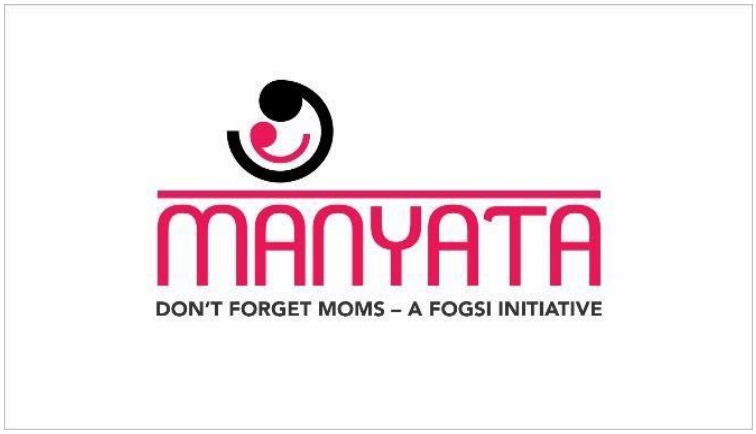

MANYATA – A QUALITY IMPROVEMENT INITIATIVE FOR PRIVATE SECTOR MATERNITY SERVICES IN INDIA

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Antenatal Care			
1	**Provider screens for key clinical conditions that may lead to complications during pregnancy. (To be verified only among booked cases)**		
1.1	Screens for Anemia	1.1.1	Estimates Hb at least once in every trimester using digital haemoglobinometer/ semi autoanlyser
		1.1.2	Provider knows the classification and management algorithm (Nutritional counselling, therapeutic interventions, and referral) for different categories of anaemia.
		1.1.3	Provider takes history of relevant risk factors for anaemia and screens for hereditary conditions like sickle cell / thalassemia
1.2	Screens for hypertensive disorders of pregnancy	1.2.1	Functional BP instrument and stethoscope at point of use is available
		1.2.2	Records BP at each ANC visit
		1.2.3	Performs proteinuria testing during all ANC contacts if a pregnant woman is hypertensive
1.3	Screens for DM	1.3.1	Uses/Refers for standard single step 75gm OGTT for screening of GDM at first ANC visit and repeats OGTT test at second ANC visit (24 -28 weeks) if negative in first screening
1.4	Screens for HIV	1.4.1	Screens/ refer for HIV during first ANC visit in all cases, and repeat HIV testing, considering window period if the spouse is positive or s/he have high-risk behavior*
		1.4.2	Pretest Counseling, informed consent, then test and again do posttest counseling in all pregnant women at first antenatal visit as a Routine. (Any HIV testing should be accompanied by pretest and posttest counseling services and informed consent and confidentiality)
		1.4.3	**Ensure involvement of Spouse** for counseling and testing (Move from *'antenatal care- centric'* approach to *'family centric approach')*
		1.4.4	**In un-booked antenatal cases**, directly presenting in labor with no prior HIV screening: Offer bedside counseling and testing by *'Whole blood finger prick test kit'* in the labor room. (Counseling and testing can be done by labor room staff nurse)
1.5	Screens for syphilis	1.5.1	Screens/ refer for syphilis in first ANC visit in all cases, and again in the third trimester or at the time of delivery if she has high-risk behavior** or untested earlier
		1.5.2	Knows how to use Point of care diagnostic kit for syphilis
1.6	Screens for Malaria	1.6.1	Offers intermittent screening and preventive treatment of malaria in pregnancy (IPTp) to all pregnant women, regardless of the number of pregnancies in high endemic areas
		1.6.2	Tests pregnant women who present with symptoms or signs suggestive of malaria with a blood slide or RDT

		1.6.3	Test pregnant women with a history of fever within the past 48 hours or an axillary temperature >37.5°C for malaria with an Rapid Diagnostic test (RDT) or a blood smear/microscopy
1.7	Establishes blood group and Rh type during first ANC visit	1.7.1	Establishes blood group and Rh type during first ANC visit
		1.7.2	Documents mother blood group in ANC records and offers appropriate counselling in case of Rh mismatch
1.8	Provider counsels mother on vaccination during pregnancy	1.8.1	Instead of the plain tetanus vaccination, diphtheria toxoid, tetanus toxoid and acellular pertussis (dTaP) vaccination should be offered by 28-32 weeks in each pregnancy.
1.9	Provider should know importance of testing for HBsAg	1.9.1	Screen for HBsAg
1.10	Provider knows about HRP Identification and Management	1.10.1	Takes thorough medical history and examination Including weight gain at every visit and height.
1.11	Screens for asymptomatic bacteriuria	1.11.1	Screens for asymptomatic bacteriuria using urine culture/urine gram staining/dipstick test for nitrite during each scheduled ANC contact.
1.12	Provider screens for Thyroid dysfunction	1.12.1	Screened all pregnant women at 1st antenatal visit by measuring TSH levels. TSH cut off should be lower rather than keeping it on 4.0 mIU/L. However, the trimester specific TSH cut off recommended are: • 1st trimester 2.5 mIU/L; • 2nd trimester, 3.0 mIU/L; • 3rd trimester, 3.0 mIU/L.

