LAQSHYA
लक्ष्य

LABOUR ROOM QUALITY IMPROVEMENT INITIATIVE

2017

NATIONAL HEALTH MISSION
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

सत्यमेव जयते

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जगत प्रकाश नड्डा
Jagat Prakash Nadda

सत्यमेव जयते

स्वच्छ भारत
एक कदम स्वच्छता की ओर

स्वास्थ्य एवं परिवार कल्याण मंत्री
भारत सरकार
Minister of Health & Family Welfare
Government of India

MESSAGE

Every pregnant woman and her family desires to have a joyful birthing experience with a safe and healthy mother and new-born. The Ministry of Health & Family Welfare is committed to support the public health system in creating such an environment within the health facilities to ensure every mother and her new-born are cared for most appropriately and also that such care is respectful of the woman and her family. The services provided within the labour-room and maternity OT are critical to meet this aspiration.

Ministry of Health & Family Welfare is launching 'LaQshya' initiative, which is intended to improve the Quality of Care in Labour Rooms & Maternity Operation Theatres in Government Medical College Hospitals, District Hospitals, Sub-district Hospitals and other high case-load health facilities. Under the LaQshya initiative, States are urged to undertake concerted efforts in a campaign mode to ensure that respectful and high quality maternal care is provided to each woman during delivery and immediate postpartum. It would essentially entail undertaking several actions simultaneously at different levels – National, States, Districts and Health Facilities.

I am also aware that there are several stakeholders who are involved in the delivery of MCH services. I solicit full cooperation and commitment from each stakeholder.

The States are urged to implement this intervention, so that the birthing experience for a mother becomes a happy and joyful experience and the new-born is able to realize full potential to become a healthy and happy citizen of the society. I trust that these guidelines would be useful in galvanizing teams at the facilities to achieve positive maternal and neonatal outcomes and building a relationship of trust and care between public institutions and community.

Let us all join hands to realize the Mission that every child survives and thrives to their fullest potential and our society is transformed in the way we care for our women and children.

(Jagat Prakash Nadda)

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Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

Dated : 22nd November, 2017

MESSAGE

We are committed to provide quality and accessible Maternal and Child Health services to every beneficiary reaching at our Public Health Facilities. During the last few years, utilization rates of MCH services provided at the public facilities has increased manifold. In an attempt to improve the quality of services, states are on their way to implement internationally accredited National Quality Assurance Standards.

These "LaQsha" guidelines are being launched for improvement of care provided around the child birth and during immediate postpartum period by having targeted intervention. Such 'patient-centric' care is expected to be based on the available scientific evidence. Improvement in Quality of interface between the beneficiaries and service providers in term of language, behavior and attitude is also an important component under this intervention for ensuring 'Respectful Maternity Care' to pregnant women. This will help in dramatic improvement of maternal and newborn outcomes.

Under the LaQshya initiative, multi-pronged strategy has been adopted for ensuring that identified gaps in the labour rooms and maternity OT against the norms are traversed within the shortest possible time and real improvement in quality of care takes place.

I would urge all the States to implement 'LaQshya' guidelines in a focused way to have tangible results within the shortest time-frame. The Ministry of Health and Family Welfare would be happy to work with the States & UTs to ensure that every pregnant woman receives most appropriate care with dignity and respect, which is her fundamental right.

(Preeti Sudan)

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Dated:20th November, 2017

FOREWORD

Maternal Mortality Ratio (MMR) in the country has reduced from 301 (2001-03) to 167 (2013) and Infant Mortality Rate has reduced from 66 (2001) to 34 (2016). However, these indicators still remain unacceptably high as compared to developed countries, hence there is a huge scope to bring about improvements in the key maternal and new-born health indicators.

It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% neonatal deaths take place on the day of the delivery. A transformational improvement in the quality of care around child-birth relating to intra-partum and immediate postpartum care can dramatically improve maternal and new-born outcomes. Delivery of appropriate and respectful care to each pregnant woman would not only go a long way in reducing mortality and morbidity for the woman and new-born, but also help in improved cognitive development of the baby.

'LaQshya' is focused and targeted approach for improving intra-partum and immediate post-partum care beginning with high case load higher level facilities. Majority of the interventions under the initiative have been drawn from the existing programme guidelines such as National Quality Assurance Standards & Quality Assurance operational Guidelines, Maternal and New-born Health Tool-kit, Guidelines for Standardisation of Labour Rooms at Delivery Points and Guidelines for Obstetric HDU & ICU and Dakshata.

Incentives and Awards, and Branding under the 'LaQshya' will not only motivate healthcare workers, but will inculcate a sense of pride for their jobs, ownership of their responsibilities and building trust with community.

LaQshya is expected to intensify efforts for improving Quality of care (QOC) and will galvanize the partnership between Union, State and Local Governments, Medical Colleges, Professional bodies and Development Partners to achieve tangible results within a short period. The PDCA (Plan, Do, Check, Act) methodology combined with Rapid Improvement Events will catalyse building of a quality culture within the health system.

The NHM is committed to provide all the financial and technical support to achieve the success of this very important initiative for the sake of our women and children, and for the development of Indian society and its human resource.

(Manoj Jhalani)

वन्दना गुरनानी, भा.प्र.से.
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Preface

Ministry of Health & Family Welfare is committed to support states in their efforts to achieve substantial reduction in maternal and new-born mortality. The Ministry has been working with the states for strengthening of MCH services. Several interventions & programme aids such as MNH Toolkit, Standardisation Guidelines for the Labour Rooms, 'Dakshata', MDR & CDR Guidelines, National Quality Assurance Standards, establishment of skill-labs, PMSMA etc. are already in place to guide to our efforts in this direction.

'LaQshya' initiative is being launched to 'fast-track' the interventions for achieving tangible results within 18 months. The targets set forth are ambitious, but the need of the hour and we also believe that they are achievable if we put our mind and soul into this.

'LaQshya' initiative targets to strengthen key processes related to the Labour Room and Maternity Operation Theatre, so that verifiable targets of maternal & new-born care are achieved as soon as possible. LaQshya is expected to enhance, supplement and boost the existing efforts, on-going initiatives and programs; and does not intend to replace them.

LaQshya is intended to 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. To achieve target of 'Zero-defect' clinical care, LaQshya addresses structural issues like Infrastructure, Human Resource, Layout of Labour room & Maternity OT, equipment, drugs, and consumables and issues affecting processes of care. 'Reward and recognition' have been incorporated in 'LaQshya' to motivate, inspire and encourage stakeholders at each level.

States are requested to draw time-bound plan for implementation of these guidelines, which, we are sure, would yield rich dividends in terms of improved Maternal and New-born Health Indicators.

(VandanaGurnani)

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Message

Reduction of Maternal and Infant Mortality is one of the key objectives of the National Health Mission. NHM supports all States/ UTs in every possible way, so that India achieves the SDG target of MMR of less than 70 per Lakh Live Births. For this it is essential that continuous efforts are made to improve the health of the mother and the child.

Given the fact that quality of care on the day of birth is critical to the reduction of maternal and neonatal mortality, LaQshya aims to transform the quality of care in Labour rooms and Maternity operation theatres. LaQshya also aims to certify, award and incentivise the facilities which comply to the targets. This will help in motivating the service providers too, for achieving the aforesaid vision of healthy mothers leading to a healthy nation.

It is critical that states make a robust plan for the initiative and submit their requirements in Annual Programme Implementation Plans (PIPs). Many of these requirements would have to be budgeted under the health system strengthening section and the NUHM portion of the PIPs and would thus require the collaborative efforts of the entire NHM team.

I am confident that States/ UTs will take this initiative forward with the zeal, collaboration and commitment that it deserves and that the initiative will be useful in accelerating our efforts towards reduction of maternal and neonatal mortality. Most importantly, it will ensure that pregnant women receive respectful and the best quality of care during child birth.

06/12/2017

(Dr. Manohar Agnani)

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Program Officer's Message

India has made substantial progress in improving the services being provided to the pregnant women which has translated into significant decline in Maternal Mortality ratio and Infant Mortality Rates. These efforts need to be accelerated and have to be intensified to achieve the NHP and SDG goals. Evidence dictates that improving the quality of care in labour rooms, especially on the day of birth, is critical in achieving our aforesaid goals.

