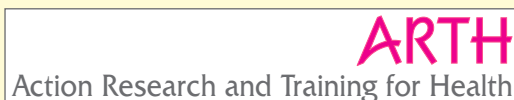


Parijaat



Assessing and Improving Quality of Childbirth Services
in Public Health Facilities

Quality Improvement Toolkit



In collaboration with
Department of Medical, Health & Family Welfare
Government of Rajasthan

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Acknowledgments

This toolkit is a result of efforts by a team of persons from ARTH.

The principal authors of this toolkit were

- Financial support from the United Nations Population Fund is gratefully acknowledged

1 Introduction

Government of India has taken several initiatives towards the reduction of maternal and infant mortality rates. These interventions have included infrastructure strengthening, building capacity of human resources through large scale training, providing equipment and drugs and conditional cash transfer through the Janani Suraksha Yojna (JSY) to promote institutional deliveries. The JSY has led to substantial increase in the number and proportion of institutional deliveries.

While the increase in institutional deliveries is a significant and positive change, women continue to receive poor quality care in large parts of India, even when they choose to deliver in health facilities. Studies have revealed that a large number of harmful or unnecessary practices are followed, which include forceful fundal pressure, routine augmentation of labour, poor monitoring after delivery and others which adversely influence maternal and newborn health outcomes. On the other hand, several beneficial evidence based care practices are not observed during labour, leading to suboptimal maternal and perinatal outcomes. Reasons for poor quality of care include providers' lack of awareness of evidence based care practices, lack of infrastructure, poor maintenance of available equipment, gaps in supplies and equipment, poor monitoring of services, etc.

In order to reduce maternal and perinatal mortality rate, and to improve the quality of services, ARTH in partnership with UNFPA and Government of Rajasthan, developed an intervention to assess and improve the quality of childbirth services in selected high workload public health facilities in 10 districts of Rajasthan. The quality improvement process included assessment of adherence to evidence based care practices and necessary inputs, planning effective steps along with providers and their district officers to ensure that the gaps are filled.

During this process of assessment and quality improvement, a set of practical implements was developed and used, which are compiled in this toolkit. We feel that this toolkit can be used (and adapted where needed) in a variety of settings across India and other countries, where concerns related to quality of childbirth services are similar. Further, the results and actions emerging from assessment of quality of childbirth services can provide inputs for state or district level programmes designed for improving maternal- neonatal health outcomes.

2 Objectives

The primary objective of this tool kit is to provide guidance to state and district programme managers to improve the quality of delivery and neonatal care services around the time of institutional delivery, within the public health system. The toolkit was used in Rajasthan, but could be used in other regions with similar practices. It consists of four main components—Assessment, Feedback, Training and Action—each of which is an essential components for improving the quality of childbirth services.

3 Who can use this toolkit?

This tool kit is designed to be used by state or district level organizations involved in the quality improvement process. For example, it can be used by quality assurance groups established by the state government, non government at organizations or by independent quality assurance groups. Members of the quality assurance team could include state level officers, district level programme managers, members of civil society, and or representatives of the community. Support from state and district health officials helps to ensure that changes are made immediately and continue long term. The toolkit is primarily designed for on going programme for quality improvement in a district or state. However, it can also be used for a single assessment.

4 Standards and criteria used in the Parijaat quality improvement toolkit

The tool kit has been developed on the basis of the most important evidence based care practices for childbirth as recommended by World Health Organization (WHO), in the document 'Care in normal birth: a practical guide' (WHO 1996) and specific recommendations in WHO Reproductive Health Library, on practices related to maternal and newborn care around the time of delivery. Further, guidelines developed by Government of India in 2005 for doctors and ANMs/LHVs, on care during antenatal period, labour and delivery and postpartum period are in accordance with evidence based care practices. Based on these standards, a set of recommendations for the most common practices and / or interventions were identified for each stage of childbirth.

Key problems in the context of Rajasthan Discussions were held with senior officials in the Directorate of Medical Health & Family Welfare and a plan for quality improvement was developed by ARTH and UNFPA. Nineteen evidence based care practices during each stage of labour and immediate postpartum period were identified. These are:

Nineteen Evidence Based Care Practices	
First Stage of labour	
1.	Encourage the woman to move about
2.	Avoid routine enema and shaving of pubic hair
3.	Where facilities for cesarean section are not available, do not induce or augment labour. Never use IM oxytocin to augment labour
4.	Always monitor labour using a partograph
5.	Restrict pelvic examinations to once in 4 hours unless delivery is imminent
Second Stage of labour	
6.	Encourage upright positions such as sitting or squatting
7.	Avoid routine episiotomy for primigravidas

8. Do not apply abdominal pressure to push the baby out
9. If fetal heart sounds (FHS) are normal, do not rush to complete the second stage of labour within 1 hour
10. Always wash hands before handling woman or newborn

Third Stage of labour

11. Practice “Active Management of Third Stage of Labour” (AMTSL) including IM oxytocin injection, controlled cord traction and uterine massage
12. Cut the cord after it stops pulsating (unless the mother is RH negative or the baby needs resuscitation)
13. Avoid packing the vagina
14. Dry and wrap the baby immediately after birth, cover and place it on the mother’s abdomen
15. Avoid routine nasopharyngeal suction (unless liquor is meconium stained or baby is asphyxiated). If suction is needed, use mucus sucker instead of electrical suction machine

Postpartum care before discharge

16. Monitor maternal bleeding and vital signs every 15 minutes in the first hour, every 1 hour within the first 1-4 hours, then every 4 hours within the first 24 hours
17. Initiate breast feeding as early as possible, within an hour of birth
18. Wrap the baby and keep close to mother
19. Discharge after 48 hours. If mother or baby have a problem, then delay discharge for a few days

These were developed into a poster with 19 evidence based practices classified by stage of labour to be displayed in labour rooms. Of these 19 practices, a shorter list of 10 critical practices was identified on the basis of their greater impact on maternal and perinatal outcomes and a guidebook for doctors and programme managers was developed entitled “Recommendations for key delivery and newborn care practices in health facilities of Rajasthan”. These recommendations were reviewed and approaches to implement them in the districts were identified and approved in a state level consultation attended by senior persons from the Directorate, medical college teachers, ARTH, UNFPA and UNICEF, in 2009.

A project entitled, “Parijaat”, for improving the quality of childbirth and immediate postpartum care practices in accordance with these identified practices was eventually implemented in 80 facilities of 10 districts of Rajasthan, jointly by Action Research & Training for Health (ARTH) in collaboration with the state government and the Rajasthan state office of the United Nations Population Fund (UNFPA) onwards from 2009.

5 Establish a quality improvement team

For implementing evidence based delivery and new born care in facilities, it is crucial to establish a core team of people who will be responsible for overseeing the activity. This will include providing guidance to the team members who will ultimately carry out assessment, coordinate quality improvement and report results to appropriate persons/authorities.

Quality Improvement Team

Core planning and oversight team: At the senior level, the project management team might comprise of clinical practitioners (gynecologists, pediatricians, doctors, nurse midwives), with sound understanding of evidence based delivery and newborn care, public health persons with experience of health systems and senior state officers. The presence of high-level representatives in the management team may serve as an effective means of securing the necessary authority for the team implementing the intervention within the public health system.

Implementation team: At the ground level, the management team can include a mixed team of clinical and non-clinical persons with training and experience of health systems, and of maternal and child health issues. All team members should have good interpersonal communication skills, and must be able to converse in the local language of service providers as well as of women. It is beneficial to have variety in a team, so that members complement each other.

The implementation team must be given sufficient authority to execute quality improvement steps and strategy of the project effectively. In some contexts, this might require an official order giving authority to the team in overseeing assessments of new born care and institutional deliveries in selected facilities.

Orientation of implementation team: The whole team should be involved in framing objectives of the quality improvement programme. In this toolkit, the objective is to strengthen implementation of evidence based maternal and new born care practices in a large number of facilities on an on going basis.

Number of persons: It is optimal if a team is constituted at district level. On an average, a team of 2 can cover 30-40 facilities.

Training of the Quality Improvement Team: Once the implementation team has been constituted it is necessary that members should be trained in core components of the project. Since they might be from different backgrounds, the team should be well versed with issues of maternal and newborn health, evidence based care practices and the rationale behind them, as well as health systems.

Depending on the prior experience of team members, training can be for 7-14 days. We have outlined a brief training schedule below. These sessions can be modified depending on the background of team members. Trainers could include members of the core planning and oversight team, and trainers of skilled birth attendants (for clinical sessions).

Tentative session plan for training of Implementation Team members		
Time	Subject	Duration
Day 1		
09.00 - 09.30 am	Introduction and expectations	30 min.
09.30 - 10.00 am	Project introduction and objectives	30 min.
10.00am - 12.30 pm	Maternal and neonatal mortality	2.30 hrs.
12.30 - 01.30 pm	Lunch	1 hr.
01.30 - 3.30 pm	Evidence based maternal and neonatal care	2 hrs.
03.30 - 05.00 pm	Current status of quality of delivery care in India	1.30 hrs.
Day 2		
09.00 -10.00 am	First stage of labour	1 hr.
10.00 -11.00 am	Partograph	1 hr.
11.00 -11.30 am	Second stage of labour	30 min.
11.30 - 12.30 pm	Third stage of labour	1 hr.
12.30 - 01.30 pm	Lunch	1 hr.
01.30 - 02.30 pm	Preparation for birth of newborn	1 hr.
02.30 - 03.30 pm	Immediate care of the newborn	1 hr.
03.30 - 04.00 pm	Examination of newborn baby	30 min.
04.00 - 05.00 pm	Asphyxia management	1 hr.
Day 3		
09.00 - 10.15 am	Importance of postpartum period and how to provide care to woman and newborn baby in postpartum period	1.15 hrs.
10.15 - 12.00 pm	Presentations on <ul style="list-style-type: none"> • Position during delivery • Effect of augmentation on labour • Episiotomy 	1.45 hrs.
12.00 - 12.45 pm	Infection prevention during childbirth and newborn care Lunch	45 min.
01.45 - 02.30 pm	Essential equipment for care of mother and baby in the labour room (demonstration)	45 min.
02.30 - 04.00 pm	Checklists for assessment of quality: <ul style="list-style-type: none"> • Facility assessment checklist • Delivery observation checklist • Checklists for interview with postpartum women • Records review 	1.30 hrs.
04.00 - 04.45 pm	Ethical issues in quality assessment, including delivery observation	45 min.
04.45 - 05.15 pm	Briefing for field visit	30 min.

Time	Subject	Duration
Day 4		
09.00am – 05.00 pm	Field visit to community health centres and district hospitals in 4 groups (facilitators to demonstrate the use of each checklist, and other aspects e.g. demonstrate identification of equipment and supplies in labour rooms)	8 hrs.
Day 5		
09.00- 11.00 am - 05.00 pm	Debriefing and discussion on field visit Field visit to community health centres and district hospitals in 4 groups (facilitator to demonstrate use of checklists)	2 hrs. 6 hrs.
Day 6		
09.00 - 10.30am	Feedback on field visit <ul style="list-style-type: none"> • Share findings of assessment and identify differences • Review facility data and discuss how to use for improvement 	1.30 hrs.
10.30 - 11.30 am	Scoring sheet <ul style="list-style-type: none"> • Overview • How to fill the scoring sheet • Tracking the pattern of improvement in scores over time 	1 hr.
11.30 am - 12.30 pm	Conducting orientation- training of providers at sites	1 hr .
12.30 - 01.30 pm	Lunch	1 hr.
01.30 - 02.15 pm	Providing feedback and taking action on field visit <ul style="list-style-type: none"> • How to give feedback to providers • How to facilitate action at the facility level 	45 min.
02.15 - 03.00 pm	Providing feedback and developing an action plan with district officials <ul style="list-style-type: none"> • Preparing a facility report card • Developing an action plan for facility improvement • Ensuring involvement of government officials in quality improvement 	45 min.
03.00-05.00 pm	Closure and next steps	2 hrs.

For conducting each session, the trainers can evolve their own training methods, making sessions as interactive as possible. Case studies, films or videos, presentations, demonstrations and experience sharing should be used as appropriate.

Further, this training programme visualizes one week training in the beginning. However, training of the implementation team is an iterative process and the team should share its findings frequently with core team members during monthly or fortnightly review meetings to allow for orientation on on-going issues as they emerge.

6 Quality Improvement Framework

The basic quality improvement framework used in this toolkit has four core steps ("AFTA") as follows:

- Assessment
- Feedback
- Training and
- Action

Once the facilities have been identified, the team can start with assessment using the checklist, give feedback to the facility in-charge, train the staff if required and trigger necessary action for improving quality.

In order to implement this training tool in a new setting, certain actions are suggested or needed in order to move forward. The following guideline provides support for the same.

Operationalising Tool Kit Implementation

1. Establish criteria for facility selection and select facilities in each district (QI team, with senior state level Government officials)
2. Develop a plan for implementing use of tool kit
3. State level authority to issue orders to district officials and facility staff to participate in QI programme, and to cooperate with the QI team
4. Constitute the team and establish a time line for implementation of the programme based on work load, divide team responsibility and areas to be covered
5. Make required copies of information / guidance materials, checklists etc.
6. Train the implementation team
7. Explain plan and operational strategy to district level Health Officer (Joint Director and/or Chief Medical & Health Officer)
8. Start regular facility visits for assessment – feedback - training- action (AFTA).

Selection of Facility

The project implementing committee can select facilities for assessment and quality improvement. This toolkit is designed for quality improvement in government facilities, although it can also be used for private facilities. We suggest initially selecting facilities with relatively higher delivery rates so that the impact of intervention is higher to begin with. For example, facilities with minimum of 900 deliveries per year may be selected. Facilities with fewer deliveries may be selected as the team moves forward.

7 Assessment

One to two QI team members should schedule a visit to each facility once in 2-3 months. Initially they may visit the facility every 2 months, this can subsequently be reduced to once in 3 months.