Safe Care During Delivery			
2	**Provider prepares for safe care during delivery (to be checked every day)**		
2.1	LR Lay Out Assessment	2.1.1	Initial assessment/triaging area/stabilization bed labor room Newborn care corner Maternity OT preferably close by
		2.1.2	Changing room Dr/Nurses room with attached toilet Nursing station, Telephone, white board, alarm for code activation, Adult resuscitation kit

		2.1.3	Check for: Handwashing Area (Elbow tap with running water and soap dispenser) Clean utility (for sterile storage unit and autoclave) Toilet with western WC and washbasin Dirty utility area
2.2	Labor Room	2.2.1	Washable wall (at least 6 feet) and floor
			Privacy maintained: Curtain
			LR table, suction machine, controlled oxygen supply
			AC (TEMP 25-26C) and ambient thermometer
			Shadow less adjustable light for examination
			7 Trays (Examination, Delivery Tray, Episiotomy Tray, NBR, Baby tray, Emergency tray, Medicine tray, PPH BOX, Eclampsia BOX Functional refrigerator for storage of medicines and samples especially Oxytocin Written Care Protocols are available in LR or nursing station
2.3	NBC Area	2.3.1	Ensures functional items for newborn care and resuscitation Shoulder roll, pre-warmed towels, head cap, mucus extractor, cord clamp, stop clock and resuscitation equipment.
		2.3.2	Switches radiant warmer 'on' 30 min. before delivery.

Assessment on Admission			
3	**Provider assesses all pregnant women at admission**		
Welcoming and explaining admission procedure		The nurse or caregiver welcomes the patient and her attendant to the facility. They explain the admission procedure to the patient and attendant. If the patient was referred, a referral slip should be attached to the file.	
3.1	Takes obstetric, medical and surgical history	3.1.1	They review the patient's obstetric, medical, and surgical history using the provided BHT/Checklist form.
			The obstetric history includes reviewing antenatal records, investigations, ultrasound, screening tests, and any events during the antenatal period.
			Immunization status and high-risk pregnancy factors are also recorded.
			The nurse or caregiver gathers information about the patient's past obstetrics history, including recurrent pregnancy loss, history of medical termination of pregnancy (MTP), preterm birth, stillbirth, post-term or prolonged pregnancy, previous caesarean section (LSCS), etc.

			The nurse or caregiver collects information about the patient's medical history, including hypertension, diabetes mellitus, bleeding diathesis, hepatitis A/B/C, HIV, epilepsy, fever, recurrent urinary tract infections, tuberculosis, drug allergies, and any other relevant medical conditions.
			They also inquire about any surgical procedures related to the uterus, prolapse repair, fistula repair, abdominal hernia repair, and any other surgeries.
3.2	Assess gestational age correctly	3.2.1	Assesses gestational age through either LMP or Fundal
3.3	Records fetal heart rate	3.3.1	Functional Doppler/ fetoscope/ stethoscope /CTG at point of use is available
		3.3.2	Records FHR for one minute
3.4	Records mother's BP and temperature	3.4.1	Functional BP instrument and stethoscope and functional thermometer at point of use is available
		3.4.2	Records BP and temperature. Conducts abdominal examination ensuring privacy

PV Examination			
4	**Provider conducts PV examination appropriately**		
4.1	Conducts PV examination as per indication	4.1.1	Conducts PV examination only as indicated (4 hourly or based on clinical indication) (Ask Doctor/ Nurse as per facility protocol)
4.2	Conducts PV examination following infection prevention practices and records findings ensuring the woman's informed consent, privacy, dignity and comfort	4.2.1	Explain procedure to the mother
		4.2.2	Obtain informed consent
		4.2.3	Ensure presence of Attendant
		4.2.4	Ensure Aseptic technique
		4.2.5	Ensure Privacy confidentiality comfort and dignity
			Nurse should know the contraindications
			Records findings

Partograph			
5	**Provider monitors the progress of labor appropriately**		
5.1	Undertakes timely assessment of cervical dilatation and descent to monitor the progress of labor	5.1.1	Partograph are available in labor room
		5.1.2	Initiates partograph plotting when cervical dilatation is >= 5 cms (LCG)
5.2	Interprets partograph (condition of mother and fetus and progress of labor) correctly and adjusts care according to findings	5.2.1	If parameters are not normal, identifies complications, records the diagnosis and makes appropriate adjustments in the birth plan (Ask Doctor/ Nurse as per facility protocol)
5.3	Obstructed labour	5.3.1	Staff knows Diagnosis & Management of Obstructed Labour (Interpreting partograph, Re-hydrates the patient, check vitals, gives broad spectrum antibiotics, perform bladder catheterization, and takes blood for Hb & grouping)
5.4	Unnecessary augmentation and induction of labour is not done using Uterotonics	5.4.1	Oxytocin and misoprostol inductions done only for clear medical indication and the expected benefits outweigh the potential harms. Outpatient induction of labour is not done

Respectful Maternity Care			
6	**Provider ensures respectful and supportive care**		
6.1	Antenatal Period	6.1.1	Treats expecting mother respectfully from first point of contact
		6.1.2	Makes good rapport with client (Greet women and her companion and ensure comfort and privacy
		6.1.3	Takes complete history asking sensitive and non- judgmental questions
		6.1.4	Explains the procedure of examination and take informed consent
		6.1.5	Ensures presence of attendant with whom patient is comfortable
		6.1.6	Explains about pregnancy in simple and easy to understand language of her choice

		6.1.7	Encourages the women to ask question and answers appropriately
		6.1.8	Talks to mother to identify potential or present stressors in her immediate environment
		6.1.9	Identifies a birth companion for the duration of the pregnancy and postpartum period, in consultation with the mother
6.2	Intrapartum Period	6.2.1	Treats pregnant woman and her companion cordially and respectfully. Confidentiality of patient's records and clinical information is maintained. Maintains PCMC-dignity, Respect, and Communication, privacy, autonomy, and supportive care.
		6.2.2	Explains danger signs and important care activities to mother and her companion.
		6.2.3	Provides continuous support to mother and birth companion throughout childbirth (onset of labour, induction, surgical intervention etc)
		6.2.4	Enables skin to skin contact and early initiation of breastfeeding if newborn is healthy
		6.2.5	Ensures mother and baby are comfortable and safe before shifting out of the labour room/OT
		6.2.6	In case of any newborn related complications, explains the same to them or facilitates communication with the newborn care provider
6.3	Postpartum Period	6.3.1	Ensures comfort, pain relief, and hydration of the mother in immediate postpartum period and encourages presence of birth companion
		6.3.2	Encourages mother and birth companion to ask questions and answers them in simple and easy to understand words
		6.3.3	Encourages mother to breastfeed and takes appropriate measures to provide support
		6.3.4	Ensures mother's concerns/queries about the baby are answered
		6.3.5	Explains danger signs related to mother and baby and guidance on post-natal care before discharge.

