DAKSHATA

Empowering Providers for Improved MNH Care during Institutional Deliveries

A strategic initiative to strengthen quality of intra- and immediate postpartum care

Operational Guidelines

Maternal Health Division
Ministry of Health and Family Welfare
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Ministry of Health & Family Welfare
Government of India, Nirman Bhawan, New Delhi-110011

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Preface

The Government of India stands firmly committed to reducing maternal and newborn mortality in the country. Substantial efforts have been made to achieve this goal through initiatives such as the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) strategic approach implementation. Consequently, considerable improvement has been achieved in the overall maternal and childbirth health services. However, the desired pace of reduction in maternal and newborn mortality is yet to be accomplished.

It is widely known that improving quality of care at the time of childbirth and considering mothers and newborns as a dyad for focus of intervention during this period have the potential to save a majority of maternal and newborn lives.

With this view, the Ministry of Health and Family Welfare, Government of India is launching this strategic initiative *'Dakshata'* to enable the service providers in providing high-quality services during childbirth in institutions. The initiative, developed carefully after considering all the major determinants of the quality of services, aims to rapidly improve the skills of health workers in performing evidence-based practices and providing them with necessary support to continue to adhere these practices in every case. While this program aims for the entire country, the initial focus will be on the high priority states of Rajasthan, Madhya Pradesh, Odisha, Bihar, and Uttar Pradesh.

The operational guidelines will be useful for the program managers at the state and district level in implementing *'Dakshata'* in an efficient and fast-paced manner. I am confident that this initiative will go a long way in making a decisive shift in maternal and newborn health service delivery in the country aimed to achieve necessary reduction in mortality.

I request the states to take this program as a priority and ensure that appropriate mechanisms are put in place to ensure high quality and timely trainings, availability of essential resources and post-training mentoring to health workers.

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Foreword

India has made significant improvements in the rate of institutional deliveries in the country with a vision to ensure access to evidence based practices at the time of childbirth. However, despite increased numbers, the goal of achieving desired reduction in maternal and newborn mortality in the country is difficult to be realized in absence of high-quality of intra and immediate postpartum care at institutions.

Taking cognizance of this fact, the Government of India has made the quality of services the primary focus of its new initiatives. The recently launched India Newborn Action Plan (INAP) recognizes quality of intra-partum and immediate postpartum care as an important pillar. The RMNCH+A strategy also focuses significantly on improving care at birth for overall improvement in maternal and child health outcomes in the country. Translation of this vision of improving quality of child birth related services into action at the state and district levels needs further impetus.

The field visits and regional reviews have revealed that skills of health workers for performing essential practices during childbirth and availability of necessary resources for these practices are major barriers to high-quality service delivery. Subsequently, this initiative *'Dakshata'* was developed for rapid improvements in quality of care for childbirth related services in the country. This program brings together maternal and newborn interventions under one umbrella of 'day of birth' services and uses a unique combination strategic skill building, ensuring availability of essential supplies, and focused mentorship targeting major causes of maternal and newborn deaths.

The guidelines clearly articulate the technical and operational aspects of *'Dakshata'* for use by program managers, trainers and mentors. A learning resource package has also been developed under this initiative for ensuring high-quality training and program implementation.

I appreciate the efforts put in by the Maternal Health Division and contributing experts for developing these guidelines and the learning resource package. I am fully confident that this program will successfully empower the health workers in providing high quality of services to mothers and newborns in the country.

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Program Officer's Message

Government of India has a commitment to ensure universal coverage of all births with skilled attendance both at institution and in community. Considering the fact that majority of maternal and newborn deaths occur during and around childbirth, improving the quality of care for childbirth related services is an important strategic focus of Government of India.

Major driver for quality of care during and around childbirth is availability of skilled health care workers. With the objective of strengthening quality of care during childbirth, Government of India has introduced Skill Birth-Attendance (SBA) programme. However, field visits demonstrated that Auxiliary Nurse Midwives (ANMs) at Subcentres have either not been trained in SBA or the quality of training has been sub-optimal.

With this background and towards strengthening of quality of care during the intra and immediate postpartum period, Government of India is launching a strategic initiative 'DAKSHATA' to enable the service provider in providing high-quality services during childbirth in institutions. The program design includes a concise training package for competency enhancement of Nurses and ANMs.

I am grateful to Shri. C.K Mishra, AS&MD for providing constant support and guidance. I am indebted to Dr. Rakesh Kumar, Joint Secretary (RMNCH+A) for his able and extraordinary leadership in taking the process forward.

I would like to acknowledge the contribution of all Expert Group members in developing the content of these operational and facilitators guidelines. I would also like to acknowledge the efforts of Dr. Bulbul Sood, Jhpiego for facilitating this process of developing this comprehensive training package. I would also like to thank Dr. Somesh, Dr. Vikas Yadav, Jhpiego India; Dr. Ravinder Kaur, Dr. Rajeev, Dr. Pushkar and Dr. Tarun, Consultants, MoHFW for their immense contributions.

I am hopeful that the efforts put in by the experts in drafting this comprehensive training package shall be useful for all stakeholders while working towards improving the quality of care during and after childbirth.

Baswal 24.4.15
Dr. Dinesh Baswal

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- Celine Gomes from Jhpiego provided support in designing and publishing the document.
- Mr. Lalit Kumar Verma from MoHFW provided administrative assistance during the process.

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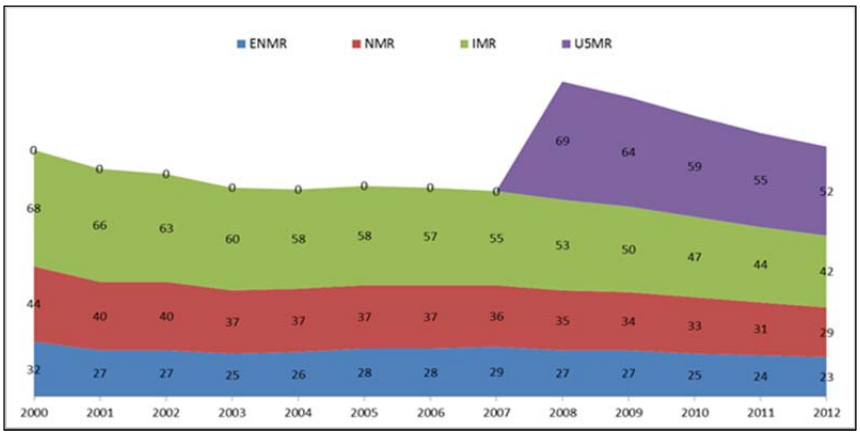
ABBREVIATIONS

AMTSL	Active Management of Third Stage of Labour
ANM	Auxiliary Nurse Midwife
DLF	District Level Facilities
ENBC	Essential New Born Care
ENMR	Early Neonatal Mortality Rate
FHS	Foetal Heart Sounds
FHR	Foetal Heart Rate
GoI	Government of India
HPDs	High Priority Districts
IFR	Infant Mortality Rate
INAP	Newborn Action Plan
JSI	Janani Suraksha Yojana
JSSK	Janani Shishu Suraksha Karyakram
MDGs	Millennium Development Goals
OSCE	Observed Structured Clinical Examination
PNMR	Perinatal Mortality Rate
PPH	Postpartum Haemorrhage
SBA	Skilled Birth Attendance
SCC	Safe Childbirth Checklist

RATIONALE

India has made considerable progress in its efforts to achieve Millennium Development Goals (MDGs) 4 and 5, however, the progress is insufficient to achieve these goals by the year 2015. The maternal mortality of the country has reduced from 212 (2007-09) to 167 (2011-13) of 100,000 live births, but it is still far from the MDG goal of 140. As per an estimate, upto 1.3 million children, under-5, died in India in year 2013. On further analysis of the under-5 mortality in India, it can be seen that while Infant Mortality Rate (IMR) has shown steady decline, Early Neonatal Mortality Rate (ENMR) has virtually remained static since the last decade. In fact, ENMR and Perinatal Mortality Rate (PNMR) actually slightly increased from years 2003 to 2009, more so in rural areas. Considering the fact that neonatal deaths account for upto 40% of Under-5 deaths, and that ENMR and PNMR are mainly the indicators of intrapartum and perinatal care, this is a significant finding indicating that the country must focus on perinatal care in order to make a decisive dent in the neonatal mortality. The Government of India (GoI) has taken cognizance of this fact and the recently launched India Newborn Action Plan (INAP) focuses heavily on intra-partum and immediate postpartum care. Other GoI strategies such as the RMNCH+A strategy also focus significantly on improving care at birth for overall improvement in maternal and child health outcomes in the country.

