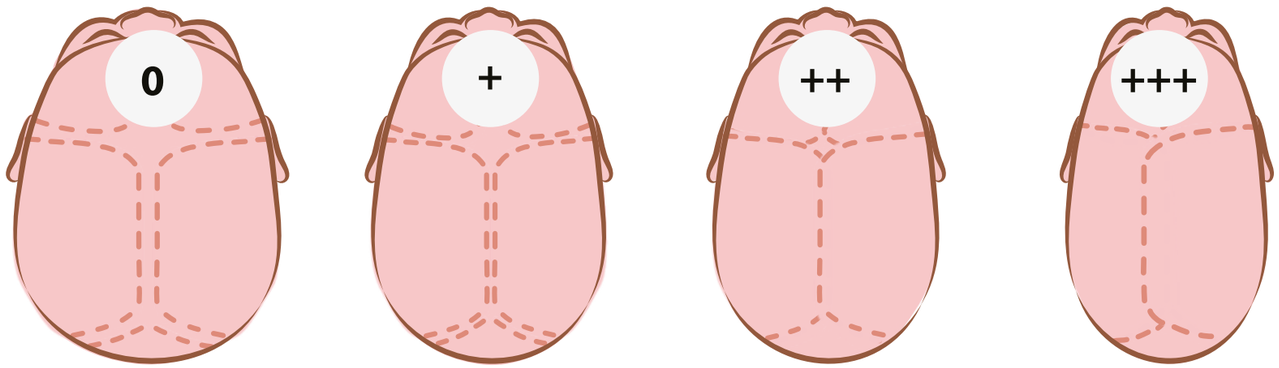


Assess well-being of baby

Caput



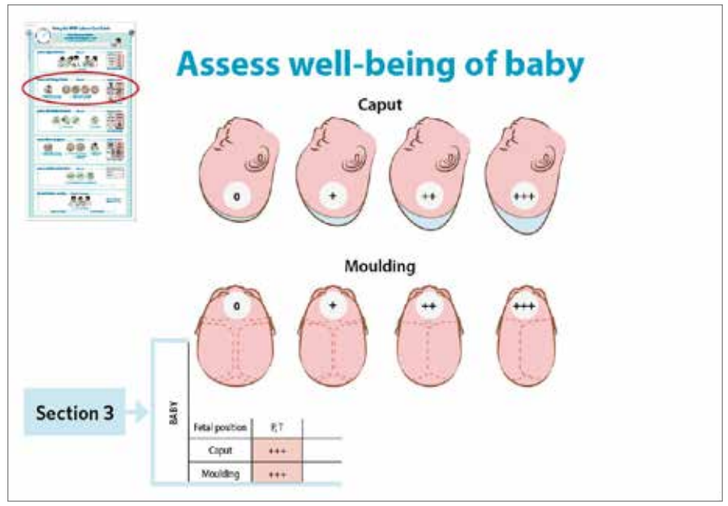
Moulding



Section 3

BABY

Fetal position	P, T
Caput	+++
Moulding	+++



Review responses to questions 9 and 10 of the Participant characteristics form. Ask participants if they are confident to assess moulding and caput. If not, make a plan to reinforce competency after this training.

Explain

Caput and moulding should be monitored at every vaginal examination to identify risks for adverse birth outcomes.

- The five bones of the fetal skull are joined together by sutures, which are flexible during birth. Movement in the sutures and fontanels allows the skull bones to overlap as the head is moving down the birth canal. The extent of overlapping is called moulding, and it can produce a pointed or flattened shape to the baby's head. The skull bones that are likely to overlap are the parietal bones, that are joined by the sagittal suture.
- **To identify moulding**, first palpate the suture lines and check if the following applies:
  - Separated bones, sutures felt easily: Record "0"
  - Sutures apposed: Record "+"
  - Sutures overlapped but reducible: Record "++"
  - Sutures overlapped and not reducible: Record "+++".

  If you find +3 moulding with poor progress of labour, this may indicate that labour is at increased risk of becoming obstructed.
- **Some baby's skulls have a swelling called a caput.** Caput succedaneum is a diffuse swelling of the scalp caused by the pressure of the scalp against the dilating cervix during labour. It may extend over the midline (as opposed to cephalhaematoma) and is associated with moulding of the head.
  - Caput can make it difficult to define the position of the fetal head.
  - Caput is graded subjectively from 0 (none) to +3 (marked). Because of its subjective nature, grading the caput as +1 or +3 simply indicates a 'small' and a 'large' caput respectively.
- ***If moulding +++ or caput +++, alert a senior provider and follow local protocols.***
  - If there is caput +++ or moulding +++, this (along with other abnormal observations) could be a sign of obstruction.

Knowledge check

What are alert values for moulding/moulding?

Alert: 3+.

How will you respond if you identify moulding 2+?

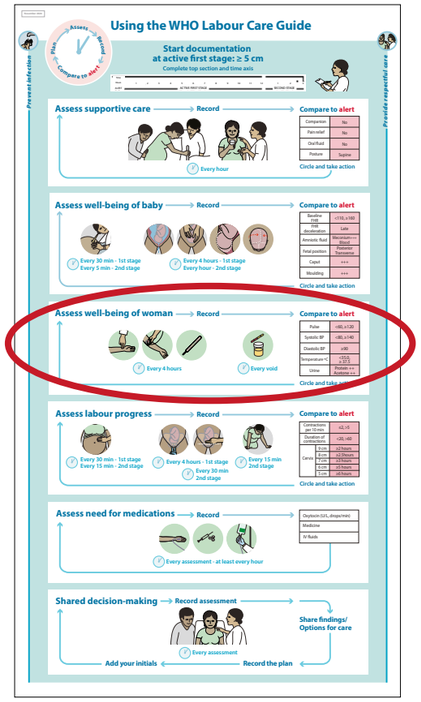
If moulding = 0 to ++, usually signs of normality (mainly if ++ is developed in the later stages of labour), reassess during next vaginal examination in 4 hours, unless otherwise indicated.

How will you respond if you identify caput 3+?

Alert a senior provider and follow local protocols. Suspect CPD.