In view of this background, Ministry of Health & Family Welfare is launching 'LaQshya' initiative. This initiative is aimed at improving intra-partum and immediate post-partum care in the Labour Room, which is where the maximum maternal deaths and still births occur. It is critical that States/ UTs undertake a baseline assessment of the labour room and the operation theatres at the earliest and plan for filling the gaps that have been identified. Six rapid improvement cycles of two months each have been defined in the guidelines and these will need to be rigorously supervised and ensured to bring about the desired rapid improvement in the coming 18 months.

The initiative must beimplemented in Government Medical Colleges (MC), District Hospitals (DHs), and high delivery load CHCs and SDHs and then progress to cover delivery points. The LaQshya guidelines will boost our already existing endeavours in the form of Guidelines for Labour room Standardisation, National Quality Assurance Standards & Quality Assurance operational Guidelines, Maternal and New-born Health Tool-kit, Guidelines for Obstetric HDU & ICU and Dakshata.

The Ministry of Health & Family Welfare, NHSRC and our Development Partners have put their heart and soul into the development of these Guidelines. I want to thank each one of them for their valuable inputs. I take pride in launching the LaQshya Guidelines along with my very able and proficient team.

I am confident, that these guidelines will motivate the States and State level policy makers to channelize their efforts in improving the quality of services provided to pregnant women and new born for a healthier nation.

(Dr. Dinesh Baswal)

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Introduction

1

After launch of the National Health Mission (NHM), there has been substantial increase in the number of institutional deliveries. However, this increase in the numbers has not resulted into commensurate improvements in the key maternal and new-born health indicators. It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery.

A transformational change in the processes related to the care during the delivery, which essentially relates to intrapartum and immediate postpartum care, is required to achieve tangible results within short period of time. Prerequisite of such approach would also hinge upon the health system's preparedness for prompt identification and management of maternal and newborn complications. Delivery of such transformed care would not only need availability of adequate infrastructure, functional & calibrated equipment, drugs & supplies & HR, but also meticulous adherence to clinical protocols by the service providers at the health facilities.

Pregnant women are often meted out rude and uncourteous treatment at the health facilities. Respectful maternity care[1] not only contributes in ensuring positive outcomes for the mothers and newborns, but also supports cognitive development of the babies later in the life. Curtailing period of the labour by use of oxytocic drugs adversely impacts natural secretion of hormones and physiological mechanism that contribute to the cognitive development. Determinants impacting health and well-being of mothers & newborns during the intrapartum & immediate post-partum period are shown in Annexure 'A'.

Do's and don'ts in the labour rooms as given in Table 1 are expected to support improved outcome for the maternal and newborn health.

For improving the quality of care at Public Health Facilities, Quality Assurance Standards for District Hospitals, Community Health Centres, Primary Health Centre and Urban-Primary Health Centres have been drafted, and their implementation has been operationalised through the National Quality Assurance Programme.

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.

Table 1: Do's & Don'ts of Labour Room

Do's	Don'ts
• Providing privacy to pregnant women during the intrapartum period, by way of separate labour room or at least a private cubicle • Presence of birth companion during the labour • Freedom to choose a comfortable position during birthing (squatting, standing, etc.) • Adherence to Clinical protocols for management of labour • Use of Labour beds instead of tables • Place baby on mother's abdomen • Initiation of Breast feeding within one hour of birth	• Induction and augmentation of labour without sound clinical indications • Any verbal or physical abuse of the pregnant women • Insisting on conventional lithotomy position for the delivery • Immediate clamping and cutting of the umbilical cord • Separating baby from the mother for routine care & procedure • 'Out of Pocket Expenditures (OOPE) on drugs, diagnostics, including demand by the staff for gratuitous payment by families for celebration of the baby's birth.

While states are in the process of implementing Quality Management System using National Quality Assurance Standards (NQAS) to obtain certification of the health facilities, the process takes substantial time and effort. While the states should continue to work towards achieving full NQAS certification of the health facilities, LaQshya Guidelines are intended for achieving improvements in the intra-partum and immediate post-partum care, which are take place in the labour room and maternity operation theatre.

Implementation of these guidelines is expected to result into delivery of respectful and zero-defect care to all pregnant women and newborns, and such improvement is incentivised.

The states are also expected to accelerate efforts for upgradation of conventional labour rooms as per norms given in 'Guidelines for Standardisation of Labour Rooms at Delivery Points', and establish HDUs as per norms given in the 'Guidelines for Obstetric HDUs and ICUs'.

Medical College Hospitals handle substantial maternal and newborn caseloads, besides imparting teaching and training the doctors, specialists, nurses and para-medical staff. This initiative will also be implemented in all Government Medical Colleges (MCs) besides District Hospitals (DHs), and high delivery load CHCs and SDHs.

These guidelines are meant to help the States' NHM Directors, Medical Education Departments, Heads of Department of Obstetrics & Gynaecology in Medical Colleges, District Health Officials, Medical Superintendents, In-charge of Gynaecology departments and teams engaged in the maternity care.

Goal

2

Reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.

Objectives

1. To reduce maternal and newborn mortality & morbidity due to APH, PPH, retained placenta, preterm, preeclampsia & eclampsia, obstructed labour, puerperal sepsis, newborn asphyxia, and sepsis, etc.
2. To improve Quality of care during the delivery and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system.
3. To enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility.

3 Strategies

1. Reorganizing/aligning Labour room & Maternity Operation Theatre layout and workflow as per 'Labour Room Standardization Guidelines' and 'Maternal & Newborn Health Toolkit' issued by the Ministry of Health & Family Welfare, Government of India.
2. Ensuring that at least all government medical college hospitals and high case-load district hospitals have dedicated obstetric HDUs as per GoI MOHFW Guidelines, for managing complicated pregnancies that require life-saving critical care.
3. Ensuring strict adherence to clinical protocols for management and stabilization of the complications before referral to higher centres.

Scope

4

Following facilities would be taken under LaQshya initiative on priority:

- All government medical college hospitals.
- All District Hospitals & equivalent health facilities.
- All designated FRUs and high case load CHCs with over 100 deliveries/60 (per month) in hills and desert areas.

5 Institutional Arrangement

Under the National Health Mission, the States have been supported in creating Institutional framework for the Quality Assurance - State Quality Assurance Committee (SQAC), District Quality Assurance Committee (DQAC), and Quality Team at the facility level. These committees will also support implementation of LaQshya interventions. For specific technical activities and program management, special purpose groups have been suggested, and these groups will be working towards achievement of specific targets and program milestones in close coordination with relevant structures within the QA organizational framework. Outlines of Institutional arrangement under LaQshya is given in Figure 1.

(a) National Level

- **National Mentoring Group** would include members of the Programme Divisions, IEC Division, NHSRC, NIHFW, AIIMS, and Medical Colleges, Nursing collages, Schools of Public Health, Professional Associations, Hospital Planners, IT professionals, Development Partners,

Figure 1: Institutional Arrangement under NQAP & LaQshya

Level	Quality Structure	Quality Drivers
National Level	CQSC	National Mentoring Group
State Level	SQAC	State Mentoring Group
District Level	DQAC	Coaching Team
Facility Level	Quality Team	Quality Circle (LR & OT)

Empanelled external assessors & eminent professionals.

Responsibilities

i. Periodic visit to the states, and to a sample of the health facilities.

ii. Orientation and training.

iii. Standardization of skill based training programs.

iv. Development of IEC & resource material.

v. Monitoring & evaluation.

vi. Recommend mid-course correction.

vii. Video conference with the QC teams and review of the MDSR/Maternal Near Miss review and NMR/Stillbirth review programmes.

(b) State Level

State NHM, Departments of Health and Medical Education would jointly create institutional arrangement for seamless flow of support and removal of the bottle-necks, if any for implementation of this initiative.

- **State Mentoring Group –** State Mission Director would constitute the State mentoring group, consisting of programme officers, suitable faculty of AIIMS and other eminent National Institutions and medical education department, State Nodal Officers for Quality, IEC, procurement, infrastructure, State Level Development Partners and eminent professionals.