Figure 1: Trend of Newborn and Child Mortality Rate in India



The risk of maternal and newborn mortality is disproportionately high around the period of childbirth and majority of causes of both maternal and newborn mortality are preventable through appropriate care of mothers during labour and birth, and appropriate care of newborn immediately after birth. In line with the global evidence on the importance of skilled care at birth, the Government of India, over the last decade, has focused on increasing institutional delivery through programs such as Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram. As a result, the country has experienced an unprecedented increase in institutional deliveries in public health facilities.

While the proportion of women delivering at health facilities has increased significantly (>73% of deliveries in India currently take place in health facilities), the country has not seen a commensurate decline in maternal and newborn mortality. Considering the fact that now more than 70% of pregnant women are under institutional care at the time of childbirth and can be easily provided all standard evidence-based care, persisting high rates of mortality indicate towards sub-optimum quality of services during institutional deliveries.

Many factors influence the quality of intra and immediate postpartum care. Major drivers are: availability of resources (both human and material), skills of health care workers, and ability and motivation of these healthcare workers to translate these skills to practice. Accountability for high-quality health services is another critical dimension for quality.

With the objective of strengthening quality of care during childbirth, Government of India has instituted mechanisms for training of in-service nurse-midwives on Skill Birth Attendance (SBA). However, various assessments and studies have demonstrated that a significant proportion of nurses working in labour rooms of health facilities or the Auxiliary Nurse Midwives (ANMs) at sub centres have either not been trained in the 21-day SBA training module or the quality of training has been sub-optimal, resulting in poor skill development even after training. This poor adherence to practices is also as a result of sub-optimal quality of and little or no post-training follow-up, no institutional mechanisms for regular supportive supervision, lack of accountability, absence of a system to measure and monitor quality, and frequent shortage of essential commodities and human resources.

With this background and towards strengthening of quality of care during the intra and immediate postpartum period, GoI decided to design a program with a modified training capsule of a shorter duration, with the trainings being competency based and focusing on the highest impact practices during and just after childbirth. The idea was to develop a focused yet comprehensive program that included a training package which is based on a tested quality improvement framework and is backed up by a strong post-training follow-up and support component. One successful example was the Safe Childbirth Checklist Program in Rajasthan, wherein, a simple checklist based on evidence-based practices formed a useful framework for training of health workers, post-training supportive supervision and ensuring the availability of essential resources, and adherence to safe practices by health workers for each client delivering at health facilities.

Subsequently, the Ministry of Health and Family Welfare (MoHFW), GoI, has developed an initiative termed ‘Dakshata’ (means adroitness) to improve the quality of care at the delivery points of the country through a focused program which includes a concise training package for competency enhancement for Medical Officers, Nurses and ANMs; developing a system of post-training follow-up and mentoring; ensuring availability of essential commodities, supplies and equipment in the labour rooms; and strengthening the capacity of the facilities and the system to measure quality of care on a regular basis.

Goal of the initiative:

To improve the quality of maternal and newborn care during the intra- and immediate postpartum period, through providers who are competent and confident (Dakshata).

Strategic approach:

This initiative aims to address the major drivers and determinants of the quality of care provided to the woman during the whole process of childbirth, from the time of her admission at the health facility, to the time of her discharge after childbirth. The focus of this initiative, therefore, is to ensure adherence to the highest impact clinical practices during the intra- and immediate postpartum period, with the labour room and the postpartum ward being the focal point of the interventions. The initiative is strategic in nature as it ultimately tries to build capacity of the providers to prevent and manage complications that are major causes of maternal and newborn mortality during and after childbirth.

The major determinants for adherence to evidence based highest impact clinical practices by providers in the labour room include:

- Availability of sufficient number of clinically competent providers, which includes updated knowledge and clinical skills.
- Availability of essential commodities, supplies and equipments.
- Strong clinical mentorship and leadership
- 360 degree accountability of all stakeholders, which in turn depends on recording, reporting, analysis and utilization of data.

Figure 2: Drivers of Quality of Care

The initiative, through a multipronged approach, will address the above-mentioned determinants of quality of care during the intra- and immediate postpartum period with special emphasis on standardizing the clinical competencies of the providers and creating an enabling environment at the health facilities, to facilitate translation of competencies into evidence based clinical practice.

The initiative will use the modified version of the WHO's Safe Childbirth Checklist (Annexure 1) as the framework for strengthening the competencies of the providers, along with their mentoring and monitoring by the supervisors. The checklist will also be used as a framework for ensuring availability of essential supplies in the labour rooms as well as for improved recording, reporting and utilization of data.

OBJECTIVES

The major objectives of the initiative are:

Objective 1: To strengthen the **competency of providers** of the labour room, including medical officers, staff nurses, and ANMs to perform evidence-based practices as per the established labour room protocols and standards.

Objective 2: To implement **enabling strategies to ensure transfer of learning** towards improved adherence to evidence based clinical practices

Objective 3: To improve the availability of **essential supplies and commodities** in the labour room and the postpartum wards.

Objective 4: To improve accountability of service providers through improved **recording, reporting and utilization of data**

Objective 5: **(intermediate term objective):** Implementation of the MNH Tool kit at the delivery points, in a phased manner.

Major interventions

Objective 1:

To strengthen the competency of the providers of the labour room, including medical officers, staff nurses, and ANMs to perform evidence-based practices as per the established labour room protocols and standards.

Clinical update cum skills standardization training: The initiative will undertake a short customized clinical update cum skills standardization training for the providers of the labour rooms. This will be a three-day activity which will be conducted by designated trainers at identified training sites. All providers of labour rooms, irrespective of their training status in the 21 day in-service SBA trainings, will be eligible for these trainings.

Technical content of the trainings

The training of service providers engaged in maternity care and childbirth will be carried out using the Safe Childbirth Checklist as a framework. The checklist provides a framework related to the natural course of events during intra- and immediate postpartum period in addition to serving as a memory tool.

The technical content of the training will be organized around four **pause points**—natural times during the course of labour where the service provider can briefly pause and review whether he/she has performed all the essential actions in the preceding period and prepare for providing the requisite care in the upcoming period. These pause points are:

- At the time of admission
- Just before pushing or at caesarean section
- Soon after delivery (within 1 hour)
- At the time of discharge

Within each pause point there are essential actions to be performed in a logical sequence. Competency of the providers including medical officers, staff nurses and ANMs will be enhanced on the following critical practices:

Care at the time of admission of pregnant woman	Care just before and at the time of delivery	Care soon after delivery	Care at the time of discharge
Initial assessment of the pregnant woman and foetal condition and triaging for decision making for level of care: • Recording Fetal Heart rate • PV examination	Preparing for safe delivery: • Personal Protective Equipment • Delivery trays • Prefilled oxytocin	Diagnosing Postpartum Haemorrhage (PPH) and initial management of PPH • Initial management of shock • Administering Uterotonics • Uterine massage • Bimanual compression	Assessing and managing post-partum complications in mothers: • Puerperal sepsis • PPH
Immediate actions for prevention of major complications: • Antibiotics for infection prevention and management • Antenatal corticosteroids for preterm births • ARV therapy for HIV	Management of 2nd stage of labour (conducting a normal delivery)	Management of maternal infection through antibiotics	Assessment of the newborn condition by measuring and recording Temperature, Heart Rate and Respiratory Rate.
Diagnosis of pre-eclampsia/ eclampsia and its management through use of Magnesium Sulphate	Active management of 3rd stage of labour • Use of uterotonics • Controlled cord traction • Uterine massage	Review of care of mother and newborn soon after birth: • Regular assessment of clinical condition • Early initiation of breast feeding • Prevention of hypothermia	Counselling on postpartum family planning
Principles of timely identification and management of prolonged and obstructed labour	Immediate care of newborn • Essential New-Born Care (ENBC) • Zero Dose Polio, BCG and Hepatitis B.	Special care for new-born pre-term and low birth weight babies • Thermal management including KMC • Assisted feeding	Discharge counselling on danger signs for mother and baby and care seeking
Promoting and Empowering birth companions	Newborn resuscitation	Prevention, identification and management of newborn infections	

Duration of the training

The duration of the training will be 3 days.

