**LDHF ACTIVITIES**

**What is “continued practice” and why is it important?**

Training alone is not enough to improve care. Regular practice and other activities are needed to reinforce new knowledge and skills. Practice also improves teamwork and clinical decision-making.

**Who helps you practice?**

One or two people from your facility will be asked to coordinate practice sessions. The coordinator will remind you to practice and will guide the sessions. She/he is a colleague who has learned how to support these activities. **Remember, though, you and your peers can practice without a coordinator if you don’t have one or they are not available!**

**Session objectives**

The objectives of each session link to key learning objectives. Skills practice will help you refine your skills, especially skills you may not use often. For all sessions, be sure to demonstrate respectful care, good teamwork, and communication.

**Session preparation**

Each session plan includes a list of items you need how you should prepare. Practice coordinators are responsible for making sure everything is ready. Session plans also include instruction for coordinators and providers about how to run the session. You will need this Provider’s Guide (PG) for reference. Coordinators will give friendly coaching as needed.

**Simulating care with role plays**

To help us practice skills and clinical decision making, we will use role plays as we did during training. When conducting a role play, coordinators will:
- Establish a safe learning environment
- Run the role play
- Conduct organized debrief
- Support discussion to improve learning
- Identify and explore gaps
- Help providers transfer what they learned into clinical practice

**Debrief**

During debrief, coordinators guide providers to analyze their own performance and performance of the team. This gives everyone the chance to learn by carefully reviewing what happened. Coordinators and providers should be constructive and avoid embarrassing each other. The goal is self-reflection and team improvement.

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**Session 1: Creating a PE&E emergency kit and referral plan**

**15 – 30 minutes**

**Read objectives aloud:**

- Assemble a PE&E emergency kit or ensure correct PE&E supplies are in a general emergency kit
- Establish protocol to maintain kit
- Review and update OR establish and post a referral plan

**NOTE:**

If you already have a PE&E emergency kit, confirm it is complete and someone is responsible for checking it, then skip to referral planning.

**Preparation:**

- If the facility has a referral plan, have it ready to review with the team.
- Open another PG to page 33.

**Materials:**

- Leak-proof box with lid—to keep contents dry and clean
- Watch, clock, or other timer
- Marker/pens/paper
- Referral plan
Activity:
The coordinator is the time-keeper. All labor
ward staff participate. The coordinator tells
providers, “When I say ‘Go!’ gather each item
on the PE&E kit list and place it in the container.”
When the coordinator says "Go!" he or she
should start the timer to see how long it takes
the team to gather all items. If items are still
missing after 10 minutes, stop the activity.
As a group, discuss each question and do
each task:
• “This exercise took (x) minutes, with (y)
people. What happens when it takes this
much time to gather what we need?”
• "Did we find everything? If not, how can
we get what is missing?"
• Label filled container “PE&E Emergency Kit”
and tape checklist of supplies to the top.
Add kit to emergency trolley or put it in a
safe place where everyone can access it.
• Decide who will check the kit weekly
to be sure it is complete and nothing is
expired.

Referral planning:
• For facilities that refer for any reason,
review the referral plan. Be sure to post
it for all to see with contact numbers for
the referral hospital and transportation.
Consider programming contact numbers
into staff mobile phones.

Session 2
Blood pressure (BP) measurement and testing reflexes
10 minutes

Read objectives aloud:
• Ensure BP machine is calibrated.
• Accurately measure BP.
• Properly assess whether reflexes are
present or absent.
• Understand that reflex testing is needed
for hourly monitoring for MgSO₄ toxicity.
• Understand MgSO₄ dose should be
withheld if reflexes are absent.

Materials:
• Recalibration key
• BP machines, stethoscopes, and reflex
hammers

Preparation: Your practice coordinator will
help you individually or in pairs (up to 3 pairs)
OR you can practice on your own. If reflex
hammers are not available, use stethoscopes
or the side of your hand.

Activity - BP measurement:
Providers do these steps together:
• Assess BP equipment. If the needle is
not at “0” or pointing straight down, use
the calibration key (comes with the BP
machine) to get the needle to “0.”
• For most machines, the calibration slot is
underneath the dial. Gently pull off the
rubber to insert the key into the slot. Turn
gently until needle is straight down or at
“0.” Store key in central location and note
location. Calibrate all machines every 6
months.