On the day of facility visit, the QI team carries out an assessment using the following 5 checklists (annexures 1 to 6):

1. Facility assessment
2. Delivery observation
3. Interview with two women in the postpartum ward
4. Review of staff deployment and training records
5. Monthly MIS report

The QI team member should first visit the labour room. If a woman is in labour, s/he should use the delivery observation checklist and observe selected practices. If there is no woman in labour, then the QI team member should follow the sequence of completing the facility assessment, staff deployment checklist, client interview checklist, and monthly MIS report. Subsequently two women may be interviewed in the postpartum ward.

a. Equipment Checklist: Team members are supposed to observe all equipment and supplies available in the labour room. It is always beneficial to have the nurse in charge of the labour room so that s/he can respond to queries. The checklist is however based on actual observation of items, and not on the basis of responses to questions by labour room staff.

The QI team member should check whether all instruments are in working condition and whether medicines are within the expiry date. S/he can check with the nurse in charge regarding missing equipment and also regarding timely supply of medicines and supplies. See Annexure 1 for facility checklist. During subsequent visits, the team members should carry with them the previous assessment checklist and feedback from previous visits so that they can confirm changes and identify persisting gaps.

Cases might arise where in supplies and medicines are present but have exceeded the expiry date. In some cases supplies may be used for some other purpose such as baby warmers being used as changing tables. The QI team should be vigilant and take note of such happenings.

b. Observation of delivery checklist: This is an important tool which gives an idea of quality of childbirth services, if the team member can be present at a time when a woman is in the labour or is delivering. The team member should take permission from the staff of labour room to observe a delivery or care of woman during labour, and should stand at head end of woman and silently observe delivery practices. Since it might be intimidating for the staff to see someone observing and filling a form, they can observe the practices and complete the checklist after the delivery is over. Remember, the checklist should not be completed on the basis of practices reported by the

providers. If it is possible to observe only some practices, then only these should be checked. Some times, a team member might reach the facility at the time of third stage of labour.

The checklist enumerates both harmful or unnecessary practices, such as application of fundal pressure, routine augmentation of labour, shaving of pubic hair, etc and beneficial practices such as use of partograph, checking of maternal blood pressure and fetal heart rate, etc. that the doctor or nurses should follow. A maximum of 2 deliveries can be observed during one visit at any facility. The filled checklist can be used later to give feedback to the providers. See Annexure 2 for observation of delivery checklist.



The QI team member should not interfere, intervene, challenge or comment while observing any procedure related to child birth. Further, they should record their findings after coming out of the labour room.

C. Client Interview Form: The QI team member should visit the postpartum ward, where s/he should meet at least 2 women who have delivered within 48 hours of the visit, and conduct interviews after seeking verbal consent for the same from women and informing family members. The interview should be conducted after an hour or more after delivery. If the woman wishes, one of two female family members who were present with her during labour or delivery, can be permitted to remain with her during the interview. Since patients beds are often close to each other in most post partum wards the interview needs to be conducted in a low voice.

The interview is based on items listed in the checklist with details like the time of delivery, shaving of pubic hair, vaginal packing, time of discharge, breast feeding, pre- delivery and postpartum blood tests, etc. being assessed. In many cases the mother might be unable to recall specific information, in which case the attendant who accompanied her in the labour room might be involved in the interview as well.

The QI team member should use local language and terms while conducting the interview and questioning women regarding practices. Hints can be given for certain questions and these may be region specific. For example, if the team member wants to know if blood pressure was checked before delivery then s/he can ask if a strip of cloth was tied across the arm to measure something or for augmentation the team member can ask if she had been given any injections, tablets, gel or drip to speed up the labour pains. The interviews should be conducted in an empathetic and not authoritative manner. See Annexure 3 for Client Interview Form.

Client interviews should be conducted even when delivery observation is possible, since they help to authenticate findings if providers altered their practices in front of QI team member. If delivery has been observed then client interviews serve as reassurance that what has been observed is being practiced in a consistent manner.

d. Progress in staff deployment: This checklist provides an idea of the number of staff and their training on evidence based care. The following are noted in this checklist:

- a. The list of all staff members deployed at the facility, including the nursing staff, gynecologist and pediatrician.
- b. How many of the nurses are SBA trained, and whether the doctors are trained in evidence based delivery care.
- c. Details of staff duty rosters and shifts such as the staff present during the morning duties, 8am-2pm, 2pm-8pm, overnight, nurses posted in Facility Based Newborn Care Unit, New Born Stabilization Unit: These should be collected from the labour room nurse in-charge this information will enable the team member to match case load with nursing staff availability at different times. There might be situations in which many staff members (nurses) are appointed for MCH duties in a facility, however, some of these are redeployed for medicine distribution, some as store keepers, some for JSY cheque distribution, and only few might actually be deployed for patient care in the labour room. Hence there might be situations, when a facility has (say) 20 nursing staff, of which 14 are posted during morning hours (8 am–2 pm), 4 during afternoon duty and only 2 during the twelve hours night duty, which makes it difficult for them to handle the numbers of women during night.

Based on training status and allocation of work timings of the staff, the team member can suggest appropriate distribution of the staff and contract appointments fill the gaps. See Annexure 4 for Staff Deployment Checklist.

e. Monthly MIS report: This report is to be filled by each team member for each preceding month, when s/he visits a facility. This report assesses the delivery load in the facility per month. It includes information regarding number of deliveries in the month, number of live births, still births, neonatal deaths, number of cesareans, normal deliveries, women referred, maternal deaths, post partum hemoglobin tests, etc. See Annexure 5 for Monthly Facility Report.

A monthly facility report should be filled with information gathered from the labour room register. This report gives idea of following indicators:

- Workload in terms of deliveries
- Still birth rate
- Neonatal mortality rate (esp. pre discharge)
- Caesarean section rate

Sometimes data is not accurately recorded by the providers (e.g., neonatal deaths, maternal complications and deaths). The team member should try and ensure that they are recorded accurately. However, s/he should refrain from commenting on the data immediately (e.g., if there is high stillbirth rate or high maternal mortality), since that might prevent accurate reporting of data in future. For example, a high still birth ratio in a facility could be an indicator of poor childbirth practices like frequent augmentation or fundal pressure being applied. Any such indication should be brought to the notice of the facility in-charge or CMHO.

f. Scoring sheet: A scoring sheet has been developed based on 3 tools - the delivery observation checklist, the facility checklist and the client interview form. It has been divided into two major sections, practices and input indicators.

In the scoring sheet, items have been scaled back from their original numbers in order to target the most pressing indicators of inputs and practices for maternal and perinatal survival. It includes a total of 17 practices and 10 items of inputs. For example, the facility assessment checklist has nearly 40 parameters, but in the scoring sheet only 10 items have been included. The score for each practice is based on its projected impact on maternal and neonatal survival as determined by experts, with zero representing presence or an incorrect practice or absence of a beneficial practice and the higher number representing the correct practice or absence of a negative practice. For practices having a higher impact on maternal or neonatal mortality, a higher score is allocated for correct practice.

Practice score: Practice score has been developed on the basis of the following:

- Delivery observation checklist
- Client interview checklist.

The maximum potential score depends on whether or not a delivery could be observed during the visit of the project staff. For example, if on the day of a particular visit, a delivery can be observed, the maximum score would be 25, and if it can't be observed, then the maximum score would be 19 because some critical indications can be assessed only through observation.

On each visit, a score is derived for each facility, and the percentage rate of change of practice is assessed (either an increasing rate demonstrating more optimal actions being implemented, or a decreasing rate demonstrating the opposite). This practice score tells us about the quality of evidence based care practices at that facility.

Input score: The second part of the score sheet covers input indicators. This has been developed on the basis of the facility checklist and the staff deployment and training checklist.

If a particular equipment item or medicine is found in the labour room at the time of the visit, then the assigned score is given. If the equipment is present but is not kept in the labour room or if the equipment is not present, then zero score is given (e.g., if stethoscope is available in the antenatal OPD but not in the labour room, then zero score is given). This also includes the training status of the nurses and doctors in SBA and EBC respectively. The maximum score for inputs is 12. The higher the score the better is the performance of the facility. See Annexure 6 for Scoring Sheet.

Finally, the total score achieved by the facility should be compared with its previous score. The scoring sheet incorporates scores for each such selected practice and input. Total percentage scores for practices and inputs should be separately calculated and assessed against the previous scores of the facility.

8 Feedback

8 a. On-the-spot feedback to facilities: This can be given by the QI team member to the facility in-charge (e.g., Principal Medical Officer/Medical Officer in charge, the nurse in-charge of the labour room) by writing a report recording correct performance harmful practices that are being followed and beneficial practices that are not being followed. Feedback should be based on practices and inputs and should discuss ways to improve them. It is important that both written and verbal feedback is given.

Verbal feedback can be given to all staff members present, such as the labour room nurses, labour room in-charge, doctors and the facility in-charge. This feedback can be in the form of a discussion regarding gaps in equipment and supplies, practices, challenges, duties of staff, availability of trained staff, and the team member can discuss with them the required steps to improve the situation.

Handwritten feedback can be given to the facility in-charge and the officer in-charge of the block (BCMHO or equipment). The feedback should include details such as dates of the visit to the facility and what was observed. Practices and inputs which need improvement can be enlisted point-wise and suggestions can be mentioned against each point. Also, the scoring sheet can be attached.



During visits when the government representative accompanies the QI team to the facility for assessment, verbal feedback can be given to the nurse in-charge/doctors during the assessment process. Simultaneously, immediate written feedback on the issues and improvements recognized at the meeting should be handed over to the government representative and his/her signatures alongside that of nurse in-charge/facility in-charge should be taken. This would ideally enable them to react faster to the improvements required. Remember, the feedback should be in the nature of constructive suggestions and not in form of negative criticism.

It is very important that the team member should know about funding guidelines issued by the health department and in the State Programme Implementation Plan (PIP). This is to ensure that if any facility reports absence of equipment and supplies due to lack of funds, then the member should be able to tell them where they can locate funds for purchase of the same. A format for feedback and report card as attached as Annexure 7.

8 b. Sharing of report cards with block and district level health officials: A bimonthly or quarterly report regarding the working of the facilities should be shared with district level officers (CMHO, RCHO, DPM). This report card consists of a brief assessment of the facility including both positive and negative findings. It should especially focus on those issues which need to be handled at the district or block level, and need administrative action. Persistent problems at any facility which are still not fixed should be mentioned with reasons. If a facility has shown improvement, then this should also be mentioned in the report. A copy of a sample report card shared with a district is attached as annexure 12

8 c. Sharing the findings with zonal and state level: Since quality improvement is carried out in partnership with state government, findings should be shared with zonal and state government officials at a frequency of 3-6 months, as appropriate. This should include a brief report of all districts, and comparative scores. Major findings in terms of improvements that occurred and persisting gaps should also be mentioned.

9 Training

9 a. On site orientation of nurses and doctors: Based on specific gaps in practices identified on a visit, the team member can carry out a short orientation of 1-2 hours for facility and nursing staff. On site orientation serves two purposes:

1. Since all nursing staff may not have attended Skilled Birth Attendance (SBA) training course, there will be some nurses who will in service not have been oriented on evidence based care practices and the rationale behind them. Similarly, all doctors may not have undergone orientation training on evidence based care.
2. Even those who have undergone SBA training may not be fully convinced about the need to change practices. They may need further orientation and explanation on some of the practices, hence brief training using audio visual aids can be useful.



In these on-site training sessions, audio visual presentations and guidance materials which have been developed within the programme can be used. The sessions can be supplemented with practical examples within the same health facility. The currently available presentations are in Hindi and designed in the form of a visual tour, which is expected to have greater impact on the understanding of why certain practices should be implemented and why some shouldn't be. In a way that makes it simple for the nursing staff to understand, e.g. the presentation demonstrates how unnecessary augmentation can be harmful to the fetus and newborn.

During pre-service training, many doctors and nurses would have observed and learnt several MNH care practices that are not evidence based (e.g., routine episiotomy, lithotomy position for delivery). Onsite training serves to change their knowledge and attitudes. Team members can conduct this session in any available room where nursing staff can sit and watch the presentations on a laptop. Ideally, the team member should decide on a suitable date in consultation with staff members, when many members of staff will be free. The most appropriate time for the training would be when there is a shift change of nurses (e.g., around 1pm to 3 pm), when more nurses can gather at the same time.

Four videos are available with this tool kit on topics such as the harmful effects of augmentation of labour, episiotomy, management of eclampsia, PPH, etc. One or more of these videos can be shown during the training session. A brief description of the videos is given below.

- Animated presentation on “Harmful Effects of Augmentation of Labour” (developed by the project): This video depicts the harmful effects of routine augmentation of labour, its indications and situations in which it might be appropriate.
- Animated presentation on Episiotomy (developed by the project): This video describes the process of episiotomy-what is it, its indications, and risks associated with it.
- Animated presentation on “Alternative Birth Positions for Delivery” (developed by the project): This video shows the advantages of upright position during labour and how to conduct delivery in non-supine (upright) positions.
- Video on Safe Institutional Delivery (developed by government of India and UNICEF): This video is in the form of 5 modules, which include: (1) antenatal care (2) care of the mother during the different stages of labour, preparations for the delivery, etc. (3) new born care, (4) management of eclampsia (5) management of post partum hemorrhage

The necessary equipment required for the training such as laptop, speakers, etc. should be arranged by the team member well in advance. After the training is over, doubts of the participants should be entertained and their feedback should be encouraged.

9b. Providing communication materials: Some materials have been developed as reminders or educational materials for the staff.

- i. **Poster on evidence based care practices during each stage of labour and immediate postpartum period:** This poster lists 19 practices for normal labour, classified for each stage of labour. It is available in Hindi and English. The poster can be displayed in labour room, to act as reminder on evidence based care practices. See annexure 8a and 8b.
- ii. **Recommendations for key delivery and newborn care practices in health facilities of Rajasthan:** This guidebook provides the rationale for 10 selected practices which have greater impact on maternal and perinatal outcomes. It is in simple English and has reader friendly content in question and answer format. It has been developed for doctors and district level officers. In very simple language it explains 10 key practices- augmentation of labour, routine episiotomy, position for delivery, active management of third stage of labour, monitoring of labour and partograph, timing of discharge, readiness to deal with birth asphyxia, initiation of breastfeeding, immediate thermal protection of the new born and hand washing for delivery and neonatal care. QI team members should carry a few extra copies of this book on each visit, and use it during discussions with doctors, especially for those

who have not gone through the orientation training programme on evidence based care. They may leave a copy of this book for doctors who request the same . See Annexure 9 .