Batch Size

Providers will be trained by designated trainers in batches of 14-16.

Training methodology

The trainings will be conducted using a variety of training approaches to keep sessions interesting and to facilitate comprehensive learning. Training agenda is attached as Annexure 2.

- Sessions focusing on skills will include practice on models using skills practice checklists. Observed Structured Clinical Examination (OSCE) will be used before and after skill practice to assess learning.
- Sessions focusing on knowledge update will be conducted using power point presentations, discussions, and innovative methods such as games
- The trainees will be sent to the labour room every evening, tagged with identified providers who will act as clinical supervisors, for practical hands on training of newly acquired knowledge and skills gained through the day's trainings sessions.
- Training will have a pre- and post-test questionnaire to be completed by all participants

Operationalization of the trainings

The programme will be rolled out rapidly to saturate all high caseload health facilities (SCs/ PHCs/CHCs/ SDHs/ DHs) with trained providers. Following steps will be taken for rolling out the training in High Priority Districts (HPDs):

1. **Identification of sites with high delivery load:** For the sake of prioritization, facilities which have high delivery load will be identified for training of the providers. The states should initiate the implementation of the program in the District Hospitals (DHs), Community Health Centers (CHCs)/Block level Primary Health Centers (PHCs) in the first phase and then cover the rest of the PHCs and Sub-Centers (SCs) subsequently.

2. **Assessment of training load:** A list of all high caseload health facilities (SCs/ PHCs/CHCs/ SDHs/ DHs) will be prepared with the number of Medical Officers, nurses and ANMs posted in each facility. This list will provide the training load for the district.

3. **Micro-planning for training:** A micro-plan for training will be prepared for each district. The micro-plan will cover details such as the dates of training of successive batches, names of facilities to be covered in each batch, and the number of trainees from each facility in each batch.

4. **Identification and Training of Trainers (ToT):** 3-4 master trainers will be identified from each district. Ideally there should be one doctor (OBG or LMO) and two nurses.
    - Existing SBA trainers should be given preference for selection as master trainers.
    - If such trainers are not available, two nurses and one doctor with the skills and knowledge required of a trainer should be selected from within the district.
    - The districts can also hire trainers on a short term basis as consultants.

- It should be ensured that only interested people are nominated as trainers.
- Trainers should also be utilized for post-training follow up of the trainees at their respective facilities.
- The trainers should be paid incentives for conducting the trainings and should also be paid transport allowance and incentives for undertaking post-training follow up visits.

These trainers will be trained at the state level in the ToT mentioned above.

5. **Site of Training**: In each district, either the DH or/and a high caseload CHC will be identified as the training site. However, before the trainings begin, the providers at these sites will be trained for standardizing the clinical practices at their facilities so that the trainees can observe and learn the correct evidence based practices during the trainings. Once these facilities themselves start adhering to the identified evidence based clinical practices, only then will these sites start conducting the training of providers of high caseload facilities of their/the neighbouring districts
6. **Training of nurses and ANMs**: Providers will be trained by the designated trainers in batches of 12-14.

Objective 2:

To implement enabling strategies to ensure transfer of learning towards improved adherence to evidence based clinical practices

It has been a common observation in the field that the clinical trainings do not translate optimally into clinical practice. The reasons for this are multi-fold and include issues like quality of trainings, lack of clinical practice during trainings, no post-training follow-up, lack of clinical mentorship and leadership at the facilities etc. This initiative will implement the following operational strategies that will enable transfer of learning into improved practices of care.

a) Ensuring that the trainings are competency based

The participants, in the above mentioned trainings, will be trained using mannequins such as simulation model for child birth and newborn and the videos developed by the GoI under the SBA and skill lab related training programs will be used to demonstrate relevant competencies. All the training sites will be equipped with these anatomic models in sufficient number for enabling self-practice by the trainees. Additionally, by design, the trainings will be conducted at sites which have been strengthened as service delivery sites and therefore, the participants will also be taken to the labour rooms of the training sites to ensure that they observe, assist and practice the skills which have been taught to them during the trainings.

b) Orientation of the clinical and administrative leaders

A half day sensitization of the clinical and administrative leaders of targeted facilities would precede the three day trainings of the providers. These sensitization meetings will be conducted at the district level and the clinical and administrative leaders would be oriented on the components of the initiative and their role in the same. This will help in ownership of the initiative by the leaders of all the targeted facilities who will in turn create an enabling environment at the facilities to facilitate translation of skills to practice after the three day training of the providers. A structured agenda and resource material will be developed for these orientation meetings and these will be conducted by a designated state level officer.

c) Post training follow-up and mentoring support for translating skills into practice

One of the major learnings from any well performing training program, focusing on influencing behaviour to improve practices, is the significance of post-training follow-up and support. A program with initial low dose training followed by high frequency supportive supervision has higher chances of successful outcomes. Post-training follow-up and support after the training will be of three main types—

- Technical mentorship by **dedicated pre-identified personnel** (can include the dedicated human resources, trainers and other resources like the DPHN, LHVs etc.). **Provision can also be made under the National Health Mission (NHM) funds for hiring such personnel for a duration of 2-3 years.** People making post-training follow-up visits will take anatomic models such as child birth simulation model and newborn simulation model along with them so that they can assess the competencies of the provider and do onsite skill building sessions for the providers who have not been able to attend the trainings at the training sites. The idea is to saturate the site with trained providers. In other words, all providers working in the labour room will be trained under this initiative.
- Handholding and programmatic support by RMNCH+A consultants,
- Administrative support by district level program managers/ supervisors.

Wherever available, other cadres of technical mentors should also be oriented on the program to provide follow-up after the training.

Frequency of mentorship visits

Ideally the first mentorship visit should be made to a facility within 15 days of the date of training of its first batch of providers. For the first two months, the mentorship visits should be made at the frequency of at least once every fortnight. After that if the trainers feel that the nurses and ANMs are performing all essential practices well, the frequency of mentorship visits can be reduced to once every month for six months and subsequently once every quarter for the next three-four quarters. This is an important consideration while planning for the initiative. Adequate numbers of mentors should be made available before the start of this program to ensure that adequate frequency of mentorship visits is maintained.

Content of mentorship visits

During each mentorship visit the mentors will first observe practices by the trained provider in the labour room. Wherever needed, they will provide on-the-job handholding to the providers in improving practices. Subsequently, they will go through the facility-based records such as labour room registers, case sheets, and completed SCCs to understand the practices and major outcomes in the facilities.

Towards the end of one such visit, the mentors will meet with the nursing in-charge and the facility leader to provide them with the feedback on the performance of the facilities from the perspective of quality and also suggest and recommended actions to address the identified gaps.

d) Non-rotation of staff posted in labour rooms

To ensure optimal utilization of the trainings, the states should ensure that the providers working in the labour rooms are not rotated. This has also been emphasized through a policy guidance from Government of India.