Feedback Form to evaluate the Quality of Care	
1	Do you think the communication/verbal interaction with service provider was congenial?
2	Did you receive supportive and respectful care?
3	Did you experience any kind of physical abuse from the service providers?
4	Was there enough provision to provide privacy during Examination/Procedures?
5	Were you subjected to any form of stigma and discrimination during the treatment?
6	Did you experience neglect of care at any point of time during treatment

Safe and Clean Birth			
7	**Provider assists the pregnant woman to have a safe and clean birth**		
7.1	Readiness of labor room	7.1.1	Availability of handwashing station with soap and running water.
		7.1.2	Staff can demonstrate the correct techniques of handwashing, gloving and draping.
		7.1.3	Availability of monitor for continuous monitoring of vital parameters or clinical monitoring is ensured.
		7.1.4	Availability of autoclaved delivery tray, surgical and back up tray
		7.1.5	Staff knows the Do's and Don'ts in the labor room.
7.2	Provider ensures six 'cleans' while conducting deliver	7.2.1	Sterile gloves are available.
		7.2.2	Antiseptic solution (Betadine/ Savlon) is available.
		7.2.3	Clean sheet is available for the mother (to be placed on labor table)
		7.2.4	Sterile cord clamp is available.
		7.2.5	Sterile cutting edge (blade/scissors) is available.
7.3	Performs an episiotomy only if indicated with the use of appropriate local anesthetic	7.3.1	Performs an episiotomy only if indicated and uses local anaesthesia
7.4	Allows spontaneous delivery of head by maintaining flexion and giving perineal support; manages cord round the neck; assists in delivery of shoulders and body	7.4.1	Allows spontaneous delivery of head by maintaining flexion and giving perineal support; manages cord round the neck; assists in delivery of shoulders and body
7.5	Provider ensures Infection prevention practices in labor room	7.5.1	Disposal of gloves, placenta, and other wastes in appropriate color-coded bins
		7.5.2	Instruments are disinfected in 0.5% sodium hypochlorite solution.

ENBC			
8	**Provider conducts a rapid initial assessment and performs immediate newborn care (if baby cried immediately)**		
8.1	Delivers the baby on mother's abdomen	8.1.1	Two towels at normal room temperature or pre warmed to room temperature
		8.1.2	Delivers the baby on mother's abdomen
		8.1.3	Calls out the time of birth, Sex and Condition of the baby
8.2	Ensures immediate drying, and asses breathing	8.2.1	If the breathing is normal, dries the baby using clean dried pre-warmed sheet, discards it and wraps the baby using another dried pre-warmed sheet
		8.2.2	If the baby is crying well, no routine suctioning is being done
8.3	Performs delayed cord clamping and cutting	8.3.1	Performs delayed cord clamping (after >1 min of birth) and cutting unless medically indicated otherwise
8.4	Ensures early initiation of breastfeeding	8.4.1	Initiates breast feeding within one hour of birth
		8.4.2	Staff can demonstrate the correct positions and attachments for breastfeeding
8.5	Assesses the newborn for any congenital anomalies	8.5.1	Provider immediately assesses the newborn for any congenital anomalies
		8.5.2	Provider ensures specialist care if required
8.6	Weighs the baby and administers Vitamin K	8.6.1	Baby weighing scale is available
		8.6.2	Vitamin K injection is available
		8.6.3	Weighs the baby and administers Vitamin K
		8.6.4	Staff knows the correct dosage and route of Vitamin K administration
8.7	Put an appropriate identification tag to new-born	8.7.1	Put pink tag for a female baby and blue tag for a male baby
8.8	Provider ensures breastfeeding is established before discharge		
8.9	Provider ensures temperature maintenance and routine immunisation at birth is established		

Active Management of Third Stage of Labour (AMTSL)			
9	**Provider performs Active Management of Third Stage of Labor (AMTSL)**		
9.1		9.1.1	Palpates mother's abdomen to rule out second baby
		9.1.2	Administers uterotonics, preferred is inj. Oxytocin 10 IU IM/IV within one minute of delivery of baby. If oxytocin is not available, then Tab Misoprostol 400-600 mcg orally or Inj.

			Carbetocin 100 mcg IM/IV over 1 min or Inj. Ergometrine 200 mcg IM/IV
		9.1.3	Performs delayed cord clamping and cutting in 1 to 3 mins.
		9.1.4	Performs CCT after uterine contraction by skilled health worker
		9.1.5	Performs Uterine Massage if the uterus is still not contracted/toned
		9.1.6	Checks placenta and membranes for completeness before discarding