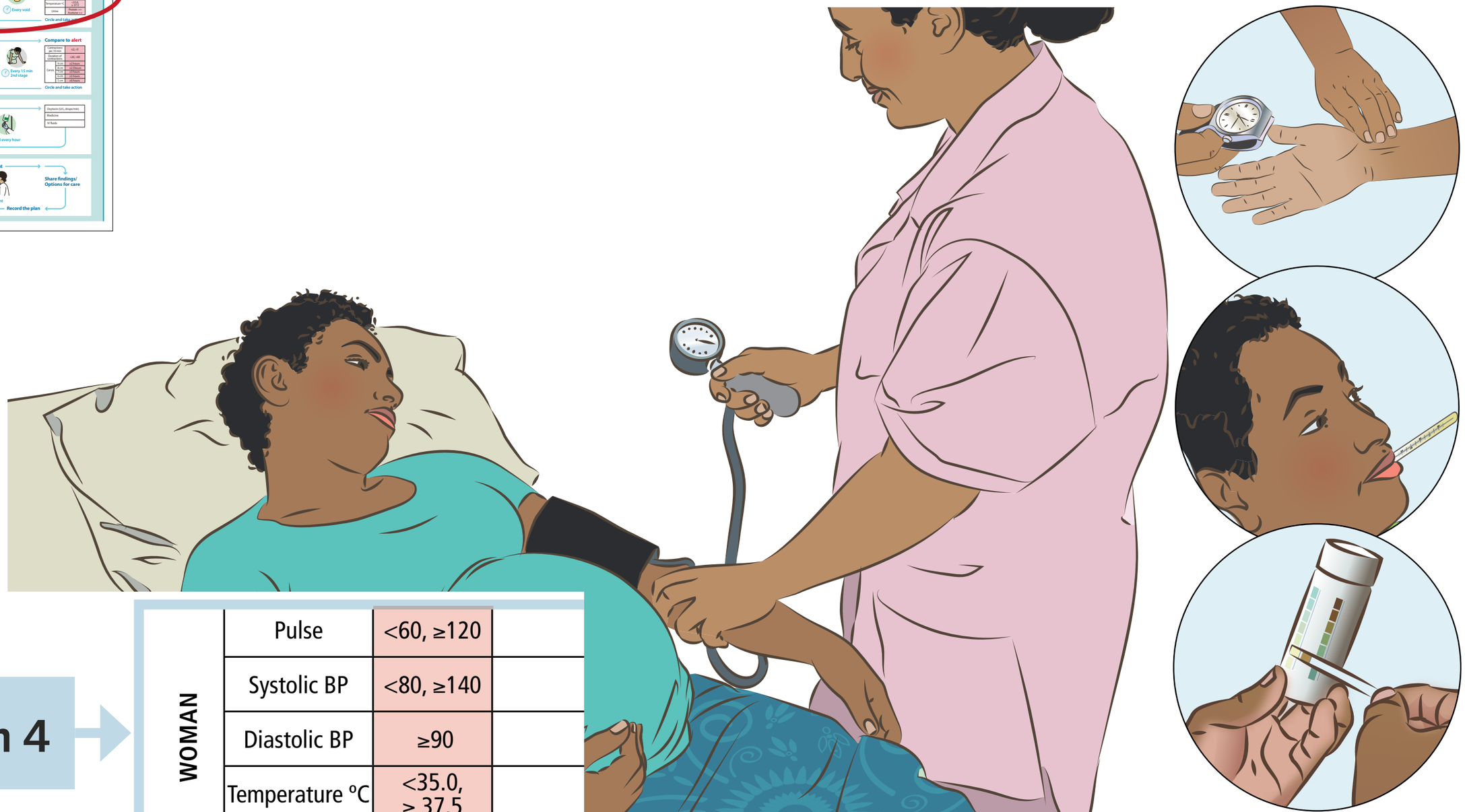
Learning activity

- *Divide participants into groups of 2-3. Ask them to read the scenarios on pages 9-10 in their worksheets and record findings on the baby's well-being on the LCG for Mary Jane.*
- *After recording findings on the baby's well-being in the LCG, ask participants to check if they have correctly filled in Section 3 based on the scenario by comparing this with the filled in Section 3 of Mary Jane's LCG on page 22 of the WHO LCG User's Manual. They should then fill in the blanks for the baby on page 10 in the Participant's Worksheets from Mary Jane's completed LCG on page 22 of the WHO LCG User's Manual.*
- *Make sure everyone feels confident about parameters to assess the baby's well-being and how to document them.*
- *Review actions to take when "alert" values are present.*



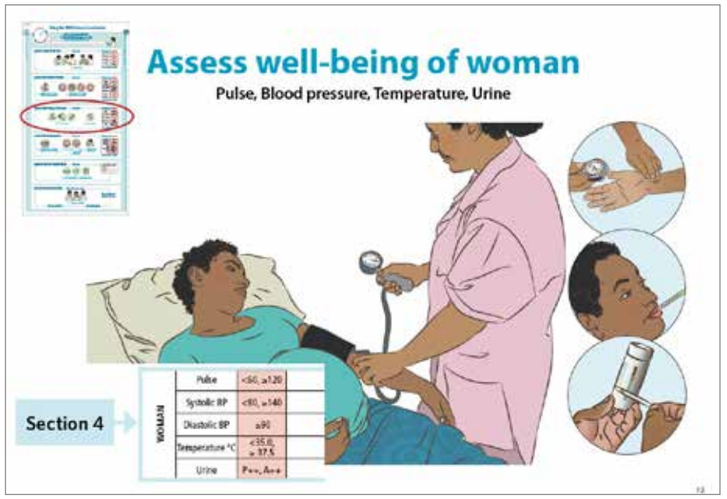
Assess well-being of woman

Pulse, Blood pressure, Temperature, Urine



Section 4

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



Explain

Refer to pages 14-16 in the WHO LCG User's Manual (or page 23 in the Participant's Worksheets).

Section 4, Care of the Woman
Facilitate decision-making based on consistent, intermittent monitoring of the woman's well-being.

- Maternal temperature, blood pressure and proteinuria/acetonuria should be regularly monitored to identify risks for adverse birth outcomes and to assess the well-being of the woman.

Vital signs

- If findings are normal, check vital signs every 4 hours.
  - Pulse alert values: <60, ≥120.
  - Systolic BP alert values: <80, ≥140
  - Diastolic BP alert values: ≥90
  - Temperature alert values: <35.0, ≥37.5
- If any finding is not normal, this should trigger a series of maternal and fetal assessments to identify the probable cause. ***Alert a senior care provider and follow local guidelines!***

Urine

- Check urine for acetone and protein every 4 hours or each time she passes urine.
- Encourage her to pass urine regularly and frequently assess if her bladder is full.
  - If her bladder is full, help her empty it. If she is not able to, catheterize the bladder.
- If P++, A++ or more, interpret measurements in the context of a full clinical examination. ***Alert a senior care provider and follow local guidelines!***
  - Proteinuria could be a sign of pre-eclampsia, urinary tract infection, severe anaemia, or previously undiagnosed renal or cardiac disease.
  - Ketonuria could be a sign of dehydration, prolonged labour or previously undiagnosed diabetes.

Discuss

Ask: **Are you able to monitor women as recommended during labour?**
If not, why not?
Facilitate a discussion on how to ensure that providers can monitor ALL women in labour and giving birth.

Ask for a volunteer to note down any solutions identified to improve monitoring the woman during labour and childbirth.

Learning activity

Divide participants into groups of 3-4. Ask them to read the scenarios on page 10 in their worksheets and record findings on the woman's well-being on the LCG for Mary Jane.

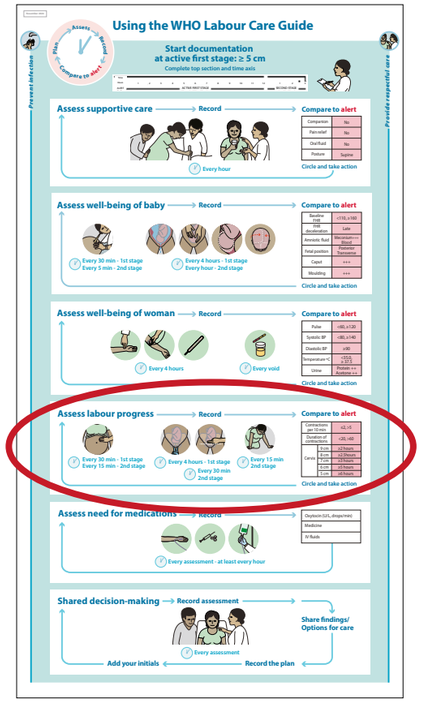
After completing the LCG, ask participants to check if they have correctly filled in Section 4 of Mary Jane's LCG based on the scenario by comparing this with the filled in Section 4 of Mary Jan'es LCG on page 22 of the WHO LCG User's Manual.

Review actions to take when "alert" values are present.

Knowledge check

What would you do if she had P++ or more?

Interpret measurements in the context of a full clinical examination. Alert a senior provider and follow local guidelines. Remember: Proteinuria could be a sign of pre-eclampsia, urinary tract infection, severe anaemia, or previously undiagnosed renal or cardiac disease.