Responsibilities

i. Visit to the facilities and 'on-site' support for under performing facilities.

ii. Training & mentoring of the coaching teams.

iii. Customisation and approval of SOPs & Work-instructions.

iv. Performance monitoring.

v. Mobilisation of State level support including providing inputs for the State PIP.

vi. Presentation of Status report to the SQAC.

vii. Identification of innovations and promoting their replication.

viii. Undertake MDSR & CDR.

ix. Assessment and modification of the referral directories prepared by the districts.

x. Tracking & reporting of Indicators.

(c) District Level

Coaching Team- An external multidisciplinary team, responsible for mentoring one or more labour rooms, would comprise of District family welfare officer/RCHO (equivalent), district/divisional quality consultants, nursing instructors/mentors from the functional skill

labs, faculty of nearest medical colleges and representatives of professional associations and development partners. The coaching team in districts with medical college could include one or more retired faculty members as a coach for medical college labour rooms and operation theatre. In the early phases, one coaching team could mentor four or five districts since training every district coaching team in a short span of time may not be possible. All coaching teams must be trained in skills lab/Dakshata, so that they are proficient mentors.

Responsibilities

i. Mentoring of the Quality circles, Support for the campaign and its monitoring.

ii. Periodic Internal review Monthly visits of coaching/support teams for hand holding, problem solving, and verifying reported quality indicators.

iii. To provide 'hands-on' training on clinical protocols.

iv. Hand-hold the quality improvement process.

v. Monitoring of availability of point of care diagnostic services and blood transfusion services.

vi. OSCE based assessment of the staff.

vii. Development of referral directory.

viii. Sample verification of the indicators.

ix. Peer assessment & support for the NQAS Certification.

(d) Facility Level

- **Quality Circle** : Quality circles are informal groups of the staff in each department that works closely to improve the QOC there. For example, Quality circle in a labour room would involve of Gynaecologist, Paediatrician, Matrons and Nursing Staff & Support Staff. In the Operational theatre, anaesthetist would also be a member of the Quality circle. The Quality Circles will work in coordination with facility level quality team headed by the Medical Superintendent or facility incharge.

Responsibilities

i. Ensuring Adherence to Protocols & Clinical guidelines.

ii. Assessment of Labour room & operation theatre using the NQAS Departmental Check-lists.

iii. Prioritisation and Action planning for closure of gaps as per 'Maternal and Newborn Health Toolkit' and 'Guidelines for Standardisation of Labour Rooms at Delivery Points'.

iv. Management of 'Campaign'/'Rapid Improvement Cycle'.

v. Collation of data elements, required for monitoring Indicators.

Targets

6

Immediate (0-4 Months)

1. 80% of the selected Labour rooms & Maternity OTs assess their quality and staff competence using defined NQAS checklists and OSCE.
2. 80% of Labour rooms & Maternity OTs have setup functional quality circles and facility level quality teams.

Short Term (up to 8 Months)

1. 80% of Labour Room and OT Quality Circles are oriented to latest labour room protocols, quality improvement processes and respectful maternity care (RMC).
2. 50% of deliveries take place in presence of the Birth Companions.
3. 60% of deliveries conducted using safe birth checklist and Safe Surgery Checklist in Labour Room & Maternity OT respectively.
4. 60% of the deliveries are conducted using real-time par to graph.
5. 30% increase in Breast Feeding within one hour of delivery.
6. 80% labour rooms and Maternity OTs take microbiological samples from defined areas every month.
7. 30% reduction in surgical site infection ratein r/o planned surgery in the Maternity OT.

Intermediate Term (Up to 12 Months)

1. 30% increase in antenatal corticosteroid administration in case of preterm labour.
2. 30% reduction in pre-eclampsia, eclampsia& PIH related mortality.
3. 30% reduction in APH/PPH related mortality.
4. 20% reduction in new-born asphyxia related admissions in SNCUs for inborn deliveries.
5. 20% reduction in newborn sepsis rate in SNCUs for inborn deliveries.
6. 20% reduction in Stillbirth rate.
7. 80% of all beneficiaries are either satisfied or highly satisfied.

8. 60% of the labour rooms are reorganized as per 'Guidelines for Standardisation of Labour Rooms at Delivery Points'.
9. 80% of labour rooms have staffing as per defined norms.
10. 100% compliance to administration of Oxytocin, immediately after birth.
11. 30% improvement in OSCE scores of labour room staff.
12. 100% Maternal death, Neonatal Death audit and clinical discussion on near miss/maternal and neonatal complications.
13. 80% Labour Room and OTs are reporting zero stock-outs of drugs and consumables.

Long Term (up to 18 Months)

1. 60% of labour rooms achieve quality certification against the NQAS.
2. 50% of labour rooms are linked to Obstetrics HDU/ICU.
3. 15% improvement in short term & Intermediate targets.

After 18 months, this initiative would be continued through sustained mentoring.

7 Interventions

Key approach under this initiative is breakthrough improvement using business process re-engineering concepts. This would require substantial reorganization of labour room structure (Infrastructure, HR, and Drugs & Equipment) and processes. Summary of interventions is given in Figure 2.

Structural improvement will include the following :

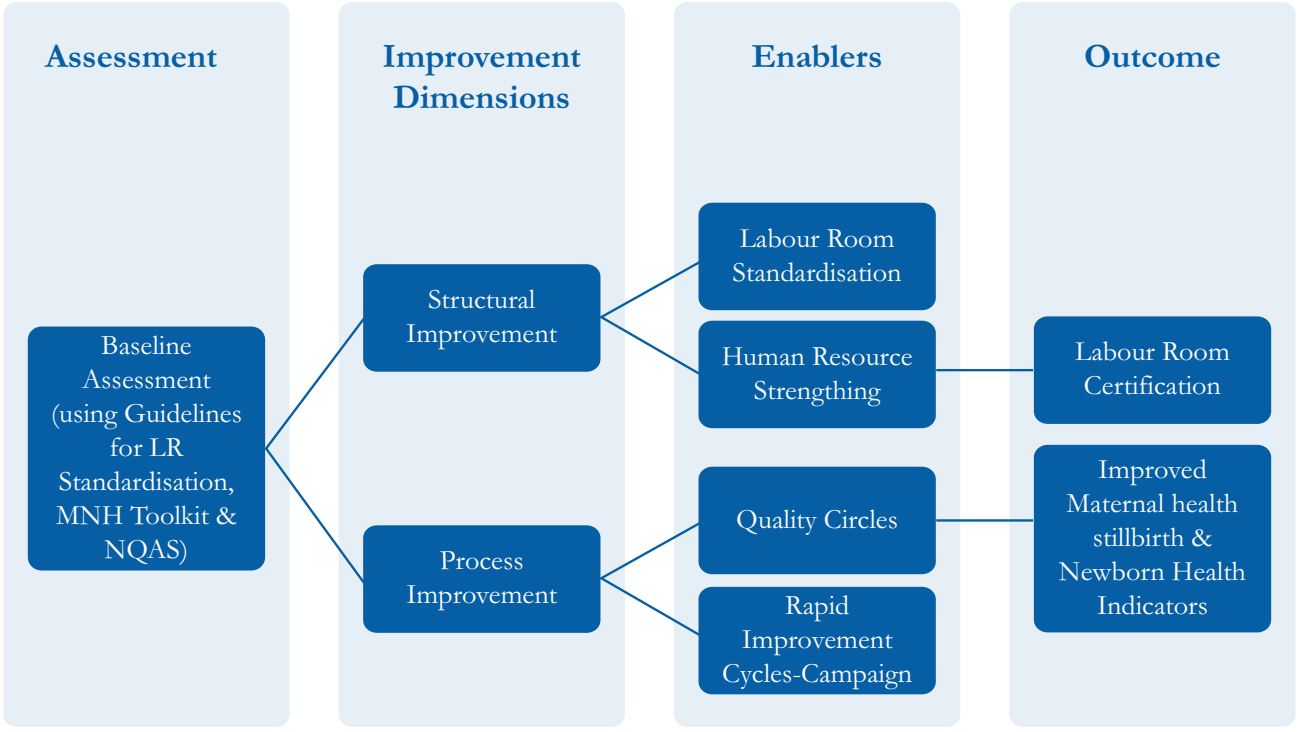
a) Upgrading the infrastructure as per norm & realistic case-load.

b) Human Resource augmentation and skill upgradation.

c) Ensuring availability of adequate functional & calibrated equipment, as per need.

d) Strengthening the supply chain system of drugs & consumables for ensuring

Figure 2: Components of QOC Improvement in Labour Room



their availability in the labour room and OT as per need.

