DIRECTORATE OF FAMILY WELFARE, ODISHA

(State Maternal & Child Survival Cell)

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Letter No 4335 / 8mcs-639/17 **Dated.** 01/11/2017

From

Dr. Sarat Chandra Sahu, MS
Director of Family Welfare (Odisha)

To

All CDMO-cum-District Mission Director (30 districts)
Odisha.

Sub : Guidelines for implementation of Labour Room Quality Improvement Initiative (LaQshya).

Madam/Sir,

Enclosed herewith please find the guideline on Labour Room Quality Improvement Initiative. The State level sensitization has been completed along with the PIP dissemination workshop. Hence, you are requested to implement the programme, along with formation of the coaching teams and quality circle. The activity related to planning of campaign to done at the district level after proper consultation.

Hence, you are requested to start implementation in your district at the earliest.

Yours faithfully

01/11/17

Director of Family Welfare (O)

Memo No 4336 **Date :** 01/11/2017

Copy submitted to the Mission Director, NHM, Odisha for favour of kind information and necessary action.

01/11/17

Director of Family Welfare (O)

Memo No: 4337 **Date:** 01/11/2017

Copy forwarded to the Joint Director (Tech) NHM Odisha for information.

01/11/17

Director of Family Welfare (O)

Memo No: 4338 **Date:** 01/11/2017

Copy forwarded to the SPM/ Sr. Consultant PHP/ Sr. Consultant M&E/ Consultant QA&QI NHM for information & necessary action.

01/11/17

Director of Family Welfare (O)

LaQshya | लक्ष्य

(Labour Room Quality Improvement Initiative)

Draft 5th Sep 2017

LaQshya

0% Error, 100% Satisfaction

Ministry of Health & Family Welfare

Government of India

Introduction – In the last decade of implementation of the National Health Mission, (NHM), there has been a substantial increase in the number of the institutional deliveries. However, this increase in the numbers has not translated into commensurate improvements in the key maternal and new-born indicators such as maternal mortality and morbidity, postpartum haemorrhage eclampsia, stillbirth rates, early new-born mortality, and early initiation of breastfeeding. Available evidence shows that the *first day of birth* is the day of greatest risk for mothers and new borns. Inappropriate care on the first day of birth results in 46 % maternal deaths, 25 % (300,000) of Under 5 mortality and 40 % (290000) of stillbirths.

A transformational change in the processes related to quality of care on the day of delivery, which essentially relates to the intrapartum and immediate postpartum period care is urgently required. This will result not only in reduction of preventable maternal and new-born mortality, and still birth rates, but will also enable reductions in related morbidities such as obstetric fistula, puerperal sepsis, birth asphyxia and newborn sepsis.

However, the current focus on ensuring structural adequacy with availability of functional equipment, robust supply system and competent human resource alone may not give expected results, unless it is supported by adherence to clinical protocols and behaviour change for ensuring delivery of respectful care.

There is evidence suggesting that Respectful Maternity care[1] and facilitating natural birthing process has outcomes not just for the mother and the physical health of the newborn, but also affects cognitive development of the baby.

There is evidence, both recent and historical that demonstrates the huge impact of maternal wellbeing on the cognitive development of the child. 100 billion neurons, each with 15,000 new connections, created over 40 weeks of gestation shape the cognitive potential of every individual. Curtailing this period by the use of oxytocics or induced labour would therefore affect cognitive development. Actions that interfere with the natural birthing process or induce stress in the mother, including a lack of respectful treatment impede the secretion of birth hormones (oxytocin) that also affect cognition and newborn health.

Steps to be taken to improve this environment include: avoiding unnecessary induction and augmentation, providing privacy to the mother during the intrapartum period, by way of separate labour room, or at least a private cubicle, sheltered from all but her service providers, use of labour beds instead of tables, a no-tolerance policy for any verbal or physical abuse of the woman, ensuring bonding of mother and child immediately after birth, stressing a comfortable position during

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[1] *Respectful care includes respect for women's autonomy, dignity, feelings, privacy, choices, freedom from ill treatment & coercion and consideration for personal preferences including option for companionship during the maternity care.*

birthing rather than insisting on a universal "lying down" position, and abolishing 'out of pocket expenditures (OOPE)' including demand by facility staff, for gratuitous payment by families for celebration of the baby's birth. All these are required to avoid undue stress in mothers.

There is thus a need to reorganise the labour room care processes to facilitate natural birthing process and to enable not only adherence to quality standards and clinical protocols, but also address issues such as respectful maternity care.

Full range of benefits after the QOC interventions in the labour rooms in short-time may not fructify through on-going programmes & interventions. While states are implementing the National Quality Assurance Standards (NQAS) for all levels of public health facilities, with its attendant mechanisms[2] and explicit Quality of Care measurement systems, it still requires time to become institutionalized. There is a need to intensify efforts for achieving improvement in the Quality of Care (QOC), and improve synergy among various stakeholders to achieve tangible results within a short period. The LaQshya initiative is being launched to meet this urgent need.