Assess labour progress

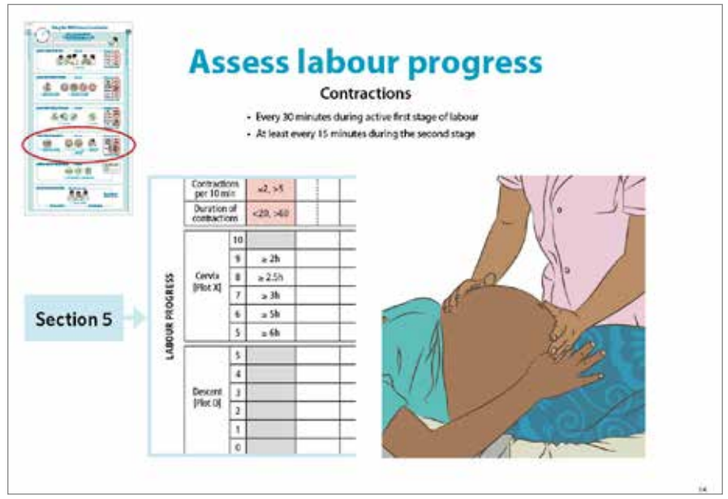
Contractions

- Every 30 minutes during active first stage of labour
- At least every 15 minutes during the second stage

Section 5

LABOUR PROGRESS

Contractions per 10 min		≤2, >5		
Duration of contractions		<20, >60		
Cervix [Plot X]	10			
	9	≥ 2h		
	8	≥ 2.5h		
	7	≥ 3h		
	6	≥ 5h		
	5	≥ 6h		
Descent [Plot O]	5			
	4			
	3			
	2			
	1			
	0			



Explain

Refer to pages 17-20 in the WHO LCG User's Manual (or pages 24-25 in the Participant's Worksheets).

Every 30 minutes during active first stage and at least every 15 minutes during second stage, assess the number of contractions in 10 minutes and how many seconds they last.

Contractions are efficient if:

- The woman is having 3-5 contractions in 10 minutes, each lasting ≥20 but ≤60 seconds.
- In the active phase of first stage, the contractions result in progressive dilatation of the cervix no matter how frequent.
- In second stage, the contractions result in progressive descent of the presenting part.

Rule-out CPD/FPD, obstruction, malposition or malpresentation if contractions are efficient and cervical dilatation is slower than normal.

Act fast! Provide emergency care and seek advanced care if you find any of these dangerous conditions:

- Constant pain that persists between contractions or comes on suddenly. This may be due to placental abruption, especially if there is vaginal bleeding.
- Contractions cease altogether. Check for signs of ruptured uterus and seek advanced care.
- Any contraction lasts 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 the woman is having two contractions or less in 10 minutes and/or contractions last less than 20 seconds:

- Decide if contractions are efficient or inefficient by assessing progress of cervical dilatation and fetal descent.
- If contractions are inefficient, suspect inadequate uterine activity.

Alert a senior care provider and follow clinical guidelines.

- NOTE: Do not perform amniotomy as a sole intervention for augmentation of labour, especially in settings with high HIV prevalence.

- Encourage the woman to move around as much as she can and be in upright positions as much as possible. However, let her choose her position.
- Provide general labour support, including pain management and treatment for dehydration that may improve contractions and improve progress.

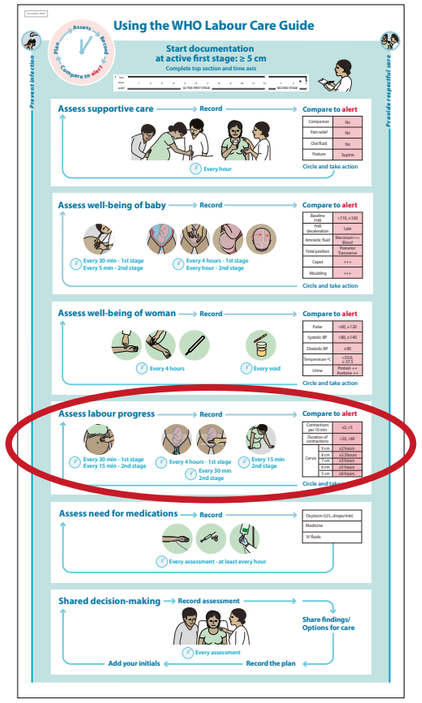
Advanced Care Note

Refer the woman to a facility that can perform a cesarean birth and care for a baby with problems if you believe the woman has:

- CPD/FPD OR
- Obstruction OR
- Placental abruption OR
- Ruptured uterus

Also refer the woman if she has ineffective contractions but your facility cannot perform augmentation with oxytocin.

Guidance should be adapted based on local protocols and standards.