Process improvement will include :

a) Assessment and Triage

b) Management of Labour including Active Management of Third stage of labour.

c) Management of complications and High-Risk Pregnancies.

d) Management of referral services.

e) Perioperative processes for C-Section.

f) Newborn care and resuscitation.

g) Management of required support services for the Labour room, Maternity OT & HDU.

h) Sensitisation of the Staff on RMC and its monitoring.

It would be ensured that quality circles at the departments and support groups (Quality team & coaching team) work in harmony for solving the problems and take all possible actions for the closure of gaps.

Interventions

1. Ensuring availability of optimal and skilled human resources as per case-load and prevalent norms through rational deployment and skill upgradation. Suggested HR for the labour room is given in Annexure 'B'.
2. Ensuring skill assessment of all staff of LR & Maternal OT through OSCE (Objective Structured Clinical Examination) testing as per Dakshata guidelines for delivery of 'zero-defect' quality obstetric and newborn care. Enhance proficiency of labour room and operation theatre staff for management of the complications through skill-lab training, simulations and drills. Ensuring that staff working in the labour room and maternity OT are not shifted from maternity duty to other departments/ wards frequently.
3. Sensitising care-providers for delivery of respectful maternity care and close monitoring of language, behaviour and conduct of the labour room, OT & HDU Staff.
4. Creating an enabling environment for natural birthing process.
5. Implementation of Clinical Guidelines, Labour Room Clinical Pathways, Referral Protocols, safe birth checklist (in labour room and Obstetric OT) and surgical safety check-list.
6. Ensuring round the clock availability of Blood transfusion services, diagnostic services, drugs & consumables.
7. Ensuring availability of triage area and functional newborn care area.
8. Ensuring systematic facility-level audit of all cases of maternal/neonatal deaths, stillbirth, and maternal near

miss etc. including with their mentor teams through clinical discussions, peer reviews in teaching institutes, Videoconference, or other distance mode mechanisms for continuous improvement and learning.

9. Operationalisation of 'C' Section audit and corrective & preventive actions for ensuring that 'C' Sections are undertaken judiciously in those cases having robust clinical indications.

10. Instituting an ongoing system of capturing of beneficiaries' independent feedback through mechanism 'Mera-Aspataal' or manual recording, or Grievance Redressal Help Desk and take action to address concerns, for continual enhancement in their satisfaction.

11. Ensuring availability of essential support services such as 24x7 running water, electricity, housekeeping, linen and laundry, security, equipment maintenance, laboratory services, dietary services, BMW management, etc.

12. Use of digital technology for record keeping & monitoring for maternity wing (MIS), including use of E partograph. Piloting of technology for managing care, such as Computer on Wheel, Computerised Physician Order Entry.

13. Use aggressive IEC, user friendly training material and IT-enabled tools. Facilitating branding of all high case load facilities meeting quality standards to improve visibility and awareness.

14. Using Quality tools for prioritisation, and gap closure such as Plan Do Check Act (PDCA), Root Cause Analysis, Run Charts, Pareto chart and Mistake Proofing for achieving desired targets.

15. Rapid Improvement Events - Six cycles of two months each as defined below will need to be rigorously supervised and ensured. This will enable competency in all critical skills needed. For each area, a targeted campaign would be launched for a two month duration, with the first month for the roll-out, followed by sustaining such efforts during the subsequent month (Period for one event – 2 months). Suggested list of the themes for campaigns is given below :

    a) **Cycle 1:** Real-time Partograph generation including shift to electronic partograph & usage of safe birth check-list & surgical safety check-list and strengthening documentation practices for generating robust data for driving improvement.

    b) **Cycle 2:** Presence of Birth companion during delivery, respectful maternity care and enhancement of patients' satisfaction.

    c) **Cycle 3:** Assessment, Triage and timely management of complications including strengthening of referral protocols.

d) **Cycle 4:** Management of Labour as per protocols including AMTSL & rational use of Oxytocin.

e) **Cycle 5:** Essential and emergency care of Newborn & Pre-term babies including management of birth asphyxia and timely initiation of breast feeding as well as KMC for preterm newborn.

f) **Cycle 6:** Infection Prevention including Biomedical Waste Management.

Phasing of Activities

8

Activities under LaQshya are divided into four phases, as shown in Figure 3.

a. Preparatory Phase - 2 Months

This will include

i. Launch and dissemination of the scheme.

ii. Identification of members for National mentoring group and operationalisation of the 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.

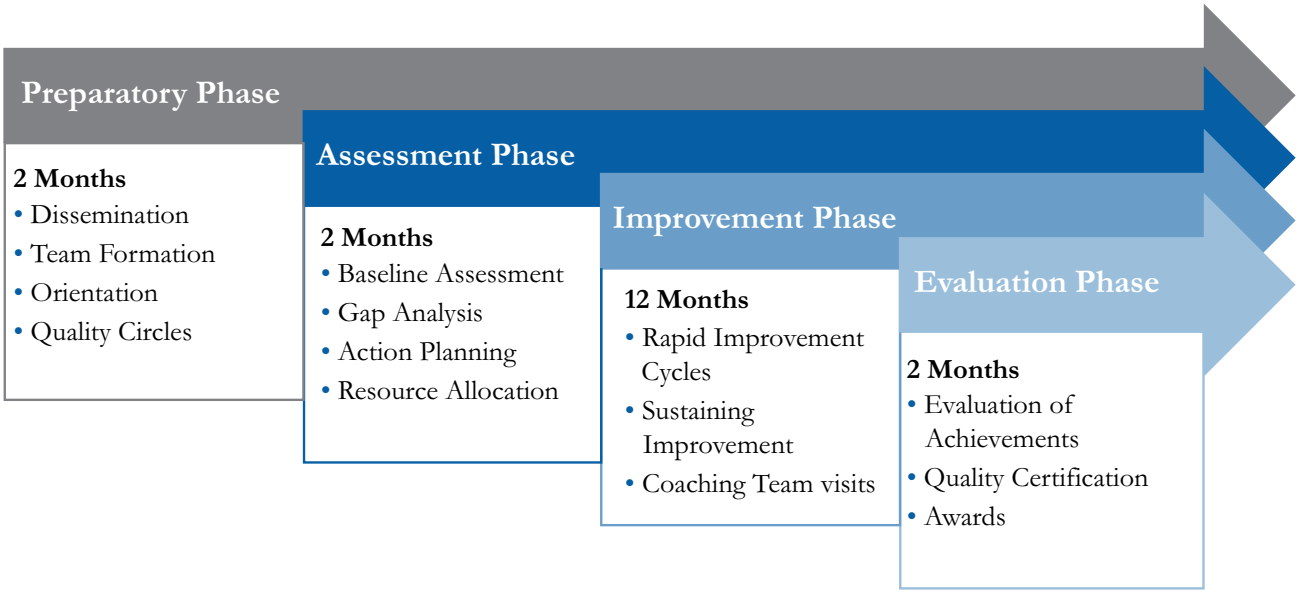
v. Formation of state mentoring group.

vi. Identification and listing of facilities to be included in the initiative.

vii. State level ToT of the Quality Coaches.

viii. Formation of Quality circles at the labour rooms and Operation Theatres.