- iii. Posters for front line workers and community members:** To improve awareness of family members who accompany the woman in labour, a set of five posters have been developed. They may be pasted in the waiting area and postnatal ward, where staff and families can see them. See annexure 10
- iv. Pamphlet for ASHAs and pregnant women:** In an effort to further educate community members—primarily ASHAs—about best practices in care related to labour and delivery, a handout has been developed in simple Hindi to explain the rationale behind important evidence based care practices. These pamphlets can be disseminated during meetings with ASHAs and other community level persons so that they may demand and comply with safe practices when they accompany a woman for delivery. See annexure 11.

10 Action

10.1 Facility level actions

In collaboration with staff of the facility, QI team members can take actions to fill some gaps on the spot. Actions might be needed to fill in the gaps related to equipment and supplies, cleanliness and practices. This may involve active engagement with all stakeholders like the nurse in-charge, doctors, facility in-charge, sweepers, store keeper etc.

a. Gaps related to equipment or supplies: The supplies of the labour room should always be up to date. In some cases, there might be a shortage of delivery equipment, while in other cases, items such as stethoscope, BP instrument or neonatal ambubag, or even bed sheets might be available in the store room and yet may have not been issued to the labour room. The team member should facilitate the labour room staff to contact the store keeper and move the necessary equipment from the store to the labour room.

The team member should first check the labour room for supplies. If s/he finds lack of supplies or missing equipment or medicines, then s/he should check with the labour room in-charge whether the indent for those supplies was filled. If not, then s/he should assist them to indent the item (s) required. If the item was indented some time ago, then the team member should follow up with the store keeper and ensure supply of the equipment, medicines and other supplies. If the supplies are lacking in store room as well, then the team member can inform the facility in-charge and discuss whom to approach or purchase it using untied funds of the NHM. Also s/he should facilitate better communication between the labour room and the store room in-charge to ensure smooth functioning of the facility.

b. Gaps related to non-use of a facility: There might be cases in which such as the Newborn Stabilisation Unit (NBSU) has been closed for a few days or weeks, with all the functional equipment lying inside. The team member can find out from staff involved about the reasons for it. Experience has revealed that at time there are trivial reasons such as "the key is missing" and "nobody has taken responsibility for it". In such cases, the team member can get the room opened and make sure it begins to be used, while also looking into human resource availability.

c. Gaps related to cleanliness: Sometimes cleanliness of facility (especially labour room) is very poor. The team member might find that the labour table, the wash basin and most of the equipment stained with old blood or having cigarette butts lying around. It might appear in such facilities, that nobody wants to take responsibility for cleanliness of the labour room and postnatal ward. In such cases, the team member should help ensure that the cleaning staff is present and that there is a system in place for regular cleaning of the labour room, labour table and all equipment.

Gaps related to staff deployment: The team member should recommend appropriate distribution of staff as per need the facility with an average of 60-70% in the day time since there are patients in the OPD and 30-40% at night. If the number of staff/doctors is inappropriate or the number of trained staff is low, the facility in-charge should be informed so as to facilitate internal transfer or new recruitment and fill in the gaps.

Discharge Card: A discharge card has been developed, to help assess and ensure that the mother and baby are in fit condition to be discharged. The team member should make sure that the staff (nurse or doctor) use it to assess condition of mother and baby before discharge. See Annexure 13 for a sample discharge card.

10.2. District level actions

During facility visits, the team member might come across some issues, in which the facility staff is unable to resolve the problem. Such issues need to be discussed with district CMHO for his/her action.

- i. **Purchasing and supplying items:** For example, the facility in charge may not be clear whether they have the authority to purchase certain items and might need approval from the district authority.
- ii. **Recruitment or deployment of staff:** Similarly, sometimes there might be a shortage of staff at facility level, and the district officer might be in a position to recruit contractual staff at the facility, or depute staff from another facility, where delivery caseload is lower.
- iii. **Quarterly visits by district level government officials:** Once the QI team has started conducting quality improvement visits, they should also try to ensure that district or block level officers visit the facilities once in 3-4 months. During these visits, the team should assess the facility in presence of district level officers, so that they understand the situation first hand, take steps to fill the gaps, and give necessary feedback and instructions to facility level staff.
- iv. **Training of nurses in skilled attendance:** In those facilities where a large proportion of nurses are not trained in skilled attendance (SBA), it is a priority that the team member discusses the situation with district level officers, and enables more nurses from high caseload facilities to undergo SBA training. S/he should also encourage more nurses who are involved in clinical work to undergo SBA training. Through SBA training, the nurses will become more skilled in providing care for women and newborns around the time of childbirth.

10.3. Zonal or state level actions

- I. **One day orientation programme for doctors:** It is useful to arrange a one day orientation programme for all the doctors of selected facilities, so that they get oriented on the rationale behind all evidence based care practices and recent research updates on childbirth practices and newborn care. If they have any queries, then these can be resolved during this orientation programme. This orientation programme should be conducted in partnership with state or zonal level government officers. Experts on evidence based maternal and neonatal health care should act as trainers. The trainers should have very sound knowledge of evidence based care practices, understanding the situation at community health centers and should conduct the session in a non-authoritarian manner. Additionally, it is important to have a Director, Reproductive and Child Health or Officer Joint Director of the zone to chair an opening or closing session, to provide guidance on behalf of the state. A sample schedule for such a programme is attached in annexure 14.

11 Conclusion

This tool kit has been developed so that the childbirth can become safer when women go to deliver at public health facilities, with the ultimate goal of reducing maternal and neonatal mortality. It contains tools used in a quality improvement programme in Rajasthan from 2009 to 2014. With necessary adaptations, it can be used in other parts of India or other similar countries, where issues related to childbirth practices are similar.

The toolkit is only an aid to various components of this can be adapted based on state or district level contexts. For effective use of this toolkit, everyone involved in quality assurance process should agree on its purpose and how the results will be used. For example, it should be kept in mind that this toolkit only serves to assess and improve the quality of routine childbirth and has not been developed for emergency obstetric and neonatal care.

At the macro level, the results of assessment and feedback might show need for some actions that need more fund allocation at country level. It might be possible that the assessment reveals a need for better reallocation of staff from state level, or developing norms for staff presence based on delivery caseloads. At national or state level, policy makers might decide to integrate the training on evidence based care practices during pre service training of doctors and nurses, and might work facilitate appropriate changes in curricula. It is also possible that the state government decides to make changes at level of medical colleges where most doctors learn their practices and which are seen as role models. We feel that this toolkit is a small step to facilitate the process of quality improvement and will continue to evolve as needs of public health facilities change over time.

Annexures

Annexure 1

Observation of Delivery Checklist	
Observation check list for evidence based delivery and new born care practices	
Name of Observer	
Name of District	
Name of Block	
Name of facility	
Date	
Time	

Sr. No	Practices	I observation	II observation
		Mother's Name/Husband's name/Address of deliveries observe	Mother's Name/Husband's name/Address of deliveries observe
1	Was the pubic hair of the labouring woman shaved?	Yes/No	Yes/No
2	Was she administered enema?	Yes/No	Yes/No
3	Was the progress of labour recorded in the partograph?	Yes/No	Yes/No
4	Was the delivery conducted in semi-sitting position or in non supine position comfortable to her?	Yes/No	Yes/No
5	During labour, were the fetal heart sounds monitored with the help of a stethoscope?	Yes/No	Yes/No
6	Was mother's blood pressure and pulse monitored during labour at least once in 2 hours?	Yes/No	Yes/No
7	Did the nurse/ doctor wash his/her hands before conducting vaginal examination?	Yes/No	Yes/No
8	Were sterilized gloves used during vaginal examination?	Yes/No	Yes/No
9	Was the mother given any medicines/ injections/gel for augmentation of labour?	Yes/No	Yes/No
10	Before delivery, did the nurse/doctor wash his/her hands?	Yes/No	Yes/No
11	Was episiotomy given ?	Yes/No	Yes/No

Sr. No	Practices	I observation	II observation
12	Was fundal pressure applied to push the baby out?	Yes/No	Yes/No
13	After delivery, was the cord cut after a minute or did they wait till the heart beat stop in the cord?	Yes/No	Yes/No
14	Was the drying and wrapping of newborn done properly?	Yes/No	Yes/No
15	Was the women given oxytocin after the baby was delivered and the doctors checked to make sure that another baby did not exist in the womb?	Yes/No	Yes/No
16	Did the nurse massage the mother's abdomen (uterus) after delivery?	Yes/No	Yes/No
17	Was the mother's vagina packed after delivery?	Yes/No	Yes/No
18	Was a suction of baby's nose and mouth carried out after birth?	Yes/No	Yes/No
19	If suction was done, which instrument was used for suction?	Mucus sucker/ Electrical suction	Mucus sucker/ Electrical suction
20	Was the breastfeeding started within an hour of the delivery?	Yes/No	Yes/No
21	Was the woman's BP checked after delivery in the labour room?	Yes/No	Yes/No
22	After delivery, was the mother's pulse checked inside the labour room?	Yes/No	Yes/No

Annexure 2

Facility assessment checklist		
Assessment of equipment and supplies in labour room and other facilities		
District- Facility -	Block- Response by-	
Assessment of practices in the facility (equipment)	Visit- Date-	Visit- Date-
Is a Generator or Invertor present? Generator+Inverto Generator/Invertor		
Is the generator or Invertor in working order?		
Cloth (1m*1m) for drying and wrapping newborn		
Scissors		
Disposable cord lamp/cord tie/thread		
Cord clamp or artery forceps		
Disposable mucus sucker		
Silicon Ambu bag for newborn		
Silicon Ambu bag for adult		
2 neonatal masks (small and large)		
Clock with seconds needle		
Baby tray		
Room heater		
Radiant Warmer/ Bulb		
Pan weighing scale for newborn		
Low reading thermometer (min reading 35° C)		
Synthetic, washable warm blanket for LBW babies		
Oxytocin available in labour room		
Magnesium sulfate in labour room		
Disposable syringe 5 ml		
Needle size: 22, 23		
Stethoscope		

BP instrument		
Partograph chart		
Gauze pieces to clean baby's mouth		
Washbasin with soap and running water		
Autoclave drum in labour room		
Steam sterilizer/ boiler in labour room		
Antiseptic solution (chlorhexidine/ savlon)		
Povidone iodine solution		
Bleaching powder/Chlorine solution		
Latex gloves		
Long rubber gloves (for cleaning floors, dirty instruments etc.)		
Labour room condition? Dirty/Clean		
Condition of the labour table? Dirty /Clean		
Was blood stuck on the labour table?		
What is the condition of the neonatal trolley? Dirty/Clean		
How many beds (neonatal warmers) does the neonatal nursery (FBNC/NBSU) have? Number of beds		
How many beds does the postnatal ward room? Number of beds		
Oxygen cylinder		
IEC Material(chart) on Evidence based practices		

Annexure 3

Checklist for Client Interview in postnatal ward			
S.N.	Name of mother/husband/Address	Woman 1	Woman 2
1-	What was the time of delivery? (For coding only) Hours after delivery?	Place- Date- Time-	Place- Date- Time-
2-	Were you given an enema before delivery?	Yes/No	Yes/No
3-	Was your pubic hair shaved before delivery?	Yes/No	Yes/No
4-	Was your baby's heart beat checked during labour pain?	Yes/No	Yes/No
5-	Was your BP and pulse checked during labour pain?	Yes/No	Yes/No
6-	Were you administered any injection or medicines before delivery to increase labour pain?	Yes/No	Yes/No
7-	Was episiotomy done? Primi / multi	Yes/ No	Yes/ No
8-	Was abdominal pressure done to push the baby out?	Yes/ No	Yes/ No
9-	Under what position/ condition was delivery conducted?	Lithotomy/ sitting	Lithotomy/ sitting
10-	Were you given any injection immediately after delivery?	Yes/ No	Yes/ No
11-	How many hours after delivery did you feed your child?	Within half hour/ Between 1-4 Hrs Between 4-12 Hrs Not yet	Within half hour/ Between 1-4 Hrs Between 4-12 Hrs Not yet
12-	Within 12 hours of the delivery, how many times did the nurse check BP?	Yes/ No	Yes/ No
13-	Did the nurse check the baby after delivery?	Yes/ No	Yes/ No
14-	After delivery, was a pad kept on the vagina?	Yes/ No	Yes/ No
15-	How long after the delivery were you discharged from the hospital?	Between 1-4 Hrs Between 4-8 Hrs Between 8-12 Hrs Between 12-24 Hrs After 48 Hrs	Between 1-4 Hrs Between 4-8 Hrs Between 8-12 Hrs Between 12-24 Hrs After 48 Hrs

Annexure 4

Progress of Staff Deployment		
Progress in Staff Deployment and Training		
District Facility	SBA Trained or Not Trained- T/ NT	
	I Visit	II Visit
Date		
Nurses Posted in LR (Mention Names)		
Nurses staff Duty Plan		
Nurses Posted in FBNC (Mention Names)		
Gynecologist (DGO,MD,MS) Mention Names	Oriented on EBC	Oriented on EBC
Pediatrician (Mention Names)		

Annexure 5

Monthly Facility Report			
District- Facility -	Block-		
Month Name			
Response by			
Total Numbers of Deliveries			
Number of live births			
Number of still births			
Number of newborn dead (after delivery & before discharge)			
Type of delivery			
a) Normal			
b) Forceps			
c) CS			
Any maternal complication			
Breech			
Number of new born referred to higher facility			
Number of maternal referrals			
Number of blood units used?			
Number of maternal deaths (in facility and those who were referred)			
Number of women with maternal complications who went LAMA/pregnant/postpartum/absconded			