Assess labour progress

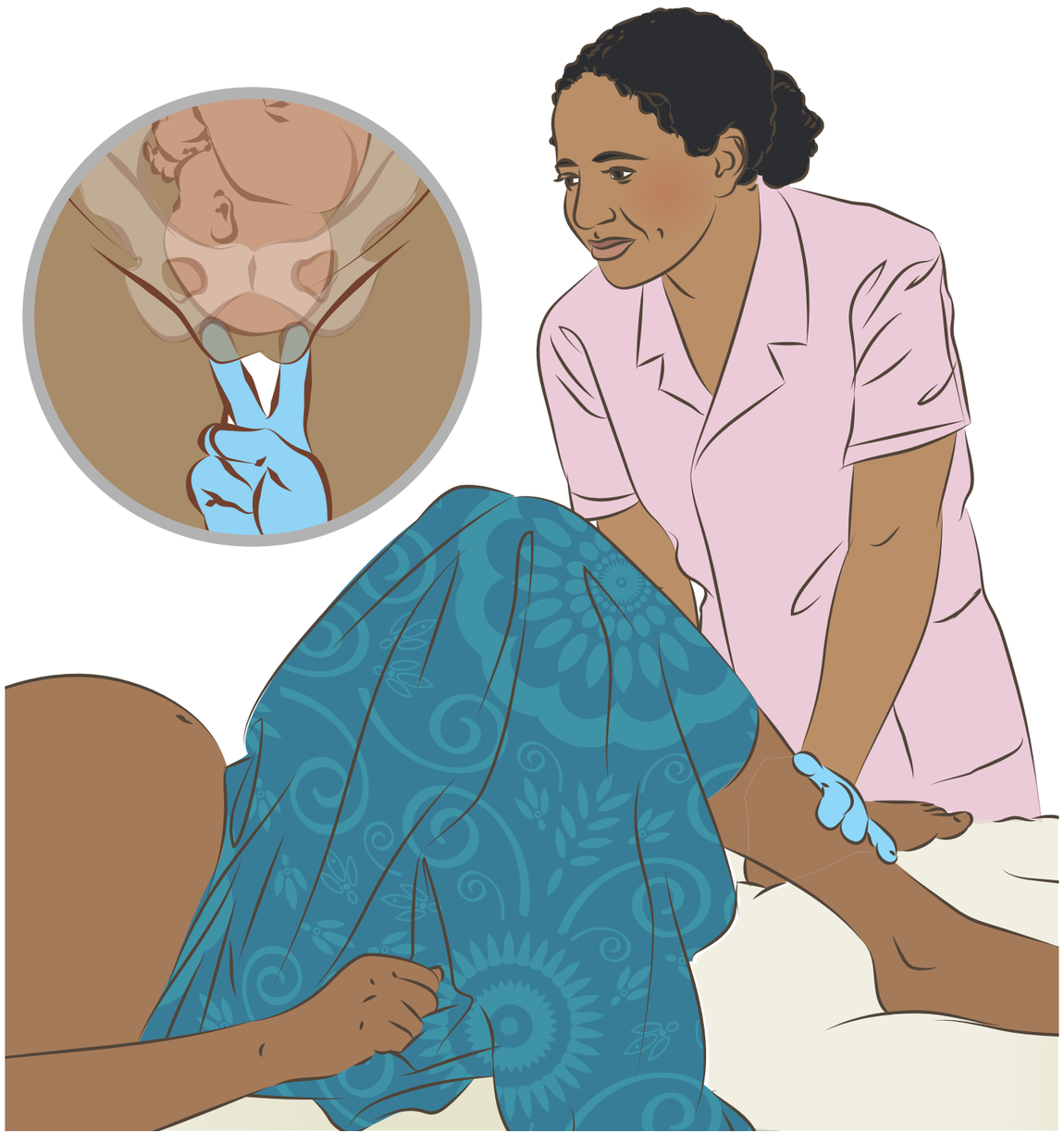
Cervical dilatation

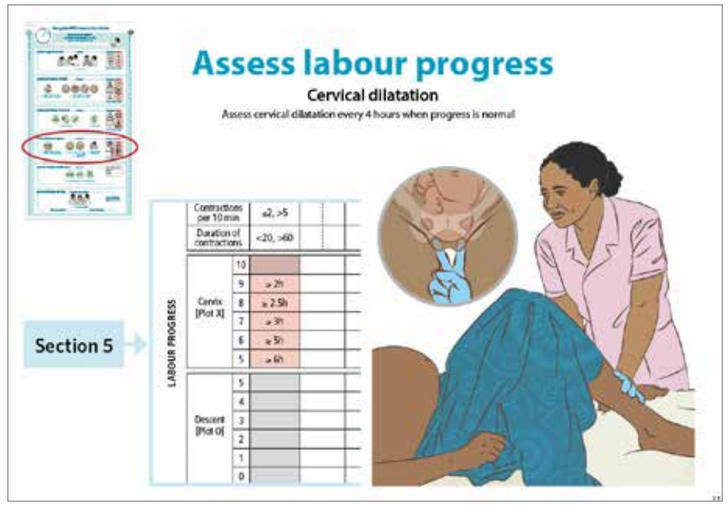
Assess cervical dilatation every 4 hours when progress is normal

Section 5

LABOUR PROGRESS

Contractions per 10 min		≤2, >5		
Duration of contractions		<20, >60		
Cervix [Plot X]	10			
	9	≥ 2h		
	8	≥ 2.5h		
	7	≥ 3h		
	6	≥ 5h		
	5	≥ 6h		
Descent [Plot O]	5			
	4			
	3			
	2			
	1			
	0			





Explain

- During the first stage, if labour progresses as expected, perform a gentle vaginal examination every 4 hours ***unless otherwise indicated.*** Do not start the examination during a uterine contraction. Assess all parameters that require a vaginal examination at the same time.
- If checking cervical dilatation less than 4 hours after the previous assessment, the examination should add important information to the decision-making process.
- Before doing a vaginal exam, review the woman's record and labour care guide to see her rate of cervical dilatation, descent and her contraction pattern from previous assessments.
- In the active first stage of labour, record "**X**" in the cell that matches the time and cervical dilatation. In the second stage, record "**P**" to indicate when pushing begins.
- The length and flow of every labour can be very different between women. It can even be different for the same woman from one labour to the next.
- Labour may not naturally accelerate until a cervical dilatation threshold of 5 cm is reached.
  - For women with spontaneous labour onset, the cervical dilatation rate threshold of 1 cm/hour during active first stage is inaccurate to identify women at risk of adverse birth outcomes and is therefore not recommended.
  - Cervical dilatation slower than 1 cm/hour should not be a reason to try and speed up labour in any way, provided fetal and maternal conditions are reassuring.

Cervical dilatation is slower than normal IF:

- it remains at 5 cm for 6 hours or more
- it remains at 6 cm for 5 hours or more
- it remains at 7 cm for 3 hours or more
- it remains at 8 cm for 2.5 hours or more
- it remains at 9 cm for 2 hours or more

Knowledge check

Ask participants to respond to the following questions and complete their answers with the information in blue italics below:

What will you assess for during a vaginal examination?

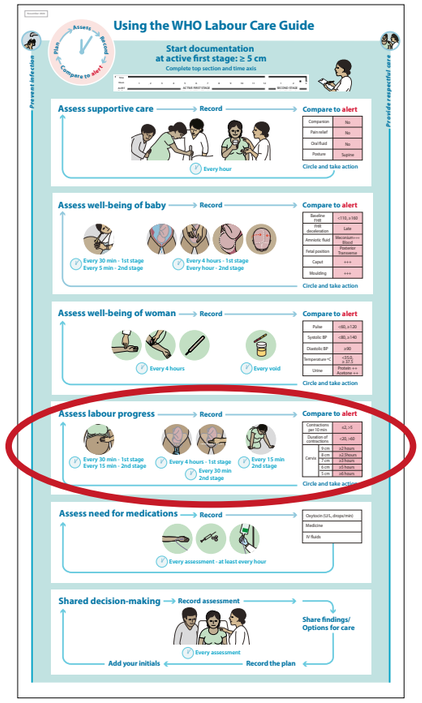
- *Status of the membranes*
- *Color and odor of fluid or discharge*
- *Sores and scars*
- *Position of cervix*
- *How long, effaced, soft, and dilated the cervix is. Is it swollen?*
- *Presenting part*
- *Position of presenting part*
- *Application of presentation part to the cervix*
- *Presence and degree of molding and caput*

What findings on vaginal examination may indicate obstruction?

- *A swollen cervix*
- *Presenting part not well applied to the cervix*
- *3+ moulding - Bones are overlapping and cannot be separated easily with pressure by your finger*
- *3+ caput - Diffuse swelling of the scalp*