Management of PPH			
10	**Provider identifies and manages Postpartum Hemorrhage (PPH)**		
10.1	Facility Preparedness for PPH	10.1.1	Ensures availability of wide bore cannulas (No. 18/16), PPH box, UBT, NASG, Obstetric Rapid Response Team (ORRT), prepares operation theaterteam and ensures availability of Blood and Blood Products/ prepares for referral and transport mechanism.
10.2	Assesses uterine tone and bleeding pervaginum regularly after delivery	10.2.1	Assesses general condition, pulse, respiration, blood pressure, temperature, uterine tone, and bleeding per vaginum after delivery every 15 mins for 2 hrs, then every 30 mins for 4 hrs, then 4 hourly for 24 hrs.
10.3	Identifies PPH	10.3.1.	Soakage of 1 pad in 5 mins, Blood loss >500ml after normal vaginal birth or >1000ml after C-section/or any loss which deteriorates maternal condition, Visual & quantitative assessment of blood loss. Do not ignore slow trickle.
10.4	Identifies shock	10.4.1	Identifies shock by signs and symptoms (pulse > 110per minute, systolic BP < 90 mmHg, cold clammy skin, increased respiratory rate, altered sensorium and scanty urine output. Shock Index (> 1), Rule of 30 – increase in heart rate by 30 per minutes, respiratory rate by >30, Urine output lessthan 30ml per hour, drop in blood pressure >30 mm of mercury ***(Call Doctor urgently)***
10.5	Determines the cause of PPH (Tone,Trauma, Tissue, Thrombin)	10.5.1	Assesses uterine tone, looks for vaginal, cervical, and perineal tears/ injuries, examines placenta for completeness, Exclude coagulopathy. Does Bed side cloting time

10.6	General Measures for PPH Management	10.6.1	Shouts for help, Checks for Airway, Breathing, Circulation, Disability and Examination, monitors vitals, Shock Index (heart rate/ systolic blood pressure), elevates the foot end and keeps the woman war, collects blood for Hb and grouping and cross matching while putting IV Line, gives oxygen at the rate of 6-8 liters per minute, monitors I/O
10.7	Initial Management of PPH (E MOTIVE) Early Identification, Massage Uterus, Oxytocin, Tranexamic Acid, IV Fluid and Examination with supportive measures	10.7.1	• Early Identification of PPH • Continues uterine massage if uterus is relaxed • Starts IV crystalloids infusions • Initiates 20 IU oxytocin drip in 1000 ml of ringer lactate/normal saline at the rate of 40-60 dropsper minute, max dose of oxytocin 100 IU in 24 hrs • Tranexamic acid 1 g (10ml) in 10 mins irrespective cause of PPH, (Most effective ifPPH occurs within 3 hours of Delivery), the dose of Tranexamic acid to be repeated if bleeding is not controlled in 30 mins after excluding thrombotic episode
		10.7.2	Empties uterus, Catheterize Bladder, Repairs tears (ask doctor)
		10.7.3	If uterus is still relaxed, gives other suitable Uterotonics as recommended
10.8	Management of refractory PPH	10.8.1	If uterus is still relaxed, performs mechanical compression in the form of bimanual uterine compression or external aortic compression, Uterine balloon tamponade ***(Ask doctor/nurse as per facility protocol)***
		10.8.2	If Bleeding persists, shift to OT if facility available orrefers to higher center, with NASG & UBT in situ with proper referral protocol, Transfuse Blood and Blood Products as per protocol
10.9	Manages PPH due to retained placenta/placental bits	10.9.1	Identifies retained placenta if placenta is not delivered within 30 minutes of delivery of baby orthe delivered placenta is not complete
		10.9.2	Initiates 20 IU oxytocin drip in 1000 ml of ringer lactate/normal saline at the rate of 40-60 drops perminute
		10.9.3	Refers to higher center if unable to manage (Referral Protocol)
		10.9.4	Performs Manual Removal of Placenta (MRP) ***(Ask Doctor)***
10.10	Post Management Follow UP	10.10.1	Monitor General Condition, Vitals, Shock Index, Tone of Uterine and Bleeding per Vaginum every 15mins for 2 hrs, every 30 mins for 4 hrs & 4 hourly for 24 hrs. Checks Perineum for status of sutures, I/O chart, continues uterotonics and antibiotics as per protocol. Check Hb and treat for anemia

Hypertension in Pregnancy			
11	**Provider identifies and manages severe Pre-eclampsia/Eclampsia (PE/E)**		
11.1	Identifies mothers with severe PE/E	11.1.1	Identifies danger signs or presence of convulsions (Severe headache, blurred vision, epigastric pain, oliguria, edema at unusual part)
		11.1.2	- Records BP at admission/ At the time of visit - Proper BP documentation (Provide sitting or lying position and tie the cuff at heart level and if BP is high then recheck) - Gestosis score calculation at first visit (to identify at risk mothers) download the gestosis app through play-store.
		11.1.3	Multi-reagent dipsticks that can detect proteins, glucose, nitrites and leucocytes in the urine are available in the labour room, and staff are aware of how to use them.
		11.1.4	- BP ≥ 160/110 mm Hg and Proteinuria in a random urine specimen or dipstick ≥2+ ≥0.3g/24-hour urine specimen or protein/creatinine ratio ≥0.3 (mg/mg) or (30 mg/mmol) OR - BP ≥ 140/90 mm Hg with danger symptoms like severe headache, blurring, epigastric pain, breathing difficulty and or new onset end organ dysfunction
11.2	Knows management of Severe Pre-eclampsia	11.2.1	Hospitalize, reassure, - Give MgSO4 as in Eclampsia (Before giving MgSO4 please monitor Knee jerk, respiratory rate and oliguria and monitor accordingly) - Start Anti-hypertensive therapy. (Inj Labetalol) - Investigate — CBC with peripheral smear and platelet count, LFT, KFT and fundus exam - BP and urine output monitoring Frequency of Investigations: - Hb, Platelets, LFT, KFT: Weekly - Fundus: Once - NST/BPP: After 32 weeks - Doppler study: 3-4 week - BP Monitoring: 4 times a day
11.3	Gives correct regimen of Inj. $MgSO_4$ for prevention and	11.3.1	MgSO4 in labor room (at least 20 ampoules) is available
		11.3.2	Inj. MgSO4 is appropriately administered