Annexure 6

Scoring Sheet				
Date of visit :	Score			
Practices indicators				
Shaving of pubic hair	Y=0	n=1	Deli obser	RDW Interview
Routine Enema	Y=0	n=1	Deli obser	RDW Interview
Partograph chart used	Y=1	n=0	Deli obser	
FHS heard during labour	Y=1	n=0	Deli obser	RDW Interview
Position of delivery	Lithotomy=0	sitting=1	Deli obser	RDW Interview
Augmentation of labour	Y=0	n=3	Deli obser	RDW Interview
Episiotomy for primis	Y=0	n=2	Deli obser	RDW Interview
Abdominal pressure	Y=0	n=1	Deli obser	RDW Interview
IM oxytocin after delivery	Y=3	n=0	Deli obser	RDW Interview
Vaginal packing	Y=0	n=1	Deli obser	RDW Interview
Proper drying and wrapping of new born	Y=1	n=0	Deli obser	
Routine suction of all new born	Y=0	n=1	Deli obser	
Initiation of breast feeding within 1 hour	N=0	y=2	Deli obser	RDW Interview
Timing of discharge	<12 hr=0	>24 hr=2		RDW Interview
Sterile gloves used for delivery	Y=1	n=0	Deli obser	
Hand washing before conducting delivery	Y=1	n=0	Deli obser	
Post partum check up in ward	Y=2	n=0		RDW Interview
Total Score for this facility			25	20
Total score possible				
% score for practices				
Input Indicators				
Ambubag kept ready in LR	Y=1	N=0	Facility assess.	
BP Instru+sthető ready in LR	Y=	N=0	Facility assess.	
Washbasin and running water in LR	Y=1	N=0	Facility assess.	
Autoclave present in working condition	Y=1	N=0	Facility assess.	
Labour room clean	Y=1	N=0	Facility assess.	
Labour room condition	Clean=1	Has blood stuck=0		
Oxytocin available in LR	Y=1	N=0	Facility assess.	
Staff in LR SBA trained	All=2	Half=1	Facility assess.	
Doctors (who conduct delivery) oriented on EBC	All=2	Half=1	Facility assess.	
IEC material (chart) on evi based practices displayed in LR	Y=1	No=0	Facility assess.	
Total Score for this facility			12	
Total score possible				
% score for practices				

Annexure 7

Facility Feedback Forms		
"Parijaat"		
<p>Date:</p> <p>Time:</p> <p>Today a joint visit was undertaken by -----(government officer) and----- (representative from ARTH) -----</p> <p>During this visit, following suggestions here made -</p>		
<p>Major suggestions</p> 	<p>Responsible person</p> 	
<p>Signature -----</p> <p>Post -----</p> <p>Name -----</p> <p>(ARTH/Govt.)</p>	<p>Signature -----</p> <p>Post -----</p> <p>Name -----</p> <p>(ARTH/Govt.)</p>	<p>Signature -----</p> <p>Post -----</p> <p>Name -----</p> <p>(ARTH/Govt.)</p>

Annexure 8 a

Poster on evidence based practices to be displayed in labour room

प्रसूता व नवजात शिशु की गुणवत्तायुक्त देखभाल

प्रसव का पहला चरण

- 1 महिला को इच्छानुसार चलने-फिरने दें
- 2 नियमित रूप से एनिमा न देकर आवश्यकतानुसार एनिमा दें
- 3 प्यूविक बालों को आवश्यकता होने पर ही हटाएँ
- 4 जब तक ज़रूरी ना हो दर्द बढ़ाने के लिए दवाओं (जैसे ऑक्सीटोसिन, मिंसोप्रोस्टॉल या प्रोस्टग्लैंडिन जैल) का प्रयोग न करें।
IM ऑक्सीटोसिन द्वारा दर्द कभी ना बढ़ाएं
- 5 प्रत्येक प्रसव की निगरानी पार्टोग्राफ भर कर ही करें
- 6 यदि आवश्यक न हो, तो चार घण्टे से पहले योनि की जांच (PV) न करें



प्रसव का दूसरा चरण

- 7 प्रथम प्रसूता में एपिसियोटमी अनिवार्य नहीं है
- 8 प्रसव को जल्दी कराने के लिए पेट पर धक्का नहीं लगाएं
- 9 यदि बच्चे की हृदय गति तथा प्रसव की प्रगति सामान्य है, तो दूसरे चरण को पूरा कराने की जल्दी न करें

प्रसव का तीसरा चरण व तुरन्त बाद देखभाल

- 10 प्रसव के तीसरे चरण का सक्रिय प्रबन्धन करें
 - प्रसव के तुरन्त बाद IM ऑक्सीटोसिन दें
 - नियंत्रित नाल खिंचाव करें
 - पेट पर हाथ रखकर गर्भाशय की मालिश करें
- 11 बच्चे के जन्म के बाद नाल को 1-2 मिनट तक न काटें (जदि माँ Rh नेगेटिव है या बच्चा शीक से सांस नहीं ले रहा है, तो तुरन्त नाल काटें)
- 12 योनि की पैकिंग न करें
- 13 बच्चे को पहले सूखे व साफ कपड़े से सुखाकर, फिर दूसरे सूखे कपड़े में लपेटें। नवजात को माँ के पेट पर रख दें
- 14 हर बच्चे का सवशन ज़रूरी नहीं (शुर्क यदि मेकोनियम है वा सांस लेने में तकलीफ है, तो म्यूकस सकर से ही सवशन करें)



प्रसवोपरांत

- 15 प्रसवोपरांत माँ व बच्चे की निगरानी पहले घण्टे में हर 15 मिनट में, फिर चार घण्टे तक हर घण्टे में, बाद में हर चार घण्टे पर करें
- 16 जन्म के तुरन्त बाद बच्चे को माँ के स्तन से लगाएं
- 17 बच्चे को पूरे कपड़े पहनाकर माँ के पास लेटा दें
- 18 प्रसव के कम से कम 24 घण्टे बाद ही अस्पताल से छुट्टी दें। यदि माँ व बच्चे में कोई समस्या हो तो आवश्यकतानुसार और दिन अस्पताल में रखें।

अधिक जानकारी के लिए देखें "Recommendations for Key Delivery and Newborn Care Practices in Health Facilities of Rajasthan"



ARTH



unicef


Poster on evidence based practices to be displayed in labour room (English)

Safe Institutional Delivery

Implementing evidence-based maternal-newborn care practices


First stage

1. Encourage the woman to move about
2. Avoid routine enema and shaving of pubic hair
3. Where facilities for caesarean section are not available, do not induce or augment labour. Never use IM oxytocin to augment labour
4. Always monitor labour using a partograph
5. Restrict pelvic examinations to once in 4 hours, unless delivery is imminent




Second stage

6. Encourage upright positions such as sitting or squatting
7. Avoid routine episiotomy for primigravidas
8. Do not apply abdominal pressure to push the baby out
9. If fetal heart sounds (FHS) are normal, do not rush to complete the 2nd stage
10. Always wash hands before handling woman or newborn




Third stage and immediately after

11. Practice active management of third stage of labour: IM oxytocin injection, controlled cord traction, uterine massage
12. Cut the cord after it stops pulsating (unless the mother is Rh negative or the baby needs resuscitation)
13. Avoid packing of the vagina
14. Dry and wrap the baby immediately after birth, cover and place it on the mother's abdomen
15. Avoid routine nasopharyngeal suction (unless liquor is meconium stained or baby is asphyxiated). If suction is needed, use mucus sucker instead of electrical suction machine.




After Delivery


16. Monitor maternal bleeding and vital signs every 15 minutes in the 1st hour, every 1 hour from 1-4 hour and every 4 hours till 24 hours
17. Initiate breastfeeding as early as possible
18. Wrap the baby and keep close to mother
19. Discharge only after 24 hours. If mother or baby have a problem, then delay discharge for a few more days




Adapted from evidence based guidelines in WHO Reproductive Health Library (RHL) and other documents




Directorate of Medical Health and Family Services, Rajasthan Government



Action Research & Training for Health



United Nations Population Fund



United Nations Children's Fund

Annexure 9

Brochure on evidence-based practices for ASHAS and Community Health Worker

सुरक्षित संस्थागत प्रसव आम पूछे जाने वाले प्रश्न



विश्वभर में होने वाली मातृ मृत्यु का एक बड़ा हिस्सा भारत में होता है, भारत में भी यदि अन्य राज्यों की अपेक्षा राजस्थान पर नज़र डालें तो स्थिति बहुत अच्छी नहीं है, जहाँ भारत में मातृ मृत्यु दर 212 है वहीं राजस्थान में यह 318 है।

इसे घटाने के लिए अनेक प्रयास किए जा रहे हैं। सन 2008 में राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के आरम्भ होने के बाद कई योजनाओं की शुरुआत की गई, जिनमें से एक प्रभावशाली व महत्वपूर्ण योजना है जननी सुरक्षा योजना। इस योजना के चलते संस्थागत प्रसव की संख्या में हुई वृद्धि विदित है, परंतु विचारणीय बात यह है कि क्या संस्थागत प्रसव ही सुरक्षित प्रसव है? एक प्रसव सुरक्षित तब कहलाता है जब प्रसव के दौरान व प्रसवोपरांत वे सभी आवश्यक कार्य किए जायें, जो महिला या नवजात शिशु में प्रसव जनित गंभीर समस्या होने से बचा सके व यदि माँ और बच्चे में कोई समस्या हो जाती है तो उसे पहचान कर तुरंत उपचार किया जा सके।

राजस्थान में किए गए शोध से यह ज्ञात हुआ है कि प्रसव के दौरान व प्रसवोपरांत कुछ ऐसी प्रक्रियाएं अपनाई जा रही हैं (उदाहरणतः दर्द बढ़ाने के लिए इन्जेक्शन, दवाईयों व जैल का प्रयोग, पेट पर धक्का लगाना व धीरा लगाना इत्यादि) जो कि उपयुक्त नहीं है, वहीं दूसरी ओर जो प्रक्रियाएं उपयुक्त हैं (उदाहरणतः प्रसवपीड़ा के दौरान नवजात शिशु के दिल की धड़कन की निगरानी करना, नवजात शिशु को सुखाकर गर्माहट में रखना व स्तनपान शुरू कराना) उन्हें अपनाया नहीं जा रहा है।

एक प्रसव को सुरक्षित बनाने के लिए जो आवश्यक प्रक्रियाएं अपनानी चाहिए उनको सूचीबद्ध करने का प्रयास इस लेख द्वारा किया गया है। हमें आशा है कि यह लेख इन प्रक्रियाओं से जुड़ी भ्रांतियों को सुलझाने में एक महत्वपूर्ण कड़ी साबित होगा व राज्य में हर प्रसव को सुरक्षित बनाया जा सकेगा ताकि मातृ व नवजात शिशु मृत्यु दर में वांछित कमी लाई जा सके।

प्रसव पीड़ा के दौरान देखभाल

1. प्रसव पीड़ा के दौरान महिला की महत्वपूर्ण जाँचे क्या हैं ?

प्रसव के प्रथम चरण में बच्चे के दिल की धड़कन को हर आधे घंटे में सुनना चाहिए, यदि दिल की धड़कन कम हो जाए तो समय से बड़े अस्पताल भेजने का फैसला किया जा सकता है, ऐसा करने से शिशु मृत्यु को रोक सकते हैं।

प्रसव के समय चार –चार घंटे के अन्तराल पर ही योनी द्वारा जाँच होनी चाहिये क्योंकि योनि की बार-बार जांच जच्चा और बच्चा दोनों के लिए हानिकारक है। किसी-किसी परिस्थिति में ही इससे जल्दी जाँच की जरूरत होती है। योनी की जाँच संक्रमण रहित दस्ताने पहनकर ही होनी चाहिये, अन्यथा माँ व नवजात शिशु को संक्रमण का खतरा रहता है।



- हर आधे घंटे में बच्चे के दिल की धड़कन को सुनना चाहिए
- दो घन्टे में महिला की रक्तचाप, नाड़ी व तापमान नापना चाहिए
- हर चार घन्टे में योनि की जांच होनी चाहिए

2. क्या प्रसव के समय दर्द बढ़ाना चाहिए ?

मीना का यह पहला बच्चा था। जापे के लिए पीहर आई थी। गर्भावस्था के दौरान उसने बराबर जांच कराई। जब उसको जापे के दर्द शुरू हुए तो घर वाले उसे पास के अस्पताल ले गए।

जब मीना अस्पताल पहुँची तो वहाँ डॉक्टर ने उसकी जांच की और नर्स ने उसे तीन-चार बार दर्द बढ़ाने के लिए सुइयाँ लगायी। तीन घण्टे बाद मीना का जापा हो गया। परन्तु बच्चा दमघुटा पैदा हुआ और कुछ घन्टो बाद मर गया।



अस्पतालों में प्रचलन यह है कि प्रसव पीड़ा को तेज करने के लिए इंजेक्शन या जैल का प्रयोग किया जाता है, ताकि प्रसव जल्द से जल्द हो, ऐसा करने से महिला के रिश्तेदार, तथा अस्पताल स्टाफ दोनों खुश होते हैं, क्योंकि स्टाफ अपनी जिम्मेदारी से मुक्त हो जाता है व परिवार वाले भी अपने घर जाकर अपने काम कर सकते हैं।

आम धारणा यह है कि प्रसव के प्रथम चरण में गर्भाशय को संकुचन को तेज करना चाहिये ताकि प्रसव जल्दी सम्पन्न हो सके।

शोध में पाया गया है कि प्रथम चरण में दर्द बढ़ाने से :-

- 1 बच्चा दमघुटा पैदा हो सकता है, या मृत जन्म हो सकता है।
- 2 महिला की बच्चेदानी जोर से सिकुड़ने से फट भी सकती है।

सामान्य प्रसव पीड़ा की अवधि

- प्रथम प्रसव में 12-24 घंटे
- दूसरे या बाद वाले में 8-18 घंटे

इसलिए प्रथम चरण में किसी भी प्रकार के दर्द बढ़ाने के साधन (इंजेक्शन ऑक्सीटोसिन, मिसोप्रोस्टोल, जैल आदि) का प्रयोग तभी करना चाहिये जब प्रसव की प्रगति बहुत धीरे हो रही हो तथा अस्पताल में तुरन्त सिजेरियन ऑपरेशन की सुविधा हो।

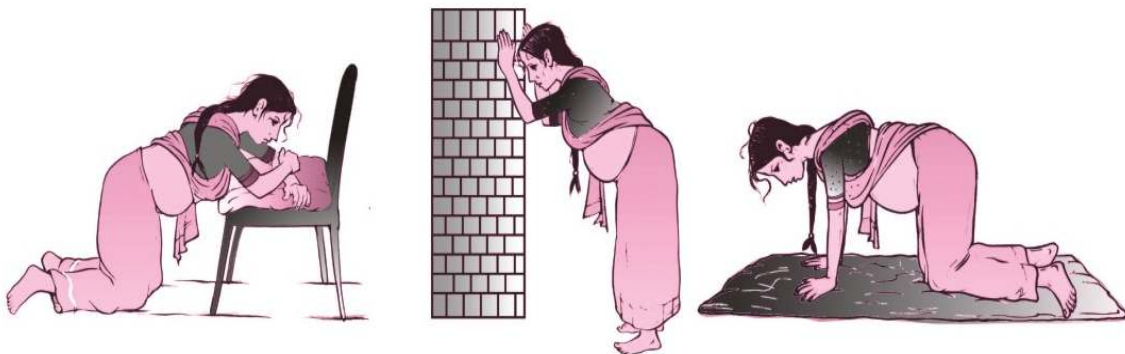
प्राथमिक स्वास्थ्य केन्द्र, उप स्वास्थ्य केन्द्र व घरों में ऐसे इंजेक्शन का इस्तेमाल नहीं करना चाहिये।

3. किस स्तर के संस्थानों में दर्द बढ़ाने की दवाईयाँ दी जा सकती हैं ?