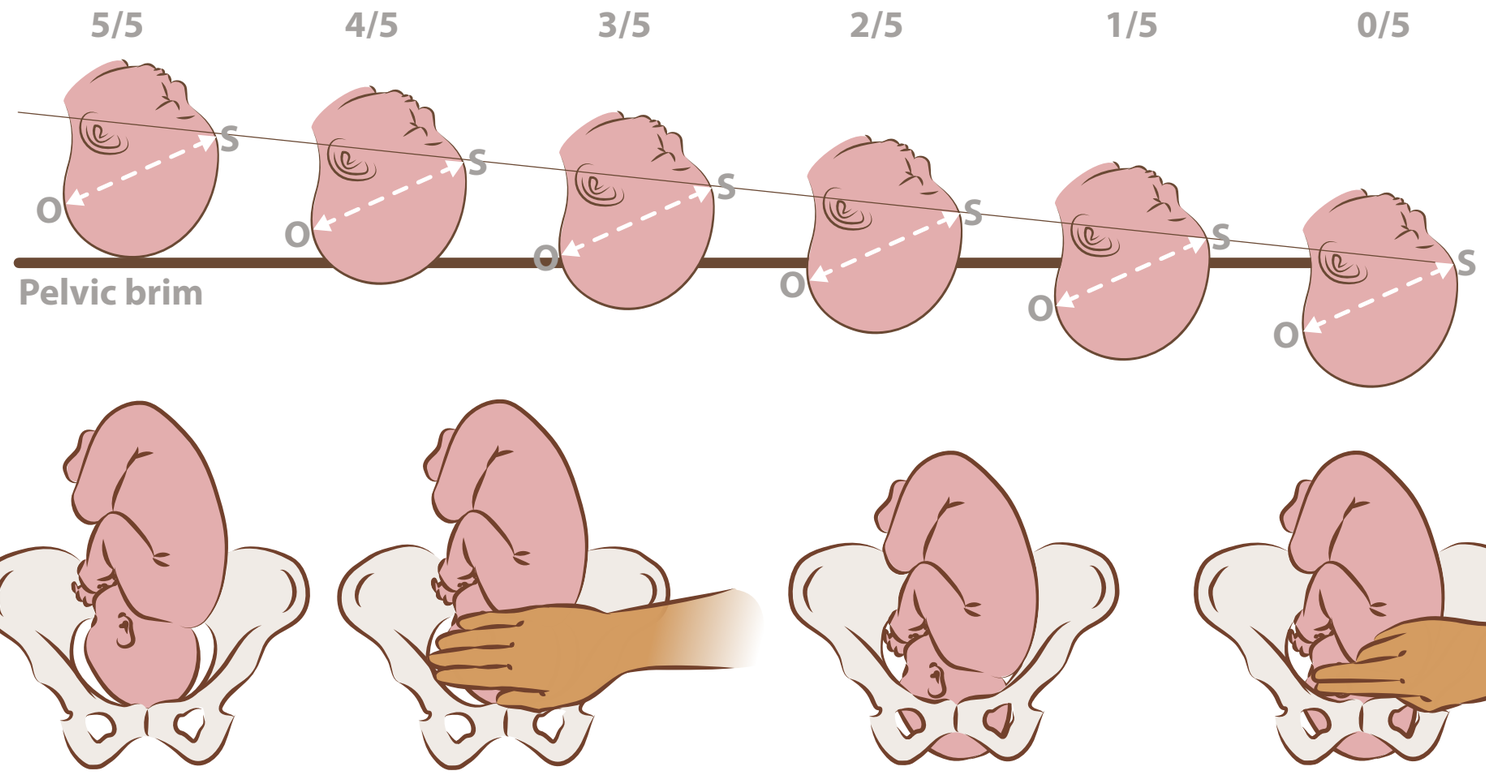
If cervical dilatation is slower than normal, what might indicate there is a problem?

- *Fetal and/or maternal conditions are not reassuring and/or*
- *Uterine contractions are effective.*



Assess labour progress

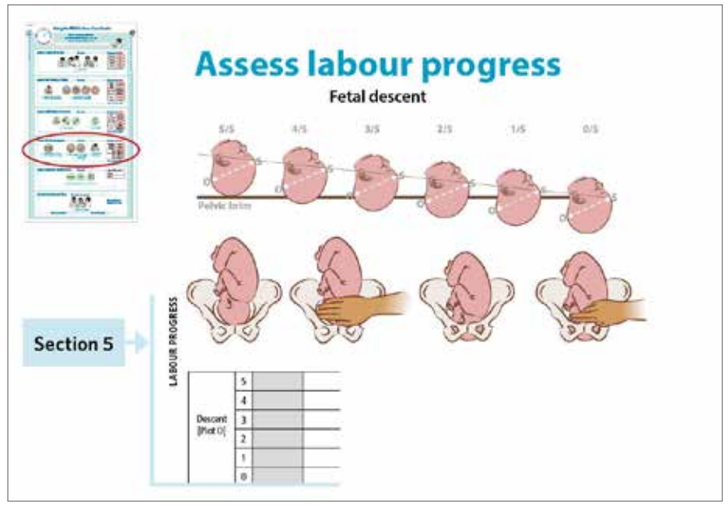
Fetal descent



Section 5

LABOUR PROGRESS

Descent [Plot O]	5		
	4		
	3		
	2		
	1		
	0		



Explain

- Fetal descent begins during active phase of the first stage of labour.
- During first stage, assess descent before performing a vaginal examination.
- Assess fetal descent during abdominal examination in terms of fifths of fetal head palpable above the symphysis pubis.
  - Record "**O**" in the cell that matches the time and the level of descent.
  - Record 5/5, 4/5, 3/5, 2/5, 1/5 and 0/5 to describe the fetal station by abdominal palpation.
- There are no reference thresholds for this observation. However:
  - Lack of descent with efficient contractions may be a sign of CPD or obstruction.
  - If the foetal head remains very high and not well applied to the cervix, it may be a sign of CPD/FPD.
  - During the second stage, take into account the woman's behaviour, effectiveness of pushing, and baby's position and wellbeing when deciding the timing of descent assessment.
- **Be alert! If the fetal head remains unengaged with efficient contractions, suspect obstructed labour. The woman and baby may be at risk!**

Advanced Care Note

Refer the woman to a facility that can perform a cesarean birth and care for a baby with problems if:

- The cervix is not dilating with efficient contractions, is swollen, or the fetal head is not well applied to it. These are all signs of obstruction.
- In active phase of first stage of labour, there is not progressive fetal descent with efficient contractions.

Guidance should be adapted based on local protocols and standards.

Note: Signs of unsatisfactory progress of labour include:

- Slower than normal cervical dilatation.
- Secondary arrest of cervical dilatation and/or descent of presenting part in the presence of adequate frequency and strength of contractions. This is a sign of obstructed labour or CPD/FPD.
- The cervix is fully dilated and the woman has the urge to push, but there is no descent.

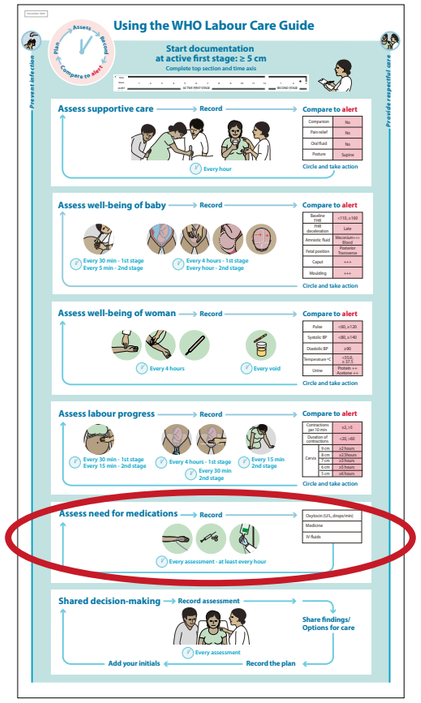
Knowledge check

If 5/5 of the head is palpable above the pelvic brim at 8 cm cervical dilatation, what do you need to rule out?