Objective 3:

To improve the availability of essential supplies and commodities in the labour room and the postpartum wards

Ensuring resources essential for performing the high-impact, evidence based practices (included in the Safe Childbirth Checklist) in the target facilities will be a critical activity independent of the pace of the trainings under this program. Ideally, resource availability activities should be initiated prior to the start of trainings. A list of resources essential for evidence-based practices is attached as Annexure 5. District managers should make facility-specific plans of ensuring the essential medicines, equipment, and consumables in the labour rooms in accordance with this list. Following steps should be followed for ensuring essential resources in target facilities:

a) **Resource needs analysis:**

Facility specific resource availability status should be prepared by the hospital manager/ district or block program manager or the assigned provider working in the labour rooms. This status will be developed by assessing the facility readiness through site visits using the Mentorship and Support Visit template (Annexure 4). The same visit will be used to assess the training load of the facilities.

b) **Facility-specific action matrices:**

Resource availability in a facility can have influencers at three main level—state, district, and facility level. Some essential supplies are easy to procure at the state level but are not available at the level of districts. For some commodities there are gaps in supply from district to the facility. Finally, in many cases even though the supplies are available in the store, they are not made available at the point of care.

A facility specific action matrix (Annexure 5) should be developed listing all the essential commodities and medicines, reason for non-availability, action for ensuring availability at the point of care, and the person responsible for ensuring availability.

c) **Implementation of availability action matrices:**

These resource availability action matrices will be implemented by the hospital manager/ facility leader or the assigned provider working in the labour room. They can be supported by the RMNCH+A consultants responsible for the high priority districts, with monthly status report.

Objective 4:

To improve accountability of service providers through improved recording, reporting and utilization of data

A dashboard of key indicators will be developed and mechanisms will be created to record data on these indicators for each delivery. The facility in-charge will monitor these key indicators on a weekly basis towards ensuring improved clinical governance at the targeted facilities. **For this purpose, data recording of facilities will also be standardized through introduction of a standard birthing register as per the recommendation in the MNH toolkit. A sample of birthing register is attached as an Annexure 3.**

An illustrative list of dashboard indicators:

Practices

- Percentage of pregnant women whose blood pressure was recorded at the time of admission
- Percentage of mothers who were administered Oxytocin immediately after delivery for active management of third stage of labour (AMTSL)
- Percentage of women whose body temperature was recorded at the time of discharge
- Percentage of new-borns breast fed within one hour of delivery
- Percentage of new-borns whose temperature was recorded at the time of discharge

Complications

- Percent of pregnant women with post-partum haemorrhage
- Percent of pregnant women with pre-eclampsia/eclampsia
- Percent of pregnant women with prolonged/obstructed labour
- Percent of newborn with Asphyxia

Objective 5: (intermediate term objective):

Implementation of the MNH Tool kit at the delivery points, in a phased manner.

While the above mentioned four objectives are related to immediate solutions and activities to bring about improvement in quality of care in the shorter term, it is also important to ensure that the major system gaps i.e. human resources, infrastructure and equipments, are also addressed in the intermediate term, which will then result in a sustainable improvement in quality of care. For this, the framework of MNH toolkit, prepared by the GoI for strengthening of labour rooms in India, will be used. **Priority will be given to hiring of additional human resources at the designated delivery points to meet the standards set by the MNH toolkit.**

OPERATIONAL PLAN FOR ROLLING OUT 'DAKSHATA' INITIATIVE

Dakshata will be initially rolled out in states that have high maternal and perinatal mortality though other states are free to adopt this program based on their perceived needs. In each state, the program will be rolled out in two stages—first in the HPDs and subsequently in remaining districts of the state. Thus, during the first phase of this initiative, the states should focus on HPDs.

For ensuring effective implementation of the program, the states should consider hiring of a dedicated resource person for each district for providing techno-managerial support to this initiative. This person will have a clinical background with public health experience/interest so that he/she can undertake post-training follow-up visits to these sites as well as coordinate and manage the inputs and activities of this program.

Following will be the steps of program rollout in each district:

A. Implementation in HPDs:

1. Implementation of program in District Level Facilities (DLF): One district level facility will be designated as the training site in each district. This designated training site will be prioritized for the training of providers and on-site post-training support. This will be done to ensure that the designated training sites will function at the highest level of performance so as to act as a training-cum-demonstration facility. It will include all the major activities under the Dakshata initiative

    a. Rapid assessment of facility to understand the status of adherence to practice, skill levels of providers, and availability of essential resources.

    b. Prioritized resource availability for essential practices as mentioned under the programmatic approach

    c. Training of health workers working in the labour rooms on the 3-day package

    d. Post-training follow up and support by the mentors

    Strengthening of district hospitals and establishing them as training sites will take approximately 3-4 months.

2. Identification and training of district pool of trainers and mentors: master trainers and pool of district level trainers will be trained in a ToT using the 3 day training capsule. This activity will run simultaneously with the strengthening of the district level facilities as training sites.

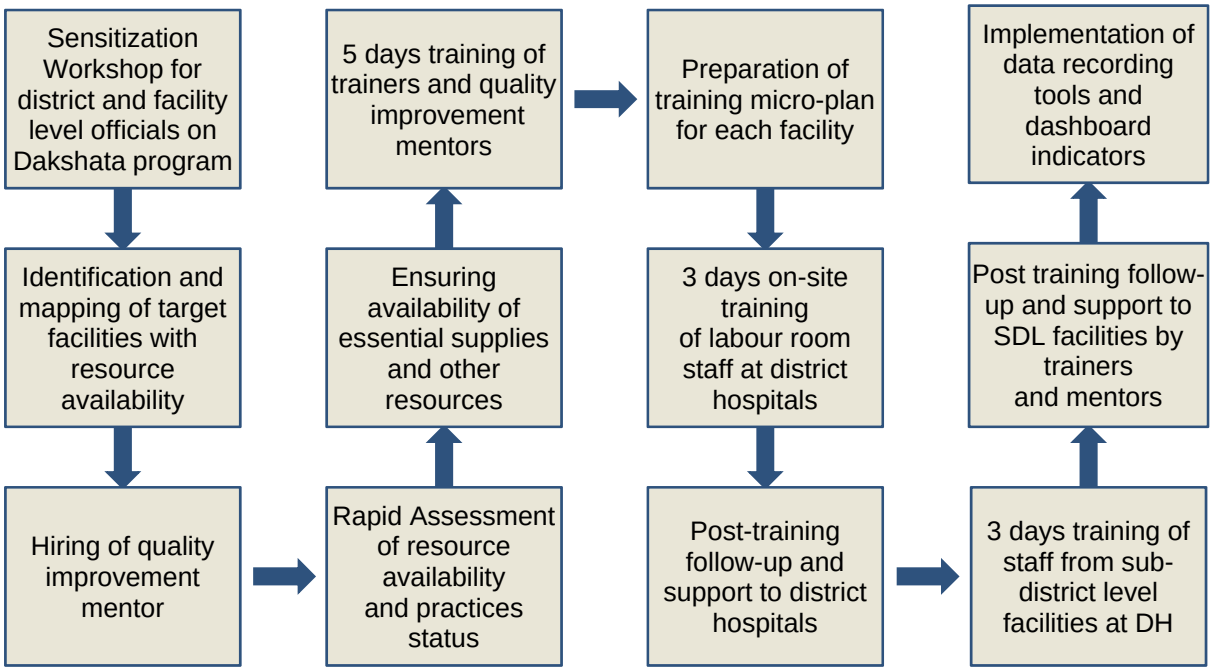
3. Identification of high delivery load facilities: in each district, facilities with more than 50 deliveries per month will be identified for implementation first. However, this threshold can vary in different states based on the number of facilities with high institutional deliveries and the implementation capacity of the state.

4. Rapid assessment of facilities: All selected facilities will be assessed for adherence to recommended practices, skill levels of providers, and availability of essential resources. This activity will run simultaneously with the implementation in the district level facilities and will take approximately 3 months.