This effort is intended to guide programme managers and service providers at state and district level to focus on strengthening key processes related to the labour room and maternity Operation Theatre within a short time frame to achieve time bound targets and ensuring outcomes. This is not intended to replace existing quality improvement and certification process. The Laqshya initiative is to be situated within existing mechanisms, but intensify focus on all processes related to the intrapartum and immediate post partum period.

LaQshay will be implemented in all Government Medical Colleges (MC), District Hospitals (DHs), and high delivery load CHCs and SDHs and then progress to cover all delivery points.

2. Goal: Reduce Preventable maternal and newborn mortality and morbidity, stillbirths associated with care around delivery- in labour room and Maternity OT and ensure respectful maternity care.

Objectives:

1. To Reduce maternal and newborn morbidity (newborn asphyxia and sepsis, obstetric fistula and puerperal sepsis.
2. To Improve primary care related to labour and delivery, ensure appropriate and timely referral and enable an effective two way follow-up system.
3. To Undertake sensitization of providers to enhance satisfaction of beneficiaries
4. To Organise care processes and behavioural modifications amongst service providers to minimize maternal stress and thereby improve realisation of cognitive potential of the new-born.

[2] Central Quality Supervisory Committee (CQSC), State & District Quality Assurance Committees (SQAC & DQAC) and Quality teams at DH level

3. Key Strategies

1. Reorganizing / aligning labour room layout and workflow as per recent "Labour Room" Standardization Guidelines, issued by the MOHFW.
2. Ensuring availability of optimal human resources as per case-load and prevalent norms. (Annex A), through rational deployment.
3. Ensuring that all the staff team in LR and connected OT is competent- well trained, caring & empathetic and they are not rotated often.
4. Ensuring strict adherence to clinical protocols for delivery of 'zero-defect' clinical care,
5. Ensuring availability of drugs, consumables and functional equipment as per guidelines (Annex A)
6. Ensure essential support services such as water, electricity, housekeeping, linen, security, equipment maintenance, etc.
7. Ensuring systematic audit of all cases of maternal/ infant deaths, stillbirth, and maternal near miss etc, including with their mentor teams through Videoconference, or other distance mode mechanisms. for continuous improvement and learning.
8. Ensuring that the LR team has operational flexibility including resources to address temporary shortages and meet exigencies
9. Ensuring that all facilities have robust teams to provide supportive supervision and mentoring.
10. Operationalisation of 'C' Section audit

4. Scope

In the first phase, following facilities would be taken for labour room improvement initiative –

- All government medical college hospitals
- All District Hospitals & equivalent
- All designated FRUs and high case load CHCs with over 100 deliveries/ 60 in hills and desert areas

5. Targets -

Immediate (0-4 Months) -

1. 90% of labour rooms assess their quality against defined standards (NQAS) and generate quality scores.
2. 90% of labour rooms list the existing gaps and report to district/state for priority action.
3. 90% of labour rooms have setup a functional quality circle
4. 90% of Labour room staff are oriented to refreshed labour room protocols, quality improvement process and respectful maternity care.

5. 90% of Labour Room reports baseline quality indicators as mentioned below.

Short Term (upto 8 Months) –

6. 60% of deliveries are assisted by the Birth Companion.
7. 60% of deliveries use safe birth checklist.
8. 50% of deliveries conducted with use of Partograph.
9. 30% increase in Breast Feeding within 1 hour.
10. 20% reduction new-born asphyxia rates attributed to labour room
11. 20% reduction in new born sepsis rates attributed to labour room

Intermediate Term (Up to 12 Months) –

12. 30% increase in antenatal corticosteroid administration in case of preterm baby
13. 30% Increase in proportion of women with pre-eclampsia or eclampsia, who were managed successfully in the health facility without referral
14. 30% reduction in puerperal sepsis
15. 30% Reduction in Intrapartum Still Birth
16. 80% of all beneficiaries are either satisfied or highly satisfied
17. 60% of the labour rooms are reorganized in LDR format as per labour room standardization guidelines.
18. 80% of labour rooms have staffing as per defined norms
19. 15% further improvements in short term targets
20. 100% compliance to administration of Oxytocin, immediately after birth.

Long Term (up to 18 Months)

21. 60% of labour room achieve quality certification against the NQAS
22. 15% Further Improvement short & Intermediate and term targets

After 18 month this initiative should be continued through sustained mentoring.

