Assessing the Quality of Intra-Partum Care Provided in the Labour Room of District Hospital, Shahdol

By

Vidya Chandran

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2014-2016

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer Airport
Jaipur-302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: www.iihmr.edu.in

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Vidya Chandran, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at National Health Mission, Madhya Pradesh from 8th February 2016 to 7th May 2016

The candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The internship is in fulfillment of the course requirements.
I wish her all success in all her future endeavors.

Col Dr. Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Dr. Tanjul Saxena
Professor
The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur-302029, Rajasthan, India.
Ph.: 0141-3924700, 2791431- 32, Fax:0141-3924738,E-mail: iihmr@iihmr.edu.in,Web: www.iihmr.edu.in

The certificate is awarded to

Dr. Vidya Chandran

In recognition of having successfully completed her Internship in the

District Hospital, Shahdol

and has successfully completed her Project on

Assessment of quality of intra-partum and essential new-born care in the labour room of Shahdol District Hospital

Date: 7th May 2016

Organisation: National Health Mission, Madhya Pradesh

She comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

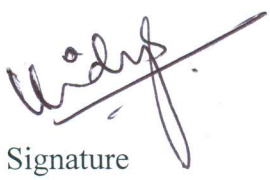
We wish her all the best for future endeavors

Dr. A.P. Dwivedi
Chief Medical and Health Officer
Shahdol District
Madhya Pradesh

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Assessing the quality of intrapartum and essential new-born care at the District Hospital – Shahdol, Madhya Pradesh,** and submitted by Dr.Vidya Chandran, Enrollment No. 19-1641, under the supervision of Dr.TanjulSaxena for award of MBA Hospital and Health Management of the University carried out during the period from February 8, 2016 to May 7, 2016 embodies my original work and has not formed the basis for the award of any degree, diploma associateship, fellowship, titles in this or any other institute or other similar institution of higher learning.



Signature

Acknowledgements:

The success of any task would be incomplete without the expression of gratitude to the people who made it possible. I hereby take this opportunity to express my sincere gratitude towards everyone who helped me directly or indirectly in completion of my internship at National Health Mission, Madhya Pradesh.

At the onset of my report, I would like to acknowledge my sincere thanks to my institute, Institute of Health Management and Research, Jaipur for providing us the platform to gain enough knowledge and skills in different aspects of health management, and National Health Mission, Madhya Pradesh for believing in my abilities.

I express my gratitude and regards to my guide, Dr.TanjulSaxena for her able guidance and useful suggestions which helped me in completing the project successfully. Her guidance was tremendous right from the onset and at each step of the project.
I would like to express my gratitude to Dr.A.P.Dwivedi(Chief Medical and Health Officer, Shahdol), Dr.N.P.Dwivedi(Civil Surgeon, District Hospital) and Dr.Parihar(Resident Medical Officer, District Hospital)who have shown faith upon me, and helped me at various stages of my project.

I would also like to thank my faculty members without whom this project would have been a distant reality. My seniors and colleagues also hold a special mention here for believing in me and supporting me throughout internship.I would like to thank all the staff of the labour room for their co-operation during my data collection.

Finally, and most importantly, I would like to thank God for allowing me to complete my project, my beloved parents, sisters and friends for their help and wishes for the successful completion of this internship.

Dr. Vidya Chandran
19-1641, IIHMR University Jaipur

Table of Contents

List of Figures

List of Abbreviations

AMTSL: Active Management of Third Stage of Labour

ANC: Ante-natal Care

CCT: Controlled Cord Traction

CHC: Community Health Centre

CMHO: Chief Medical and Health Officer

CS: Civil Surgeon

DH: District Hospital

ENBC: Essential New-born Care

FHR: Foetal Heart Rate

HLD: High Level Disinfection

IM: Intramuscular

KII: Key Informant Interview

NRHM: National Rural Health Mission

PHC: Primary Health Centre

PV Examination: Per Vaginal Examination

RCH: Reproductive and Child Health

RMO: Resident Medical Officer

SC: Sub-health Centre

1. Abstract:

A study to assess the quality of intra-partum care provided in the labour room of District Hospital, Shahdol

Author: Dr. Vidya Chandran - Second year MBA-HM student, The IIHMR University, Jaipur

Advisor: Dr TanjulSaxena - Associate Professor, The IIHMR University, Jaipur

Introduction

Most of the maternal mortality (44%) is centred around the delivery of the baby, in the intra-partum and immediate post-partum period (16% intra-partum period and 28% on the birth day). Similarly, 40% of neonatal mortality and stillbirths happen during the same period (21% intra-partum and 19% birthday). This is the period of highest risk for mortality for both mothers and new-borns. During this period, the woman is usually at a health facility if she has chosen to deliver at an institution. These deaths could be averted if prompt care is given with quality. Hence, quality of care for intra and immediate postpartum period (care in labour rooms) at institutions needs improvement. As no studies have been done in Shahdol to assess the quality of intra-partum and essential new-born care provided, the results of this study will provide information on the gaps in providing care and the reasons for the same. It will help in planning strategies to provide improved care in the labour room.

Objective

To assess the quality of intra-partum care provided

Methodology

Study design: Cross-sectional observational descriptive study

Study area: Madhya Pradesh

Study period: April 2016

Study setting: District Hospital, Shahdol

Study population: Women delivering at District Hospital, Shahdol

Data:

- Quantitative – Occurrence of different parameters during labour
- Qualitative – Key informant interviews with the staff nurses of the labour room

Inclusion criteria: Deliveries of all the women who come to the labour room in the active phase of labour were observed

Exclusion criteria:

- Simultaneous deliveries being conducted at the same time
- Delivery of babies who died intra uterine

Sampling: 60 deliveries were observed from the admission of the woman to the labour room till discharge. The average number of deliveries in a month at the district hospital is 400 per month. 30% of the deliveries were observed during the period in consideration (2 weeks).