5. Ensuring resources in sub-district level high delivery load facilities. Using the methodology described in the programmatic approach, availability of essential resources will be facilitated in sub-district level facilities. This activity will start immediately after the rapid assessment of facilities and will take approximately 3 months.
6. Training of providers from sub-district level high delivery load facilities: staff from sub-district level facilities will be trained at district level trainings in successive batches. Trainings will be planned in a way that at least 3 training batches are organized in each month, leaving some time for the trainers and mentors to provide onsite post-training support. This activity will take approximately 6 months and will start after the establishment of training sites at district level facilities.
7. Post training follow-up and support: Post training follow up and support will be provided to the facility staff by the trainers and mentors as per the frequency and methodology described under the programmatic approach. This activity will start within 15 days of start of trainings and will continue till one year after the completion of last training. Subsequently, the post-training follow-up and support activity will continue at a lesser frequency.
8. Program implementation in remaining facilities: districts will subsequently decide upon the need for implementation in remaining delivery points. The operational approach will be same as described under step numbers 4-7.

B. Implementation in remaining districts: after completion of the implementation of the program in the HPDs, states will prioritize other districts for this approach based upon the need. The operational plan for implementation of Dakshata will remain the same as described under item B.

Key Activities under Dakshata



PROGRAM MONITORING

Program monitoring will comprise of three important actions—program management monitoring by supervisory cadre workers, clinical monitoring by mentors and trainers, and periodic reviews of dashboard of indicators at various levels.

1. Program management monitoring: this will be done by the designated supervisors, development partners, and other supervisory cadre workers using the GoI's supportive supervision checklist. Information included for Maternal and Newborn Health section in the checklist is sufficient to cover program management monitoring for Dakshata initiative. The frequency of these visits will be decided as per the norms given in the supportive supervision checklist guideline and standard operating procedures.

2. Clinical monitoring by the mentors: all the trainers and mentors will monitor and report the adherence to quality of care practices at the target institutions apart from providing post training follow-up and support. For this purpose, they will use a short tool for mentorship and support visits (annexure 4). The frequency of their monitoring visits will be as per the guidance given under objective 2, item C.

3. Dashboard of indicators: Facilities participating under the program will send monthly reports to districts and districts will send monthly reports to the states for inclusion into the dashboard of indicators. These reports will be compiled at district levels and will be fed to both state level and facility level. At all levels, the dashboard of indicators will be reviewed during appropriate and relevant platforms such as the District Health Society meetings. At facility levels, these dashboards will be displayed prominently at the facility and will be discussed during routine visits of supervisors and mentors. Each review of the dashboards will trigger discussion to troubleshoot low rates of any practice included in the dashboard, such as, making supplies available, additional skill development, administrative orders, knowledge update, etc. based on facility/district specific needs.

BUDGET

The initiative will require additional expenditure to be incurred for hiring of dedicated human resources and logistics of post-training follow-up and support, procurement of training materials, and conducting training of health workers. Additional funds will be provided for these activities under the NHM funds. Funds for ensuring adequate resources, including human resources, will need to be budgeted as routine activities as per the need of districts and facilities in respective Program Implementation Plans (PIPs).

ANNEXURES

Annexure 1: Safe Childbirth Checklist (SCC)

Before Birth | SAFE CHILDBIRTH CHECKLIST

Registration No. .....

CHECK-1 On Admission

Record temperature of mother:.....
Record BP of mother:.....
Record Fetal Heart Rate (FHR): .....

Does Mother need referral?
☐ Yes, organized
☐ No

Refer to FRU/Higher centre if any of following danger signs are present, mention reason and given treatment on transfer note:
☐ Vaginal bleeding
☐ High fever
☐ Severe headache or blurred vision
☐ Convulsions
☐ Severe abdominal pain
☐ History of heart disease or other major illnesses
☐ Difficulty in breathing

Partograph started?
☐ Yes
☐ No: will start when ≥ 4 cm

Start when cervix ≥4 cm, then cervix should dilate ≥1 cm/hr
- Every 30 min: Plot maternal pulse, contractions, FHR and colour of amniotic fluid
- Every 4 hours: Plot temperature, blood pressure, and cervical dilation in cm

NO OXYTOCIN/ other uterotonics for unnecessary induction/ augmentation of labor

Does Mother need
- Antibiotics?

☐ Yes, given
☐ No

Give antibiotics to Mother if:
☐ Mother's temperature ≥38°C (≥100.5°F)
☐ Foul-smelling vaginal discharge
☐ Rupture of membranes >12 hrs without labour or >18 hrs with labour
☐ Labour >24 hrs or obstructed labour
☐ Rupture of membranes <37 wks gestation

- Inj. Magnesium Sulfate?

☐ Yes, given
☐ No

Give first dose of inj. magnesium sulfate and refer immediately to FRU/Higher center OR give full dose (loading and then maintenance) if at FRU if:
Mother has systolic BP ≥160 or diastolic ≥110 with ≥+3 proteinuria **OR** BP systolic ≥140 or diastolic ≥90 with proteinuria trace to +2 along with any of:
☐ Presence of any symptom like:
- Severe headache
- Pain in upper abdomen
- Blurring of vision
- Oliguria (passing <400 ml urine in 24 hrs)
- Difficulty in breathing

☐ Convulsions

Corticosteroid
☐ Yes, given
☐ No

Give corticosteriods in antenatal period (between 24 to 34 weeks) to mothers if:
☐ True pre-term labour
☐ Conditions that lead to imminent delivery like APH, Preterm Premature ROM, Severe PE/E
Dose: Inj. Dexamethasone 6 mg IM 12 hourly - total 4 doses

HIV status of the mother:
☐ Positive
☐ Negative

☐ **Follow Universal Precautions**

If HIV+ and in labour:
☐ If mother is on ART, continue same
☐ If not on ART, start ART/Nevirapine prophylaxix (if ART is not available) and refer immediately after delivery to ICTC for further HIV management
If HIV status unknown:
☐ Recommend HIV testing

Encouraged a birth companion to be present during labour, at birth and till discharge ☐ Yes ☐ No

Are soap, water, gloves available?
☐ Yes, I will wash hands and wear gloves for each vaginal exam
☐ No, supplies arranged

☐ **Confirm if mother or companion will call for help during labour if needed**

Explain to call for help if there is:
- Bleeding
- Severe abdominal pain
- Difficulty in breathing
- Severe headache or blurring vision
- Urge to push
- Can't empty bladder every 2 hours

Counsel Mother and Birth Companion on:
- Support to cope up with labour pains
- No bath/oil for baby
- No Pre-Lacteal feed
- Initiate breastfeeding in half-an-hour
- Clothe and wrap the baby

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

Registration No. .....

CHECK-2 Just Before and During Birth (or C-Section)

Record temperature of mother:.....
Record BP of mother:.....
Record Fetal Heart Rate (FHR): .....