	management of convulsions		
11.4	Facilitates prescription of anti-hypertensive	11.4.1	Antihypertensive are available (tablet Labetalol/Inj Labetalol, Tab Nifedipine/Inj Hydralazine)
		11.4.2	Facilitates prescription of anti-hypertensive (Eclampsia Kit and Emergency drug kit must be present in Labour Room and Triage Area) Aim for SBP between 130-150 mm Hg DBP 80-100 mm Hg. - Inj Labetalol 20 mg IV bolus slowly over 1-2 min, if BP not controlled, repeat 40 mg after 10 minutes, repeat 80 mg every 10 minutes if BP not controlled (max 300 mg) with cardiac monitoring OR - Inj Hydralazine 5 mg I/V slowly over 1-2 min, if BP not controlled, repeat 5-10 mg over 2 min after 20 min. If BP not controlled again repeat 10 mg over 2 min (max 20mg). If no response switch to other anti-hypertensive drug OR - Tab Nifedipine orally 10 mg stat, repeat 10-20 mg after 20 min, if BP not controlled repeat 10-20 mg after20 min (max 30 mg). {Give through Ryle's tube if unconscious patient}. If no response, switch to other anti-hypertensive drug • Keep record of BP to avoid sudden hypotension • Continue B.P monitoring every 15 minutes for 2 hours after stabilization then every 30 min for 1hour. Then every hour, if in labor or 4 hours, if not in labor Severe PE: Treatment should be individualized
11.5	Ensures specialist attention for care of mother and newborn	11.5.1	Ensures specialist attention for care of mother and newborn/ Referral protocol after giving loading dose of MgSO4
11.6	Performs adequate nursing care	11.6.1	- Performs nursing care. (Shout for help, ABC in unconscious patient and bladder care) - Keep women in bed with padded rails on sides, preferably near nursing station - Position her on left side, regular suction. - To remove secretions and Maintain airway (Put mouth Gag in unconscious patient) - Start Oxygen by mask at 6-8 l/min, Start IV fluids-RL/ NS at 75 ml/hr - Monitor vital signs: pulse, BP, temperature, respiration. - Catheterizes and monitors inputs and outputs.
11.7	Monitors before and while	11.7.1	- Presence of Patellar Jerks - Respiratory Rate (RR)>16/min

	treatment on MgSO4		- Urine Output ≥30ml/hr in last 4 hours
11.8	Eclampsia	11.8.1	- Convulsion-delivery interval should not be more than 12 hours. - Check the cervix condition its favorable or unfavorable through Bishop score. - If Bishop score is good then vaginal delivery may be tried.

Newborn Resuscitation			
12	**Provider performs newborn resuscitation if baby does not cry immediately after birth**		
12.1	Performs steps for resuscitation within first 30 seconds	12.1.1	Suction equipment/mucus extractor is available
		12.1.2	Shoulder roll is available
		12.1.3	Performs following steps on mother's abdomen: dries the baby; immediate clamps and cuts the cord and shifts the baby to radiant warmer if still not breathing
		12.1.4	Performs following steps under radiant warmer:(Positioning, Suctioning, Drying Stimulation, Repositioning (PSDSR) - Clamp & cut cord immediately - Place under radiant warmer - Position head with neck slightly extended - Clear airway by suctioning mouth then nose if required - Dry baby, discard wet linen - Stimulate by rubbing the back - Reposition
	If breathing well	12.1.5	If breathing well: observational care with mother - Place the baby prone between the mother's breasts - Cover baby and mother together - Initiate breastfeeding - Monitor neonate (temperature, heart rate, breathing and colour, every 15 minutes in first hour and then every 30 minutes in next one hour)
12.2	Provider initiates bag and mask ventilation for 30 seconds if baby still not breathing	12.2.1	Functional ambu bag with mask for pre-term baby is available
		12.2.2	Functional ambu bag with mask for term baby is available
		12.2.3	Initiates bag and mask ventilation using room air, If not breathing well – - Applies appropriately sized mask correctly - Gives 5 ventilatory breaths and looks for chest rise

		12.2.4	If there is no chest rise after 5 breathes, takes corrective measures (Corrects the position / sucks mouth and nose / checks the seal / gives ventilation with increased pressure). If there is adequate chest rise, continues bag and mask ventilation for 30 seconds and reassess
12.3	Provider takes appropriate action if baby doesn't respond to ambu bag ventilation after golden minute	12.3.1	Functional oxygen cylinder (with wrench) with new born mask is available
		12.3.2	Functional stethoscope is available
		12.3.3	Assesses breathing, if still not breathing, calls for help and continues bag and mask ventilation.
		12.3.4	Checks heart rate/cord pulsation
		12.3.5	If heart rate is <100 / ≥ 100/ min and baby is still not breathing, continues bag and mask ventilation and connects oxygen. (Ask Doctor/ Nurse as per facility protocol)
		12.3.6	If heart rate is >=100 and baby is breathing well or at any point, if baby starts breathing, provides observational care with mother (Ask Doctor/ Nurse as per facility protocol)
		12.3.7	If baby is still not breathing and advance help is not available, then refers to higher centre continuing bag and mask ventilation with oxygen (Ask doctor/nurse as per facility protocol) If help* available, then intubate, provide chest compression and medication if required (*Help: A person skilled to provide chest compression, intubation, and medication)

Care of small and vulnerable newborns			
13	**Provider ensures care of small and vulnerable newborns at birth**		
13.1	Facilitates specialist care in newbornweighing <2500 gm	13.1.1	Refers newborn <2500 gm to specialist/pediatrician for advice (refer toFBNC/seen by pediatrician)
		13.1.2	The Gestational age should be calculated by first USG dating scan or the LMP for identifying preterm or SGA
13.2	Facilitates assisted feeding whenever required	13.2.1	Facilitates assisted feeding preferably with breast milk as required
		13.2.3	Identifies difficulties in breast feeding (If any) and refers to appropriate specialist
13.3	Healthcare personnel should take measures to	13.3.1	Adequate measures to be taken by the healthcare personnel to measure the room temperature on continuous basis.