Findings

Conclusion

- The quality of care has been majorly compromised on the infection prevention front.
- Quality of care with respect to the preparation to receive the new-born was grossly deficient.
- Reasons for not giving quality care in the labour room can be summed up in three points from the KII:
    1. Lack of human resource
    2. Huge patient load
    3. Not enough time to give each patient

Recommendations

- Posting more staff nurses and housekeeping staff in the labour room
- Strictly enforcing the infection prevention protocols
- Strictly enforcing use of partographs to monitor the progress of labour and not to fill it post-delivery to maintain records

DISSERTATION REPORT

Assessing the quality of intra-partum and essential new-born care provided at the labour room at the District Hospital, Shahdol

2. Introduction

Intra-partum care is the care given during the intra-partum period. Intra-partum period is defined as the period from the onset of labour to the end of the third stage of labour.It consists of assessing the condition of the woman and providing prompt care.

Essential new-born care is the care given to the new born in the labour room itself. It focuses on providing interventions through which most of the new born deaths can be averted. The components of ENBC are

Both are carried out in the labour room ideally which gives a window to provide quality care. This period

Most of the maternal mortality (44%) is centred around the delivery of the baby, in the intra-partum and immediate post-partum period (16% intra-partum period and 28% on the birth day).Similarly, 40% of neonatal mortality and stillbirths happen during the same period (21% intra-partum and 19% birthday). This is the period of highest risk for mortality for both mothers and new-borns. During this period, the woman is usually at a health facility if she has chosen to deliver at an institution. These deaths could be averted if prompt care is given with quality. The rates of institutional births increased since the advent of National Health Mission and Janani Suraksha Yojana, whereas, reduction in maternal and neonatal mortality is not proportional with increase in institutional births. Hence, quality of care for intra and immediate postpartum period (care in labour rooms) at institutions needs improvement.

High maternal mortality and infant mortality has been a matter of public health concern in India for decades. Various programmes such as RCH I, RCH II were also launched to tackle the same. 41% total maternal mortality and 48% total neonatal mortality happen during the ante partum and intra partum period. Hence, women are at highest risk during the period between onset of labour and immediate to post-partum. JSY was launched under NRHM by incentivising institutional deliveries to provide professional care and hence reduce the mortality. As a result there was over 75% increase in institutional deliveries in 5 years between 2007(DLHS 3) and 2012(HMIS). However the decrease in MMR(decreased by 25%) and NMR weren't proportional during this period. Hence, this study is planned to understand the utilization of maternal care services and the gaps in delivering quality care to mothers.

The concept of quality of care is complex and multidimensional. The definition of quality of care varies from excellence to expectations or goals which have been met to "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". All dimensions of quality of care reduce to two questions. First, can an individual get the care they need when they need it (i.e., is the care accessible)? Second, when they get care, is it effective both in terms of clinical

effectiveness and interpersonal relationships? Quality of care can be achieved when evidence based, high-impact practices are practised. All of such practices should be performed in each case, in a timely manner as per standards.

Madhya Pradesh, being one of the empowered action group states has been in special focus under NRHM. Most of the state health indicators fall below the national average. Shahdol is one of the seventeen high priority districts of Madhya Pradesh, which is also a tribal district.

The flow of a pregnant woman coming in for delivery in the maternity wing is as follows:

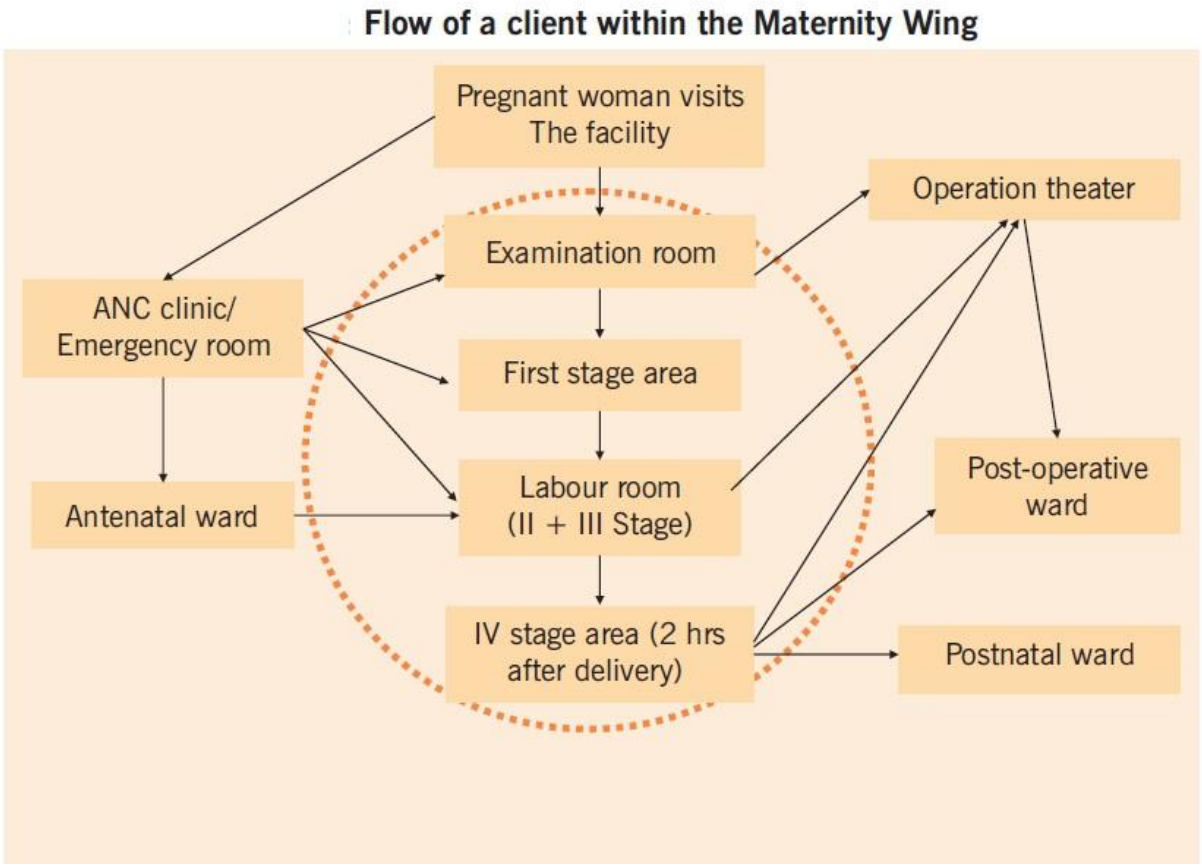


Figure 1: Flow of a client within the maternity wing

3. Rationale

The District Hospital in Shahdol is the highest referral facility in Shahdol district. It is the only functional L3 delivery point in the district which gets referrals from 33 other public delivery points spread across the district. The average normal deliveries that are conducted in the hospital is400 per month. Compromising on the quality of care provided at the labour room can result in compromised health of the mother and the new-born. This could result in their mortality and morbidity that could have been prevented. As no studies have been done in Shahdol to assess the quality of intra-partum and essential new-born care provided, the results of this study will provide information on the gaps in providing care and the reasons for the same. It will help in planning strategies to provide improved care in the labour room.

4. Aim

To assess the quality of intra-partum and essential new-born care provided in the labour room at District Hospital in Shahdol, Madhya Pradesh

5. Objectives

To assess the quality of intra-partum care provided

6. Review of literature

According to NFHS 4, even when the institutional deliveries in Shahdol are almost 72%, only 7% of the women got full ante-natal care.

A study conducted by S. Bhattacharyya et al suggest that even though the institutional deliveries have increased to a large extent, the hospitals are not equipped to handle the patient load, which then affects the quality of care given. A lot of deaths of new-borns due to hypothermia, asphyxia and infection can be prevented by providing essential new born care to all new-borns immediately after birth. The ten point ENBC(essential new-born care) ensures early initiation of breastfeeding, healthy breathing, prevention of hypothermia, infection and neonatal anaemia

7. Methodology

A descriptive cross-sectional study was conducted at the District Hospital Shahdol during the month of April 2016.

The study was conducted in two stages. In the first stage, deliveries were observed and the gaps were understood in delivering quality care. In the second stage key informant interviews were conducted with the nurses posted in the labour room to understand the reasons for the gaps in delivering quality care.

A sample of 60 deliveries was observed on the basis of a checklist derived from the standardised checklist of Dakshata programme. The deliveries were observed from the point of admission of the woman to the labour room, following her through the labour and delivery, till the discharge of the patient from the labour room. Simultaneous deliveries at the same time were excluded from the study.

In the second stage of the study, key informant interviews were conducted with the nurses of the labour room to understand the barriers in delivering quality intra-partum and essential new-born care.

The deliveries were assessed on the following parameters:

1. Provider conducting internal examination appropriately
2. Provider monitoring progress of labour on a partograph and adjusting care accordingly
3. Provider ensuring respectful and supportive care for the woman coming for delivery
4. Preparation of the provider for safe care during delivery
5. Assistance the provider gives the woman to have a safe and clean birth
6. Provider's rapid assessment and performance of immediate new-born care(if baby cried immediately)
7. Performance of AMTSL
8. Breastfeeding counselling

8. Results

A) Provider conducting internal examination appropriately

Contrary to the indication of PV examination that has to be done every 4 hours, this was not followed in any of the cases. PV examination was conducted as soon as the patient comes to the labour room, and was repeated when the patient requests for a repeat examination.

Soap, running water and sterile gloves were available in the labour room during all of the deliveries. None of the service providers performed hand hygiene prior to per vaginal examination, and only 30% of them wore gloves on both hands with the correct technique. The common practice observed was to wear a single glove while conducting PV examination.

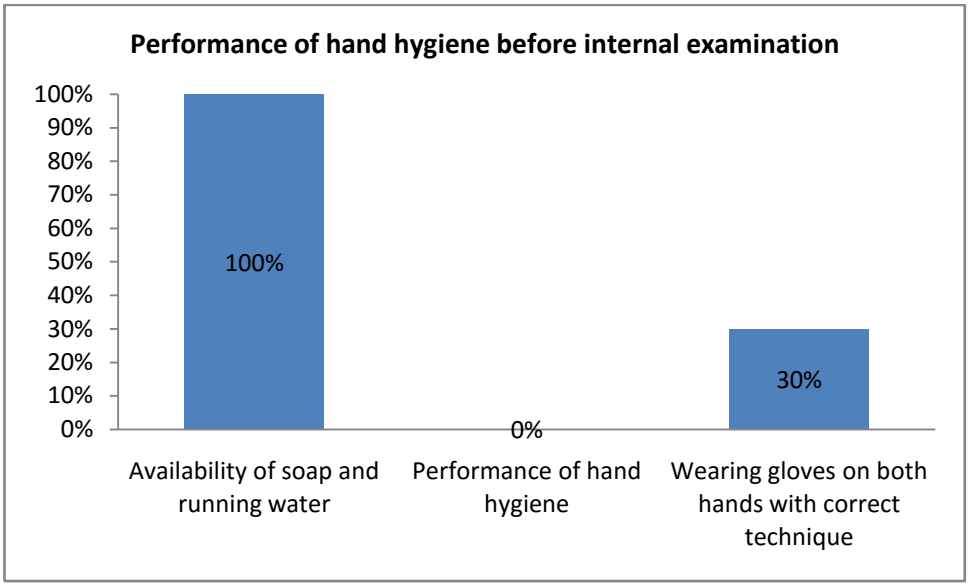


Figure 2: Performance of hand hygiene before internal examination

Antiseptic solution and sterile gauze/pad was available during all of the deliveries, whereas the perineum was not cleaned before conducting the PV examination. Recording the finding of PV examination during active phase of labour was done only during 31.7% deliveries.