ऐसे संस्थान जहां प्रसव के लिये ऑपरेशन की सुविधा हो तथा बच्चे के दिल की धड़कन बार-बार सुनने के लिए पर्याप्त संख्या में कुशल प्रसवकर्ता उपलब्ध हो। परंतु वह भी तब ही जब महिला को प्रसव पीड़ा सामान्य रूप से नहीं आ रही हो। परिवार वालों को डाक्टर या नर्स पर दर्द बढ़ाने की दवाईयाँ देने के लिये नहीं कहना चाहिये।

4. क्या प्रसव के दौरान महिला का लेटे रहना जरूरी है ?

ज्यादातर अस्पतालों में प्रसव के दौरान महिला को लेटाकर रखते हैं क्योंकि धारणा यह है कि महिला लेटे रहने से ज्यादा स्वस्थ रहती है, स्टाफ को भी बच्चे की धड़कन सुनने में या योनी द्वारा जांच करने में आसानी रहती है।



परंतु शोध से पता चला है कि ज्यादातर महिलाएं इस समय बैठना, खड़े रहना या चलना पसंद करती हैं, इससे महिला ज्यादा स्वस्थ व फुर्तीली रहती हैं, व बच्चे को भी कोई नुकसान नहीं होता है।

अतः प्रसव पीड़ा के समय महिला को अपनी पसंद की स्थिति में रहने के लिए प्रोत्साहित करना चाहिए।

5. प्रसव पीड़ा के दौरान महिला को क्या खाना चाहिए ?

आम धारणा यह है कि प्रसव के दौरान महिला को कुछ भी खाना पीना नहीं चाहिए, इसलिए घरों में तथा बहुत से अस्पतालों में महिला को खाने में कुछ खास नहीं दिया जाता है, परन्तु शोध से पता चला है कि सामान्य प्रसव के दौरान महिला को तरल पदार्थ या हल्का भोजन लेने से कोई परेशानी नहीं होती बल्कि लाभ ही होता है। भोजन लेने वाली महिलाओं में ज्यादा उर्जा रहती है और ये ज्यादा आसानी से प्रसव पीड़ा सहन कर सकती हैं।

6. क्या महिला के साथ प्रसव कक्ष में किसी को रहना चाहिए ?

कई अस्पतालों में प्रसव पीड़ा के दौरान महिला को एकदम अकेला रखा जाता है। ऐसे में कई बार महिला में तनाव हो जाता है व उसके गर्भाशय के संकुचन कम हो जाते हैं।



शोध से यह पता चला है कि जन्म के समय महिला को जिस पर भरोसा हो, ऐसे किसी व्यक्ति को महिला के साथ रहने देना चाहिए।

यह व्यक्ति महिला को मानसिक संबल के साथ-साथ खाने पीने में मदद कर सकता है, व यदि महिला को कोई भी तकलीफ हो तो तुरन्त नर्स या डॉक्टर को भी बुला सकता है।

7. क्या प्रसव के समय चीरा (एपिसियोटमी) लगाना चाहिए ?

ज्यादातर अस्पतालों में प्रथम प्रसव में तथा कई बार दूसरे में भी नियमित रूप से नीचे एक चीरा (एपिसियोटमी) लगाया जाता है।

आम धारणा यह है कि चीरा (एपिसियोटमी) लगाने से डिलीवरी आसानी से होती है।

तुलसी की यह पहली गर्भावस्था थी वह जापे के लिए पीहर आई थी। गर्भावस्था के दौरान उसने अपनी तीनों जांचे करवाई थी।

जापे का दर्द शुरू होते ही घरवाले उसे पास के अस्पताल ले गए। जापा करवाने के लिए डॉक्टर ने उसे चीरा लगाया और तुलसी का जापा पूरा हुआ। जापे के बाद उसे नीचे को दर्द होता था और वह अपने पति के पास जाने में बहुत असहज महसूस करने लगी।



शोध से पता चला है कि चीरा लगाने से महिला को

- कभी कभी चीरे से अधिक रक्तस्राव होने की संभावना होती है।
- टांको में संक्रमण का खतरा रहता है, तथा
- महिला को बाद में यौन संपर्क के समय दर्द और मानसिक तनाव रहता है।

जबकि चीरा नहीं लगाने से बच्चे को कोई नुकसान नहीं होता है, तथा महिला के नीचे की मांसपेशियां ज्यादा स्वस्थ रहती हैं। अतः हर महिला को चीरा (एपिसियोटमी) नहीं लगाना चाहिये व आवश्यकतानुसार ही लगाया जाना चाहिये।

प्रसव के तुरन्त बाद देखभाल

8. प्रसव के तुरन्त बाद रक्तस्राव कम करने के लिए क्या करना चाहिए ?

शोध से पता चला है कि प्रसव के बाद रक्तस्राव होने का प्रमुख कारण है गर्भाशय का संकुचन कम होना। जन्म के तुरन्त बाद और आंवल निकलने से पहले ऑक्सीटोसिन इंजेक्शन के प्रयोग से गर्भाशय अच्छी तरह से संकुचित हो जाता है, जिससे प्रसवोपरान्त रक्तस्राव कम होता है। यह मातृ मृत्यु रोकने में अहम् भूमिका निभाता है, तथा महिलाओं को खून की कमी से भी बचाता है।

अतः सभी प्रसवों के तुरन्त बाद महिला को गर्भाशय संकुचन के लिए ऑक्सीटोसिन इंजेक्शन लगाना चाहिए।



9. क्या प्रसव के बाद योनि की पैकिंग करनी चाहिए ?

बहुत से अस्पतालों में प्रचलित रीति है प्रसव के बाद योनि में पैक (पैड या रूई) रखना। धारणा यह है कि पैक एपिसियोटमी/चीरे पर जरूरी दबाव बनाए रखता है जिससे कि रक्तस्राव कम होता है, इसलिए 1-2 घंटे के लिए पैक रखने में कोई हानि नहीं है।

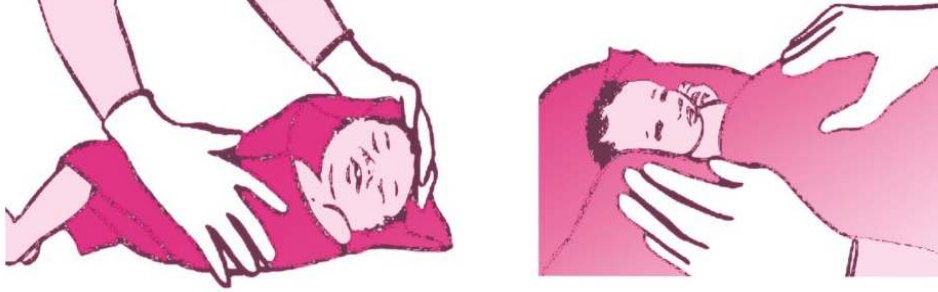
परंतु शोध से पता चला है कि यदि प्रसव के बाद महिला के अधिक रक्त स्राव हो (खून जाये) और योनि के अन्दर पैक रखा हो तो पैक के कारण खून अंदर ही अंदर जमा होता रहता है और महिला या उसकी देखभाल करने वाली नर्स को इसका पता भी नहीं चलता। कभी-कभी इससे महिला की हालत बिगड़ सकती है। कई बार स्टाफ पैक्स निकालना भूल भी जाते हैं, जिससे संक्रमण पैदा होता है।

इसलिए प्रसव के बाद चाहे साधारण प्रसव हो या नीचे चीरा दिया हो, योनि में पैक नहीं रखना चाहिये।

10. क्या जन्म के तुरन्त बाद बच्चे को नहलाना चाहिए ?

साधारणतः घरों में व अस्पतालों में बच्चे को जन्म लेने के तुरन्त बाद उसे नहला दिया जाता है, सोच यह रहती कि बच्चे के शरीर पर जो सफेद परत रहती है उसे साफ करना चाहिये। शोध से यह पता चला है कि **बच्चे को जन्म के बाद सात दिन तक नहीं नहलाना चाहिए।** बच्चे के शरीर के सफेद परत उसे ठंडा पड़ने से बचाती है, इसलिए जन्म के बाद बच्चे को **सिर्फ एक सूखे कपड़े से ढाँककर दूसरे सूखे कपड़े में लपेटना चाहिए।**

11. नवजात शिशु को सुखाना व पोंछना क्यों जरूरी है ?



जन्म के समय बच्चे गीले होते हैं, और शुरू के कुछ मिनटों में अगर उन्हें गीला छोड़ दिया जाये, तुरन्त ढंका न जाये या कमरे में हवा आ रही हो तो उनका शरीर अचानक से ठंडा पड़ सकता है। ठंडा पड़ने से शिशु के मरने की संभवना बढ़ जाती है। इसलिये यह जरूरी है कि जन्म के तुरन्त बाद बच्चे को सुखाया जाये और फिर गीला कपड़ा हटाकर एक सूखे कपड़े से लपेटा जाये।

जन्म के तुरन्त बाद बच्चे को ढक देने से उसका शारीरिक तापमान नियंत्रित रहता है तथा बच्चे को ठण्डा पड़ने का खतरा कम हो जाता है। बच्चे के जन्म के बाद के 6-12 घन्टे तक उसके ठण्डा पड़ने की सबसे अधिक संभावनाएं होती हैं।

बच्चे को गर्म रखने के तरीके

शिशु को माँ की त्वचा के संपर्क में रखना चाहिए, क्योंकि माँ की गर्माहट से शिशु का शारीरिक तापमान नियंत्रित रहता है। शिशु को जन्म के बाद माँ की छाती पर रखना चाहिए तथा माँ व बच्चे दोनों को एक गर्म कपड़े या कम्बल से ढक देना चाहिए, बच्चे के सिर को ढकना बहुत जरूरी है।



12. स्तनपान कब शुरू करवाना चाहिए ?

ग्रामीण क्षेत्रों में यह माना जाता है कि जापे के तीन दिन तक माँ का दूध नहीं आता, इसलिए शुरू के दिनों में बच्चे को स्तनपान नहीं करवाया जाता।

शोध से पता चलता है कि जन्म के तुरंत बाद स्तन से निकलने वाला पीला चिकना खीस शिशु को विभिन्न प्रकार की बीमारियों से सुरक्षा करता है, शिशु मृत्यु दर कम करता है व माँ को भी कई प्रसवोपरान्त समस्याओं से बचाता है।

अतः प्रसव के तुरन्त बाद (किसी भी हालत में एक घन्टे के अन्दर) बच्चे को स्तनपान शुरू करवा देना चाहिए ताकि माँ और बच्चा दोनों स्वस्थ रहें। कोई भी अन्य तरल पदार्थ बच्चे को नहीं पिलाया जाना चाहिए।



13. प्रसव के बाद पहले दिन पर महिला की क्या क्या देखभाल होनी चाहिए ?

प्रसव के बाद के 24 घंटे बहुत नाजुक होते हैं इस दौरान माँ व बच्चे की समय – समय पर जाँच होनी चाहिये:

माँ की जाँच

- नाड़ी व रक्तचाप की जाँच
- रक्तस्राव की मात्रा

शिशु की जाँच

- सांस की गति
- गर्माहट
- रंग
- नाल से रक्तस्राव
- स्तनपान



- शुरु के 1 घन्टे में - हर 15 मिनट में
- 1 से 4 घन्टे में - हर 1 घन्टे में
- उसके बाद - हर 3-4 घन्टे में

प्रसव के बाद कभी कभी महिलाओं को बहुत ज्यादा खून जाता है और उनको पता भी नहीं चलता। इसके लिए साथ आए हुए व्यक्ति को देखना चाहिए कि खून कितना जा रहा है यदि ज्यादा खून जा रहा है तो तुरंत नर्स या डॉक्टर को सूचित करें। ऐसी स्थिति में समय पर महिला का इलाज किया जाना चाहिए, अन्यथा महिला की मृत्यु भी हो सकती है।



14. प्रसव के बाद अस्पताल से छुट्टी कब होनी चाहिए ?