- *Ineffective contractions, obstruction, or CPD.*

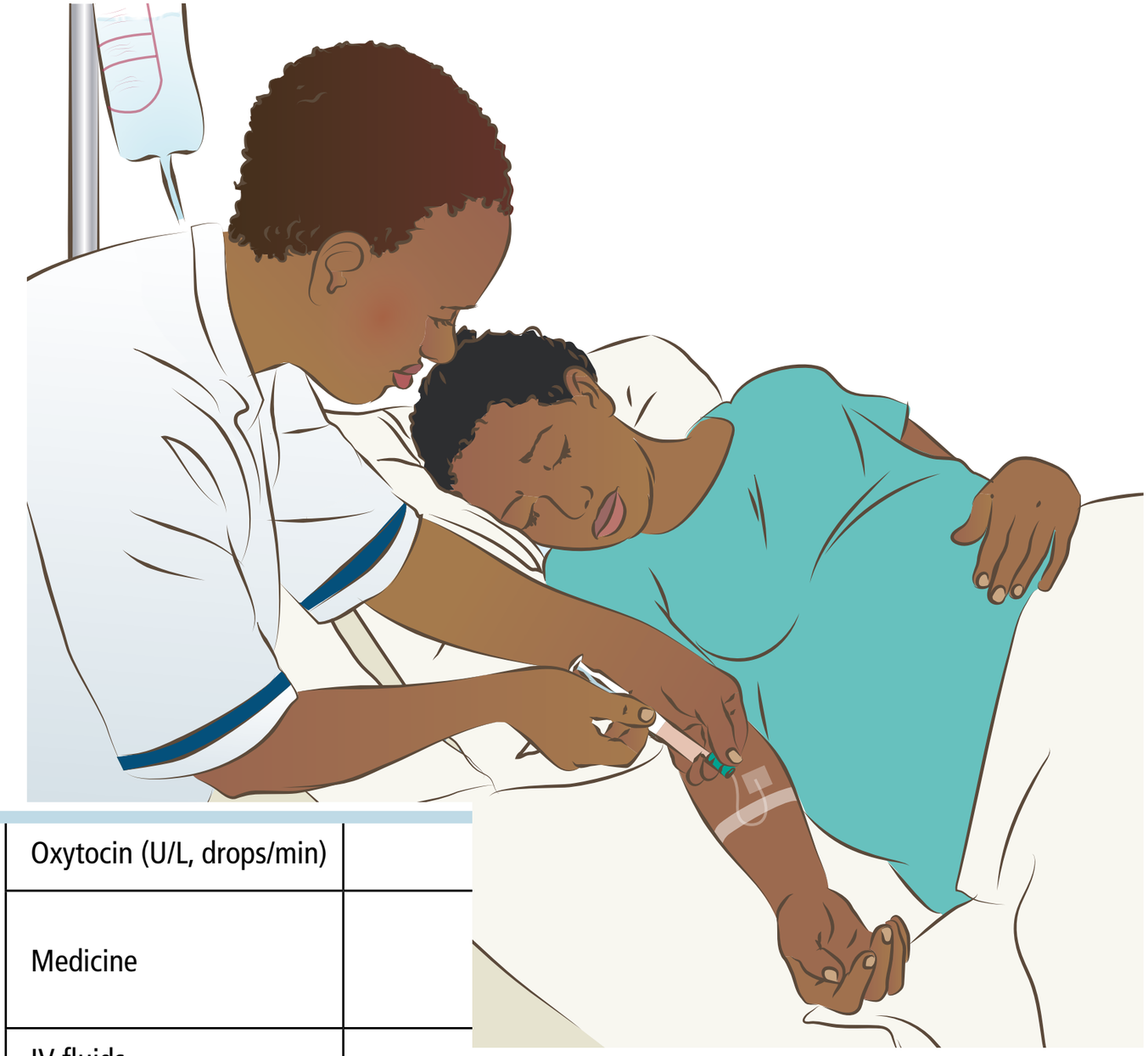
Learning activity

- *Divide participants into groups of 2-3. Ask them to read the scenarios on page 11 in their worksheets and record findings on labour progress on the LCG for Mary Jane.*
- *After recording findings on labour progress, ask participants to check if they have correctly filled in Section 5 by comparing this with the filled in Section 5 on page 22 of the WHO LCG User's Manual. They should then fill in the blanks for labour progress on page 10 in the Participant's Worksheets from Mary Jane's completed LCG on page 22 of the WHO LCG User's Manual.*
- *Ask if there are questions about alert values and how to assess if cervical dilatation is slower than normal. Facilitate a discussion.*
- *Review actions to take when "alert" values are present.*



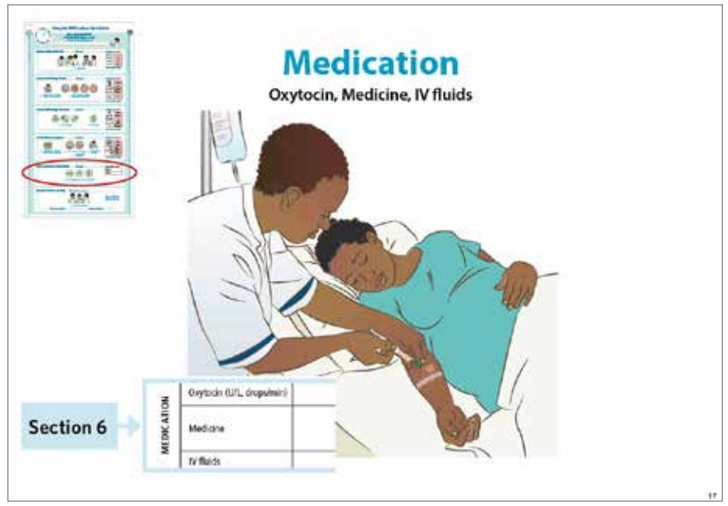
Medication

Oxytocin, Medicine, IV fluids



Section 6

MEDICATION		
	Oxytocin (U/L, drops/min)	
	Medicine	
	IV fluids	



Explain

Refer to pages 20-21 in the WHO LCG User's Manual (or page 25 in the Participant's Worksheets).

- **Section 6, Medication**, aims to facilitate consistent recording of all types of medications, oxytocin, and IV fluids being administered.
- ***Do not intervene*** if the condition of the woman and baby is reassuring, there is progressive cervical dilatation, and the expected duration of first and second stage is within the recommended limits.
  - Active phase of first stage of labour usually lasts 12 hours or less in first labors and 10 hours or less in subsequent labors.
  - Second stage usually lasts 3 hours or less in first labours or 2 hours or less in subsequent labours.
- Administration of medications, oxytocin, or IV fluids should only be considered after a series of maternal and fetal assessments have identified the probable cause.
- ***The routine administration of IV fluids for all women in labour is not recommended,*** given that it reduces women's mobility, increases the risk of infection, and unnecessarily increases costs.
- The decision to intervene when the first stage of labour appears to be prolonged must not be taken on the basis of duration alone.

Learning activity 1

Ask participants to refer to pages 20-21 in the WHO LCG User's Manual (or page 25 in the Partipant's Worksheets) to respond to the following questions:

1. **What will you record if the woman's labour is NOT being augmented with oxytocin?** *(Record "N" in the cell for oxytocin).* **What will you record if her labour is being augmented with oxytocin?** *(Record "U/L and drops/min" in the cell for oxytocin.)*
2. **What will you record if the woman is NOT receiving any medications or IV fluids?** *(Record "N" in the cells for medicine and IV fluids).*
3. **What will you record if the woman is receiving IV MgSO4?** *(Record "1g/h IV MgSO4" in the cell for medicine.)*

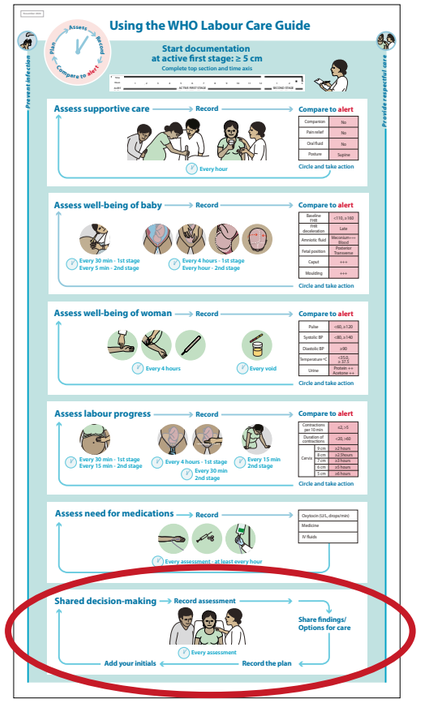
Learning activity 2

Ask participants to refer to page 12 in their worksheets. Divide participants into groups of 2-3. Ask them review the LCG for Mary Jane and assess if she needs any medications, an IV infusion, or augmentation of her labour.