Figure 3: Summary of Activities



ix. Assigning states to development partners.

b. Assessment Phase - 2 Months

i. Orientation of Quality Circles on Quality Improvement and Clinical Protocols.

ii. Assessment of the Labour Rooms & Maternity OT against National Quality Standards.

iii. Planning for expansion of Labour rooms as per 'Guidelines for Standardisation of Labour Rooms at Delivery Points' and upgradation the Maternity OT.

iv. Preparation of time bound action plan, based on the identified gaps.

v. Planning for creation of Obstetrics HDU as per recommendations of 'Guidelines for Obstetrics HDU & ICU'.

vi. Collation of requirements and resource allocation through the PIP process under the NHM.

vii. Mapping of referral facilities (type of facility, distance & travel time, contact details, availability of services including facility for the blood transfusion, availability of other specialities such as Physician, Surgeon, Pathology & Biochemistry lab & Ultrasound facility, nearest tertiary care institution).

viii. Ensuring availability of updated version of clinical protocols for end users and training of labour room & OT staff.

ix. Training of the staff in recording of data elements for monitoring of the indicators and implementation of Quality Management System.

x. Ensuring availability of drugs & supplies.

xi. Development of resource package for monthly campaigns.

xii. Initiation of Patients' satisfaction survey among all patients reporting in the labour room & operation theatre.

xiii. Development of IT platform for the initiative or integration with existing IT platform.

c. Improvement Phase - 12 Months

i. Launch of rapid improvement cycles. Each cycle includes one month of improvement and subsequent month of consolidation and sustenance.

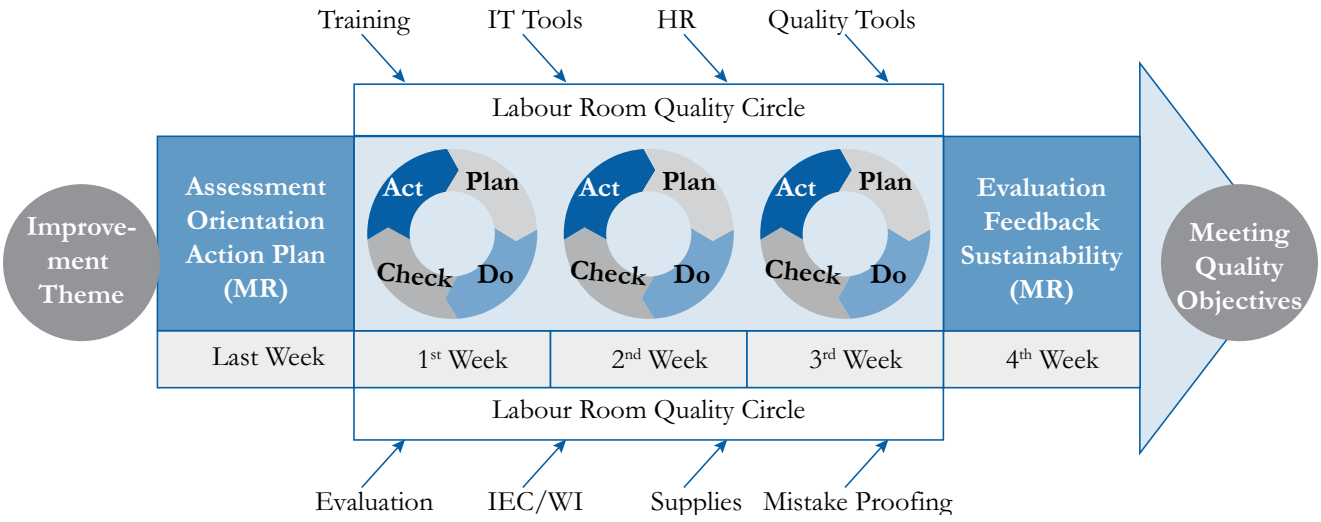
ii. Ensuring adherence to clinical protocols & peer-mentoring.

iii. Establish Standard Operating Procedures for labour rooms& maternity OT.

iv. 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 them (Figure 4).

v. Preparatory visit, followed by monthly visits – Visits in the second month of

Figure 4: PDCA Cycle & Enabling Activities



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.

vi. Documentation and photography of the improvement.

vii. Observation and assessment of processes, refresher & hands-on training, demonstrations and hand-holding.

viii. 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.

ix. Collection and reporting of indicators linked with quality objectives of each cycle from quality circle to State Mentoring Group & SQAC.

x. Structural augmentation including re-arranging the layout & human resource deployment & skill upgradation in the labour room & OT will go in parallel.

xi. Concurrent evaluation of quality indicators by SQAC and MH Division/ NHSRC and feedback to quality circles.

xii. Analysis of Patients' feedback and taking actions for addressing the beneficiaries' concerns.

d. Evaluation Phase - 2 Months

i. Evaluation of the quality objectives and indicators.

ii. External Assessment & Quality certification of labour rooms & Maternity OT.

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 & Branding

a. **Quality Certification:** The Labour Room & Maternity OT Checklists developed for NQAS, will be used as tools for the assessment and certification. The external assessment and certification will be done by external assessors empanelled with NHSRC. Certification will be valid for 3 years subject to annual verification of the scores by the State Quality Assurance Committee.

b. **Incentivisation:** The teams in the Labour rooms and Maternity OT's at Medical Colleges, District Hospitals and SDH/CHCs could be given incentives of Rs. 6 Lakhs, 3 Lakhs and 2 Lakhs (for each department) respectively on achievement of following criteria:

- Quality Certification of Labour Room and/or OT as per protocol under the NQAS.
- Attainment of at least of 75% of commensurate facility level targets and its verification by the SQAC. List of such verifiable indicators the facility, its source and means of verification is given in Annexure 'C'.
- 80% of the beneficiaries are either satisfied or highly satisfied (or Equivalent score $\geq$ 4 on Likert scale).

LaQshya facilities should endeavour to introduce 'Mera-Aspataal' ICT based feedback system. As an interim measure, feedback from the beneficiaries may be taken manually.

This incentive is recognition of the good work done by the quality circles and facility's quality team. This amount can be used as cash incentive to the staff and also for the welfare activities.

c. **Branding :** The achievement of quality benchmarks should be used for branding of the QoC at the health facility. This will give sense of pride to the staff as well as provide confidence to the community that they are getting quality care at public hospitals. The departments may be provided badges (LaQshya Medal) based on the quality score, achieved in the state level assessment.

Platinum Badge : Achieving more than 90% Score.

Gold Badge : Achieving More than 80% Score.

Silver Badge : Achieving more than 70% Score.

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

Financial Arrangements 10

Based on Gap analysis, the state may budget the resource requirements and request for allocation of the funds in relevant financial heads through the NHM PIPs. The PIP would include proposals for strengthening the Labour rooms & maternity OTs in the government medical colleges as well.

Suggested activities for the budgetary support is given in Box 1.

There will also be resource requirements for organising trainings, assessment, mobility support and other incidental expenses. The State may request for allocation of the resources through PIP under NHM.

Box 1. Suggestive List of Activities for support under the NHM

- Restructuring & upgradation of labour room as per Labour Room Standardisation Guidelines
- Upgradation of Maternity OT as per case load
- Procurement of Equipment and Furniture
- Creation of Obstetrics' High Dependency Unit
- Services of planning/architectural consultants
- Additional qualified staff for labour room and OTs
- 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 the JSSK
- Health Innovations

11 Roles & Responsibilities

The initiative will be coordinated by the Maternal Health Division and supported by the Child Health Division and NHSRC. Maternal Health Division will facilitate preparation of resource package for the labour room reorganization & standardization and improvement in Quality of Care (QOC), coordinate with the states &UT's for smooth roll out of the initiative, collate quality scores and indicators, ensure synergy with the development partners, review PIP proposals for labour room & maternity OT upgradation, creation of obstetric HDU and staff augmentation. NHSRC would coordinate quality certification activities under this initiative, undertake documentation of best & replicable practices for cross-learning and provide necessary support for successful implementation of the programme. Development partners may synergize their activities for supporting the roll-out of the scheme in their priority States, support National& State Mentoring Groups, and support development of technical resource material as required.

A small project management unit may be established with full time program managers and consultants at the national level for coordination and intense monitoring of activities in the States. This unit will keep track of the scheduled activities, collate and analyse the indictors, coordinate with the national mentors and facilitate the training programs. This unit will report to Deputy Commissioner I/C Maternal Health and Advisor QI NHSRC.