The list of target linked quality indicators with source and means of verification are in Annexe B

6. **Approach –**

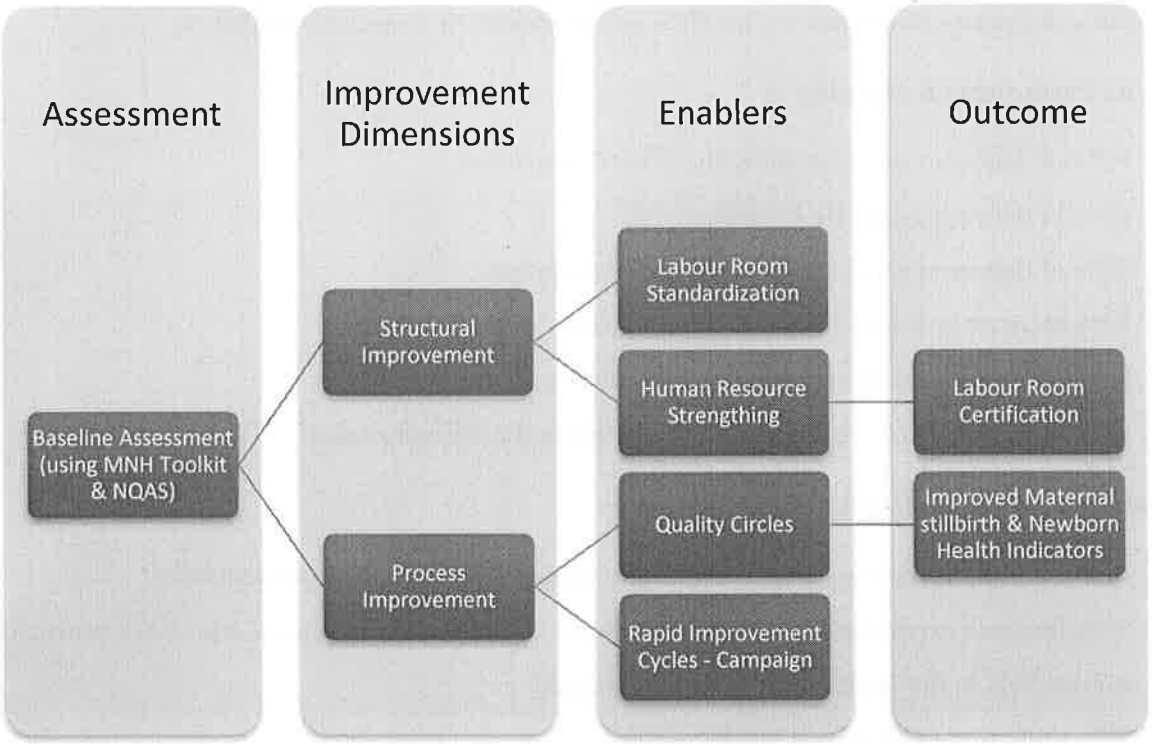

Figure 1: Components of QOC Improvement in Labour Room

Key approach under this initiative would be of 'breakthrough improvement' using 'business process re-engineering concept'. This would require substantial reorganization of labour room structure and processes. Structural improvement will be achieved through upgrading the infrastructure and equipment as per Government of India guidelines and bridging the Human Resource gaps with financial support under the National Health Mission & from State budget.

Meticulous adherence to clinical protocols is one of the key interventions under this initiative It would be ensured that the teams at the facility and district are well trained and continue to work upon all-round improvement. At the same time, dedicated team at labour room (quality circle) and Supporting Group (coaching team) would work together on solving problems and taking all possible actions for the gap-closure in 'campaign mode' during one-month time, followed by sustaining it in subsequent months. Suggested list for themes for the campaigns is given below –

Cycle 1 - Real-time Partograph generation & usage of safe birth check-list

Cycle 2 - Presence of Birth companion during delivery, respectful care and enhancement of patients' satisfaction

Cycle 3 - Management of Labour as per protocols including AMTSL & Rationale usage of Oxytocin

Cycle 4 - Assessment, Triage and timely management of complications

Cycle 5 - Resuscitation, Care of Newborn & Pre-term babies including initiation timely initiation of breast feeding

Cycle 6 - Infection Prevention including Bio Medical Waste Management

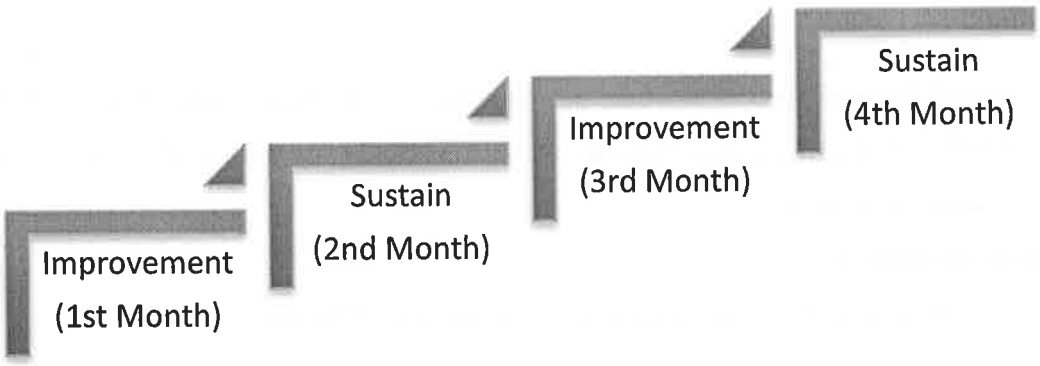

Figure 2: Rapid Improvement Cycle - 'Campaign'