Give participants a chance to respond. Then explain:

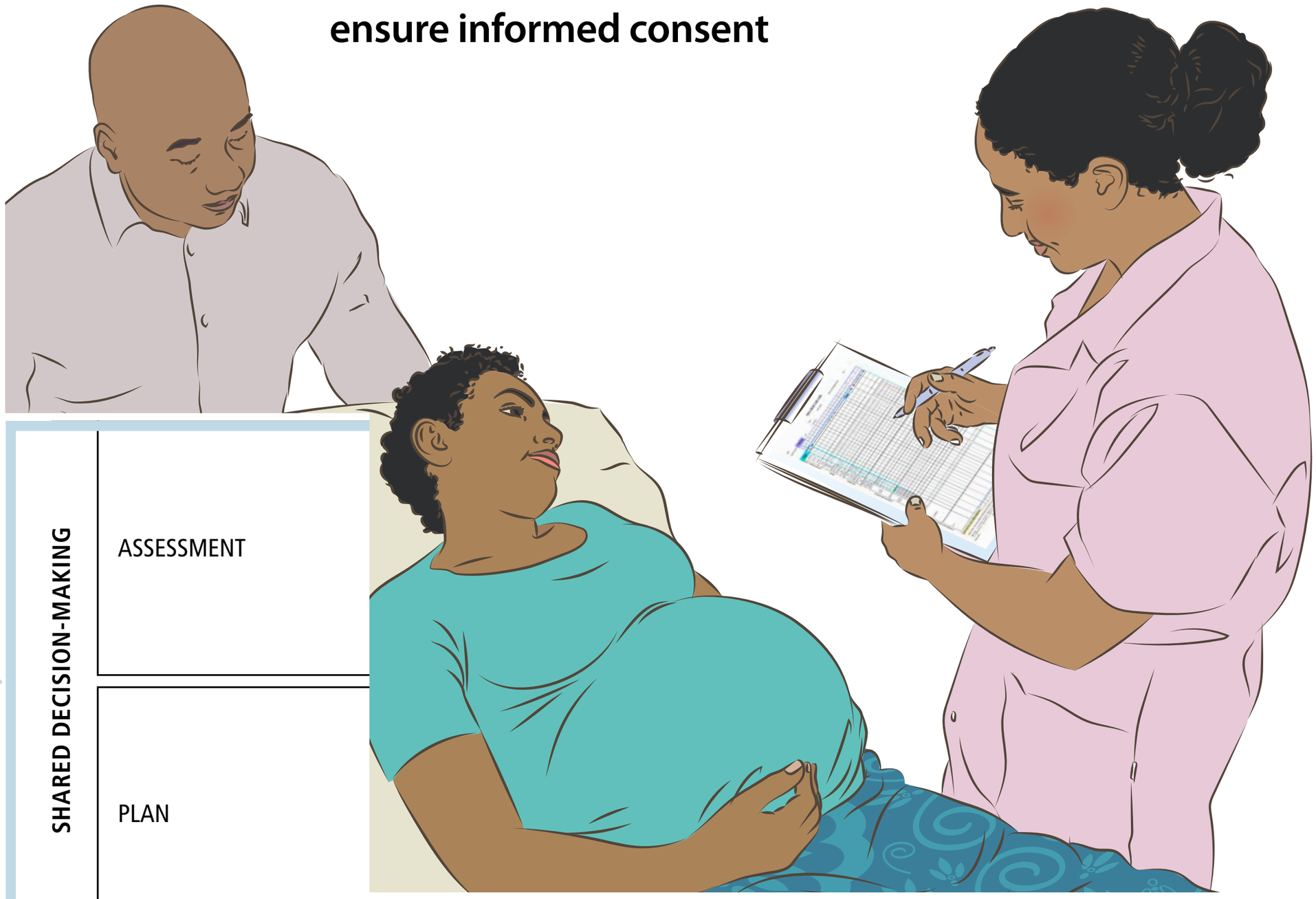
- FHR is within normal limits, with only one finding of variable decelerations.
- Vital signs are normal – there are no indications she has an infection.
- Urine protein/acetone are negative.
- Labour progress is within normal limits.
- Therefore, there is no indication that Mary Jane needs any medications or an IV, and does not need augmentation of labour. Any medication interventions would be considered "unnecessary".

Ask participants to complete the medication section for Mary Jane's LCG. Ask them to check if they have correctly filled in Section 6 by comparing this with the filled in Section 5 of Mary Jane's LCG on page 22 of the WHO LCG User's Manual.



Shared decision-making

Share findings and options for care, ensure informed consent

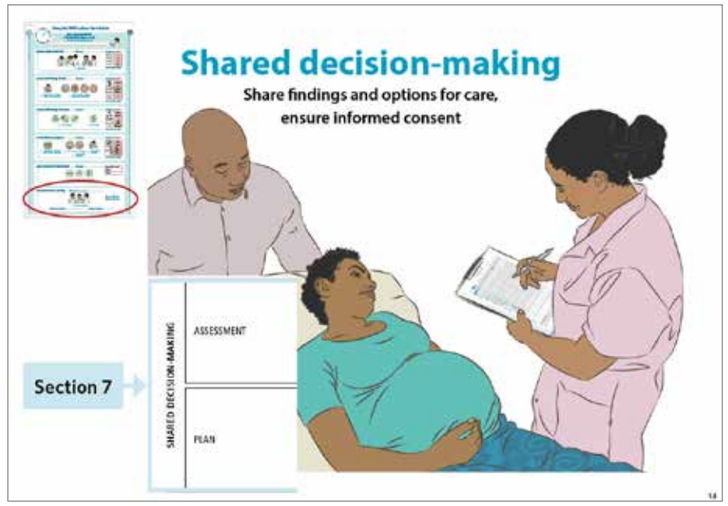


Section 7

SHARED DECISION-MAKING

ASSESSMENT

PLAN



Explain

Refer to page 21 in the WHO LCG User's Manual.

- **Section 7, Shared decision-making**, aims to facilitate continuous communication with the woman and her companion and ***consistent recording of all assessments, plans of care agreed upon, and initials of the provider.***
- Shared decision-making is the process of applying person-centered communication, deliberation, and decision-making to ensure a woman receives the best, individualized care.
- To enable shared decision-making:
  - Ensure effective communication between maternity healthcare providers and women in labour.
  - Take into consideration a woman's values, preferences, fears and concerns regarding her hoped-for birth experience.
  - Use appropriate language, and culturally appropriate terminology, taking into consideration the woman's and her companion's language, health literacy, education level and familiarity with the physiology of pregnancy and birth.
  - Give clear, simple explanations of findings of physical examinations and their implications.
  - Give clear explanations of a full array of care options, and unbiased explanation of potential benefits or risks for the woman and the baby.
  - Give ample time for the woman to ask questions.
  - Come to agreement on the plan of care and obtain informed consent.
- Women say they have a positive experience, regardless of outcome if they:
  - feel free to make their own choices, even when things do not happen as they expect
  - feel safe and cared for
  - feel connected to providers, family and their babies
  - feel they are being treated with respect
  - understand what happened
  - understand that they could not fully control what happened and that complications are not their fault

Discuss

Ask the following question and facilitate a discussion: **How can you enable "shared decision-making" with women and their companions during labour and childbirth?**

Effective communication between maternity health providers and women in labour, using simple and culturally appropriate language. Clear explanations of procedures and their purpose, findings of physical examinations and their implications, and care options should be explained to the woman and her companion, and the subsequent course of action agreed on and documented.