In the States, Maternal Health Program officer/ State Quality Assurance Nodal Officer may be designated as nodal officer for implementation of the initiative. Coordination with the Medical Colleges through Medical Education Department would be critical. Based on the number of facilities under this initiative in first phase, the states may hire a full-time project manager.

At the district level, Maternal Health Nodal officer & Nodal Officer for Quality Assurance will be responsible for this implementing the activities.

Details of activities, required to be undertaken by different stakeholders are given in Annexure 'D'.

Monitoring and Reporting 12

Under the LaQshya initiative, multiple interventions are envisaged to be undertaken within the stipulated time frame and impact of interventions is required to be simultaneously measured through verifiable indicators in real time. Therefore, efficient reporting of status of activities and achievement of targets are critical for the success of initiative.

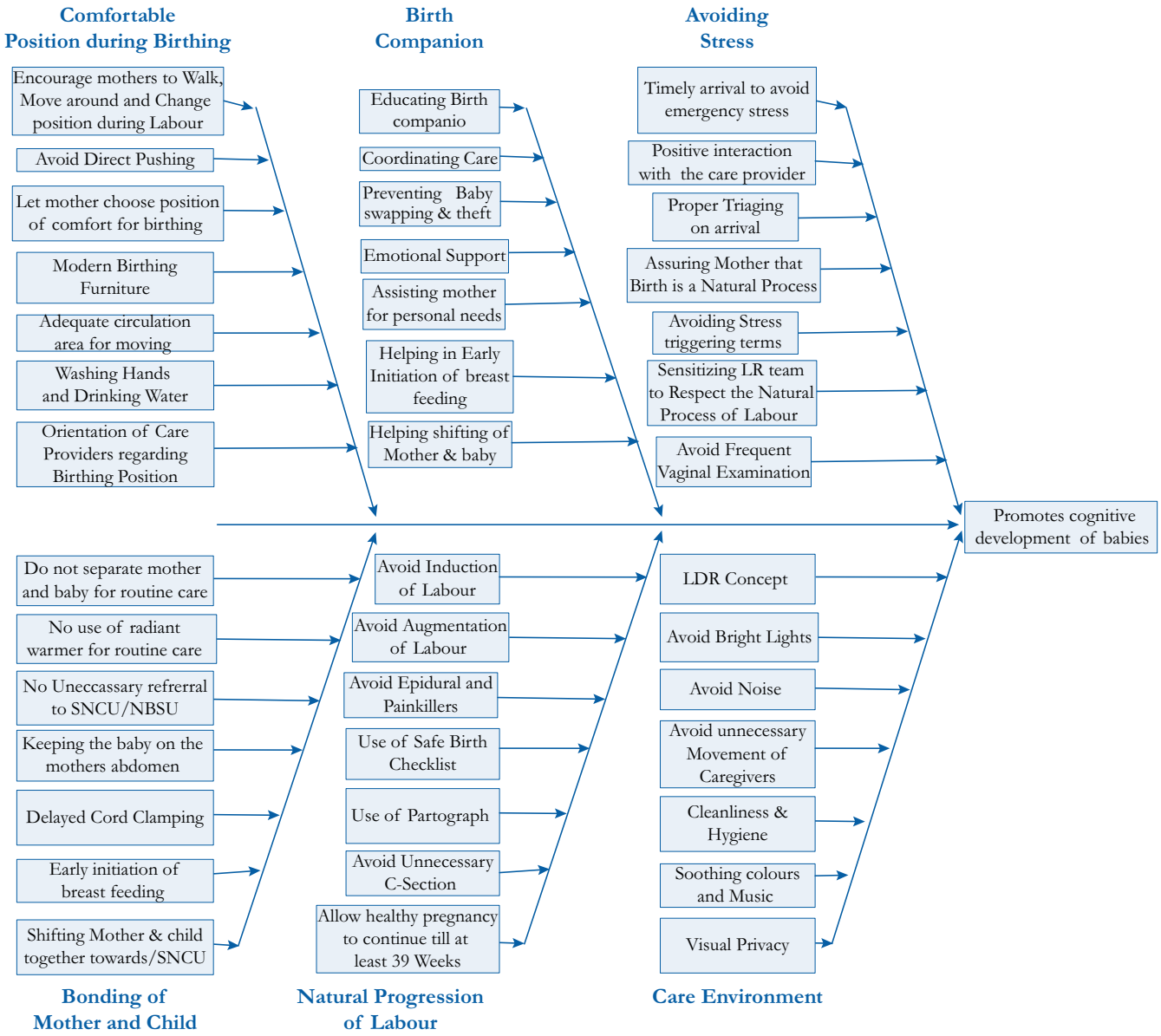
A dedicated data entry module and dashboard may be created in this purpose. Many of these indicators are already reported through HMIS, Labour room, HIS and SNCU online system. The data for these indictors can be directly pulled from the respective systems. All indicators need to be reported by facility on monthly basis after verification from respective coaching teams.

Monitoring of the program activities such as assessment, labour room & OT reorganization, progress on establishing HDU, trainings, visits of coaching teams etc. Will be done through a dedicated web based tracking system. This website will also host all relevant guidelines, resource material, updates and progress reports.

Annexures

Annexure 'A'

Promoting Respectful Maternity Care & Cognitive Development of Baby



Annexure 'B'

Recommended Minimum Human Resource for the Labour Rooms

Human Resource exclusively for Labour Room

All the labour rooms, whether newly constructed or re-rganized 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, EmoC trained MO, and anaesthetists should also be available on call always.

Annexure 'C'

Facility Level Targets for Incentives

S. No	Indicator	Source	Means of Verification
1.	Facility has assessed Labour Room and OT using NQAS checklist and reported Baseline Quality Scores and indicators	Collated & Reported by DQAC	Reports verified by SQAC
2.	Facility has set Quality Team at facility level and Quality Circles in Labour Room & Maternity OTs	Collated & Reported by DQAC	Reports Verified by SQAC
3.	Facility has oriented the Labour room and Maternity OT staff on LR protocols, RMC & QI	Collated & Reported by DQAC	Reports Verified by SQAC
4.	At least 90% of deliveries are attended by a birth companion	Reported by Facility	Verified by Coaching Team during facility visit SQAC verification on sample basis
5.	At least 90% deliveries are conducted using safe birth and Safe Surgery checklist in Labour Room and Maternity OT	Reported by Facility	Verified by Coaching Team during facility visit SQAC verification on sample basis
6.	Partograph is generated using real-time information in at least 90% deliveries in Labour Rooms	Reported by Facility	Verified by Coaching Team during facility visit SQAC verification on sample basis
7.	Achieved 80% percentage or more breastfeeding within 1 hour or at least 30% increment from baseline.	HMIS	Verified by Coaching Team during facility visit SQAC verification on sample basis
8.	Achieved 0% neonatal asphyxia rate in Labour Room or at least reduction of 20% from baseline	SNCU online (DH) Reported by facility (Where SNCU online is not available)	Verified by Coaching Team during facility visit SQAC verification on sample basis
9.	Achieved 0% neonatal sepsis rate in-born babies or at least reduction of 20% from baseline	SNCU online (DH) Reported by facility (Where SNCU online is not available)	Verified by Coaching Team during facility visit SQAC verification on sample basis

S. No	Indicator	Source	Means of Verification
10.	Achieved 5% or less Surgical Site infection Rate in Maternity OT or at least reduction of 30% from baseline	Facility Report / HMIS	Verified by Coaching Team / DQAC
11.	Achieved 80% or more antenatal corticosteroid administration rate in case in preterm labour or at least increment of 30% from baseline	SNCU online (DH) Reported by facility (Where SNCU online is not available)	Verified by Coaching Team during facility visit SQAC verification on sample basis
12.	No case of pre-eclampsia, eclampsia & PIH related mortality or at least 25% reduction from baseline	Facility Report	Verified by Coaching Team during facility visit SQAC verification on sample basis
13.	No case of APH/PPH related mortality or at least 25% reduction from baseline	Facility Report	Verified by Coaching Team during facility visit SQAC verification on sample basis
14.	Facility Labour Room is reorganised as labour room standardization guidelines	DQAC onsite verification report	Report Verified by SQAC
15.	Facility Labour room has staffing as per defined norms in annexure B	DQAC onsite verification report	Report verified by SQAC
16.	100% of Women, administered Oxytocin, immediately after birth.	Facility Report	Verified by Coaching Teams
17.	80%and more OSCE scores or at least increment of 30% from baseline	Facility Report	Verified by Coaching Team
18.	Facility conducts referral audit on Monthly basis	Facility Report	Verified by Coaching Team
19.	Facility conducts Maternal death, Neonatal death and near-miss on monthly basis	Facility report	Verified by Coaching Team
20.	Facility report zero stock outs in Labour Room & Maternity OT	Facility Report	Verified by Coaching Teams