Divide into pairs to practice taking BPs
and testing reflexes. Open another PG to
page 9 and give supportive feedback to each
other as you ensure:
• Proper position of “client”
• Proper position of cuff and stethoscope.
• Inflation to 180mmHg then release at
about 3mm/sec.

It is important to use what you hear and not
what you see for each value. Remember, each
bar is 2mmHg.
• After first providers have taken BPs, ask
what they got.
• Remind each other not to round up or
down but give precise numbers.
• Switch roles and repeat.

Activity—reflexes
Ensure a private, safe learning space.
Providers need to touch each other’s knees
and “clients” must be relaxed. The “client”
should either lie on a bed with legs relaxed or sit with legs hanging freely. Feet should not rest on the ground. The provider should:
• Feel for the deep tendon just below the kneecap.
• Bring the wide edge of a reflex hammer, edge of a stethoscope, or side of the hand down onto the tendon in a rapid, smooth movement. This should make the lower leg jerk.
Once providers successfully elicit reflexes a few times, switch roles. If someone cannot elicit reflexes, they should try using different methods (hammer, hand, stethoscope) or partners.

**Session 3**

**Labor Role Play**

*30 minutes*

**Read objectives aloud:**
• Correctly assess for PE&E
• Correctly classify PE&E based on assessment
• Provide correct initial management of PE&E

**Materials:**
• PE&E emergency kit
• Action Plan/Provider’s Guide
• BP machine and stethoscope
• Urine dipsticks
• Pregnancy wheel or calendar
• Tape measure and fetoscope
• MgSO4 Monitoring Sheet

**Preparation:**
• You need at least 3 people: 1 “client” (coordinator), 1 provider, 1 assistant
• For this session, only “clients”/coordinators should have their PGs open. Set out materials in advance.

**Activity:**
“Client” should know the information below but not share until “provider” conducts related assessment during simulation.
• History of PE in previous pregnancy
• BP: 142/84
• Urine: 1+ protein
• Fundal height: 36 cm
• Fetal heart rate: 154
• Cervix: 6 cm dilated
• Contractions: every 4 min x 40 sec
• Danger signs: **bad headache with no relief with medication, blurry vision**, no right upper quadrant pain, no difficulty breathing, no rales, and no history of convulsions.
If other items are assessed, give normal values. Coordinator acting as “client” reads below and proceeds with the role play, treating the scenario as if a real clinical situation: “Sara is 35 years old and is pregnant with her 5th child. She just came to the labor ward in active labor. Her record shows a confirmed LMP giving her a GA of 37 wks 0 days today. Interview her and proceed to give care to Sara. **If you are taking any measurement except vaginal exam, do so.** For all measurements, your client will give the answer. For vaginal exam, simply ask.”

Coordinator/client should stop role play upon completion of loading dose. Team should debrief and discuss questions below using Action Plan and Flip Chart where appropriate. Note the answers are on page 64. Ask:

1. How do you think it went?
   How did you feel?
2. Regarding assessment, what information did you gather and what else might you ask/assess?
3. What was your diagnosis?
   (Refer to classification table on pg. 18)
4. What did you do for Sara and why?
5. What is something you learned that you might use with a real client? What could you improve for next time?
Session 4
Gestational age (GA) assessment by LMP
15 minutes

Read objective aloud:
• Assess GA by LMP

Materials:
• Pregnancy wheels or calendars, paper and pencils

Preparation:
• Practice in pairs
• Go to page 23 for reminders on EDD and GA calculations.

Discuss:
If women cannot remember the 1st day of their LMP, help them by associating their LMP with holidays or other events. Use gestational age wheel or a calendar. If these are new to providers, take time to review how to use.

Practice GA calculation:
Providers should work on calculations on their own first. Use 10th April as today's date. Note the answers are on page 64. Compare answers and discuss after each case.

Case 1: A woman arrives for her first ANC visit and is sure her LMP was 28th September, her birthday.
1. What is her expected due date and GA today (10 April) based on LMP?
2. If her fundus measures 27 cm, do you have high or low confidence in this GA estimation?