The following "enabler" activities would be taken for the success of the campaign -

i. Continuous measurement of Quality in terms of Indicators and set time bound targets
ii. Implementation of Clinical Guidelines, Labour Room Clinical Pathways and Referral Protocols
iii. Use aggressive IEC, user friendly training material and IT-enabled tools.
iv. Monthly visit of coaching teams for handholding, problem solving and verifying the quality indictors reported
v. Using Quality tools such as PDCA, Root Cause Analysis, Run Charts and Mistake Proofing for achieving desired targets

7. Institutional Arrangements –

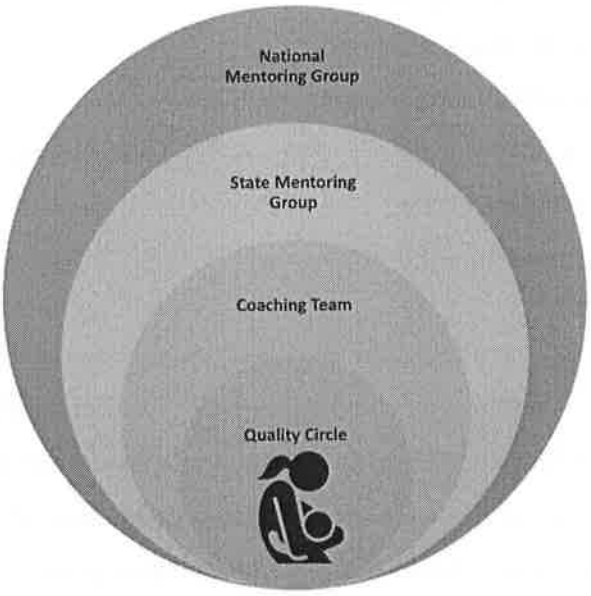

Figure 3: Institutional Arrangement

(a) National Level

- **National Mentoring Group** would have members of the Programme Divisions, NHSRC, NIHFW, Medical Colleges, Schools of Public Health, Professional Associations and Development Partners.

  Responsibilities –

  i. Periodic visit to the states, and also to sample of the health facilities
  ii. Orientation, and training
  iii. Development of IEC & resource material
  iv. Monitoring & evaluation
  v. Recommend mid-course correction
  vi. Videoconference with the QC teams and undertake the MDR/ Maternal Near Miss and NMR/Stillbirth Review

(b) State Level –

- **State Mentoring Group –** State Government/ State Mission Director would constitute the State mentoring group, consisting of programme divisions, suitable faculty of AIIMS or other eminent national institution and medical education department, state level Development Partners and eminent professionals.

  Responsibilities –

  i. Visit to each facility and 'on-site' support by spending quality time as per need
  ii. Training of the coaching teams
  iii. Mobilisation of State level support
  iv. Presentation of Status report to the SQAC
  v. Identification of Innovations and promoting its replication
  vi. Undertake MDR/ CDR etc

(c) District Level -

- **Coaching Team-** An external multidisciplinary team, responsible for mentoring one or more labour rooms. These teams would comprise of District family welfare officer/RCHO (equivalent), district/divisional quality consultants, district level experts from partner agencies, faculty of nearest medical colleges and representatives of professional associations. Usually one coaching team should look after selected facilities in one district, though the states may modify composition or allocation of facilities as per local requirements and availability of resources.

  Responsibilities –

  i. Mentoring of the Quality circles

ii. Support for the campaign and its monitoring
iii. To provide 'hands-on' training on clinical protocols
iv. Monitoring of the labour room upgradation process
v. Hand-hold the quality improvement process
vi. Sample verification of the indicators
vii. Support for NQAS Certification

(d) Facility Level –

- **Quality Circle** - A relatively informal group of staff in the department that works closely to improve the QOC in labour room. Quality circle in a labour room would consist of Gynaecologist, Paediatrician, Hospital Manager, Nursing Staff & Support Staff posted in the Labour room. This group will be the key driver for improving processes at labour room.

  Responsibilities –

  i. Ensuring Adherence to Protocols & Clinical guidelines
  ii. Assessment of Labour room using NQAS Check-list
  iii. Prioritisation and Action planning for closure of gaps as per MNH Toolkit and MH Guidelines
  iv. Management of 'Campaign' /'Rapid Improvement Cycle'
  v. Collation of Data elements, required for monitoring Indicators
  vi. Periodic Internal review

List of suggested members is given at Annexure 'A'.