Annexure 'D'

Detailed Action Plan for LaQshya Initiative

	National Level	State Level	District Level DQAC,	Facility Level
Institutions	MH Division, CH Division, NHSRC and National Partners	Directorate, NHM, SQAC/ SQAU, State level partners	DQAC	Quality Team
Primary Resp-onsibility -	DC Maternal Health, MoHFW	Program Officer, MH State Nodal Officer	District Nodal officers for Maternal Health / RCH	Labour Room & OT Incharges/ HOD Obs&Gynae.
Support Teams	Project Management Unit, QI Division NHSRC, Child Health Division	State Quality Assurance Units Child Health Program Officers	District Quality Assurance Unit	
Quality Drivers	National Mentoring Group	State Mentoring Group	Coaching Teams	Quality Circle
Preparatory Phase				
1st Month	National Level Launch Issue of Instructions to the states & UTs Identification and selection of National Mentoring Group members Finalization of Assessment Checklist (NQAS) Orientation workshop for National Mentors and Key State Officials (Two Batches) Preparation of Initial IEC package Creation of special task group for 'LaQshya'	Dissemination of LaQshya Guidelines to target facilities Identification and selection of State Mentoring Group Identification and orientation of District level officers Formation of State Mentoring Group, Finalisation of list of facilities & district nodal officers Communication of contact details to GoI Coordination meeting – NHM, Medical Education, Medical Colleges, Medical Directorate	Listing of eligible facilities and reporting to the state Identification and selection for the Coaching Teams	Formation of Quality Circles One meeting of quality team with quality circle to discuss LaQshya guidelines and Future plan Ensuring Quality Circle has hard copy of LaQshya, Labour Room Standardization

	National Level	State Level	District Level DQAC,	Facility Level
	Issuing guidelines for strengthening referral system Developing a standardising branding for the program	Recruitment of HR (Existing Vacancies)		
2nd Month	Finalization of Initial Resource package Orientation workshop for National Mentors (2 batch) Launch of IEC campaign Assigning National Mentors for states and facilities Preparation of visit roster of National Mentors Finalisation of IT platform and Instructions	IEC campaign through press, electronic media Orientation of coaching teams, state mentoring group and representatives of Medical Colleges by National mentor in optimal size group	First meeting of DQAC with the coaching team to discuss future plan Preparation of visit roster of coaching teams Familiarisation of guidelines and required activities	Assessment of Labour rooms & Maternity OT using NQAS Check-lists
Assessment Phase				
3rd Month	Preparation of resource package for Rapid Improvement for first two improvement cycle Visit of National Mentors to facilities as per roster Launch of IT platform and Instructions	Mobilisation of coaching teams for peer assessment Empanelling architects/planning consultants for labour room redesign Coordinating visits of National Mentors	Joint visit of Mentors and coaching team Peer Assessment of Labour Room and Maternity OT by Coaching team Verifying the baseline Indicators	Gap analysis Reporting of HR and structural requirements to state Collection of baseline indicators Orientation of Quality Circles for Quality Improvement and Clinical Protocols

	National Level	State Level	District Level DQAC,	Facility Level
4th Month	Visit of National mentors to facilities as per roster Soft Launch of IT platform for Labour room Finalization of Resource and IEC package for Improvement Cycle 1 Approval of State PIPs & release of funds	Collation of Resource Requirements from facility Proposal for financial allocation (including resource requirement for Medical Colleges) submitted through the NHM PIP (Supplementary) Planning for creation of obstetrics HDU as per MoHFW guidelines	Joint visit of National mentors and Coaching Teams Handholding Quality circles in preparing action plans	Preparation of Time bound Action Plan Initial Reorganization of Labour Rooms Reallocation of Human Resource Collection of baseline indicators Mapping of referral facilities Ensuring availability of updated versions clinical protocols Initiation of patient satisfaction surveys
Improvement Phase				
5th Month Improvement Cycle 1	Launch on Improvement Cycle "Real-time Partograph generation & usage of safe birth checklist"	Ensuring formats for standardized Labour Room case sheet including partograph and safe birth checklist is distributed Monitoring of coaching teams Planning for visits Facilitating implementation of IT platform Initiation of 'gap-closure' action Hiring of approved HR (Supplementary PIP)	Visit to assigned facilities for onsite training and handholding of quality circle for use of Standardized Labour room case sheets Real Time use of Partograph Real time use of safe birth checklist	Identifying gaps and opportunity for improvements in use of safe birth checklist and partograph Introduction of Digital partographs in selected medical colleges Assuring that all deliveries are conducted with help of safe birth checklist and partograph Ensuring use of case sheets and labour room registers. Entry of data in IT SYSTEM

	National Level	State Level	District Level DQAC,	Facility Level
6th Month	Collating and analysing state wise progress Assisting states not making expected progress Visit of National Mentors to sample facilities Finalization of Resource package and material for next cycle	Collating & analysing the progress, Improvements and Indicators, Focusing on the facilities not making expected progress including onsite visit if necessary	Handholding the Quality Circle for sustaining the efforts Verifying the indicators Assessment of staff competence and processes	Standardizing and sustaining the improvement gained in Cycle 1 Reporting the Indicators Initiate project on 'lean labour room' in selected medical colleges & DHs
7th Month Improvement Cycle 2	Launch of Improvement Cycle on Birth Companion, Respectful care & satisfaction IEC campaign on importance of Birth Companion and respectful care to enable natural birthing process Dissemination of Resource package on respectful care and natural birthing process Video Conferencing by National Mentors with their respective Coaching Teams and Quality Circles	State level orientation of Labour Room In charges and coaching teams with for Birth Companion and respect full IEC campaign in Local Media and Press for promoting Birth Companion Implementing patient feedback system in labour rooms	Facility visit for on-site training and handholding the quality circle for Birth Companion, respectful care and Natural birthing process	Counselling attendants for roles as Birth Companion Ensuring all the deliveries are conducted with active support of birth companion Implementing the protocols for Natural Birthing Process Maintaining the full privacy through three side curtains or LDR cubicles Taking feedback for Mothers and attendants
8th Month	Collating and analysing state wise progress	Assisting states having made expected progress	Collating & analysing the progress, Improvements and Indicators,	Standardizing and sustaining the improvements gained in Cycle 1 & 2

	National Level	State Level	District Level DQAC,	Facility Level
	Visit of National Mentors to sample facilities Finalization of Resource package and material for next cycle	Focusing on the facilities not making Expected progress including onsite visit if necessary	Handholding the Quality Circle for sustaining the efforts of Cycle 1 and 2 Verifying the indicators Assessment of processes and staff competence and onsite rectification if any	 Reporting the Indicators
9th Month Improvement Cycle 3	Launch of Improvement Cycle Labour Management Protocols including AMTSL, Oxytocin Issue of guidelines for C-Section Audit Dissemination of Resource package on Labour Room Protocols Video Conferencing by National Mentors with their respective Coaching Teams and Quality Circles	Ensuring labour room protocols including AMTSL and rational use of oxytocin have been disseminated to all labour rooms Dissemination of C-Section Audit guidelines Arranging refresher trainings on labour room protocols through existing program such as Dakshata and skill labs.	Facility visit for onsite training and handholding for labour room protocols	Ensure augmentation and induction practices are restricted unless these are indicated All staff is trained, skilled and confident in labour protocols including AMTSL Do's and Don'ts are clearly communicated and adhered
10th Month	Collating and analysing state wise progress Assisting states not making expected progress Visit of National Mentors to sample facilities Finalization of Resource package and material for next cycle	Collating & analysing the progress, Improvements and Indicators, Focusing on the facilities not making expected progress including onsite visit if necessary	Handholding the Quality Circle for sustaining the efforts of Cycle 1 and 2, 3 & 4 Verifying the indicators Assessment of processes and staff competence and onsite rectification if any	Standardizing and sustain the improvement gained in Cycle 1, 2 & 3 Reporting the Indicators