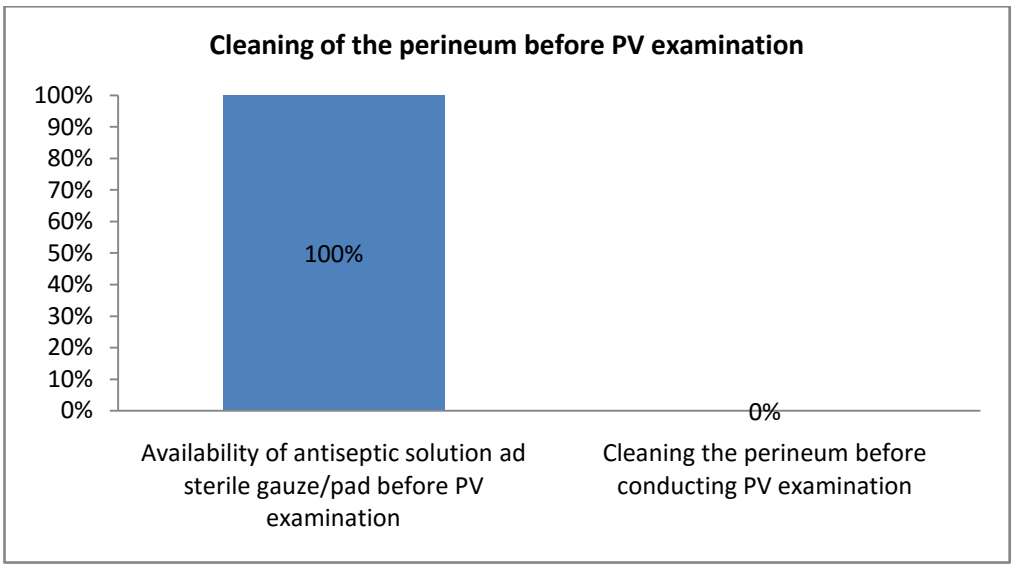


Figure 3: Cleaning of the perineum before PV examination

B) Provider monitoring progress of labour on a partograph and adjusting care accordingly

During all of the deliveries, partograph was available and was attached to the case sheet. In 26.7% cases, plotting the partograph was initiated when the cervical dilation was greater than or equal to 4cm. But in none of the cases, all the parameters were plotted and care adjusted according to the findings after interpreting the partograph.

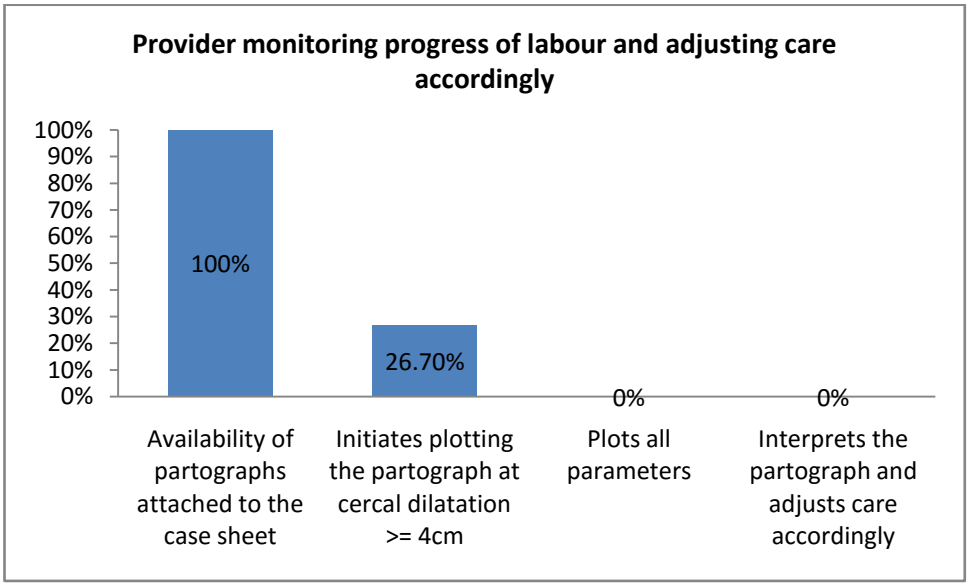


Figure 4: Provider monitoring progress of labour and adjusting care accordingly

On enquiring the reason for not plotting the partograph appropriately, most of the nurses reported the reason for the same as lack of time to deal with the large number of patients with the limited staff and infrastructure available in the labour room and ANC ward. Knowledge on plotting and interpreting the parameters on the partograph seemed up to the mark. They also mentioned about dealing with multiple patients at the same time that makes it difficult for them to follow a patient from the beginning of labour till the delivery.

"I can fill in the partograph efficiently if I had to dedicate my time to just one patient throughout her labour. Since I have to look at multiple patients, it practically gets difficult to monitor all the parameters on the partographs mentioned."

- *Respondent number: 6*

"In a situation when the patient comes at 4cm (cervical) dilatation and I start the partograph since the patient is in the active phase of labour, she is asked to come and get the PV(examination) done every 4 hours. But since there is lack of beds and we ask the patient to stay in the ANC ward (which usually has over 20 patients admitted at a time and has just 13 beds available), the patients roam around in the corridor and make them comfortable wherever there is place outside the labour room. Also, the 13 beds in the ANC ward don't have patients

admitted with bed numbers allotted to them. The patients usually then return back when they have marked discomfort. Because of these reasons, they are difficult to track every half an hour to record the readings on the partograph."

- *Respondent number: 3*

"There are not enough beds to conduct FHRs, uterine contractions and status of membranes and amniotic fluid every half an hour. Since the patients who need to be given blood transfusion and iron sucrose are also done on the same few available labour tables in the labour room, the other services like plotting and interpreting the partographs are compromised."

- *Respondent number: 2*

C) Provider ensuring respectful and supportive care for the woman coming for delivery

In all of the cases, the provider treated the woman and her companion cordially and respectfully according to the respectful maternity care standards. She was ensured privacy and confidentiality during her stay. The provider also encouraged the presence of a birth companion during labour.