8. Activities – Activities under this initiative are divided into following phase

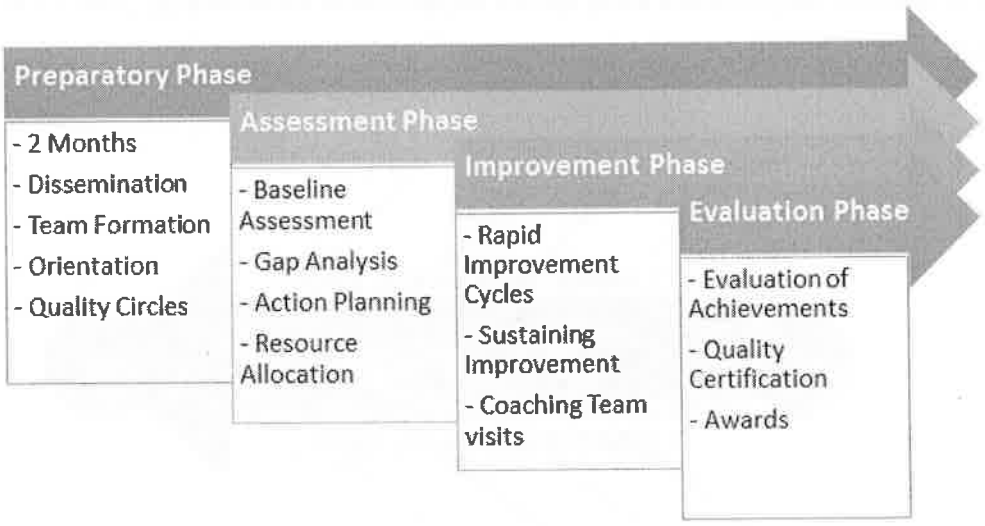

Figure 4: Summary of Activities

a. Preparatory Phase – 2 months

This will include

i. Launch and dissemination of the scheme
ii. In-house Identification and selection of National mentoring group
iii. National level orientation workshop of national resource team and state nodal officers
iv. Issue of the instructions to the State and district stakeholders
v. Formation of Quality circles at the labour rooms
vi. Formation of state mentoring group and assignment of facilities
vii. State level ToT of the Quality Coaches

b. Assessment Phase – 2 months

i. Ensuring availability of updated version of clinical protocols
ii. Ensuring availability of drugs & supplies
iii. Development of resource package for monthly campaigns (RIC)
iv. Base line assessment of structure, human resource and practices.
v. Preparation of time bound action plan, based on the identified gaps
vi. Collation of requirements and resource allocation through PIP process
vii. Development of basic IT platform for the initiative

c. Improvement Phase - 12 months

i. Ensuring adherence to clinical protocols & peer-mentoring.
ii. Establish Standard Operating Procedures for labour rooms
iii. Quality Circle understands the issues regarding selected theme of alternate month and will try to improve the processes using quality improvement methodology (Plan – DO – Check –Act) cycle, and sustain it

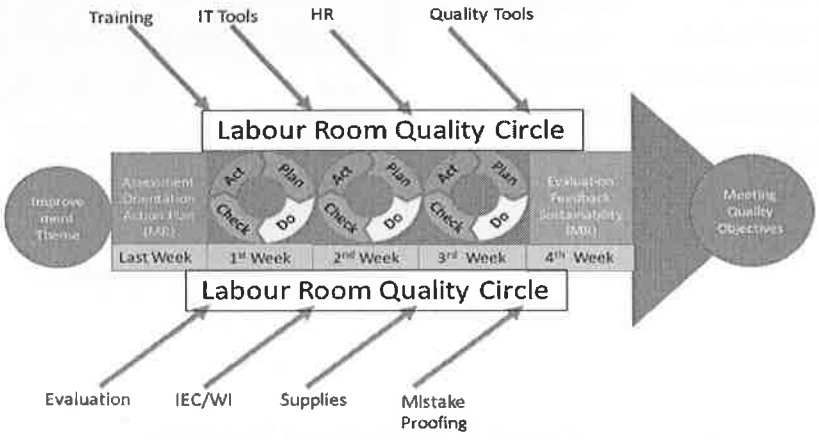

Figure 5: PDCA Cycle & Enabling Activities

iv. Preparatory visit, followed by monthly visits. Visits in the second month of each improvement cycle would be in last week for performance review through objective indicators. Support for the forthcoming campaign would also be extended during this visit

v. Documentation and photography of the improvement.

vi. Observation and assessment of processes, training and hands-on training, demonstrations and hand-holding the action plan.

vii. IEC campaign for each improvement cycle - This includes reading material/ brochure on the theme, short videos, presentations, etc. disseminated through social media/ dedicated IT platform

viii. Collection and reporting of indicators linked with quality objectives of each cycle from quality circle to State Quality Assurance Units.

ix. Structural augmentation including re-arranging the layout, human resource and labour room environment improvement will go in parallel

x. Concurrent evaluation of quality objectives by SQAC and MH Division & NHSRC and feedback to quality circles.

d. Evaluation Phase (2 months)

i. Evaluation of the quality objectives and Indicators

ii. External Assessment & Quality certification of labour rooms.

iii. Awards to best performing quality circles and Coaching Teams

iv. National level dissemination of achievements.

v. Development of Strategy for sustenance and scaling-up.

