tests and relation between accurate volume of hemorrhage and estimated volume andtreatment, occupation and experience of participants were determined.

Results: Accuracy visual estimation of blood loss in different volume of postpartum hemorrhage was between 14.3% to 52%. There was no significant association between the position of the participants and accuracy of their estimation and proposed treatments. There was no association between the staffs' work experience and accuracy of their estimation.

Conclusions: Visual estimation of blood loss was not accurate in the majority of participants. For prevention of maternal morbidity and mortality education is necessary that to be skilled for accurate estimation of blood loss.

P0642

DOES ETHNICITY AND TIMING OF DELIVERY IN POSTDATE PREGNANCY AFFECT MATERNAL AND FETAL OUTCOME? A CROSS SECTIONAL STUDY FROM THE NATIONAL OBSTETRICS REGISTRY MALAYSIA

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Objectives: Postdate pregnancy is defined as pregnancy that extends beyond 40+0 weeks of gestation. Studies have shown that induction of labour at or from 41 weeks reduce perinatal morbidity without increasing caesarean section (CS) rates and other adverse outcomes. In Malaysia, there is no guidelines on timing of induction of labour. There is wide variation in practise of induction among hospitals ranging from 40 weeks +3 days, 40 weeks+ 6 days, 41 weeks+ 2 days and beyond 41 weeks + 3 days. This study was to see if the difference in timing of induction contributes to maternal and perinatal outcomes.

Method: This is a retrospective cohort study using data from the National Obstetrics Registry (NOR). NOR is a clinical data base that compiles obstetric data from 14 tertiary hospitals in Peninsular Malaysia and East Malaysia. Specific variables were analysed against the 3 major ethnicity in Malaysia namely Malay, Chinese and Indians to see if timing of induction by ethnicity has any significance on the outcomes. The study period was from 1st January 2011 to 31st Dec 2012. The analysis was performed using STATA statistical software. Descriptive statistics was obtained initially followed by multinomial regression. P value <0.001 was taken as significant.

Results: The prevalence of postdate pregnancy is 20.1% in this study. There was less risk for a CS in all ethnicity when induced at 40+3 and 40+6 days. In Malays there was a higher risk of AS <7 at I min (Crude odd ratio (OR) 1.36 (1.20, 1.55) $p<0.001$) at 41+2 days and beyond 41+3 days (Crude OR 1.38 (1.20, 1.58) $p<0.001$). There was no statistical significance among ethnicity and AS <7 at 5 min and timing of induction. Among Malays and Chinese no statistical significance on macerated stillbirth rates. In Indians there were no cases captured during the study period.

Conclusions: From our analysis we did not see any correlation between ethnicity and timing of induction on maternal and fetal outcomes.

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RESPECTFUL MATERNITY CARE IS QUALITY CARE: RESULTS FROM A STUDY IN ETHIOPIA

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Objectives: To assess clients' experience of disrespect and abuse by health workers during their recent institutional child birth.

Method: The study was conducted as part of a wider evaluation to evaluate the effects of a quality improvement intervention, Standards-based Management and Recognition (SBM-R). The study design employed intervention and comparison health facilities. Eight health centers and three hospitals in intervention sites that initiated the quality intervention from 2011 were selected; similar numbers of facilities from comparison sites were also included. All sites were located in the same regions of Ethiopia. The study looked at health care worker skills in providing RMC using observation by a non-participant observer and client perceptions of RMC from a postnatal exit interview.

Results: Observation during labour and delivery showed higher level of competency in providing RMC in intervention areas. 88% of women observed were never left alone during labour, compared with 75% in the comparison. Allowing women their birth position of choice was significantly higher in intervention areas, 54% Vs. 20%. Allowing support person during labour was higher in intervention areas, 84% Vs. 74%. Client perceptions, varied and were not statistically significant. Overall, 37% of women in both sites reported they experienced at least one form of abuse and disrespect; 28% (27% in intervention Vs. 29% in comparison) felt that they were disrespected by providers.

Conclusions: RMC is becoming an aspect of standardized maternal and newborn care in Ethiopia and its inclusion needs to be an integral part of efforts to increase institutional delivery in a country with one of the lowest skilled birth attendant rates in Sub-Saharan Africa. While the study showed client perceptions of RMC and assessors observations are different, this could be attributed to their low expectations of RMC due to the normalization of disrespect and abuse.

P0644

WHO'S SAFE-CHILDBIRTH CHECKLIST (SCC): A POTENTIAL SOLUTION FOR IMPROVING PROVIDER PERFORMANCE FOR ADHERENCE TO LIFE SAVING PRACTICES DURING THE INTRA- AND IMMEDIATE POSTPARTUM PERIOD

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Objectives: To assess the utilization of the SCC in the existing context of public health facilities of Rajasthan, India.

To assess the influence of the SCC in adherence to life-saving practices in the intra- and immediate postpartum period.

Method: WHO developed the SCC to strengthen quality of care during intra- and immediate postpartum period. Jhpiego, together with Government of Rajasthan, India, adapted the SCC to Indian context and implemented a program to use the SCC in >100 facilities in 7 districts of Rajasthan, catering to a population of >15 million. The providers were oriented on the use of SCC and supported by onsite visits to institutionalize the use of SCC. Scalability and implementation through the system, with minimal incremental inputs, were the cornerstones of the programmatic approach. Structured recording of practices was undertaken to measure the adherence to practices.

Results: SCC was used for at least single pause point in $>75\%$ deliveries. Initial assessment of clients by recording of maternal BP and Temperature at time of admission improved from 50% and 7% at baseline to $>90\%$ after introduction of SCC. Use of Oxytocin for AMTSL and appropriate management of Severe Pre-Eclampsia/Eclampsia improved from 73% and 9% at baseline to $>90\%$ after introduction of SCC. Essential newborn interventions like recording of neonatal temperature and respiratory rate within one hour of birth improved from $<10\%$ at baseline to $>90\%$ However, practices at the point of discharge did not improve as dramatically.

Conclusions: The SCC can be institutionalized in the public health facilities in the Indian context by a programmatic approach that focuses on implementation through the system and utilization of minimal incremental resources towards ensuring scalability and sustainability of the utilization of SCC. The SCC has also been effective in