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MINISTRY OF HEALTH

MATERNAL & NEWBORN HEALTH STANDARDS

For improving quality of care in health facilities

2022

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Foreword

Kenya has witnessed an increase in access to and utilization of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services as documented by the Kenya Demographic Health Survey (KDHS) 2014. Despite the increase in access to services, high rates of adverse outcomes for childbearing women and their infants, including maternal and newborn mortality, stillbirths, and short and long term ill-health still persist. This is a reflection of the quality of pre-conception care, antenatal, intra-partum, postnatal and skilled-birth services in health facilities. Poor quality maternal and newborn health (MNH) services remain a hindrance to ending preventable maternal and newborn deaths as envisioned in the Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC).

A huge gap continues to exist between the actual and achievable health care outcomes, primarily because effective interventions are not implemented for every client/patient, every time. A good understanding of the quality of RMNCAH services in health care facilities across the continuum-of-care is essential to guide quality improvement interventions at all levels of the health system.

The Confidential Enquiry into Maternal Deaths (CEMD) Report 2017, on maternal deaths conducted by the Ministry of Health for 2014 through the Reproductive Maternal Health Services Unit (RMHSU), found that poor quality of care contributed to over 80% of deaths. These deaths could have been avoided were quality measures and practices institutionalized. National standards to monitor Quality of Care (QoC) in health facilities exist but they have not been widely disseminated or implemented.

“The success, value and effectiveness of UHC depends on its ability to provide quality services to all people, every time, everywhere

The quality of health services is critical to achieving effective UHC and meeting the health-related SDGs. The success, value and effectiveness of UHC depends on its ability to provide quality services to all people, every time, everywhere. Various National guidelines have been developed to build the capacity of health facilities and health workers to enhance RMCAH-QoC including experience of care by clients.

WHO reviewed global guidance on quality of Maternal and Newborn Health (MNH) care to assist countries in accelerating efforts to reduce adverse outcomes during pregnancy and childbirth and enhance the achievement of SDGs. In response to the global call to place quality of care at the center of country, regional and global action and in order to progress towards effective UHC, Kenya has adapted WHO Standards for improving quality of Maternal Newborn Health. These MNH standards will be used to improve quality of care of MNH services across all health care service delivery levels.



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The development of these MNH quality of care standards and assessment tool took a consultative approach and involved in-depth Consultations with a wide range of multi-disciplinary stakeholders including specialized and experienced individuals and experts in matters obstetric, perinatal and quality of health care. Through, literature review, key informant interviews and consultative meetings, drafts were developed and refined incrementally to this final validated guidelines and standards. We wish to thank Dr. Florence Murila - University of Nairobi the lead consultant to this process who together with various technical divisions of the MOH Led by Divisions of Reproductive and Maternal Health and Standards and Quality Assurance. The is greatly indebted to the host Department of Family Health through the Division of Reproductive and Maternal Health and specifically the Maternal Newborn Health Programme for providing invaluable oversight, inputs and coordination of the entire development process.

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Abbreviations

ADR	Alternative Dispute Resolution
ANC	Antenatal Care
BCG	Bacillus Calmette Guerin
CEMD	Confidential Enquiry into Maternal Deaths
CHEWs	Community Health Extension Workers
CHVs	Community Health Volunteers
CME	Continuing Medical Education
CO	Clinical Officer
DIC	Disseminated Intravascular Coagulation
D&A	Disrespect and Abuse
DHIS	District Health Information Systems
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ICU	Intensive Care Unit
IFAS	Iron/Folic Acid tablets
IPTP	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide Treated Net
KSA	Kenya Society of Anesthesiologists
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MPDSR	Maternal, Perinatal Death Surveillance and Response
NICE	National Institute for Health and Care Excellence
PACU	Post Anesthesia Care Unit
QoC	Quality of Care
RMC	Respectful Maternity Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	Sustainable Development Goals
SOPs	Standard Operating Procedure
SVD	Spontaneous vaginal delivery
TB	Tuberculosis
TT	Tetanus Toxoid
UHC	Universal Health Coverage
UNICEF	United Nations Children Emergency Fund
WBC	White blood cells
WFSA	World Federation of Societies of Anesthesiologists
WHO	World Health Organization
WIT	Work Improvement Teams
WRA	Women of Reproductive Age

SECTION A



Introduction

Kenya is a signatory to all the global strategies and commitments for ending preventable, maternal newborn, child and adolescent deaths. Despite the increase in access to services, high rates of adverse outcomes for childbearing women and their infants persist including Maternal and Newborn mortality, stillbirths, and short and long term ill-health. This is a reflection of the quality of antenatal, intrapartum postnatal and skilled-birth services in our health facilities. Poor quality of maternal and newborn health services remains a hindrance to achieving the Sustainable Development Goals (SDGs) and ending preventable maternal and newborn deaths. The statistics of KDHS 2014 stand at MMR 362/100,000, NMR 22/1,000 and teenage pregnancy 18%. Most of the maternal deaths are mainly from five morbidities: severe obstetric hemorrhage, preeclampsia / eclampsia, unsafe abortion, sepsis and obstructed labour. The leading causes for childhood deaths are neonatal causes which include birth asphyxia, neonatal sepsis, prematurity, pneumonia, malaria, diarrhoea and malnutrition. These deaths are 'mostly preventable' because the necessary medical interventions exist and are well known.