	prevent hypothermia.	13.3.2	Mother and Newborn to be roomed in if both are stable and skin-to-skin contact is encouraged
		13.3.3	Able to guide mother and family on keeping baby warm through covering of head and extremities
13.4	Provider ensures to provide adequate infrastructure, staffs and IEC for KMC.	13.4.1	Ensures counseling and adequately supportive environment to family members for KMC. (Dedicated and private space near Special Newborn Care Unit (SNCU)/post-natal ward or neonatal ward/ NBSU which is furnished with comfortable preferably reclining chairs & cots).
		13.4.2	Facilitates Kangaroo Family Care with adequate environment and IEC in case mother is unable to give KMC to the low birthweight baby
		13.4.3	Ensure privacy for expression of breast milk and is equipped with storage facility for expressed breast milk.
		13.4.4	Ensure adequate IEC material on KMC in local language for mothers, families, and community.
		13.4.4	The availability of trained and willing health service providers for 24x7 services for assisting mothers in KMC practice and LBW feeding.
13.5	Provider is aware of signs of respiratory distress in newborn	13.5.1	Assess the case sheet for records of SPO2.
		13.5.2	If detected below normal limits, then refers to SNCU/NBSU ASAP.
13.6	Provider ensures the baby is assessed at every visit to mother	13.6.1	Provider is familiar with danger signs in newborn such as apnea, cyanosis, convulsions, and lethargy
		13.6.2	Knows the referral pathway in case of any abnormal or danger signs
13.7	Provider is able to counsel mother and family in case of small and vulnerable newborn	13.7.1	Provider can explain to the mother/family that their newborn is small and vulnerable and may need support with feeding/thermoregulation/breathing
		13.7.2	Refers to specialist for further counselling as and when required by the mother or family.

Infection Prevention			
14	**The facility adheres to universal infection prevention protocols**		
14.1	Instruments and re-usable items are adequately and	14.1.1	Facilities for sterilization of instruments are available
		14.1.2	Maintenance and cleaning schedule for Labour room and OT is followed strictly

	appropriately processed after each use	14.1.3	Designated Place for Autoclave and sterilization process for small and large instrument should be displayed
		14.1.4	Unidirectional flow for soiled item and sterile item is followed
		14.1.5	Spillage Management Protocol is displayed and known to providers.
		14.1.6	Instruments are sterilized after each use
		14.1.7	Delivery environment such as labor table, contaminated surfaces and floors are cleaned after each delivery
		14.1.8	Regular swabbing of OT and LR is carried out.
14.2	Biomedical waste is segregated and disposed of as per the guidelines	14.2.1	Color coded bags for disposal of biomedical waste are available and bin should be covered
		14.2.2	Biomedical waste is segregated and disposed of as per the guidelines and Protocol should be displayed at BMW Area
14.3	Performs hand hygiene before and after each procedure, and sterile gloves are worn during delivery and internal examination	14.3.1	Performs hand hygiene before and after each procedure, and sterile gloves are worn during delivery and internal examination
		14.3.2	WHO 5 Movement for hand washing poster should be displayed and known to care providers.
14.4	PPE	14.4.1	Availability of Masks, caps and protective eye cover, sterile gloves, elbow length gloves, disposable gown/Apron, utility gloves for housekeeping staff.
14.5	Infection control protocols	14.5.1	Separation of routes for clean and dirty items; Availability of disinfectant & cleaning agents, Standard practice of mopping and scrubbing are followed.
		14.5.2	Distance between two labour table is according to MNH Toolkit
14.6	Spill Management	14.6.1	Spill management kit should be available in Labour room
14.7	Microbiological surveillance	14.7.1	Provision for Passive and active culture surveillance of critical & high-risk areas. Microbiological surveillance: Swab are taken from infection prone surfaces such as delivery tables, door, handles, procedure lights etc.
		14.7.2	Surgical site infection record and regular audit is maintained.
14.8	Facilitates prevention of mother to child transmission of HIV	14.8.1	Facility staff adheres to standard protocols for Management of HIV in Pregnant Woman & Newborn.
14.9		14.9.1	Staff should be immunized against Hepatitis B
		14.9.2	PEP KIT is available at facility

	Prevention of Infection health care workers	14.9.3	Staff is trained in Handling of sharp items
		14.9.4	Providers know management of Needle prick injury
14.10	Documentation	14.10.1	PEP Register is maintained
		14.10.2	Autoclave register is maintained
		14.10.3	Microbial survillance register is maintained
		14.10.4	Surgical site infection register is maintained
		14.10.5	Staff Health Record register is maintained

Postnatal Care			
15	**Provider ensures adequate postpartum care package is offered to the mother and baby – at discharge**		
15.1	Conducts proper physical examination of mother and newborn during postpartum visits	15.1.1	Conducts mother's examination: breast (tenderness, flat/inverted nipples etc.), perineum for inflammation; status of episiotomy/tear suture; lochia; calf tenderness/redness/ swelling; abdomen for involution of uterus, tenderness or distension.
		15.1.2	Conducts newborn's examination assesses feeding of baby; checks weight, temperature, respiration, color of skin and cord stump, Ensure the breast-milk is sufficient for newborn by measuring the urination of newborn (6-8 times are adequate). At least one feed to the newborn in night.
		15.1.3	Assess about incontinence of stool and urine.
15.2	Identifies and appropriately manages maternal and neonatal sepsis	15.2.1	Checks mother's history related to maternal infection
		15.2.2	Check Perineal hygiene of mother in the facility and explain for self/home care.
		15.2.3	Check bleeding by gentle fundal palpation/inspection of Vulva only (PV/PS examination is not recommended to assess only bleeding, to be done only if necessary).
		15.2.4	Checks mother's temperature
		15.2.5	Gives correct regimen of antibiotics
		15.2.6	Checks discoloration of skin & eyes. Check for baby's temperature, breathing and other signs of infections like umbilical stump.
		15.2.7	Gives correct regime of antibiotics/refers for specialist care.
		15.2.8	Only one or two attendants should be allowed to take aseptic care while handling the newborn.
15.3	Correctly diagnoses	15.3.1	Provides emotional support and if needed refers woman to specialist care.