In 46.7% cases, the provider explained danger signs to the mother and her companion, whereas in 70% of the cases, important care activities were explained to the mother and her companion.

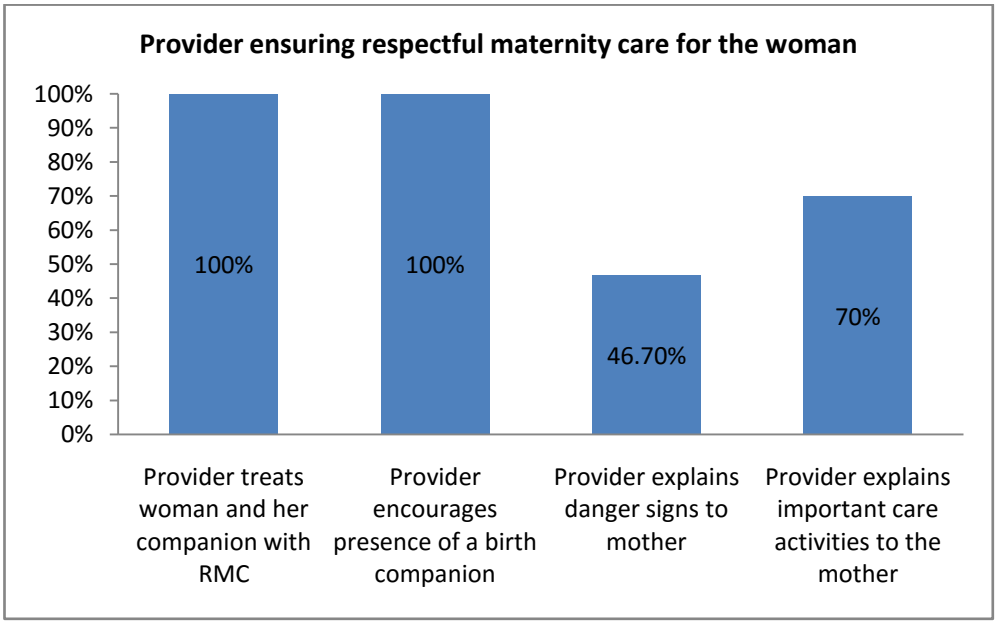


Figure 5: Provider ensuring respectful maternity care for the woman

D) Preparation of the provider for safe care during delivery

Only in 11.7% of the deliveries observed, the provider ensured sterile/HLD trays available. 63.3% of the providers ensured availability pre-filled oxytocin syringe. Even though a designated NBCC is present at the labour room in DH, only 23.3% of the deliveries were prepared with the radiant warmer switched on 30 minutes before childbirth and 6.7% cases ensured with functional items for new-born care and resuscitation.

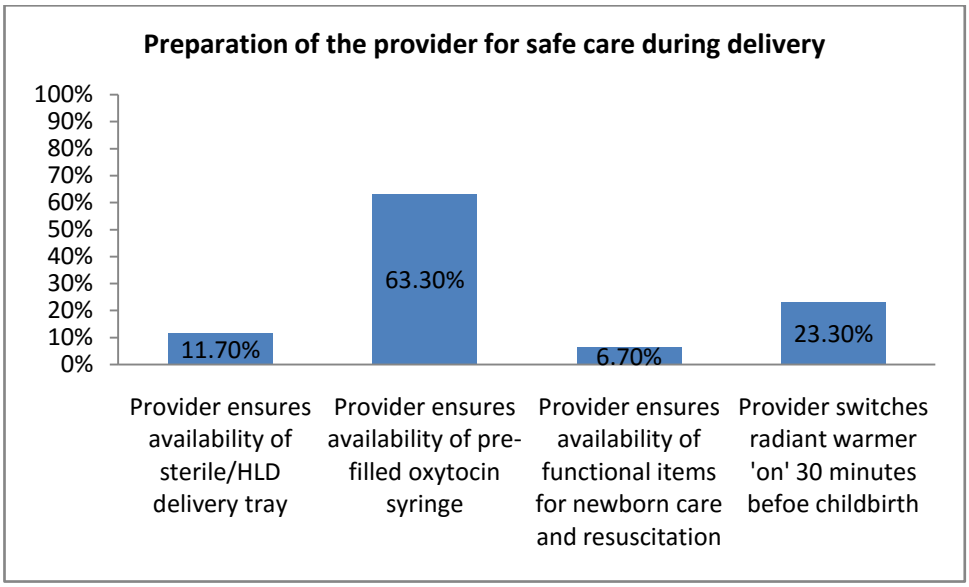


Figure 6: Preparation of the provider for safe care during delivery

E) Assistance the provider gives the woman to have a safe and clean birth

In all of the deliveries observed, sterile gloves, antiseptic solution, sterile cord clamp and sterile cutting edge (blade/scissors) were available. On observation, only 13.3% of the cases received care with 6 cleans. 90% of the cases were allowed spontaneous delivery of the head by flexing it and giving perennial support, managing cord around the neck and assisted delivery of head and shoulders.