बहुत से अस्पतालों में प्रसव के दो-चार घण्टे बाद ही प्रसूता को छुट्टी दे दी जाती है। इसके पीछे आम धारणा यह है कि प्रसव यदि सही हो गया है तो अस्पताल में रुकने की जरूरत नहीं है, घरवाले अपने घर जाकर घर के काम को संभाल सकते हैं, तथा प्रसव के लिए लाई गई जीप को ज्यादा देर तक रुकना नहीं पड़ता है।

सज्जू का नवां महिना चल रहा था। उसे जब जापे के दर्द शुरू हुए तो परिवार के लोग उसे एक जीप से पास के अस्पताल ले गए। वहां दोपहर एक बजे ठीक से उसका जापा हो गया और जापे के एक घण्टे बाद सज्जू की छुट्टी हो गई। जब वह घर पहुंची तो उसके बहुत ज़्यादा खून बहने लगा और उसे चक्कर आने लगे। घर वालों ने फटाफट दूसरी जीप बुलाई, और उसे जीप में डालकर अस्पताल ले गये। परन्तु रास्ते में ही सज्जू की मृत्यु हो गई।



परंतु शोध के अनुसार प्रसव के पहले 48 घन्टे माँ व बच्चे के लिए सबसे खतरे का समय होता है, क्योंकि इस समय उनमें निम्न जटिलताएं आ सकती हैं: जैसे ज्यादा खून पड़ना, बच्चे का ठीक से सांस नहीं लेना, बच्चे की धड़कन बन्द हो जाना। शोध यह भी बताते हैं कि लगभग 40 प्रतिशत शिशु मृत्यु पहले 24 घन्टे में ही होती हैं।

अतः प्रसव के 48 घंटे बाद ही प्रसूता की अस्पताल से छुट्टी होनी चाहिए।

छुट्टी होने से पहले मां व बच्चे की पूरी जांच होनी चाहिए। कई महिलाओं में प्रसव के बाद खून की कमी हो जाती है, **इसलिए यदि प्रसव के बाद महिला के हीमोग्लोबिन की जाँच हो, तो यह लाभकारी है।** छुट्टी के समय महिला को आयरन की गोलियाँ देनी चाहिए। छुट्टी से पहले शिशु की भी पूरी जाँच होनी चाहिए। अधिकांश अस्पतालों में छुट्टी से पहले शिशु को बी.सी. जी., पोलियो और हीपेटाइटिस बी. का टीका भी दिया जाता है। यदि कम वजन का शिशु है, तो उसे अधिक दिन तक अस्पताल में रखना चाहिए।

निष्कर्ष:-

प्रसव महिला के जीवन की बहुत ही महत्वपूर्ण प्रक्रिया है। अतः इसका सुरक्षित होना ना केवल माँ के लिए बल्कि नवजात के लिए भी बहुत जरूरी है। उपरोक्त प्रक्रियाओं को अपनाकर हम हर प्रसव को सुरक्षित बना सकते हैं ताकि संस्थागत प्रसव के बाद परिवार एक स्वस्थ माँ व स्वस्थ शिशु को लेकर घर जा सके।

Annexure 10

Sample facility report card for district officers

"Parijaat"

प्रसव व नवजात शिशु देखभाल की गुणवत्ता सुधारना

जिला रिपोर्ट कार्ड

I पृष्ठभूमि

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन के अन्तर्गत मातृ व नवजात शिशु मृत्यु में कमी लाने के लिये कई योजनाएं संचालित की जा रही हैं। जिसमें सुरक्षित संस्थागत प्रसव को बढ़ावा देना मुख्य है। इसके फलस्वरूप संस्थागत प्रसवों में 42 प्रतिशत वृद्धि हुई है, उदाहरण के तौर पर सन् 2005-06 में यह दर 28 प्रतिशत थी जो सन् 2011-12 में 70 प्रतिशत तक हो गई।

एक संस्थागत प्रसव तब सुरक्षित कहलाता है जब प्रसव के दौरान व प्रसवोपरान्त वे सभी आवश्यक कार्य किये जाये जो महिला या नवजात शिशु को प्रसव जनित गंभीर समस्या होने से बचा सकें, व यदि मां और बच्चे में कोई समस्या हो जाती है तो उसे तुरन्त पहचान कर उसका उपचार किया जा सके। राजस्थान में किये गये शोध से यह ज्ञात हुआ है कि संस्थानों पर प्रसव के दौरान कुछ ऐसी प्रक्रियाएं अपनाई जा रही हैं जो उपयुक्त नहीं है उदाहरण के तौर पर प्रसव पीडा के दौरान दर्द बढ़ाने के इन्जेक्शन दवाईयां व जेल का प्रयोग, पेट पर धक्का लगाना, प्रसव के समय चौरा लगाना, एपिसियोटॉमी देना आदि।

संस्थागत प्रसव की गुणवत्ता को सुधारने के लिये निदेशालय चिकित्सा स्वास्थ्य एवं परिवार कल्याण विभाग राजस्थान सरकार, संयुक्त राष्ट्र जनसंख्या कोष एवं अर्थ द्वारा पारिजात कार्यक्रम के अन्तर्गत प्रसव व नवजात शिशु देखभाल की गुणवत्ता में वृद्धि हेतु पहल कर मातृ एवं शिशु मृत्यु दर में कमी लाने की दिशा में प्रयास किया है। इस कार्यक्रम में स्वास्थ्य विभाग राजस्थान सरकार के सुझाव से भरतपुर व उदयपुर संभाग के सभी जिलों (भरतपुर, धौलपुर, करौली, सर्वाइमाधोपुर, उदयपुर, बांसवाड़ा, प्रतापगढ़, चित्तौडगढ़, राजसमन्द, डूंगरपुर) में कार्य किया गया।

II उद्देश्य

1. स्वास्थ्य संस्थानों पर प्रसव के दौरान एवं प्रसव के बाद मातृ एवं शिशु देखभाल की गुणवत्ता सुधारना
2. स्वास्थ्य संस्थानों पर कार्यरत सेवा प्रदाताओं को गुणवत्ता युक्त देखभाल पर प्रशिक्षण

III जिले में स्वास्थ्य संस्थानों की चयन प्रक्रिया

जिले में पीसीटीएस आंकडे 2011 के अनुसार 900 से अधिक वार्षिक प्रसव भार वाले स्वास्थ्य संस्थानों पर इस कार्यक्रम का संचालन किया गया।

IV मुख्य गतिविधियाँ

स्वास्थ्य संस्थान पर नियमित (दो तीन माह में एक बार) विजिट किये गये तथा निम्न चरणों के माध्यम से गुणवत्ता सुधार हेतु प्रयास किये गये।

- स्वास्थ्य संस्थानों का आंकलन (Assessment)
- आंकलन से प्राप्त परिणामों की जानकारी देना (Feedback)
- गुणवत्ता सुधार हेतु सेवा प्रदाताओं को कम समय का मल्टीमीडिया प्रशिक्षण (Training)
- संस्थान पर कमियों को दूर करने के लिये उचित कदम (Action)

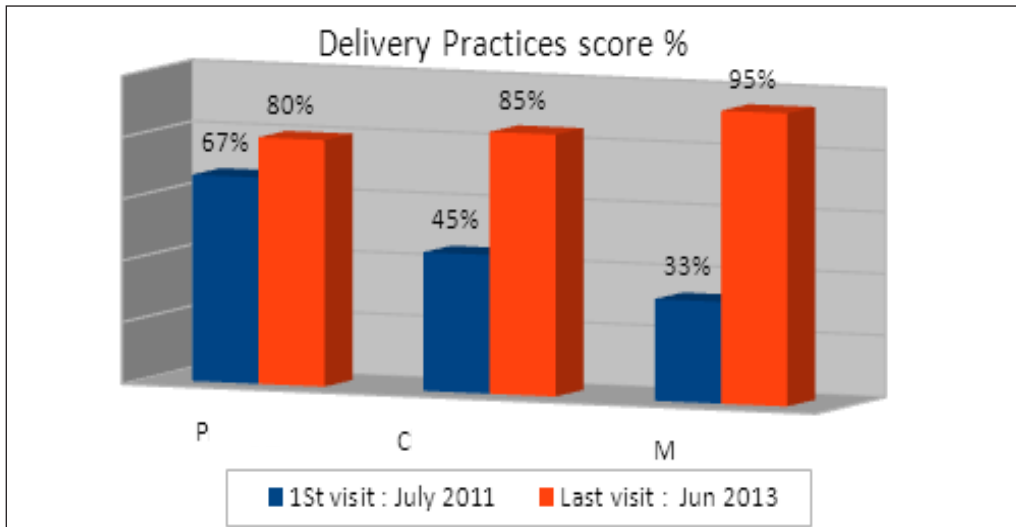
V परिणाम

प्रसव प्रक्रियाओं के अभ्यास में सुधार एवं प्रसव कक्ष में उपकरणों की उपलब्धता की प्रगति को जानने के लिए स्कोर पद्धति को अपनाया। इसके एक स्कोर चैकलिस्ट तैयार की गई। इस स्कोर चैकलिस्ट के अनुसार प्रत्येक विजिट में संस्थान के प्रसव प्रक्रियाओं के अभ्यास में सुधार एवं प्रसव कक्ष में उपकरणों की उपलब्धता का स्कोर प्रदान किया। जिसके परिणामों का विवरण इस प्रकार है।

1. प्रसव प्रक्रियाओं के प्रथम व अन्तिम आंकलन का स्कोर

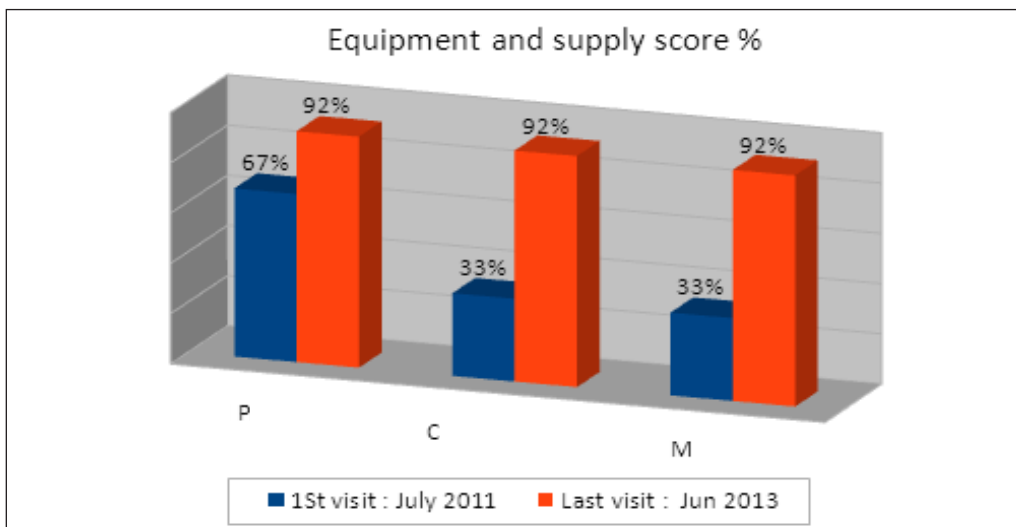
प्रत्येक संस्थान को प्रक्रियाओं के आधार पर स्कोर दिया गया जिसका विवरण निम्नानुसार है।

प्रसव प्रक्रियाओं का अभ्यास का स्कोर



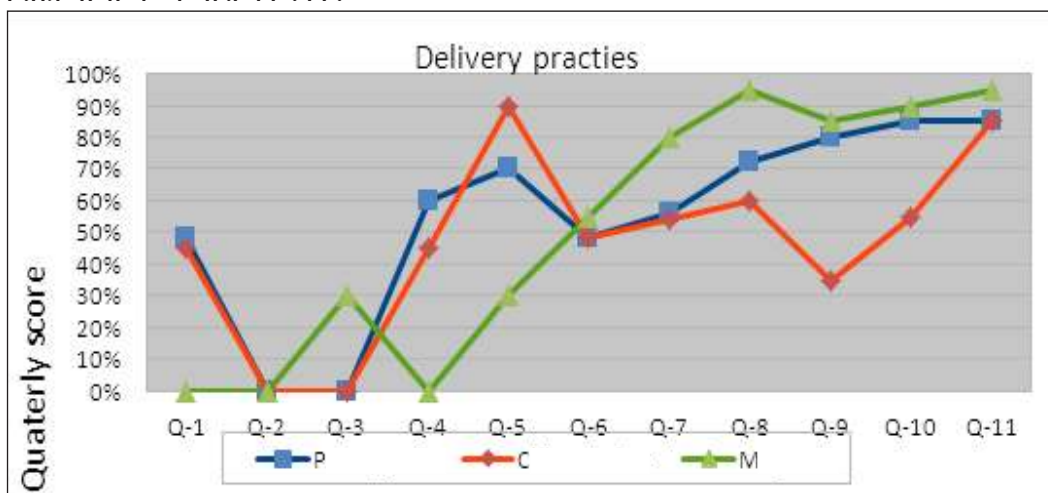
संस्थानों पर प्रसव प्रक्रियाओं के अभ्यास में सुधार लाने के लिए AFTA रणनीति को अपनाया। जिसके परिणामस्वरूप संस्थानों में सुधार हुआ। स्वास्थ्य संस्थानों पर लगातार विजिट, सरकारी प्रतिनिधियों के साथ संयुक्त विजिट, प्रसव कक्ष स्टॉफ व संस्था प्रभारी को समय-समय पर फीडबैक, डॉक्टर कार्यशाला तथा नर्सिंगकर्मियों को मल्टीमीडिया प्रजेन्टेशन आदि गतिविधियों की संस्थानों के स्कोर वृद्धि की मुख्य भूमिका में रही है। सभी संस्थानों पर प्रसव प्रक्रियाओं के अभ्यास स्कोर की तुलना (प्रथम व अन्तिम स्कोर) से करें तो सभी संस्थानों के स्कोर में वृद्धि हुई है।