	postpartum depression based on history and symptoms	15.3.2	Assess the availability of EPDS, GAD-2 forms to assess the postpartum depression and anxiety.
15.4	Counsels on importance of exclusive breast feeding and Perineal exercise.	15.4.1	Assess staffs' knowledge on providing counselling and assistance on the importance of exclusive breast feeding and techniques of breast feeding.
		15.4.2	Assess nursing staffs' knowledge on teaching perineal exercises (after 06 weeks).
		15.4.3	Assess the patient/attendants whether staffs teach the attendants and patients regarding importance of clean and healthy environment for the patient and newborn through health education.
15.5	Provider ensures available options post-partum family planning and counseling on danger signs	15.5.1	Counsels on return of fertility and healthy timing and spacing of pregnancy – Counsels on postpartum family planning to mother at discharge.
		15.5.2	Danger signs should be written on discharge slip and ensure that danger signs are well explained to the attendants and patient both.
15.6	Provider ensures the postpartum immunization of mother and baby.	15.6.1	Assess the provision of Post partum immunization like HPV & MMR (if not received before).
		15.6.2	Refer previous records to assess zero dose at the facility and explain about the importance of complete immunization for baby.
15.7	Provider ensures to counsel on nutrition of the mother.	15.7.1	Explains the nutritious economic options for mother.

C-Section Care			
16	**Provider reviews clinical practices related to C-section at regular intervals**		
16.1	Provider ensures that C section should be done only when medically indicated and on the basis of clinical evidence.	16.1.1	Assess medical records of C section of previous months and verify whether Indications for C section co relates with clinical findings.
16.2	Provider must ensure mother and her family have been counselled	16.2.1	Assess previous case records for counseling notes.
		16.2.2	Assess from the mother and family whether they have been counselled.

	and the same documented in the case sheet.		
16.3	Provider ensures that the consent is signed by mother/family AND treating doctor.	16.3.1	Assess previous records for verified consent forms.
16.4	Provider ensures availability of the Safe Surgical Checklist and that it is filled and signed for each case.	16.4.1	Ensure availability from the posted staffs.
		16.4.2	Assess the previous case record for filled & signed Safe Surgical checklist.
16.5	Provider ensures that broad spectrum anti-microbial prophylaxis administered (Intra venous) within 60 minutes of incision.	16.5.1	Assess the case sheets/Safe surgical checklists are filled as per requirements.
		16.5.2	Verify with the treating doctor/anaesthetist and treatment record.
16.6	Provider ensures AMTSL is done with all C-section cases.	16.6.1	Assess the case sheets
		16.6.2	Verification with posted staff
16.7	Provider ensures post-partum care with all C-section cases.	16.7.1	Ask the mother or the birth companion
		16.7.2	Ask the staffs about the protocols.
16.8	Provider ensures breast feeding initiated within first hour of the delivery.	16.8.1	Verify with the staffs and the mother or birth companion.
16.9	Ensure early ambulation for all low-risk C-section cases	16.9.1	Verify with the mother and birth companion.
16.10	Ensure Post-partum counseling on danger signs and post-partum	16.10.1	Assess the nurses/counselor for post-partum counseling.
		16.10.2	Ensures that rate of complications of C-sections are periodically monitored in the facility.
		16.10.3	Ask about Cafeteria approach from nurses

	family planning by the cafeteria approach.		
16.11	Ensures classification as per Modified Robson's criteria and reviews indications and complications of C-section at regular intervals	16.11.1	Ensure all C-section cases are classified as per modified Robson's criteria and rates of different categories are monitored in facility.
		16.11.2	Assess the case sheets of C section of previous months for indications and fulfilling criteria are documented.
		16.11.3	Review of C-section cases is done through a clinical audit at least on quarterly basis

HDU Care			
17	**Provider delivers HDU care to obstetric patients with advanced care needs**		
17.1	Facility has provisions of HDU care as per prescribed guidelines.	17.1.1	For a facility with 250 deliveries and over should preferably have an 8-bedded HDU as per GoI guidelines
		17.1.2	The HDU is within easy access of the emergency, LR and OT areas
		17.1.3	Assess the availability of basic cardiac and respiratory monitoring systems, Blood Component therapy, Fetal Monitoring, Sonography with Color Doppler/ Echo, transport ventilator etc.
17.2	Facility has adequate human resources for providing HDU care.	17.2.1	Check availability of at least 01 EmoC and CCOB (Critical Care in Obstetrics) trained Medical Officer round the clock.
		17.2.2	Check availability of SBA and CCOB trained Obstetric nursing staff round the clock. Nurse patient ratio should be 1:2 along with 01 extra for lay off or covering leave/ day off.
17.3	Providers are trained in providing adequate HDU care to the patients admitted in the unit.	17.3.1	Assess the trainings record: Basic resuscitative measures, Intubation, SBA, EmOC and CCOB trained, Blood and component transfusion.
		17.3.2	Trained on use of available monitoring and diagnostic equipment, HDU procedures and emergency drills (every 3 months).
17.4	Providers are trained in adequate documentation of admission/discharge/referral and in-patient care.	17.4.1	Assess the admission records for documentation of admission criteria (Obstetric/medical complications like): Severe anemia, hemorrhage, hypertensive disorders, sepsis, jaundice, renal dysfunction, coagulopathies, ABG abnormalities,