	National Level	State Level	District Level DQAC,	Facility Level
11th Month Improvement Cycle 4	Launch of Improvement Cycle on Assessment Triage and management of complication Dissemination of Resource package Video Conferencing by National Mentors with their respective Coaching Teams and Quality Circles	Ensuring protocols for management of assessment, triage and management of complications has been disseminated Arranging refresher training of Labour Room In charges/ Coaching teams if necessary through existing program such as Dakshata and Skill Labs	Facility visit for onsite training and handholding for implementation of assessment, triage and management of complication protocols	Earmarking the Triage area in labour room Implementing the triage processes Ensuring that initial assessment of each pregnant mother has been done as per labour room case sheet Ensuring management of complication protocols are displayed in labour room Ensuring staff is well trained and skilled for management complication protocols
12th Month	Collating and analysing state wise progress Assisting states not making expected progress Visit of National Mentors to sample facilities Finalization of Resource package and material for next cycle	Collating & analysing the progress, Improvements and Indicators, Focusing on the facilities not making expected progress including onsite visit if necessary	Handholding the Quality Circle for sustaining the efforts of Cycle 1, 2, 3 & 4 Verifying the indicators Assessment of processes and staff competence and onsite rectification if any	Standardizing and sustain the improvement gained in Cycle 1, 2, 3 & 4 Reporting the Indicators
13th Month Improvement Cycle 5	Launch of Improvement Cycle on Newborn Care, Resuscitation and Breast feeding Launch of IEC campaign on Breast feeding	Ensuring Newborn care and resuscitation protocols are disseminated to all labour rooms Arranging booster training of Labour room charges/ Coaching teams if necessary through existing program such as Dakshata and Skill Labs	Facility visit for on-site training and handholding for Newborn care & resuscitation. Breastfeeding and care of Low birth weight	Ensuring newborn care and resuscitation protocols are displayed Staff is trained, skilled and confident Equipment and supplies are available

	National Level	State Level	District Level DQAC,	Facility Level
	Dissemination of resource package	Ensuing equipment and supplies for newborn care to labour rooms		Breastfeeding is promoted and ensured within one hour of birth
14th Month	Collating and analysing state wise progress Assisting states not making expected progress Visit of National Mentors to sample facilities Finalization of Resource package and material for next cycle	Collating & analysing the progress, Improvements and Indicators, Focusing on the facilities not making expected progress including onsite visit if necessary	Handholding the Quality Circle for sustaining the efforts of Cycle 1 and 2, 3, 4 & 5 Verifying the indicators Assessment of processes and staff competence and onsite rectification if any	Standardizing and sustain the improvement gained in Cycle 1, 2, 3, 4, & 5 Reporting the Indicators
15th Month Improvement Cycle 6	Launch of Improvement Cycle on Infection Prevention and Waste management Dissemination of Resource Package on infection control	Ensuring Infection Control protocols are disseminated to all labour rooms Arranging booster training of Labour Room In charges/ Coaching teams if necessary through existing program such as Dakshata and Skill Labs Ensuring supplies for infection control and waste management are in place	Facility visit for on-site training and handholding for Infection prevention and waste management	Ensuring Hand Hygiene and personal protection practices Ensuring waste is disposed as per BMW rules 2016 Ensuring sterilized instrument and supplies are available for delivery and newborn care Ensuring staff is trained and skilled for infection control and Waste Management
16th Month	Collating and analysing state wise progress Assisting states not making expected progress Visit of National Mentors to sample facilities	Collating & analysing the progress, Improvements and Indicators, Focusing on the facilities not making expected progress including onsite visit if necessary	Handholding the Quality Circle for sustaining the efforts of Cycle 1, 2, 3, 4, 5 & 6 Verifying the indicators	Standardizing and sustain the improvement gained in Cycle 1, 2, 3 & 4, & 5 & 6 Reporting the Indicators

	National Level	State Level	District Level DQAC,	Facility Level
			Assessment of processes and staff competence and onsite rectification if any	
Evaluation Phase				
17th Month	Collating and evaluation of overall performance on Quality Indicators Assigning Assessors external certification	Collating the quality scores Sending Request for Quality Certification External Assessment of Labour rooms coring more than 70% score for awards	Second round of peer assessment by coaching teams against NQAS standards	Applying for Labour Room Quality Certification
18th Month	Award of Quality Certification National Level Felicitation of Award Winners Dissemination of Achievements Roll out for program for next phase	Awards at state level winners and coaching teams Branding of Labour rooms	Branding of Labour Rooms	Branding of Labour rooms

- If Labour rooms are ready they can apply for the NQAS certification early.
- Actions for closure of structural and HR gaps will be initiated simultaneously. State and facility incharges should ensure that Labour Room preferably in LDR format with requisite equipment and HR are ready within one year of commencement of this initiative.
- Rapid Improvement Cycles have been planned to emphasize and improve critical processes through more focused campaign mode. Focusing on one issue doesn't mean that other issues will not be addressed in that window period. Critical gaps should be addressed as and when required. Improved practices and performance gained during one campaign should be sustained during the subsequent cycles.
- Indicators will be reported on monthly basis in the first week of next month.

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 Centres
CQSC	Central Quality Supervisory Committee
DH	District Hospitals
DQAC	District Quality Assurance Committee
DQAU	District Quality Assurance Unit
EmOC	Emergency Obstetric Care
FRU	First Referral Units
HDU	High Dependency Unit
IEC	Information Education Communication
IT	Information Technology
JSSK	Janani Shishu Suraksha Karyakram
LDR	Labour Delivery Recovery
LR	Labour Room
LSAS	Life Saving Anaesthetic Skills
MC	Medical College
MDSR	Maternal Death Surveillance & Review
MH	Maternal Health
MoHFW	Ministry of Health & Family Welfare
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIHFW	National Institute of Health & Family Welfare
NMR	Neonatal Mortality Review
NPMU	National Programme Management Unit
NQAS	National Quality Assurance Standards
OBG/Obs & Gynae.	Obstetrics & Gynaecology
OSCE	Objective Structured Clinical Examination
OT	Operation Theatre
PDCA	Plan Do Check Act

PHC	Primary Health Centres
PIP	Program Implementation Plan
QC	Quality Circle
QOC	Quality of Care
RCH	Reproductive & Child Health
RIC	Rapid Improvement Events
SDH	Sub Divisional Hospital
SQAC	State Quality Assurance Committee
SQAU	State Quality Assurance Unit

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28.	Dr. Sachin Gupta	USAID
29.	Dr Anuradha Jain	USAID

30.	Dr Usha Kiran Tarigopula	BMGF
31.	Dr Mrunal Shetye	BMGF
32.	Dr Leila Varkey	C3/WRAI
33.	Dr Kasonde Mwinga	WHO
34.	Dr Paul P Francis	WHO
35.	Dr Amrita Kansal	WHO
36.	Dr Ritu Agrawal	LSTM
37.	Dr Bulbul Sood	Jhpiego
38.	Dr Neeraj Agarwal	Jhpiego
39.	Dr Vikas Yadav	Jhpiego
40.	Dr Deepti Singh	Jhpiego
41.	Dr Yaron Wolman	UNICEF
42.	Dr Gagan Gupta	UNICEF
43.	Dr Asheber Gaym	UNICEF
44.	Dr Apurva Ratnu	UNICEF
45.	Dr Rajeev Gera	IPE Global
46.	Dr Gunjan Taneja	IPE Global
47.	Dr Devina Bajpayee	IPE Global
48.	Dr Rakesh Parashar	IPE Global
49.	Dr Tarun Singh Sodha	IPE Global
50.	Dr Ajit Sudke	Access Health International

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