Does Mother need:

- *Antibiotics?*
  - ☐ Yes, given
  - ☐ No

Give antibiotics to Mother if any of the following are present:
- ☐ Mother's temperature ≥38°C or ≥100.5°F
- ☐ Foul-smelling vaginal discharge
- ☐ Rupture of membranes >18 hrs with labour
- ☐ Labour >24 hrs or obstructed labor now
- ☐ Cesarean section

- *Inj. Magnesium sulfate?*
  - ☐ Yes, given
  - ☐ No

Give first dose of inj. magnesium sulfate and refer immediately to FRU/Higher center OR give full dose (loading and then maintenance) if at FRU if:
Mother has systolic BP ≥160 or diastolic ≥110 with ≥+3 proteinuria **OR** BP systolic ≥140 or diastolic ≥90 with proteinuria trace to +2 along with any of:
- ☐ Presence of any symptom like:
  - Severe headache
  - Pain in upper abdomen
  - Blurring of vision
  - Oligouria (passing <400 ml urine in 24 hrs)
  - Difficulty in breathing
- ☐ Convulsions

☐ **Skilled assistant identified and ready to help at birth if needed**

Confirm essential supplies are at bedside/labour room:

For Mother
- ☐ Gloves
- ☐ Soap and clean water
- ☐ Oxytocin 10 units in syringe
- ☐ Pads for mother

Prepare to care for mother immediately after birth of baby (AMTSL)*
- ☐ Confirm single baby only (rule out multiple babies)
- ☐ Give inj. oxytocin 10 units IM within 1 minute
- ☐ Do controlled cord traction to deliver placenta
- ☐ Massage uterus after placenta is delivered, check for completeness (all Cotyledons and Membranes)

For Baby
- ☐ Two clean dry, warm towels
- ☐ Sterile scissors/blade to cut cord
- ☐ Mucus extractor
- ☐ Cord ligature
- ☐ Bag-and-mask

Prepare to care for baby immediately after birth
- ☐ Dry baby, wrap, and keep warm, give Vit. K, start breastfeeding
- ☐ If not breathing: clear airway and stimulate
- ☐ If still not breathing:
  - Cut cord
  - Ventilate with bag-and-mask
  - Call for help (Pediatrician/SNCU/NBSU/F-IMNCI trained doctor if available)

***AMTSL - Inj. Oxytocin 10 units IM given within one minute of birth of baby?**
- ☐ Yes
- ☐ No

Breastfeeding initiated in first half-an-hour of birth of the baby
- ☐ Yes
- ☐ No

*AMTSL - Active Management of Third Stage of Labour

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

After Birth | SAFE CHILDBIRTH CHECKLIST

Registration No. .....

CHECK-3 Soon After Birth (within 1 hour)

Record temperature of mother:.....
Record BP of mother:.....
Record temperature of baby:.....
Record respiratory rate of baby:.....

Is Mother bleeding too much?
- ☐ Yes, shout for help, refer if needed or treat if facilities available
- ☐ No

If bleeding ≥500 ml, or 1 pad soaked in <5 min:
- Call for help, massage uterus, start oxygen, start IV fluids, start oxytocin drip 20 units in 500 ml of RL@40-60 drops/min, treat cause
- If placenta not delivered or completely retained: give IM or IV Oxytocin, stabilize, and refer to FRU/Higher centre
- If placenta is incomplete: remove if any visible pieces, and refer immediately to FRU/ higher centre

Does Mother need:

- *Antibiotics?*
  - ☐ Yes, given
  - ☐ No

Give antibiotics to mother if manual removal of placenta is performed, or if mother's temperature ≥38°C (≥100.5°F) and any of:
- ☐ Chills
- ☐ Foul-smelling vaginal discharge
- ☐ Lower abdominal tenderness
- ☐ Rupture of membranes >18 hrs during labour
- ☐ Labour was >24 hours

- *Inj. Magnesium sulfate?*
  - ☐ Yes, given
  - ☐ No

Give first dose of inj. magnesium sulfate and refer immediately to FRU/Higher center OR give full dose (loading and then maintenance) if at FRU if:
Mother has systolic BP ≥160 or diastolic ≥110 with ≥+3 proteinuria **OR** BP systolic ≥140 or diastolic ≥90 with proteinuria trace to +2 along with any of:
- ☐ Presence of any symptom like:
  - Severe headache
  - Pain in upper abdomen
  - Blurring of vision
  - Oligouria (passing <400 ml urine in 24 hrs)
  - Difficulty in breathing
- ☐ Convulsions

Does Baby need:

- *Antibiotics?*
  - ☐ Yes, given
  - ☐ No

Give baby antibiotics if antibiotics were given to mother, or if baby has any of:
- ☐ Breathing too fast (>60/min) or too slow (<30/min)
- ☐ Chest in-drawing, grunting
- ☐ Convulsions
- ☐ Looks sick (lethargic or irritable)
- ☐ Too cold (baby's temp <36°C and not rising after warming)
- ☐ Too hot (baby's temp >38°C)
- ☐ Excessive crying

- *Referral?*
  - ☐ Yes, organized
  - ☐ No

Refer baby to NBSU/SNCU/FRU/higher centre if:
- Any of the above (antibiotics indications)
- Baby looks yellow, pale or bluish

- *Special care and monitoring?*
  - ☐ Yes, organized
  - ☐ No

Arrange special care/monitoring for baby if any of the following is present:
- ☐ Preterm baby
- ☐ Birth weight <2500 gms
- ☐ Needs antibiotics
- ☐ Required resuscitation

- *Syrup Nevirapine*
  - ☐ Yes, given and will continue upto 6 weeks
  - ☐ No

Give if mother is HIV+

- ☐ **Started breastfeeding. Explain that colostrum feeding is important for baby.**
- ☐ **Started skin-to-skin contact (if mother and baby well) and KMC in pre-term and low-birth weight babies.**
- ☐ **Explain the danger signs and confirm mother/companion will call for help if danger signs present.**

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

After Birth | SAFE CHILDBIRTH CHECKLIST

Registration No. .....

CHECK-4 Before Discharge

Record temperature of mother:.....
Record BP of mother:.....
Record temperature of baby:.....
Record respiratory rate of baby:.....

Is Mother's bleeding controlled?
- ☐ Yes
- ☐ No, treat, observe and refer to FRU/ higher centre if needed

Does mother need antibiotics?
- ☐ Yes, give and delay discharge
- ☐ No

Give antibiotics to mother if mother has temperature ≥38°C or ≥100.5°F with any of:
- ☐ Chills
- ☐ Foul-smelling vaginal discharge
- ☐ Lower abdominal tenderness

Does baby need antibiotics?
- ☐ Yes, give, delay discharge and refer to FRU/ higher centre
- ☐ No

Give baby antibiotics if baby has any of:
- ☐ Breathing too fast (>60/min) or too slow (<30/min)
- ☐ Chest in-drawing, grunting
- ☐ Convulsions
- ☐ Looks sick (lethargic or irritable)
- ☐ Too cold (baby's temp <36°C and not rising after warming)
- ☐ Too hot (baby's temp >38°C)
- ☐ Stopped breastfeeding
- ☐ Umbilical redness extending to skin or draining pus

Is baby feeding well?
- ☐ Yes, encourage mother for exclusive breastfeeding for 6 months.
- ☐ No, help mother, delay discharge; refer to NBSU/ SNCU/ Higher centre if needed

- ☐ **Discuss and offer family planning options to mother**
- ☐ **Explain the danger signs and confirm mother/companion will seek help/ come back if danger signs are present after discharge**
- ☐ **Arrange transport to home and follow-up for mother and baby**

Thank mother for availing services from you

Danger Signs

Mother has any of:
- Excessive bleeding
- Severe abdominal pain
- Severe headache or visual disturbance
- Breathing difficulty
- Fever or chills
- Difficulty emptying bladder
- Foul smelling vaginal discharge

Baby has any of:
- Fast/difficulty breathing
- Fever
- Unusually cold
- Stops feeding well
- Less activity than normal
- Whole body becomes yellow

Name of Provider: .....Date: ..... Signature: .....