प्रसव कक्ष उपकरण व अन्य सामान की उपलब्धता का स्कोर



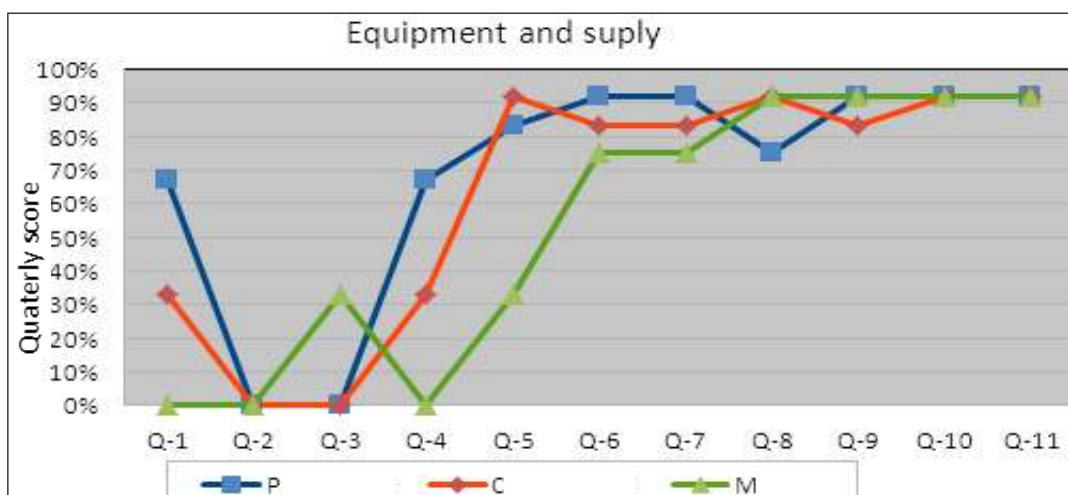
संस्थानों के प्रसव कक्ष में आंकलन सूची के अनुसार आवश्यक सभी उपकरण व सहायक सामग्री की उपलब्धता नहीं थी। जिसे क्वालिटी इम्प्रूवमेन्ट टीम के सहयोगात्मक सुपरविजन व संस्था प्रभारी और प्रसवकक्ष प्रभारी के द्वारा उठाये कदमों से इस कमी को पूरा किया गया। वर्तमान में आंकलन चैकलिस्ट के अनुसार आवश्यक उपकरण व सहायक सामग्री की उपलब्धता का स्कोर 92 प्रतिशत तक पूर्ण हुआ है।

2. विजिट के अनुसार प्रसव प्रक्रियाओं में बदलाव व प्रसव कक्ष में उपकरण व अन्य सामग्री की उपलब्धता की स्थिति प्रसव प्रक्रियाओं के अभ्यास का स्कोर



शुरुआती क्वार्टरों में प्रसव प्रक्रियाओं के अभ्यास काफी बेहतर हुए जिसके कारण प्रसव कक्ष के नर्सिंग स्टॉफ का एसबीए प्रशिक्षण लेने के बाद इन्होंने अपने अभ्यास में बदलाव किया। विजिट टीम के सुझावों का अनुसरण किया। क्वार्टर 5 से 6 के मध्य के महीनों में संस्थान पर कोई विजिट नहीं हुई जिसके परिणामस्वरूप प्रसव अभ्यास की गुणवत्ता में कमी आयी। क्वार्टर 9 में प्रसव कक्ष के स्टॉफ की ड्यूटी बदल जाने के कारण एक बार फिर स्कोर कम हुए।

प्रसव कक्ष में उपकरण व अन्य सामान की उपलब्धता का स्कोर



VI निष्कर्ष

स्वास्थ्य संस्थानों में जो बदलाव हो सके

अ) प्रसव प्रक्रियाओं में जो बदलाव हुए

- दर्द बढ़ाने के लिए उपयोग में लिये जा रही दवाईयों का अनियन्त्रित उपयोग कम हुआ।
- प्रसव की तीसरी अवस्था के सक्रीय प्रबन्धन के रूप में प्रसव के तुरन्त बाद ऑक्सीटोसिन इन्जेक्शन का उपयोग होने लगा।
- प्रत्येक प्रसव के लिए स्टरलाइज्ड ग्लव्स का उपयोग हुआ है।
- शिशु जन्म के एक घन्टे के अन्दर उसे माँ का दूध पिलाने की शुरुआत सुनिश्चित होने लगी।
- प्रसव के दौरान महिला के पेट पर धक्का लगाना बन्द हुआ है।
- प्रत्येक महिला को प्रसव से पूर्व लगाया जा रहा ऐनिमा बन्द हुआ।
- अधिकतर संस्थानों पर वजाईनल पैकिंग बन्द हुई है।

ब) प्रसव कक्ष में उपकरण व आवश्यक सामान की उपलब्धता

- संस्थानों के प्रसव कक्ष में कम से कम तीन प्रसव किट की उपलब्धता सुनिश्चित हुई है।
- प्रसव कक्ष में बीपी इस्टूमेन्ट, स्टेथोस्कोप, अम्बू बैग, म्यूकस सकर की उपलब्धता हुई है।
- प्रसव कक्ष में ऑटोक्ले ड्रम, स्टीम स्टरलाइजेशन की उपलब्धता।
- सभी संस्थानों पर नई प्रसव टेबिलों की उपलब्धता।
- प्रत्येक संस्थान पर प्रसव हेतु स्टरलाइज ग्लव्स की उपलब्धता।

हानिकारक प्रक्रियाएं जो बन्द हुई	लाभदायक प्रक्रियाएं जो शुरू हुई
<ul style="list-style-type: none"> • प्रत्येक महिला को प्रसव से पूर्व लगाया जा रहा ऐनिमा बन्द हुआ। • अधिकतर संस्थानों पर बैजार्डनल पैकिंग बन्द हुई है। • प्रसव के दौरान महिला के पेट पर धक्का लगाना बन्द हुआ है। 	<ul style="list-style-type: none"> • दर्द बढ़ाने के लिए उपयोग में लिये जा रही दवाईयों का अनियन्त्रित उपयोग कम हुआ। • प्रसव की तीसरी अवस्था के सक्रीय प्रबन्धन के रूप में प्रसव के तुरन्त बाद ऑक्सीटोसिन इन्जेक्शन का उपयोग होने लगा। • किसी किसी संस्थान में यदि महिला सहमत है तो बैठी स्थिति में प्रसव करवाया जाना लगा है। • प्रथम प्रसव वाली सभी महिलाओं को एपिसियोटोमी दिया जाना बन्द हुआ है।

स्वास्थ्य संस्थानों पर जो बदलाव कम हो सके**अ) प्रसव देखभाल सम्बन्धित प्रक्रियाओं हेतु**

- प्रत्येक महिला के प्रसव से पहले व प्रसव बाद बीपी की जाँच नहीं होती है। बीपी उसी महिला का लिया जाता है जिसको कुछ समस्या हुई है। प्रभारी सभी महिलाओं के बीपी की जाँच नहीं होने का कारण स्टॉफ की कमी बताते हैं।
- प्रसव दर्द के गर्भस्थ शिशु के हृदयगति (एफएचएस) जाँच सभी महिलाओं की नहीं होती है। नर्सिंग स्टॉफ का मानना है कि आवश्यकता होती है तो देख लेते हैं, बार बार देखना जरूरी नहीं है।
- पार्टोग्राफ का उपयोग स्टॉफ बताता है कि हमारे पास जेएसवाई का इतना लिखित कार्य होता है, वह ही पूरा नहीं हो पाता तो पार्टोग्राफ कैसे भरें।
- प्रसव दर्द बढ़ाने वाली दवाई के अनियन्त्रित प्रयोग। इसमें विशेषकर गोकॉलोजिस्ट का मानना है कि संस्थान पर प्रसव का भार अधिक है तो जल्दी प्रसव कराकर निपटाना होता है। इसके अलावा महिला के साथ वाले जल्दी प्रसव कराने के लिए दबाव डालते हैं तो इन्जेक्शन लगाकर एपिसियोटोमी देकर प्रसव कराते हैं।
- बैठी स्थिति में प्रसव करवा जाना। स्टॉफ को इस तरह प्रसव कराने का अनुभव नहीं होने से आत्म विश्वास नहीं है।
- प्रसव कराने से पूर्व नर्स द्वारा अपने हाथ नहीं धोना। इसका कारण स्टॉफ को इसकी आदत नहीं है एवं इस ओर ध्यान नहीं देते हैं।
- प्रसव के बाद मां व शिशु की जरूरी जाँच नहीं होती है। इसमें भी कारण स्टॉफ की ओर से ध्यान नहीं देना है। इनका मानना है कि समस्या होगी तो लोग खुद आकर बतायेंगे।

ब) प्रसव की व्यवस्थाओं हेतु

- प्रसव कक्ष व प्रसव टेबिलों की हमेशा सफाई व्यवस्था। इसका कारण सफाईकर्मी की कमी एवं कहीं कहीं सफाईकर्मी के द्वारा कार्य नहीं करना आदि कारण देखे गये हैं। प्रसव टेबिलों पर समय-समय पर मैकनटॉस का बदलाव नहीं होता है।
- प्रसव सम्बन्धित सामान का सही तरीके से स्टरलाइजेशन नहीं होता है। इस स्थिति का स्पष्ट कारण स्टॉफ का इस ओर ध्यान नहीं देना है।
- प्रसव कक्ष में शिशु को पौछने के टावल व लपेटने के लिए कंबल की उपलब्धता नहीं है।
- ब्लीचिंग का नियमित घोल नहीं बनता है।

प्रसव के बाद मां व शिशु देखभाल की गुणवत्ता को बेहतर बनाने में प्रभावी कार्य

- स्थानों का नियमित आंकलन
- नर्सिंग स्टॉफ का एसबीए पर प्रशिक्षण व मल्टीमीडिया के द्वारा संस्थान पर प्रसव प्रक्रियाओं पर स्टॉफ का प्रशिक्षण
- जिला स्तरीय अधिकारी को संस्थान की स्थिति की जानकारी उनके साथ संस्थान पर संयुक्त विजिट एवं मीटिंग

उपरोक्त कदम संस्थानों पर बदलाव लाने में सबसे प्रभावी रहे हैं। जिसके माध्यम से सेवा प्रदाताओं की कुलताओं में वृद्धि हुई है और प्रसव एवं शिशु देखभाल की गुणवत्ता को बेहतर बनाया गया है।

प्रत्येक अस्पताल/स्वास्थ्य केन्द्र का रिपोर्ट कार्ड

1.1 जिला अस्पताल—

संस्थान पर अर्थ स्टाॅफ द्वारा विजिट की गई। जिसके अन्तर्गत उपकरणों की उपलब्धता, प्रसव प्रक्रिया अवलोकन, नव प्रसूताओं के साक्षात्कार तथा प्रसव कक्ष के मासिक आंकड़ों का एकत्रीकरण कर संस्थान का आंकलन किया गया।

आंकलन वर्ष	संस्थान पर विजिट संख्या
2010	1
2011	2
2012	3
जून 2013	6
कुल	12

इन आंकलनों के अनुसार निम्न प्रक्रियाओं में सुधार की आवश्यकता है —

1. **ऐपीसियोटमी**— संस्थान पर अधिकांश प्रथम प्रसवों में ऐपीसियोटमी लगाई जा रही है। महिला की प्रसव के बाद वैजाईनल पैकिंग की जाती है।
2. **पार्टोग्राफ का उपयोग**— संस्थान पर प्रसव निगरानी के लिए पार्टोग्राफ का उपयोग नहीं किया जा रहा है।
3. **प्रसव से पहले महिला के बी पी की जाँच**— संस्थान पर ज्यादातर महिलाओं की प्रसव से पहले बीपी की जाँच नहीं की जा रही है।
4. **पी एन सी चैक अप**— संस्थान पर प्रसव के बाद अधिकांश महिलाओं को पीएनसी वार्ड में शिफ्ट करने के बाद नहीं देखा जाता है।
4. **प्रसव के दौरान महिला की स्थिति**— प्रसव के दौरान लाभकारी स्थिति (बैठी अवस्था) में प्रसव नहीं कराया जाता है।

उपकरण व सामग्री की आवश्यकता:—

1. मैकिनटॉस :- प्रसव कक्ष में प्रसव टेबिलों पर मैकिनटॉस नहीं बिछाया जाता है।
2. ग्लव्ज:- स्वीपरों के लिए औजार, प्रसव कक्ष व प्रसव टेबिलों की सफाई के लिए लॉग रबड ग्लव्ज नहीं हैं।

Hospital check list as annexure to facility report card

Facility :

Date of first visit	Score	Desirable scores	31/5/13
Practices			
Shaving of pubic hair	y=0, n=1	n=1	1
Routine Enema	y=0, n=1	n=1	1
Partograph chart used	y=1, n=0	y=1	
FHS heard during labour	y=1, n=0	y=1	1
Position of delivery	lithotomy=0, sitting=1	sitting=1	0
Augmentation of labour	y=0, n=3	n=3	3
Episiotomy for primis	y=0, n=2	n=2	0
Abdominal pressure	y=0, n=1	n=1	1
IM oxytocin after delivery	y=3, n=0	y=3	3
Vaginal packing	y=0, n=1	n=1	0
Proper drying and wrapping of newborn	y=1, n=0	y=1	
Routine suction of all newborn	y=0, n=1	n=1	
Initiation of breast feeding within 1 hr	n=0, y=2	y=2	2
Timing of discharge	<12 hr=0, >24 hr=2	>24hr=2	2
Sterile gloves used for deli.	y=1, n=0	y=1	
Hand washing before conducting deli.	y=1, n=0	y=1	
Postpartum checkup in ward	Y=2, n=0	y=2	2
Total Score for this facility			16
Toral score possible			20
% score for practices			80.00%
Equipment and supply			
Ambubag kept ready in LR	y=1, n=0	y=1	1
BP instru+stetho ready in LR	y=1, n=0	y=1	
1Washbasin and running water in LR	y=1, n=0	y=1	1
Autoclave present in working condition	y=1, n=0	y=1	1
Labour room clean	y=1, n=0	y=1	1
Labour table condition	Clean =1, Has blood stuck=0	Clean=1	1
Oxytocin available in LR	y=1, n=0	y=1	1
Staff in LR SBA trained	all =2 Half =1	All=2	1
Doctors (who conduct delivery) oriented on EBC	all =2, Half =1	All=2	2
IEC material (chart) on evi based practices displayed in LR	Y=1, N=0	y=1	1
		12	11
Input score for this facility			12
% score for inputs			92.00%

Annexure 11

Discharge Card

प्रसव डिस्चार्ज कार्ड

सील/रजिस्ट्रेशन नं.

अस्पताल/स्वास्थ्य केन्द्र का नाम.....
 नाम/पति काशेविडा.....पेरा.....
 पूरा पता.....
 प्रसव की दिनांक.....प्रसव का समय..... प्रसव की संख्याछुट्टी की दिनांक
 प्रसव किस प्रकार हुआ ? 1. सामान्य योनि प्रसव 2. फॉरसेप्स/ वैक्यूम से प्रसव
 (गोला लगाएँ) 3. उल्टा बच्चा योनि द्वारा प्रसव 4. सिजेरियन
 जे.एस.वाई. चेक संख्या..... राशि.....