			electrolyte disturbances, abnormal vitals, or any other medical disorders
		17.4.2	Check records for completeness of documentation of admitted patients including vitals, investigations, and clinical progress records, baby details, Severe Organ Failure Assessment (SOFA) etc.
		17.4.3	Assess the step down (ward) is followed as: When a patient's physiologic status has stabilized. Patient is hemodynamically stable. The need for intensive patient monitoring is no longer necessary. No further continuous intravenous medication or frequent blood tests required. No active bleeding. No supplementary oxygen required. Patient is ambulatory. The patient can be cared for in a general ward unit.
		17.4.4	Assess the step-up protocol (ICU) is followed as: Obstetric or medical complication in a pregnant woman requiring ventilatory support, multi-organ failure, dialysis, DIC etc.
		17.4.5	Check records for completeness on death/discharge/referral/DAMA documentation

Mental Health & Well-being			
18	**Provider ensures screening and timely referral of mothers with mental ill health.**		
18.1	Provider knows when and how often to screen mothers for mental health issue	18.1.1	Provider ensures screening for psychosocial risk factors and signs of mental ill health at least once at first (booking visit) and postnatally (4-6 weeks and 3-4 months) using a standardised tool (e.g. annexure 1*)
18.2	Provider ensures screening for risk factors, during the first antenatal visit.	18.2.1	Assess whether the provider uses sensitive and inclusive language to screen for risk factors through suggestive questions mentioned in annexure 1*.
		18.2.2	Provider assesses past medical and obstetric history through past medical records for:

			Post natal depression history, difficulty in breast feeding with previous births, History of deliberate self-harm. etc.
18.3	Provider is able to assess the mental health status of mother	18.3.1	Assess the records to check whether the provider asks all or most of the questions to the mother or her companion, mentioned in annexure 1*.
		18.3.2	Assess the records to check whether the provider assesses the general mood/appetite/sleep hygiene and other behavioral aspects of the mother
		18.3.3	Assess the providers' knowledge on GoI guidelines for nurses/EPDS/GAD or PHQ-2 form (must be able to fill it properly).
		18.3.4	Assess the previous EPDS/ PHQ-2/GAD-2 filled forms.
Referral Pathway			
18.4	Provider ensures timely decision-making based on assessment scores.	18.4.1	Assess the case sheet for documentation of risk and mental health status assessment
		18.4.2	Assess knowledge of the provider about scoring systems and its implementation during decision making.
18.5	Provider ensures consultation or referral to specialist after identifying mental ill health.	18.5.1	Assess the knowledge of the provider about availability of mental health specialists within easy access for the mother.
		18.5.2	Assess follow-up procedures and feedback loops being used by the providers
		18.5.3	Adequate communication being given to mothers and her family regarding treatment compliance (pharmacological or non-pharmacological)

Safe Surgery			
19	**Provider ensures safe surgery in the facility**		
19.1	Provider ensures the availability and functionality of all necessary equipment	19.1.1	All staff are trained on: • Record Keeping • Equipment Inventory • Regular Inspection • Quality Control Measures • Maintenance Schedule
19.2		19.2.1	Access to facility is provided without any physical barrier and friendly to people with disabilities

	OT is easily accessible	19.2.2	Availability of wheelchair or stretcher for easy Access.
		19.2.3	Door is wide enough for passage of trolley and staff
19.3	Adequate visual privacy is provided at every point of care.	19.3.1	Patients are properly draped/covered before and after procedure
		19.3.2	Visual Privacy maintained between two tables
19.4	Departments have adequate space as per patient or workload	19.4.1	Adequate space for accommodating surgical load.
19.5	Departments have layout and demarcated areas as per functions	19.5.1	Demarcated Protective zone
19.6	The staff is provided training as per defined core competencies and training plan	19.6.1	Staff should be trained on Advanced Life Support
19.7	Facility has established procedure for continuity of care during departmental transfer	19.7.1	Pregnant women are not left unattended or ignored during care in the OT.
		19.7.2	There are defined procedures for patient handover from OT to maternity ward, HDU and SNCU
		19.7.3	Transfer register should be maintained
19.8	Surgical notes are duly completed and attached with patient records	19.8.1	Operative notes are recorded
		19.8.2	Name of person in attendance during procedure, pre- and post-operative diagnosis, procedures carried out, length of procedures, estimated blood loss, fluid administered, specimen removed, complications should be documented

Medicolegal documentation in Obstetrics			
20	**Provider ensures complete medicolegal documentation**		
20.1	Provider ensures availability and completeness of records in labour room and OT.	20.1.1	Completed case sheet Partograph Safe child birth checklist Safe surgery checklist Pre-Anesthesia assessment checklist Delivery notes

			Baby notes Anesthesia notes Vitals Chart Adverse reaction sheet Blood transfusion monitoring sheet OT Register, delivery register, transfer register, stillbirth register, fumigation register, autoclave register, MTP & PCPNDT register, Inventory management register
20.2	Providers ensure complete and timely communication and informed consent with mother/ family members.	20.2.1	Ensures following documents are complete and counter signed. - Blood transfusion consent - High-risk consent - Cesarean consent - Anesthesia consent
		20.2.2	Documents communication with mother/family members regarding any changes in clinical condition and/or management.
		20.2.3	Takes verbal consent before any procedure or examinations.
		20.2.4	All communication with mother/family members is carried out in easy-to-understand language and ensured it is understood by them.
20.3	Providers ensure availability of updated essential documents.	20.3.1	Fire NOC
		20.3.2	BMW NOC
		20.3.3	Facility registrations with relevant authorities
		20.3.4	Citizen charter
		20.3.5	Cost of services
		20.3.6	Hospital emergency contacts number should be displayed