Adapted from "WHO Safe Childbirth Checklist"

Annexure 2: Training Agenda

Duration	Topic	Suggested methodology
Day 1		
Section 1: Introduction to the concept of quality of care and role of SCC in it		
20 mins	Registration, Welcome and opening session (introduction, participants' expectations, training norms, goal and objectives of training, agenda, orientation to training package)	Interactive presentation and facilitation
45 mins	Pre-training knowledge assessment and pre-training OSCE	Simultaneous activity by learners, observed by trainers
15 mins	Importance of ensuring quality care in labour room	Interactive presentation
20 mins	Current practices in client management in labour rooms at worksite of learners (flow of client care)	Brain storming and discussion using flipchart
10 mins	Understanding stages of labour in relation to flow of client care	Interactive presentation
15 mins	**Tea Break**	
30 mins (10 mins+ 20 mins)	Introduction to the Safe Childbirth Checklist (SCC)–A simple tool to improve quality of care Orientation to the layout of SCC	• Interactive presentation • Checklist reading
Section 2: Care at the time of admission		
90 mins	Triaging based on history, examination and decision for level of care Demonstration of critical assessment skills– a. Correct estimation of gestational age b. Appropriate assessment of uterine contractions c. Localizing and appropriate recording of FHR d. Hand washing, wearing gloves e. Conducting PV examination and removing gloves BP measurement, Hb estimation by Sahli's method, Urine protein estimation by Uristix	• Interactive presentation • Videos on BP, Hb, urine protein and sugar • Demonstration on models
10 mins	Importance of monitoring vitals during labour	• Refer to SCC section • Interactive presentation and discussion
45 mins	**Lunch**	
30 mins	Immediate actions for prevention of major complications in the mother: a. Antibiotics for infection prevention and management b. Antenatal corticosteroids in pre-term delivery	• Refer to SCC • Interactive presentation and discussion

Duration	Topic	Suggested methodology
	c. Antiretroviral therapy for HIV management	
30 mins	Prevention, identification and management of pre-eclampsia and eclampsia	• Interactive presentation and discussion • Refer to SCC • Video on management of PE/E (SBA module)
60 mins	Monitoring the progress of labour–plotting and interpreting partograph	• Interactive presentation • Practice on case study 1
15 mins	**Tea**	
30 mins	Principles of timely identification and management of prolonged and obstructed labour	Interactive presentation and discussion
10 mins	Empowering birth companions for participation in care of the mother and the baby	Interactive presentation and discussion with SCC
5 mins	Summary and review of the day's activities	Presentation by learners

Duration	Topic	Suggested methodology
Day 2		
Section 3: Essential practices just before, during and after delivery		
40 mins	• Recap of day one. • Review partograph exercise • Present agenda day 2	• Recap by learners • Review and facilitation by trainer
30 mins	Preparing for safe delivery: a. Personal protective equipment (PPE) b. Trays relevant for safe delivery as per MNH toolkit c. Importance of pre-filled oxytocin in sterile syringe	• Demonstrate PPE • Demonstrate delivery and baby trays • Explain other trays using job aid
15 mins	Normal delivery and active management of third stage of labour (AMTSL)	• Interactive presentation and discussion
15 mins	Essential new born care (ENBC)	• Interactive presentation and discussion
15 mins	**Tea**	
120 mins	Management of second and third stage of labour a. Conducting normal delivery (ND) b. ENBC and AMTSL c. New Born Resuscitation (NBR)	• Demonstration followed by skill practice using models and skills checklist
15 mins	Preventing complications in newborn	Interactive presentation and discussion
45 mins	**Lunch**	
60 mins	Prevention, identification and management of postpartum hemorrhage (PPH) a. Prevention of PPH–AMTSL b. Initial management of shock and PPH c. Bimanual compression	• Interactive presentation • Video on PPH (SBA module 5) • Demonstration and practice on models using skills checklist
30 mins	Review of care of mother and newborn soon after birth a. Regular assessment of clinical condition of mother and newborn (Routine care) b. Early initiation of breast feeding c. Prevention of hypothermia	• Interactive presentation and discussion
30 mins	Prevention, identification and management of newborn infections a. Antibiotics and referral b. ART for newborn	Interactive presentation and discussion referring to SCC
15 mins	**Tea**	
45 mins	Special care for pre-term and LBW babies: a. Thermal management including KMC b. Assisted feeding c. Infection prevention	• Interactive presentation • Demonstration and practice on models on position and attachment for breastfeeding • Demonstration on KMC and assisted feeding (OGT insertion)
10 mins	Summary and review of the day's activities	Presentation by learners

Duration	Topic	Suggested methodology
Day 3		
Section 4: Essential practices at the time of discharge		
15 mins	• Recap of day 2 • Agenda of day 3	• Recap by learners • Facilitation by trainer
20 mins	Assessing and managing postpartum complications in mothers a. Puerperal sepsis b. Delayed PPH	• Interactive presentation and discussion • Refer to SCC
30 mins	Postpartum family planning counselling (return to fertility, healthy timing and spacing of pregnancy, postpartum family planning options)	• Interactive presentation using job-aids • Role play
20 mins	Discharge counselling on danger signs for mother and baby and seeking care	Refer to SCC and discussions
15 mins	**Tea**	
15 mins	Respectful maternity care	Video RMC (MAF) and discussion
30 mins	Do's and Don'ts for all four stages of labour	Game
Section 5: Creating a quality enabling environment in labour rooms		
30 mins	Infection prevention practices and biomedical waste management	• Interactive presentation, discussion • Video • Demonstration using IP material
85 mins	Organization of labour room as per GoI guidelines	• Photographs based interactive presentation and discussion • Group work for organizing LR with prompts • Video on organization of labour room (GoI)
45 mins	**Lunch**	
30 mins	Recording and reporting • LR Register • Monthly Reporting Format	Discussion with hand outs
45 mins	Post-training knowledge assessment and OSCE Learners' feedback of training Sharing knowledge and OSCE results	Learners activity observed and presented by trainers
30 mins	Next steps, certificate distribution and closing	Trainer/Government or facility official
15 mins	**Tea**	

Annexure 3: Template of Birthing Register

Labor Room Register

Year SN	Month SN	Client Detail	Age and Obstetric History	Admission Details	Detail of interventions for Delivery	Details of Delivery	Information about Baby	Condition of the mother and child at discharge		Complications		Postpartum Family planning	Addition Info./ Follow up details
										Mother	Baby		
1	2	3	4	5	6	7	8	9	10	11	12	13	14
		Registration No Name Husband's Name Address Mobile No. Religion Education	Age (in Years) LMP/EDD Gravida/Parity Abortion Living children Previous LSCS Other previous complications:	Date Time Booked ☐ Unbooked ☐ **Term** Pre- term ☐ Full-term ☐ Post-term ☐ BP Temp FHR Proteinuria Hb gms% Pulse Rate Blood Group HIV Malaria Hep B	**Partograph Filled** ☐ **Inducted** ☐ **Augmented** ☐ **Episiotomy** ☐ **AMTSL** Yes ☐ No ☐ **Type of Uterotonic** Oxytocin IM ☐ If others, then specify: Antibiotics ☐ Blood transfusion ☐	Date Time **Type:** Normal ☐ Assisted Delivery (Instrumental, Vacuum, etc.) ☐ Caesarean ☐ **If caesarean, Indication:** Conducted By:	**Identification No** **Sex:** Male ☐ Female ☐ Other ☐ **Weight (Kgs):** Dried immediately after birth Yes ☐ No ☐ Breast feed within 1 hour Yes ☐ No ☐ Vitamin K given Yes ☐ No ☐	**Child** Alive ☐ Still birth ☐ IUD ☐ New born death ☐ **Mother** Alive ☐ Maternal Death ☐	Date and time of Discharge BP Temp Bleeding PV **Child** Temp Feeding Respiratory Rate	APH ☐ PPH ☐ Pre-eclampsia ☐ Eclampsia ☐ Sepsis ☐ Obs. Labour ☐ Prolonged labour ☐ Others (specify): Referred Yes ☐ No ☐	Sepsis ☐ Asphyxia ☐ LBW ☐ Pre Maturity ☐ Others ☐ (specify): Referred out Yes ☐ No ☐	Counselling Yes ☐ No ☐ **Method chosen:** LAM ☐ Condoms ☐ Injectable ☐ PPIUCD ☐ Male Sterilization ☐ PPS ☐ Others ☐ Date of method adopted Due date of Follow-up	
		Registration No Name Husband's Name Address Mobile No. Religion Education	Age (in Years) LMP/EDD Gravida/Parity Abortion Living children Previous LSCS Other previous complications:	Date Time Booked ☐ Unbooked ☐ **Term** Pre- term ☐ Full-term ☐ Post-term ☐ BP Temp FHR Proteinuria Hb gms% Pulse Rate Blood Group HIV Malaria Hep B	**Partograph Filled** ☐ **Inducted** ☐ **Augmented** ☐ **Episiotomy** ☐ **AMTSL** Yes ☐ No ☐ **Type of Uterotonic** Oxytocin IM ☐ If others, then specify: Antibiotics ☐ Blood transfusion ☐	Date Time **Type:** Normal ☐ Assisted Delivery (Instrumental, Vacuum, etc.) ☐ Caesarean ☐ **If caesarean, Indication:** Conducted By:	**Identification No** **Sex:** Male ☐ Female ☐ Other ☐ **Weight (Kgs):** Dried immediately after birth Yes ☐ No ☐ Breast feed within 1 hour Yes ☐ No ☐ Vitamin K given Yes ☐ No ☐	**Child** Alive ☐ Still birth ☐ IUD ☐ New born death ☐ **Mother** Alive ☐ Maternal Death ☐	Date and time of Discharge BP Temp Bleeding PV **Child** Temp Feeding Respiratory Rate	APH ☐ PPH ☐ Pre-eclampsia ☐ Eclampsia ☐ Sepsis ☐ Obs. Labour ☐ Prolonged labour ☐ Others (specify): Referred Yes ☐ No ☐	Sepsis ☐ Asphyxia ☐ LBW ☐ Pre Maturity ☐ Others ☐ (specify): Referred out Yes ☐ No ☐	Counselling Yes ☐ No ☐ **Method chosen:** LAM ☐ Condoms ☐ Injectables ☐ PPIUCD ☐ Male Sterilization ☐ PPS ☐ Others ☐ Date of method adopted Due date of Follow-up	