नोट - इस कार्ड का पहला पेज स्वास्थ्य केन्द्र के नर्स/डॉक्टर के द्वारा भरा जाए। पेज 2-4 के माध्यम से छुट्टी के समय परिवार को स्वास्थ्य शिक्षा दें।

छुट्टी के समय माँ की स्थिति	छुट्टी के समय शिशु की स्थिति
(a) प्रसवोपरान्त माँ का हीमोग्लोबिन ग्राम	(a) शिशु की स्थिति • छुट्टी के समय स्वस्थ • जीवित पैदा हुआ परंतु छुट्टी से पहले मृत्यु (Neo natal death) • मृत जन्म (still Birth)
(b) कोई अन्य समस्या	(b) जन्म के समय वजन किलो ग्राम (c) लिंग (d) कितने बच्चों का जन्म हुआ एक/जुड़वा/अन्य

माँ व नवजात शिशु की शारीरिक स्थिति देखने के लिए नीचे दी गयी चेकलिस्ट भरें।
 हाँ/नहीं पर गोला लगायें। यदि सभी जवाब हरे बॉक्स में हो तो छुट्टी के योग्य है

माँ की स्थिति	शिशु की स्थिति
1. नब्ज, रक्तचाप व तापमान सामान्य है ? हाँ नहीं	1. शिशु की त्वचा का रंग सामान्य है ? हाँ नहीं
2. हीमोग्लोबिन 7 ग्राम से अधिक है ? हाँ नहीं	2. शिशु ठीक से रो रहा है ? हाँ नहीं
3. माँ स्वस्थ महसूस कर रही है ? हाँ नहीं	3. शिशु की सांस की गति 60 प्रति मिनट से अधिक है, सांस में आवाज है या छाती अंदर धंस रही है। हाँ नहीं
4. स्तन सामान्य है ? (कोई ललाई या सूजन नहीं हैं, निपल चपटा या अन्दर धंसे नहीं हैं) हाँ नहीं	4. शिशु का तापमान सामान्य है व ठीक से लपेट हुआ है ? हाँ नहीं
5. पेट में दर्द है ? हाँ नहीं	5. शिशु की नाल के सिरे से कोई खून या मवाद आ रहा है ? हाँ नहीं
6. गर्भाशय कड़क (संकुचित) है ? हाँ नहीं	6. शिशु सामान्य रूप से स्नानपान कर रहा है ? हाँ नहीं
7. पेरीनियम में सूजन, दर्द या बदबूदार स्राव है ? हाँ नहीं	7. शिशु को पीलिया है ? हाँ नहीं
8. अन्य कोई खतरे के लक्षण हैं ? हाँ नहीं	8. शिशु का वजन 2 किलोग्राम या इससे अधिक है ? हाँ नहीं
	9. शिशु ठीक से टट्टी-पेशाब कर रहा है ? हाँ नहीं
	10. अन्य कोई खतरे के लक्षण (जैसे बेहोशी, उल्टी, पेट फूलना) हैं ? हाँ नहीं

छुट्टी के समय माँ को दी गयी दवाईयाँ :	बच्चे को जन्म के समय दिया गया टीकाकरण
1..... 2..... 3..... 4..... 5.....	1. बी सी जी 2. ओ पी वी 3. हिप्पेटाइटिस
	छुट्टी के समय शिशु को दी गयी दवाईयाँ :
	1..... 2..... 3..... हस्ताक्षर



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प्रसवोपरान्त निर्देश

माँ की नियमित देखभाल

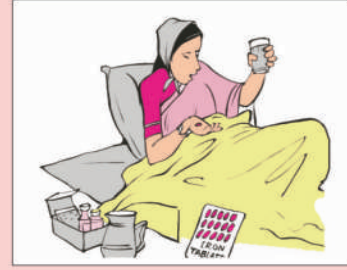
1. सभी प्रकार का पौष्टिक भोजन अधिक मात्रा में खायें। (जैसे दालें, मूंगफली, दूध, दही, सब्जियाँ, अन्न आदि)
2. पर्याप्त आराम व नींद लें।
3. 3 महीने तक प्रतिदिन आयरन की गोलियाँ लें।
4. जब तक पेरीनियम में दर्द है, यौन संपर्क न करें।



पर्याप्त मात्रा में पौष्टिक आहार खायें



घर जाने के बाद किसी कुशल नर्स से 3 से 7 दिन के अन्दर जांच करवायें



रोज आयरन की गोलियाँ खायें

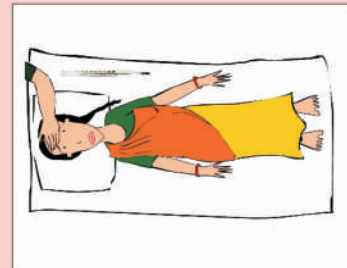
यदि माँ को इनमें से कोई भी समस्या हो, तो तुरंत बिना इंतजार के, अस्पताल या स्वास्थ्य केन्द्र आयें:



यदि रक्तस्राव बन्द न हो
या अधिक हो जाये



ताण/दौरे आना



बुखार



सांस तेजी से चले या
सांस लेने में परेशानी



पेट में तेज दर्द



अत्यधिक कमजोरी

निम्नलिखित समस्याएँ होने पर भी महिला जल्दी स्वास्थ्य केन्द्र जाये



बहुत दुखी रहती है या बार-बार रोती है



सूजन आना



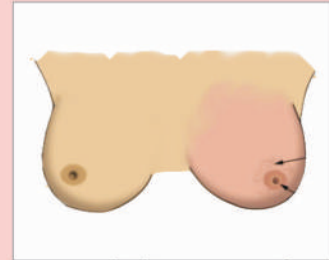
खून की कमी



टांको में दर्द व सूजन



बदबूदार स्त्राव



स्तनों में सूजन, ललाई, दर्द या दूध का जमाव

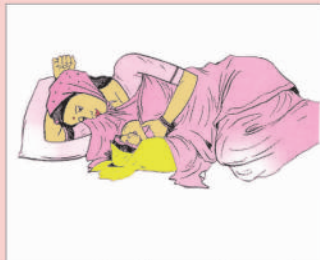
शिशु की देखभाल

1. शिशु को गर्म रखें, हर समय कपड़ों में लपेटकर रखें, सिर को भी ढकें। माँ के साथ एक ही बिस्तर पर लेटाएँ।
2. शिशु की नाल के सिरे पर कुछ न लगायें। इसे साफ कपड़े से ढका रखें। इस पर पट्टी न बाँधें, न कोई दवाइयाँ लगायें।
3. शिशु दिन या रात में, जब भी माँगे, उसे माँ का दूध पिलायें। शिशु को ऊपरी दूध या पानी की जरूरत नहीं है। शुरु के 6 माह तक बच्चे को सिर्फ स्तनपान ही करायें।
4. बच्चे को 3 दिन बाद ही नहलायें। सुनिश्चित करें की नहलाते समय कमरा हल्का गर्म व पानी गुनगुना हो। नहलाने के बाद पूरी तरह बच्चे को सुखाएँ, कपड़े पहनायें व ओढ़ा कर रखें।

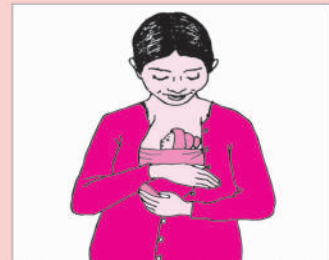
बच्चे की आवश्यक देखभाल



बच्चे को गर्म रखें



प्रसव के तुरंत बाद शिशु को स्तनपान करायें



शिशु का वजन 2½ किलो से कम होने पर उसे ज्यादा लपेटे या माँ की त्वचा से लगाए।

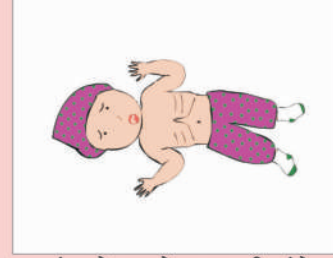
यदि बच्चे को निम्नलिखित लक्षण हों, तो तुरंत वापस लायें या नर्स को बुलायें



शिशु ठीक से स्तनपान न करे या दूध पीना बन्द कर दे



सुस्त या ढीला पड़ जाए



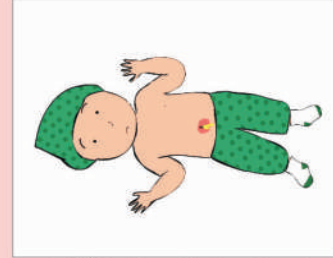
सांस तेज चले या छती धंसे



छूने पर ठण्डा लगे या तेज बुखार हो



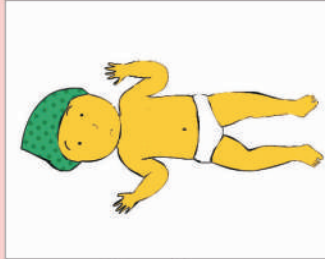
ताण या दौरे आए



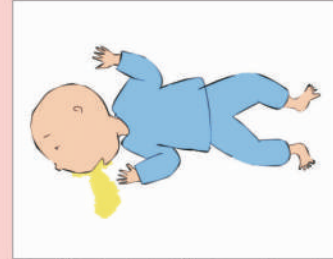
नाभी या उसके आस-पास की त्वचा लाल होना



त्वचा पर मवाद भरी फुन्सियाँ हो जायें।



पीलिया हो जाए



उल्टी, दस्त या पेट फूल जाना

पुनः संपर्क

- नर्स/आशा से 2-3 दिन बाद आपका व शिशु का सम्पर्क होना आवश्यक है। इस संपर्क के लिये नर्स या आशा बहन जी आपके घर आयेगी।
- माँ व शिशु की देखभाल के लिए स्वास्थ्य विभाग ने स्थानीय आशा को तीसरे दिन, सातवें दिन, 14वें दिन, 21वें दिन, 28वें दिन व 42वें दिन पर आपके घर आने के लिए निर्देशित किया है।
- यदि 28 दिन के अन्दर माँ या शिशु को कोई समस्या हो तो रेफरल के लिए 104 या 108 नम्बर पर फोन करके वाहन बुलायें। यह सुविधा निशुल्क उपलब्ध है।
- यदि माँ या शिशु को कोई समस्या नहीं है, तो डेढ़ महीने बाद आंगनवाड़ी/स्वास्थ्य केन्द्र पर टीकाकरण के लिए वापस आयें व साथ में यह कार्ड अवश्य लायें।

- **Purpose of the discharge card:** Normally families are not acquainted with the health related complications that might arise for the mother and the child after the delivery of a new born. Thus, they are not aware of the complications that might arise after child birth leading to harmful consequences and a cause of maternal and child mortality. Since the majority of the deliveries have become institutionalized, it has grown to be even more important to orient the families with the mother and childcare practices as well as danger signs. Thus, a discharge card was developed where all the information regarding the mother and child's health has been included along with information regarding danger signs they should look out for. While getting discharged from the hospital, if the scores of health check ups undergone by the women is mentioned in the discharge card, then accurate information regarding their health can be documented.
- **When to use the discharge card:** During the time of discharge the discharge card is filled in with the relevant information of mother and child. This can be done by the nursing staff as general information has to be filled in and may not specifically require a doctor. Secondly, after the mother is discharged from the hospital, the family members can use the discharge card to identify danger signs in the mother and immediately bring her to the hospital to avoid complications.
- **How to use the discharge card and by whom:** The discharge card is made of four different colored pages. In the first page general information such as name and address of the mother and child to be discharged is given. Additional information includes: that of admission and discharge, information regarding the state of the mother and child (in terms of their health) such as hemoglobin of mother post partum and other danger signs and the skin color of the child, its respiratory rate, temperature, etc. is written. In the lower half of the page, an information column regarding the medicines given to the mother and child during discharge along with the vaccination to be given (such as BCG, OPV, hepatitis, etc.) are noted. This page is filled in by the nursing staff or the doctor.

While handing over the discharge card to the mother or the family members it is the responsibility of the nursing staff to explain to them how to use the discharge card and its purpose in detail.

On the second page, instructions regarding the regular care of mother post delivery, such as having nutritious food and an adequate amount of rest and sleep, etc are given. Also, information regarding danger signs for mothers accompanied by its pictorial representations is given so that the family and mother can easily identify them and avoid any complications by contacting the doctor in time.

In the lower half of the third page, information regarding newborn care is given, such as keeping the neonate warm and wrapped up in a clean cloth, keeping it near its mother on the same bed, not to apply anything on its belly button, exclusive breast feeding till six months, etc.

On the last page, the danger signs for the neonate are conveyed through pictorial representations. By looking at the pictures, the family members can easily understand the danger signs in the neonate. In the lower half of the page, information regarding how to contact a nurse or ASHA or other government services, such as 104/108 ambulance services, if complications arise are given. This can be used by the families when needed.

Annexure 12

Sample session plan for orientation program for medical officers on safer institutional delivery

Objectives:

To build consensus among senior doctors, facility in charges and district officials on best delivery & newborn practices in the context of institutional deliveries in Rajasthan.

To plan strategies for improving quality of delivery and newborn care within health facilities.

Agenda

Time	Session
9.30-10.00 am	Registration and tea
10.00-10.15 am	Welcome and introduction
10.15-10.35 am	Perspective from Government of India
10.35- 11.00 am	Janani Shishu Suraksha Yojana and situation of institutional delivery in Rajasthan
11.00- 11.15 am	Objectives of the project
11.15-12.05 pm	Evidence based delivery care
12.05 noon 12.20 pm	Tea break
12.20-1.20 pm	Evidence based newborn care (50 min presentation followed by 10 min discussion)
1.20- 2.00 pm	Lunch
2.00-2.30 pm	Assessment and improvements in quality of childbirth services in 6 districts of Bharatpur zone
2.30- 2.50 pm	Discharge card
2.50- 3.45 pm	Group work: Planning to improve delivery - newborn care services in districts
3.45-4.45 pm	Plenary discussion : Planning to improve delivery- newborn care services in districts
4.45- 5.15 pm	The way ahead
5.15-5.30 pm	Vote of thanks and closure

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