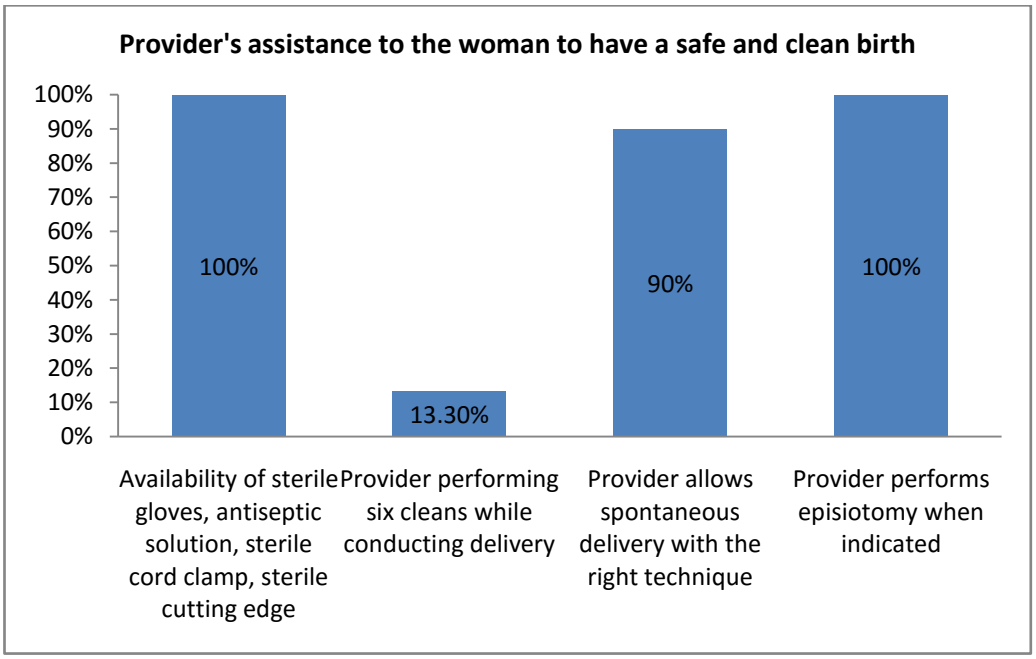


Figure 7: Provider's assistance to the woman to have a safe and clean birth

On enquiring with the nurses to know the reason for not performing six cleans while conducting deliveries, there were multiple reasons that most of them spoke about. Lack of adequate housekeeping staff and a designated area for disinfection makes it difficult to provide a clean surface that could be provided by spreading a clean mackintosh sheet for each delivery along with a clean Kelly's pad. They also reported that everything looks ideal when there are superiors visiting the labour room as they follow the protocols just during that time.

"Maintaining clean surface is usually not in my hands since the Mackintosh is not usually cleaned and disinfected by the cleaning staff properly and Kelly's pad is not usually in use unless there is some team visiting the facility to monitor what we do. In such cases, we try and conduct ideal deliveries here. But during the other times, Kelly's pad is never used routinely. The problem with using Kelly's pad is that cleaning it becomes a problem here. There is only one cleaning area for the patients and for cleaning the Mackintosh and the Kelly's pad. The patients usually dirty the area and there is urine and stool all over the area outside the commode inside the washroom. The cleaning staff hesitates to use the same area for washing

the mackintosh and Kelly's pad in the same area. As a result, the mackintosh sheets once soiled are thrown away and the Kelly's pads are barely used. We find it comfortable to conduct deliveries when the patients lie on a Kelly's pad. But since the cleaning staff don't keep it available during deliveries at the labour room, it gets difficult for me to make that also ready for each delivery that I conduct."

- *Respondent number: 7*

"The quality of care has gone down in the past couple weeks since no team has visited the hospital or labour room, from Bhopal. When something like that happens, the superiors in the hospital personally visit the labour room and make sure everything is available so that good reports are sent from here. For example, Kelly's pads are used in this labour room only when some team is visiting here. It is never routinely used."

- *Respondent number: 6*

F) Provider's rapid assessment and performance of immediate new-born care(if baby cried immediately)

During the study, of all the deliveries that were observed, all of the babies were delivered on the mother's abdomen and baby was weighed after the delivery. Pre warmed towels were not available in any of the cases, and hence even when the baby's breathing is normal, the baby was not wrapped in a warm towel. Even though vitamin K injection was available in all of the cases, only 56.7 babies were administered vitamin K after birth. In 58.3% cases, delayed cord clamping was done and initial breast feeding was done within one hour of birth.

G) Performance of AMTSL

As a part of AMTSL, during all of the deliveries observed, after the baby was delivered, the mother's abdomen was palpated by the service provider to rule out second baby and uterine massage was performed. In 80% of the cases, injection oxytocin 19MU IM was administered within one minute of delivery of the baby. Controlled cord traction was performed on 96.74% of the deliveries. Only 48.3% of the cases had the placenta and membranes checked for completeness before discarding.