9. Certification, Incentives, Awards & Branding –

i. Certification- As discussed above one important aim of scheme is to ensure that all labour rooms meets the defined standards of care. Under National Health Mission there is already a Quality Certification program to certify the public health facilities against National Quality Assurance Standards (NQAS). The Labour Room Checklist will be used as criteria and tool for assessment. It is envisaged that with in a year all labour room taken in for this initiatives will achieve at least 70% score on labour room checklist and apply for external assessment. The external assessment and certification will be done by external assessors empanelled by NHSRC. Certification will be valid 3 years subject to annual verification of scores by state quality assurance committees SQAC.

ii. Incentives- Labour rooms at Medical Colleges , District Hospitals and SDH/CHCs will be given incentives of Rs. 10 Lakhs, 5 Lakhs and 3 Lakhs respectively on achievement of National Certification. This incentive is recognition of the good work done by the labour room team (Quality Circle) and should be used for cash incentive, welfare activities, improvement in duty room, developing library, etc.

iii. Awards- To instigate a spirit of positive competition this initiative also envisages institution of Labour Room awards at state level. The criteria of assessment will be labour room quality score on NQAS checklist. State Quality Assurance Committee will facilitate one state level independent assessment of labour room in last quarter of the year. The awards will be given 11th April every year on occasion of safe motherhood day. Following would be the scheme of awards

Category	Award Norms
Medical Colleges	Winner – 15 Lakh Runner# – 5 Lakh
District Hospitals	Winner – 10 Lakh Runner* – 5 Lakh
CHCs/SDHs	Winner* – 5 Lakh Runner – 2 Lakh
PHCs	Winner* – 2 Lakh Runner – 1 Lakh

Award money can also be used for IEC activities, incentivisation and staff & patient welfare activities.

* Runner award is only for states with > 25 facilities in the respective categories

Runner awards for state having > 5 medical colleges in the state

iv. Branding – The achievement of quality benchmarks should be used for branding of the labour rooms. This will give sense of pride to the labour room staff as well as provide confidence in care seekers and community that they are getting quality care at public hospitals. Labour rooms will be provided badges based on the quality score they achieved in state level assessment

Platinum Badge – Achieving More than 95% Score

Gold Badge – Achieving More than 85% Score

Silver Badge – Achieving more than 70% Score

Bronze Badge – Achieve more than 60% Score

These badges should be worn by care providers as well as prominently displayed at relevant places in the hospitals.

10. Financial Arrangements – Based on Gap analysis state may budget the resource requirements and request for allocation of funds in relevant financial heads through NHM PIPs. Suggested activities are budgeted for in Box 1. Hitherto, medical colleges were not funded under NHM, but states could now obtain funds for strengthening LR in medical colleges through the NHM PIP as

well. State NHM & Secretary Medical Education would jointly institutionalise arrangement for seamless flow of such support and remove bottle-necks.

The initiative will also require services of experts who needs to be compensated. There will also be resource requirements for organising trainings, assessment, mobility support and other incidental expenses. The financial norms for all such activities have already been set under quality assurance program. State should budget for these activities under quality assurance (FMR code: B15.2) and request for allocation of resources through PIP/ Supplementary PIP. The activities of National Level Mentoring Group can be financed through NHSRC.

Box1. List of Suggestive Activities can be funded under National Health Mission

- Restructuring of labour room as per LDR concept
- Upgradation of existing conventional labour rooms
- Purchase of labour room equipment and furniture
- Services of planning/ architectural consultants
- Additional staff nurses/ ANM to make up for human resource deficit
- Labour Room Quality Manager for Medical Colleges
- IT Equipment and software
- Signage, IEC, Displays etc.
- Hiring of professionals (individuals and/or organisations) for preparation and execution of improvement plans
- Training support
- Support under JSSK
- Health Innovations

11. Roles & Responsibilities of Stakeholders

At the national level, the programme divisions of the MOHFW (Maternal and Child Health Divisions) wound enable the Preparation of resource package on labour room reorganization & standardization and improvement in Quality of Care (QOC), Coordinate with the states & UTs for smooth roll out of initiative, Collating quality scores and indicators, ensure synergy with the development partners ,Review PIP proposal for labour room upgradation and staff augmentation, and Clarify any technical query raised by the states & Medical Colleges. NHSRC would coordinate quality certification activities of labour room, Organizing orientation workshops at national level, Identify technical resource person for National Mentoring Group, provide Technical Assistance to Programme Divisions on Quality Improvement issues, and undertake Documentation of best & replicable practices and 'platform' for cross-learning. Development partners would synergize their

efforts with the initiative in addition to providing support for roll-out of the scheme in their priority States, support to National & State Mentoring Groups, and Development of technical resource material as required. The role of state NHM would be programme management of initiative in their respective states and ensuring that targets agreed have been achieved.