Case 2: A woman says her LMP finished just before Election Day, or 15th August, and her menses usually last between 5 and 7 days.
1. What would you guess is her LMP?
2. What is her EDD and GA today (10 April) based on LMP?
3. If she measures 36 cm, do you have high or low confidence in this GA estimate?

Case 3: A woman says the first day of her LMP was around the last day of July.
1. What would you use for her LMP?
2. What is her EDD and GA today (10 April) based on LMP?
3. If her fundal height is 32 cm, do you have high or low confidence in this GA estimate?

Session 5
GA assessment by fundal height measurement
10 minutes

Read objectives aloud:
• Assess GA and fetal growth by fundal height (FH) measurement.

Materials:
• Tape measure

Preparation:
The coordinator will coach each provider during 1–2 ANC exams (women should be > 24 weeks GA). The coordinator and provider should review steps for FH measurement on page 21 before seeing the client.

Activity:
Provider should:
• Greet client, introduce yourself.
• Review EDD, LMP and expected GA for today.
• Tell the client what you are doing and why.
• Place the “0” on the tape measure at the top of pubic bone. Stretch the tape over the belly. Place second hand around top of fundus, holding the tape. FH and GA = cm on tape at the top of fundus.
• Compare findings with GA from LMP to decide if they match.
• Explain findings

Away from the client, discuss if both coordinator and provider agreed on measurement. Coordinator will provide supportive feedback on technique and communication. Provider can repeat measurement if needed. If more practice is needed, the coordinator can support the provider during more exams.

Session 6
ANC Role Play 1
30 minutes

Read objectives aloud:
• Correctly assess for PE&E in ANC.
• Correctly classify PE&E based on assessment.
• Provide initial correct management in ANC setting.

Materials:
• Action Plan / Provider’s Guide
• BP machine
• Stethoscope
• Urine dipsticks
• Pregnancy wheel, if available
• Tape measure and fetoscope

Preparation:
• You need at least 2 people: one provider and the coordinator to act as “client.”
• For this session, only “clients”/coordinators should have their PGs open. Find a private, available space and set out materials in advance.

Activity:
“Client” should have information below but not share until “provider” conducts related assessment during role play.
• Known LMP 16th August
• Fundal height 33cm
• BP is 148/88
• Urine is 2+ protein
• Danger signs: None at any time
• FHTs present 150

If other items are assessed, give normal values.

“Client” reads below and proceeds with the role play, treating the scenario as if a real clinical case:

“Mrs. N is 21 years old, G3P2 presenting to you for her fourth ANC visit today which is 10 April. Interview her and proceed normally for a routine ANC visit. If you are taking any measurement, do so. Your client will tell you the measurement.”

Coordinator/client should interrupt role play at the end of the visit and say, “It’s been 4 hours and her BP is 150/86. What will you do now?”

“Providers” should debrief and discuss questions below using Action Plan and Flip Chart where appropriate. Note the answers are on page 65. Ask:

1. How do you think it went? How did you feel?
2. Regarding assessment, what information did you gather and what else might you ask/assess?
3. What is her EDD and GA?
4. What is the most likely diagnosis?
5. What did you do for Mrs. N? Why?
6. What is something you learned that you might use with a real client? What could be improved?
Session 7  
Postpartum Role Play  
30 minutes  

Read objectives aloud:  
• Correctly assess for MgSO₄ toxicity  
• Correctly administer maintenance dose.  
• Correctly administer antihypertensive  
• Provide correct ongoing management of PE&E  

Materials and Preparation:  
Same as session 6  

Activity:  
“Client” should have information below but not share until “provider” conducts related assessment during role play.  
• BP: 160/108  
• Reflexes: present  
• Urine output: 150mL over 4 hours  
• RR: 18, lungs clear  
If other items are assessed, give normal values.  

Client or coordinator reads the note below and then proceeds with the simulation, treating the scenario as if a real clinical situation:  
“Mrs. S delivered a healthy baby girl last night. She developed SPE with a BP of 170/114 within 2 hours after birth and was given a loading dose of MgSO₄ 4gm IV and 10 gm IM and also nifedipine 20mg PO at 5 this morning. It is now 9:00am and you come to check on her. Proceed to care for her as you would normally. **If you are taking any measurement, do so. Your client will tell you the measurement.**”  

Coordinator/client should stop role play upon completion of interaction.  