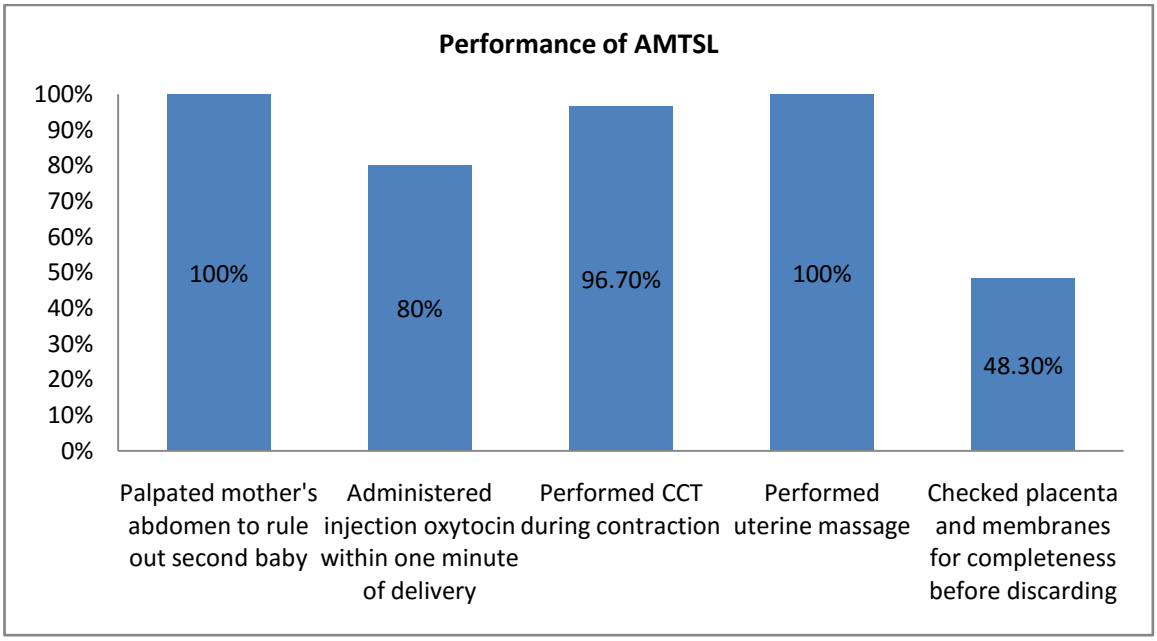


Figure 8: Performance of AMTSL

H) Breastfeeding counselling

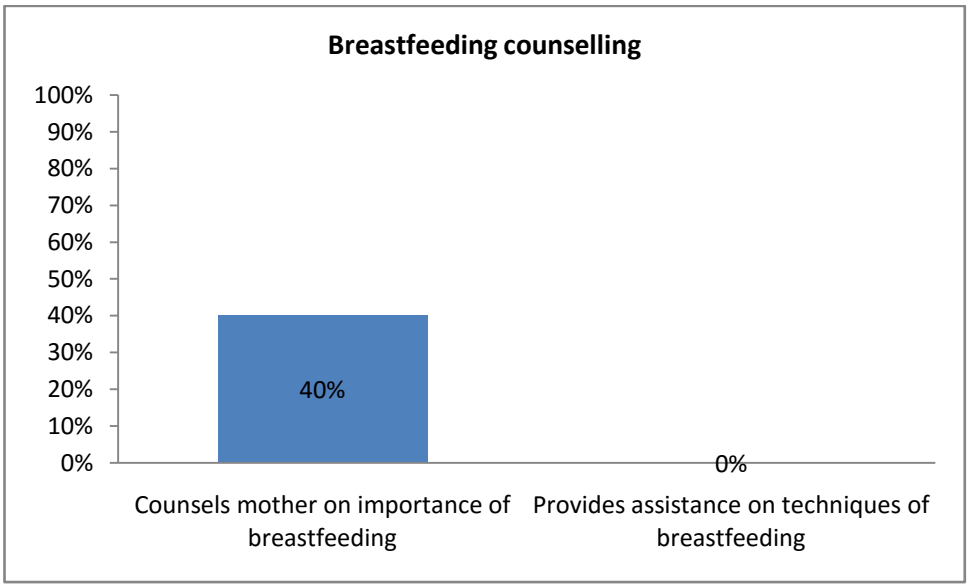


Figure 9: Breastfeeding counselling

"I usually ask the patient to start breastfeeding immediately on the table itself after the delivery, but the patients don't really listen. She is usually tired and the family also doesn't support breastfeeding and providing the mother with good nutrition soon after delivery. The women also don't comprehend much on the labour table as she has just gone through labour and we also don't have time to give detailed breastfeeding counselling at that time since we mostly have more patients waiting. Also, once the delivery is completed, since we have to go ahead with filling the records of the delivery, we rush to do that and hence this is compromised. If we were provided an extra hand for assistance during the delivery and for filling in the records of the patients, we could provide the quality care as mentioned in the protocols."

- *Respondent number: 8*

9. Discussion

The quality of care has been majorly compromised on the infection prevention front.Quality of care with respect to the preparation to receive the new-born was grossly deficient.

Reasons for not giving quality care in the labour room can be summed up in three points from the KII:

1. Lack of human resource
2. Huge patient load
3. Not enough time to give each patient

10. Recommendations

- Post more staff nurses and housekeeping staff in the labour room
- Strictly enforce the infection prevention protocols
- Strictly enforce use of partographs to monitor the progress of labour and not to fill it post-delivery to maintain records

Annesxure1 :Checklist for assessing the quality of intra-partum and essential new-born care

Study to assess the quality of intra-partum care				
Survey Number:	**Name of the birth attendant**			
	Training:			
S. No.	**Standard**	**Verification criteria No.**	**Verification criteria**	**Observations (Date and time)**
2	**Provider conducts internal examination appropriately**			
2.1	Provider conducts PV examination as per indication	2.1.1	Conducts PV examination only as indicated (4 hourly or based) on clinical indication	
2.2	Provider performs hand hygiene	2.2.1	Soap and running water is available	
		2.2.2	Sterile gloves is available	
		2.2.3	Performs hand hygiene	
		2.2.4	Wears gloves on both the hands with correct technique	
2.3	Provider cleans the perineum appropriately before conducting PV examination	2.3.1	Antiseptic solution is available	
		2.3.2	Sterile gauze/pad is available	
		2.3.3	Cleans the perineum appropriately before conducting PV examination	
2.4	Provider records the finding of PV examination (in Case	2.4.1	Records the finding of PV examination (in Case	

	sheet/Partograph during active phase of labour)		sheet/Partograph during active phase of labour)	
	Total Score			

7	**Provider monitors progress of labour in every case and adjusts care accordingly correctly fills partograph to monitor progress of labour and timely**			**Observations**
7.1	Provider timely uses partograph in every case.	7.1.1	Partographs in labor room are available	
		7.1.2	Attaches partograph in case sheet	
		7.1.3	Initiates Partograph plotting once the Cx dilation is >=4 cm	
7.2	Provider correctly plots all parameters	7.2.1	Plots all parameters	
7.3	Provider interprets partograph correctly and adjusts care according to findings	7.3.1	Provider interprets partograph correctly and adjusts care according to findings	
	Total Score			

8	**Provider ensures respectful and supportive care for the woman coming for delivery**			**Observations**
8.1	Provider treats woman and her companion cordially and respectfully (RMC), ensures privacy and confidentiality to woman during her stay	8.1.1	Curtain in labor room to ensure privacy to woman are available	
		8.1.2	Treats woman and her companion cordially and respectfully (RMC), ensures privacy and confidentiality to woman during her stay	
8.2	Provider encourages the presence of birth companion during labour	8.2.1	Encourages the presence of birth companion during labour	
8.3	Provider explains danger signs and important care activities to mother and her companion during her stay (for mother and baby)	8.3.1	Explains danger signs to mother and her companion during her stay (for mother and baby)	
		8.3.2	Explains important care activities to mother and her companion during her stay (for mother and baby)	
	Total Score			