Annexure 4: Supportive Supervision Checklist for Mentors

Post-training Mentorship and Support (MSV) Checklist			
Format S. No.:			
Date of visit:			
District Name:			
Facility Name:			
Name of the mentor:			
Designation:			

A	Enabling environment	Response		Remarks
1	Whether all providers have been trained under the Dakshata package? *Please ask Doctor/ Nursing Incharge*	Select		
	If no, numbers not oriented yet	MO		
		SN		
		Others		
2	Mention tentative plans and date of completion			

3	Whether vital supplies for critical practices are available? (Mention Yes or No in the box after Physical verification)				
SN	**Items**	**Response**	**SN**	**Items**	**Response**
1	Checklists		15	Pads	
2	Magnesium sulphate (atleast 20 vials)		16	Towels for receiving new-borns	
3	Antibiotics for mother		17	Syringes	
4	Antibiotics for baby		18	IV Sets	
5	Oxytocin (5/10 IU/ ml)		19	Ambu bag for babies (240 ml) with both pre & term mask (size 0,1)	
6	Vitamin K (1mg/ml or 1mg/0.5 ml)		20	Ambu bag for adults	
7	IV Fluids		21	BP apparatus	
8	Anti-retrovirals		22	Stethoscope	
9	Soap & Running water		23	Thermometer	
10	Gloves		24	Mucus extractor	
11	Uristick		25	Suction device	
12	Partograph		26	Functional radiant warmer	
13	Cord clamps		27	Protocols posters displayed	
14	Sterile scissors				

		Response	**Remarks**
4	Where relevant protocol posters have been displayed at appropriate locations?		
B	**Dashboards and action plans**		
1	Was dashboard of indicators reviewed with facility leader and the team		
2	Number of practices not meeting desired targets		
3	Were action plans developed for addressing the issues identified through the dashboard?		

C	**Adherence to practices (Please physically verify from five randomly selected case records. Records include the Safe Childbirth Checklist (SCC) (Mark a positive response only if a practice is performed in at least 3/5 records reviewed)**		
1	The SCC is attached to all case sheets?		
2	The SCCs are being filled for all pause points?		
4	The SCCs are appropriately filled? (verify practices ticked in SCC with providers)		
4.1	Recording of Fetal Heart Rate (FHR) on admission		
4.2	Recording of mother's BP on admission, before and after delivery		
4.3	Recording of mother's temperature on admission and discharge		
4.4	Recording of baby's temperature on admission and discharge		
4.5	Recording of respiratory rate of the baby after delivery and discharge		
4.6	Partograph being filled (filled Partograph attached?)		
D	**Observation of practices [observe practices in the labour room/ other pause point location on any available client(s)]**		
1	Is the checklist used for this client?		
2	Are the relevant pause points completed for this client?		
3	Fetal heart rate (FHR) recorded at the time of admission		
4	Mother's BP recorded at the time of admission		
5	Partograph used to monitor the progress of labour		
6	Antenatal corticosteroids used for preterm labour		
7	Uterotonic (Oxytocin or Misoprostol) given to mother immediately after birth of baby		
8	Newborn care corner adequately equipped (bag-and-mask, radiant warmer, mucous extractor, shoulder roll, thermometer, clock, Oxygen source)		
9	Early initiation of breastfeeding practices		

10	Practice of skin to skin contact being promoted		
11	Babies dried with clean and sterile sheets/towels just after delivery		
12	Provider aware about the steps of new-born resuscitation (Positioning, stimulation, suctioning, repositioning, PPV using Ambu bag)		
13	New-borns given BCG,OPV, Hep-B within 24 hours of birth		
E	**Onsite training/ orientation/ knowledge update**		
1	Was onsite skill update session organized at this site?		
2	Mention the topic(s) covered		
3	Number of participants trained		
3	Topic(s) planned for the next onsite training as a part of MSV		
F	**Problem solving and hands on support (Discuss issues in adherence to practices with the facility incharge and facility team)**		

	Issues	**Discussed with facility incharge?**	**Action suggested**	**Person responsible**	**Timeline**
1					
2					
3					
4					
5					

Any other observation:

Annexure 5: Template for Resource Availability

S.No	Supply	Functional Availability status at the point of use (circle one)	Level of Issue (End user/ facility store/ district)	Bottleneck Analysis	Plan of Action	Person Responsible	Timeline
1	Magnesium Sulphate (at least 20 vials)	Available/ Non-Available/ Available-non-functional					
2	Antibiotics for mother	Available/ Non-Available/ Available-non-functional					
3	Antibiotics for baby	Available/ Non-Available/ Available-non-functional					
4	Oxytocin (5/10 IU per ml)	Available/ Non-Available/ Available-non-functional					
5	Vitamin K (1mg/ml or 1 mg/0.5 ml)	Available/ Non-Available/ Available-non-functional					
6	IV Fluids	Available/ Non-Available/ Available-non-functional					
7	Antiretrovirals	Available/ Non-Available/ Available-non-functional					
8	Soap & Running water	Available/ Non-Available/ Available-non-functional					
9	Gloves	Available/ Non-Available/ Available-non-functional					
10	Uristick (for proteinuria and glucose)	Available/ Non-Available/ Available-non-functional					
11	Partograph	Available/ Non-Available/ Available-non-functional					
12	Cord clamps	Available/ Non-Available/ Available-non-functional					
13	Sterile scissors	Available/ Non-Available/ Available-non-functional					
14	Pads	Available/ Non-Available/ Available-non-functional					
15	Towels for receiving newborns	Available/ Non-Available/ Available-non-functional					
16	Syringes	Available/ Non-Available/ Available-non-functional					
17	IV Sets	Available/ Non-Available/ Available-non-functional					
18	Family planning options	Available/ Non-Available/ Available-non-functional					
19	Ambu bag for babies (240 ml) with both pre & term mask (size 0,1)	Available/ Non-Available/ Available-non-functional					
20	BP Apparatus	Available/ Non-Available/ Available-non-functional					
21	Stethoscope	Available/ Non-Available/ Available-non-functional					
22	Thermometer	Available/ Non-Available/ Available-non-functional					
23	Mucus extractor	Available/ Non-Available/ Available-non-functional					
24	Suction device	Available/ Non-Available/ Available-non-functional					
25	Functional radiant warmer	Available/ Non-Available/ Available-non-functional					
26	Protocol posters displayed	Available/ Non-Available/ Available-non-functional					