“Providers” should debrief and discuss questions below using Action Plan and Flip Chart where appropriate. Note the answers are on page 65. Ask:  
1. How do you think it went? How did you feel?  
2. Regarding assessment, what information did you gather and what else might you ask/assess?  
3. What did you do for Mrs. S? Why?  
4. When will you stop her MgSO₄?  
5. When can Mrs. S and her baby be discharged home?  
6. What is something you learned that you might use with a real client? What could be improved?  

Session 8  
ANC Role Play 2  
30 minutes  

Session Objectives:  
• Correctly manage a convulsion.  
• Correctly classify PE&E.  
• Provide correct initial management of PE&E.  

Materials and Preparation: Same as session 6 and add oxygen mask  

Activity:  
Client or coordinator reads the note below and then proceeds with the role play, treating the scenario as if a real clinical case:  
“Lindi is pregnant with her 1st baby. She came to you today with a severe headache. You greet her, bring her into the examination area, and take her BP which is 152/108. As you remove the BP cuff, Lindi starts convulsing.” Proceed to care for her. **If you are taking any measurement, do so. Your client will tell you the measurement.**”  

Manage Lindi as if a true emergency. After role play is over and the “client” is stable, review convulsion management steps on page 15 together and discuss. Note the answers are on page 65. Ask:
1. How do you think it went? How did you feel?
2. What was Lindi's diagnosis?
3. Regarding assessment, what information did you gather and what else might you assess?
4. What did you do for Lindi? Why?
5. What is something you learned that you might use with a real client? What could be improved?

**SESSION ANSWERS**

**Session 3**  
**Labor Role Play**

1. Allow discussion—Consider communication with the team and the client, amount of time to initiate treatment, and other observations.
2. Did they assess: history, GA, abdominal exam, contractions, vaginal exam, FHTs, BP, protein, danger signs? If they did not, discuss why.
3. SPE (elevated BP plus danger sign)
4. Did they:
   - Mobilize team and get PE&E emergency kit.
   - Give correct loading dose of MgSO4 and start MgSO4 Monitoring Sheet.
   - Conduct laboratory tests (if possible).
   - Arrange for urgent referral (if this is not advanced care facility) once Sara has delivered.
   - Inform Sara about what is happening and why.
5. Guide providers to identify a specific behavior or skill change. Consider teamwork, communication, preparing treatment, etc.

**Session 4**  
**GA Assessment by LMP**

Case 1:
1. EDD: July 5; GA today: 27 wks 5 d
2. High confidence

Case 2:
1. Aug 8th
2. EDD: May 15; GA today: 35wks 0 d
3. Fairly confident

NOTE: Providers should account for 5 – 7 days for length of menses and subtract to get 1st day of her LMP

Case 3:
1. July 31st
2. EDD: 7th May; GA today: 36 wks 2 d
3. Low > 3 wks off

NOTE: The woman is measuring small for dates. Her LMP may be incorrect OR the fetus may be growing poorly. Discuss how measuring small or large for dates is managed at this site.
Session 6
ANC Role Play 1

1. Allow discussion—Consider communication with the client.
2. Did they assess: history, GA, abdominal exam, FHTs, BP, protein, danger signs? If they did not, discuss why. Did they have her return in 4 hr?
3. EDD = 23rd May, GA (today 10 April) = 34wk 0 days
4. Dx = PE (elevated BP plus proteinuria)
5. Repeated BP in 4 hours, if she could wait. Asked Mrs. N again if she has any of the danger signs. Told Mrs. N that she has PE. Drew labs if possible. Increased visits to twice weekly. Counseled her about PE & E danger signs and advised her to come back immediately if she has these. Provided routine ANC counseling, including birth preparedness and complication readiness.
6. Guide providers to identify a specific behavior or skill change. Consider assessment, communication, risk counseling, etc.