Annexure 'A'

Recommended Minimum Infrastructure for the Labour Rooms

Level I (SC/Non-24x7 PHC)	Level II (24x7 PHC/Non-FRU CHC)	Level III (FRU CHC/SDH/DH/ Medical Colleges)
Labour bed and Delivery area	Waiting/Registration Area	Waiting/Registration Area
Newborn care area	Triage/ Examination Room	Triage/ Examination Room
Nursing station	Staff room	Doctor's Duty Room
Handwashing Station	Labour table and Delivery area	Nurse's Duty Room
Power supply	Newborn care area	Space for changing shoes at the entrance of the Labour room
	Nursing station	Air Handling unit/ Adequate AC
	Clean utility room	Doctor's and nurse's changing room
	Dirty utility room	Store
	Space for changing shoes at the entrance of the Labour room	Clean utility room
	Store	Dirty utility room

Essential Components required in Labor Room for creating new infrastructure:

Level I (SC/Non-24x7 PHC)	Level II (24x7 PHC/Non-FRU CHC)	Level III (FRU CHC/SDH/DH/ Medical Colleges)
• No. of labor beds as per the delivery load. • Each delivery bed should have adequate circulation space (Average 10 x 10 ft space). • Windows with smoked glass, well lighted. • Ceiling mounted single curtain (Adeqjuate privacy of pateint should be maintained) • Labour table (min 2) with mackintosh, Kelly's pad and buckets. • 7 trays namely delivery, baby, medicine, episiotomy, MVA/ EVA, PPIUCD and emergency tray • NBCC equipment for autoclave/ sterilization • Colour-coded bins • Tub for 0.5% chlorine solution.	**Same as in Level 1, plus the following:** • Size of LR as per the case load; Stainless steel top labour table with foam mattress (Preferably labour bed), • Buffer zone, • Clean and dirty utility room, attached hand washing area and • Toilet with running water supply • Air conditioning • NBCC with adequate number of radiant warmer as per case load • Proper IMEP including waste management.	**Same as in Level 2, plus the following:** • As per case load (Min 4) labour beds • Central supply of oxygen/oxygen concentrator and suction facility • Adequate air conditioning, • Functional telephone connection, • Functional laboratory and ultrasound machine, • Foetal monitor, • Pulse oxymeter, etc.

Human Resource exclusively for Labor Room

All the labour rooms, whether newly constructed or re-organized from an existing labour room, should have human

resources (HR) in adequate numbers strictly, as per the recommendations given below. If needed, redeployment or hiring of new staff should be done. HR posted in the labour room should not be rotated outside the labour room.

CHC/AH/SDH/DH/Medical Colleges:

No. of Deliveries (per month)	Staff Nurse (with LDR)	Staff Nurse (without LDR)	MO	House-keeping	DEO	Guard
100 - 200	In LDR facility there should be 4 staff nurses per LDR unit (1 for each shift and 1 back up)	8	4 MO, 1 OBG/ EmoC, 1 Anaesthetist/ LSAS, 1Pediatrician	4	1	4
200- 500		12	1 OBG (Mandatory) + 4 OBG/EmOC +1 Anaesthetist + 4 LSAS + 1 Paediatrician + 4 MO	8	1	6
>500		16	3 OBG (Mandatory) + 4 EmOC +1 Anaesthetist + 4 LSAS + 1 Paediatrician + 4 MO	12	1	8

PHC:

MO	Staff Nurse/ ANM	Housekeeping	Guard
1-2	4 ANM/ Staff nurses	Round the clock Services	Round the clock services

*All normal deliveries in labour room in the district hospital should be conducted by staff nurses. OBG, CEmOC trained MO, and anaesthetists should also be available on call always.