Learning activity

Ask participants to refer to page 12 in their worksheets. Divide participants into groups of 2-3. Ask them to review the LCG for Mary Jane and then write down an assessment and a plan of care for every hour. Remember to initial the LCG. Ask participants to check if they have correctly filled in Section 7 based on the scenario by comparing this with the filled in Section 7 of Mary Jan'es LCG on page 22 of the WHO LCG User's Manual.

After each group has checked if they have correctly completed the LCG, ask the following questions and facilitate a discussion:

1. **Do you agree with the assessments recorded on the LCG - If so, why; if not, how would you have recorded the assessment?**
2. **Do you agree with the plan of care recorded on the LCG - If so, why; if not, how would you change the plan of care?**

Ask if there are any questions about writing the assessment and plan of care.

Learning activities

Learning activities

Refer to the Participant's Worksheets for answers to the questions. Circulate around the room to assist participants, as needed. Remind them to refer to the User's Manual or the Quick Guide in the Participant's Worksheets for help with actions to take..

Case: ELIZABETH

Ask participants to individually complete the LCG using the findings for Elizabeth on pages 13-14 in the Participant's Worksheets, and remember to circle any alert values. Ask them to record findings and raise their hand when they see the question below:

What is your assessment?

How will you plan to care for Elizabeth?

When everyone has raised their hand, ask the question above and facilitate a discussion. They should then complete the assessment and plan of care sections.

When they have completed filling in the LCG, participants should compare how they have completed the LCG with the answer sheet on page 28 in the Participant's Worksheets.

Give participants a chance to ask questions and clarify any problems prior to the post-module assessment.

Post-Module Assessment

Pass out the post-course questionnaire and let participants know they may refer to the WHO LCG User's Manual / Quick Guide to fill in the LCG. Explain that participants should also use the WHO LCG User's Manual / Quick Guide when caring for women to ensure they are filling the LCG correctly and responding to alert signs appropriately.

Correct the post-course questionnaire, giving one point for every correct entry. If there is an alert value that is not circled, this response should get a "0" even if the value was correctly recorded. Passing score is 80%. Review the completed LCG with participants and respond to any questions or problems identified. If the participant did not get 80%, they should take the second post-module questionnaire on day 2.

Clinical day

On the second day of training, divide participants into groups of 2. Plan for 4-6 hours in the clinical area.

If there are women in labour, assign a group of 2 participants to one woman. Inform participants that they will be responsible for caring for and completing the LCG for a woman. They should refer to the User's Manual or Quick Guide to assist them with recording findings and making a plan of care with the woman and her companion. Get consent from the woman before introducing the participants who will be caring for her. If she does not give consent, thank her but do not allow participants to monitor her labour. Circulate between participants caring for women to mentor and provide support to participants. Review the LCGs completed by participants who cared for women. Provide constructive feedback, as needed, and answer any questions.

If there are not enough women for all of the participants, assign participants not caring for women with completing an LCG from the case study for Ms. Zakia on pages 15-16 in the Participant's worksheets. When they have completed the LCG, ask them to check their LCG by comparing it to the completed LCG on page 29 in the Participant's Worksheets. Provide constructive feedback, as needed, and answer any questions.

Debriefing after clinical

After returning from the clinical area, conduct a debriefing with all the participants. Ask the following questions and facilitate a discussion:

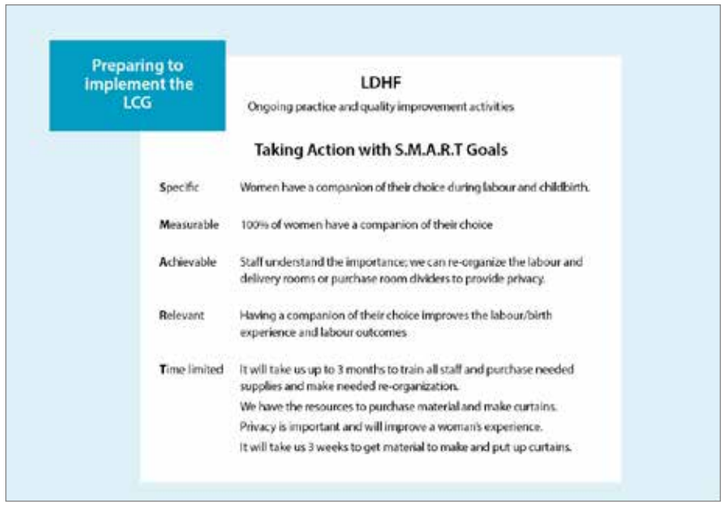
- **What barriers exist to ensuring privacy and confidentiality? What can we do to improve this?**
- **What barriers exist to facilitating the presence of a companion? What can we do to improve this?**
- **What did you find positive about the LCG?**
- **What did you find challenging about completing the LCG?**
- **Were there any areas that you want further training on?**
- **What do you feel may be some challenges to LCG completion on the labour ward where you work?**
- **What are some solutions to these challenges?**

LDHF

Ongoing practice and quality improvement activities

Taking Action with S.M.A.R.T Goals

Specific	Women have a companion of their choice during labour and childbirth.
Measurable	100% of women have a companion of their choice
Achievable	Staff understand the importance; we can re-organize the labour and delivery rooms or purchase room dividers to provide privacy.
Relevant	Having a companion of their choice improves the labour/birth experience and labour outcomes
Time limited	It will take us up to 3 months to train all staff and purchase needed supplies and make needed re-organization. We have the resources to purchase material and make curtains. Privacy is important and will improve a woman's experience. It will take us 3 weeks to get material to make and put up curtains.



Explain

What will we do individually to improve care during labour and childbirth and correctly complete the LCG?

Have each participant take 5 minutes to write it down things they need help with to confidently and correctly complete the LCG and put a time limit on how long it will take them to do it and a resource person they can work with.

What will we do differently together to improve care during labour and childbirth?

Ask the group what they think they are doing well when they care for women in labour and childbirth. Then ask the group to review the list the volunteers developed during discussions today to ensure that they can care for women using the LCG.

Ask if there is anything they learned that will be easy to change. Ask what may be hard to change: Companion in birth? Shared decision-making? Woman-centred care? Encouraging choice of position for pushing and birth?

Ask participants to reflect on the following questions as they review their list:

1. Which of these items do we want to change?

2. Which are we able to change on our own?

3. How are we going to make this change?

If you are in a large group, divide the group so there are 6 or fewer participants. Based on the discussion above, ask them to come up with 3 - 5 SMART goals to answer the question:

What will we do differently together to improve care during labour and childbirth?

Give SMART examples below:

- **S**pecific - Women have a companion of their choice during labour and childbirth.
- **M**easurable - 100% of women have a companion of their choice during labour and childbirth.
- **A**chievable - Staff understand the importance; we can re-organize the labour and delivery rooms or purchase room dividers to provide privacy.
- **R**elevant - Having a companion of their choice improves the labour/birth experience and labour outcomes.
- **T**ime limited - It will take us up to 3 months to train all staff and purchase needed supplies and make needed re-organization.

Have the groups share their goals. Make a plan to review and update the action plans.

How will we together make sure we are completing the LCG correctly, giving optimal care, and using results of our assessments to make appropriate care plans?

- Use the LCG User's Manual to assist you with completing the LCG and responding to findings.
- Ask for help from others when you have questions.
- Work together to make sure your care is the best possible care you can provide.
- Use the WHO tool to evaluate how the LCG was completed and the care provided.
- Make a plan to conduct audits on completed LCGs to evaluate how the care team is doing.

Review the LDHF activities on page 30-37 in the Participant Worksheets. Encourage them to actively participate in these activities that will be led by a Peer Practice Coordinator.

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