Session 7
Postpartum Role Play

1. Allow discussion—Consider communication with the client, amount of time to assess and give treatment.
2. Did they assess: BP, reflexes, respirations, urine output? If they did not, discuss why.
3. Did they: Prepare MgSO4 50% 5gm with 1mL of 2% lignocaine and give IM. Give antihypertensive (per context). Document assessment and medications on MgSO4 monitoring sheet. Inform Mrs. S about what is happening and why.
4. MgSO4 will be stopped if Mrs. S shows signs of toxicity. Otherwise it will be discontinued at 5 the next morning IF she does not have any seizures.
5. Mrs. S and her baby can go home when Mrs. S is stable—meaning her BP is within normal range, she has no danger signs, and her laboratory tests are reassuring. This is according to provider’s clinical judgment. Careful follow-up and counseling should be provided. This should include telling her about danger signs, risk of PE or E in a future pregnancy, and risk of high blood pressure later in life.
6. Guide providers to identify a specific behavior or skill change. Consider teamwork, communication, preparing treatment, etc.

Session 8
ANC Role Play 2

1. Allow discussion—Consider clear communication of team roles.
2. Eclampsia
3. Did they: Shout for help, ensure airway is open and turn her on her side, give oxygen 4–6L if available, use bag/mask if not breathing, assess circulation, protect her from injury without restraining, not put anything in her mouth, initiate the loading dose of MgSO4 and antihypertensive.
4. Same information as for 3 above
5. Guide providers to identify a specific behavior or skill change. Consider teamwork during an emergency, communication, preparing treatment, etc.
**Helping Mothers and Babies Survive**

**Pre-Eclampsia & Eclampsia**

**ACTION PLAN 1 - INITIAL CARE**

**Assess (if > 20 weeks pregnant)**

- Blood pressure
- Urine for protein
- Danger signs
- Convulsions

**CLASSIFY**

**PRE-ECLAMPSIA**
- dBP ≥ 90 or sBP ≥ 140 and ≥ 2 + proteinuria
- No Danger Signs

**SEVERE PRE-ECLAMPSIA**
- dBP ≥ 110 or sBP ≥ 160 and ≥ 2 + proteinuria
- ≥ 1 Danger Sign

**ECLAMPSIA**
- Convulsions or Unconscious

**Routine Care**
- Yes
  - Normal? Yes → Reassess
  - Normal? No → Do laboratory tests
  - Normal? Yes → Increase follow up
  - Normal? No → Confirmed gestational age
  - Deliver at 37 weeks

**Provide essential care**
- Continue to monitor

**Continually assess for Danger Signs**

**Do laboratory tests**
- Normal? Yes → Increase follow up
- Normal? No → Confirmed gestational age
- Deliver at 37 weeks

**Mobilize team**

**Give loading dose of magnesium sulfate (MgSO₄) IV + IM**

**Give medication to reduce severe BP**

**Seek advanced care**

**Safely manage all convulsions**
Helping Mothers and Babies Survive

Pre-Eclampsia & Eclampsia

ACTION PLAN 2 - ADVANCED CARE

**SEVERE PRE-ECLAMPSIA**
Pre-Eclampsia and One or More Danger Signs

**ECLAMPSIA**
Convulsions or Unconscious

- Safely manage all convulsions

**Receive referral OR Continue care**

**Begin OR Continue MgSO₄**

**Begin OR Continue medication to reduce severe BP**

**Continue close monitoring of woman and fetus**

- If no convulsions and conscious
- If convulsions or unconscious

**Confirm Gestational Age**

- Pre-viable
  - Within 24 hours
  - End pregnancy
  - Continue MgSO₄ for 24 hours after birth or last convolution
  - Continue monitoring

- Viable to < 34 weeks
  - Give dexamethasone

- ≥ 34 week to < 37 weeks
  - Within 24 hours

- ≥ 37 weeks
  - Continue medication to reduce severe BP

**Deliver**

- Within 12 hours

**Provide essential maternal and newborn care**

- Continue to monitor after birth

- Yes to any

- Convulsions
- Uncontrolled severe hypertension
- Worsening maternal condition (danger signs, exam, lab tests)
- Worsening fetal condition or demise
- Reaches 37 weeks 0 days