Annexure 'B'

Target Linked quality indicators

S.No	Indicator	Source	Means of Verification	Targets
1.	Percentage of labour rooms assess their quality against defined standards (NQAS) and generate quality scores.	Collated & Report by DQAC	Reports to verified by SQAC	90%
2.	Labour rooms list the existing gap and report to district/state for priority action.	Collated & Report by DQAC	Reports verified by SQAC	90%
3.	Percentage of Labour Room set up functional quality circle	Collated & Report by DQAC	Reports Verified for SQAC	90%
4.	Percentage of Labour Room Staff oriented	Collated & Report by DQAC	Reports Verified for SQAC	90%
5.	Percentage Labour Room reports baseline quality indicators as mentioned below	Reported by Facility	Indicators Verified by SQAC	90%
6.	Percentage of Deliveries are assisted by Birth Companion	Reported by Facility	Verified by Coaching Team during facility visit SQAC verification on sample basis	Short Term- 50% Intermediate- 70% Long Term – 90%
7.	Percentage of deliveries safe birth checklist is used	Reported by Facility	Verified by Coaching Team during facility visit SQAC verification on sample basis	Short Term- 50% Intermediate- 70% Long Term – 90%
8.	Percentage of deliveries conducted with use of Partograph	Reported by Facility	Verified by Coaching Team during facility visit SQAC verification on sample basis	Short Term- 60% Intermediate- 80% Long Term – 100%
9.	Percentage increase in Breast Feeding within 1 hour	HMIS	Verified by Coaching Team during facility visit SQAC verification on sample basis	Short Term- 30% Increase of Base Line Subsequent Phases- 20% increase of on previous phase or 100% whichever earlier

10.	Percentage reduction in new-born asphyxia rates attributed to labour room	SNCU online (DH) Reported by facility (Where SNCU online is not available)	Verified by Coaching Team during facility visit SQAC verification on sample basis	Short Term- 20% reduction in Base Line Subsequent Phases- 20% reduction on previous phase or 0% whichever earlier
11.	Percentage reduction in new born sepsis rates attributed to labour room	SNCU online (DH) Reported by facility (Where SNCU online is not available)	Verified by Coaching Team during facility visit SQAC verification on sample basis	Short Term- 20% reduction in Base Line Subsequent Phases- 20% reduction on previous phase or 0% whichever earlier
12.	Percentage increase in antenatal corticosteroid administration in case of preterm baby	SNCU online (DH) Reported by facility (Where SNCU online is not available)	Verified by Coaching Team during facility visit SQAC verification on sample basis	Intermediate Term- 30% Increase of Base Line Subsequent Phases- 20% increase of on previous phase or 100% whichever earlier
13.	Percentage Increase in proportion of women with pre-eclampsia or eclampsia, who were managed successfully in the health facility without referral	HMIS	Verified by Coaching Team during facility visit SQAC verification on sample basis	Intermediate Term- 30% Increase of Base Line Subsequent Phases- 20% increase of on previous phase or 100% whichever earlier
14.	Percentage reduction in puerperal sepsis	Facility Reporting	Verified by Coaching Team during facility visit SQAC verification on sample basis	Intermediate Term- 30% reduction in Base Line Subsequent Phases- 20% reduction on previous phase or 0% whichever earlier

15.	Percentage Reduction in Intrapartum Still Birth	HMIS	Verified by Coaching Team during facility visit SQAC verification on sample basis	Intermediate Term- 30% reduction in Base Line Subsequent Phases- 20% reduction on previous phase or 0% whichever earlier
16.	Percentage of all beneficiaries are either satisfied or highly satisfied	Facility Report Mera Aspatal	Verified by Coaching Team during facility visit SQAC verification on sample basis	Intermediate- 80% Long Term – 100%
17.	Percentage of the labour rooms are reorganized in LDR format as per Labour room standardization guidelines.	DQAC onsite verification report	Report Verified by SQAC	Intermediate – 60% Long Term - 80%
19.	Percentage of Labour rooms have staffing as per defined norms	DQAC onsite verification report	Report verified by SQAC	Intermediate – 80% Long Term - 100%
20	Percentage of Women, administered Oxytocin, immediately after birth.	Facility Report	Verified by DQAC	Immediate – 100%
21	Percentage of labour room achieve quality certification against the NQAS	National Certification Register	Verified by CQSC	Intermediate – 80% Long Term - 100%

List of Abbreviations

AIIMS	All India Institute of Medical Sciences
AMTSL	Active Management of Third Stage of Labour
CDR	Child Death review
CHC	Community Health Centers
CQSC	Central Quality Supervisory Committee
DH	District Hospitals
DQAC	District Quality Assurance Committee
FRU	First Referral Units
IEC	Information Education Communication
IT	Information Technology
JSSK	Janani Shishu Suraksha Karyakaram
LDR	Labour Delivery Recovery
LR	Labour Room
MC	Medical College
MDR	Maternal Death Review
MH	Maternal Health
MoHFW	Ministry of Health & Family Welfare
NHM	National Health Mission
NHSRC	National Health Systems Resource Center
NIHFW	National Institute of Health & Family Welfare
NMR	Neonatal Mortality Review
NQAS	National Quality Assurance Standards
OT	Operation Theatre
PDCA	Plan Do Check Act
PHC	Primary Health Centers
PIP	Program Implementation Plan
QC	Quality Circle
QOC	Quality of Care
RIC	Rapid Improvement Events
SDH	Sub Divisional Hospital
SQAC	State Quality Assurance Committee