9	**Provider prepares for safe care during delivery**			**Observations**
9.1	Provder ensures sterile/HLD delivery tray is available	9.1.1	Ensures required number of sterile/HLD delivery tray is available (atleast 2 trays per labor table),	
9.2	Provider ensures availability of pre-filled oxytocin syringe	9.2.1	Ensures availability of pre-filled oxytocin syringe	
9.3	Provider ensures functional items for newborn care and resuscitation	9.3.1	Designated new born corner is present	
		9.3.2	Ensures functional items for newborn care and resuscitation	
9.4	Provider switches radiant warmer ‘on’ 30 min before childbirth	9.4.1	Switches radiant warmer ‘on’ 30 min before childbirth	
	Total Score			

10	Provider assists the woman to have a safe and clean birth			Observations
10.1	Provider ensures six 'cleans' while conducting delivery	10.1.1	Sterile gloves are available (refer above)	
		10.1.2	Antiseptic solution (Betadine/Savlon) is available (refer above)	
		10.1.3	Sterile cord clamp is available	
		10.1.4	Sterile cutting edge (blade/scissors) is available	
		10.1.5	Ensures six cleans while conducting delivery	
10.2	Provider performs an episiotomy only if indicated	10.2.1	Performs an episiotomy only if indicated	
10.3	Provider allows spontaneous delivery of head by flexing it and giving perineal support; manages cord round the neck; assists delivery of shoulders and body	10.3.1	Allows spontaneous delivery of head by flexing it and giving perineal support; manages cord round the neck; assists delivery of shoulders and body	
	Total Score			

11	**Provider conducts a rapid initial assessment and performs immediate newborn care (if baby cried immidiately)**			**Observations**
11.1	Provider delivers the baby on mother's abdomen,	11.1.1	Delivers the baby on mother's abdomen	
11.2	Provider ensures immediate drying, and asses breathing	11.2.1	Two pre warmed clean towels are available	
		11.2.2	If breathing is normal, dries the baby immediately and wraps in second warm towel	
11.3	Provider performs delayed cord clamping and cutting	11.3.1	Performs delayed cord clamping and cutting	
11.4	Provider ensures early initiation of breastfeeding	11.4.1	Initiates breast feeding within one hour of birth	
11.5	Provider weighs the baby and administers Vitamin K	11.5.1	Baby weighing scale is available	
		11.5.2	Vitamin K injection is available	
		11.5.3	Weighs the baby	
		11.5.4	Administers Vitamin K	
	Total Score			

12	**Provider performs newborn resuscitation if baby does not cry immediately after birth**			**Observations**
12.1	Provider performs steps for resuscitation within first 30 seconds:	12.1.1	Suction equipment/mucus extractor is available (refer to 9.3.2)	
		12.1.2	Shoulder roll is available	
		12.1.3	Performs following steps within first 30 seconds on mothers abdomen: Suction if indicated; dries the baby; immediate clamping and cutting the cord and shifting to radiant	
			warmer if still not breathing	
		12.1.4	Performs following steps within first 30 seconds under radiant warmer: Positioning, Suctioning, Stimulation, Repositioning (PSSR)	
12.2	Provider initiates bag and mask ventilation for 30 seconds if baby still not breathing	12.2.1	Functional ambu bag with mask for pre-term baby is available	
		12.2.2	Functional ambu bag with mask for term baby is available	
		12.2.3	Initiates bag and mask ventilation for 30 seconds if baby still not breathing	
12.3	Provider takes appropriate action if baby doesn't respond to ambu bag ventilation after golden minute	12.3.1	Functional oxygen cylinder (with wrench) with new born mask is available	
		12.3.2	Assesses breathing, if still not breathing continues bag and mask ventilation; starts oxygen	
		12.3.3	Checks heart rate/cord pulsation	
		12.3.4	Calls for advance help/arranges referral	
	Total Score			

13	**Provider performs Active Management of Third Stage of Labour (AMTSL)**			**Observations**
13.1	Provider performs AMTSL and examines placenta thoroughly	13.1.1	Palpates mothers abdomen to rule out second baby	
		13.1.2	Administers Injn Oxytocin 10 I.U. IM/IV within one minute of delivery of baby	
		13.1.3	Performs controlled cord traction (CCT) during contraction	
		13.1.4	Performs uterine massage	
		13.1.5	Checks placenta and membranes for completeness before discarding	
	Total Score			

15	**Provider assesses condition of mother and baby before shifting them from labour room**			
15.1	Provider looks for signs of infection in baby	15.1.1	Looks for signs of infection in baby	
15.2	Provider looks for signs of hypothermia in baby	15.2.1	Measures baby's temperature	
15.3	Provider looks for signs of infection in mother	15.3.1	Looks for signs of infection in mother	
		15.3.2	Functional thermometer at point of use is available	
		15.3.3	Records mother' s temperature at admission	
15.4	Provider records BP of mother	15.4.1	Functional BP instrument and stethoscope at point of use is available	
		15.4.2	Records mother`s BP at admission	
	Total Score			

16	**Provider ensures exclusive and on demand breastfeeding**			
16.1	Provider counsels mother on importance of exclusive breast feeding	16.1.1	Counsels mother on importance of exclusive and on demand breast feeding	
		16.1.2	Provides assistance on techniques of breast feeding and on minor problems encountered whenever needed	
	Total Score			

18	**Provider counsels mother and family at the time of discharge**			
18.1	Provider counsels on danger signs, post-partum family planning and exclusive breast feeding	18.1.1	Counsels on danger signs to mother at time of discharge	
		18.1.2	Counsels on post partum family planning to mother at discharge	
		18.1.2	Counsels on exclusive breast feeding to mother at discharge	
	Total Score			