Kenya as a country has responded to the global call to urgently place quality care at the center of country, regional and global action, in order to progress towards effective Universal Health Coverage and achievement of Sustainable Development Goals. As part of the national efforts to effect this, the Country has adapted WHO Standards for improving quality of Maternal Newborn Health (MNH Quality of Care Standards). The framework of eight domains of quality of care for pregnant women and newborns in facilities increases the likelihood that the desired individual and facility outcomes will be achieved. There are eight quality standards which comprise five Provision of care standards and three patients experience of care standards.

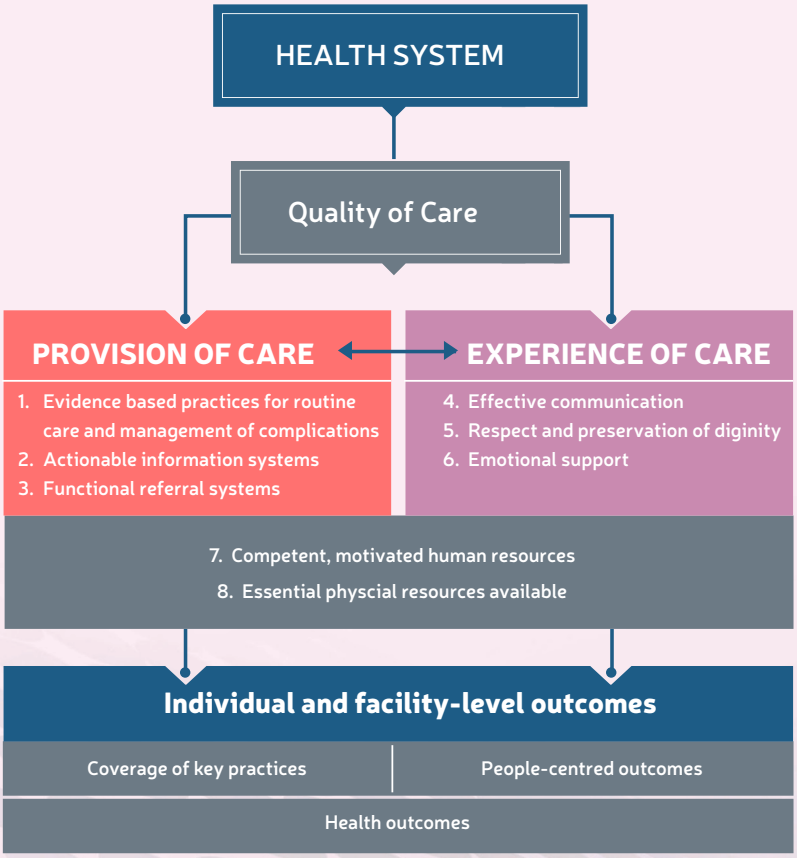


Figure 1: WHO Frame work for the quality of maternal and newborn health care
Source: Standards for Improving Quality of Maternal and Newborn Care in Health Facilities (WHO)

Kenya has further added three quality Standards on provision of care
The standards are as follows:-

1. Evidence-based care for Preconception and Antenatal Care
2. Evidence-based practices for routine care and management of complications
3. Health information system
4. Referral
5. Communication
6. Respect
7. Emotional support
8. Competent motivated staff for EmONC and ENC
9. Physical environment
10. Safe Obstetric Anaethesia and Surgery
11. Community Engagement

These standards are aimed at ensuring that every woman, new-born, child and adolescent receives quality health services throughout the continuum of their life course and care.

Priorities for reducing maternal and perinatal mortality

Effective prevention and management of conditions in late pregnancy, childbirth and the early newborn period are likely to significantly reduce the numbers of maternal deaths, antepartum and intrapartum-related stillbirths and early neonatal deaths. Therefore, improvement of the quality of preventive and curative care during this critical period could have the greatest impact on maternal, foetal and newborn survival.

On the basis of the current evidence on the burden and impact, the following thematic areas are considered high priorities for evidence-based practices in routine and emergency care.

- Routine care during childbirth, including monitoring of labour and newborn care at birth and during the first week
- Management of pre-eclampsia, eclampsia and its complications
- Management of difficult labour with safe, appropriate medical techniques
- Management of postpartum hemorrhage
- Newborn resuscitation
- Management of preterm labour, birth and appropriate care for preterm and small babies
- Management of maternal and newborn infections

Kenya has therefore adapted these thematic areas so as to meet the country's national needs

Definition and structure of standards

A "standard" is defined as "a description of what is expected to be provided to achieve high-quality care around the time of childbirth". The standard of care has two main components: the quality statement and the quality measure (Fig. 2).

A quality statement sets out the requirements to achieve compliance with the standard and **quality measures** provide objective evidence for determining whether or not the requirements have been met.

Quality statements are concise statements of priorities for measurably improving quality of care around childbirth (adapted from NICE quality standards). They define the markers of quality derived from evidence on the thematic area and the resources required.

Quality measures are criteria for assessing, measuring and monitoring the quality of care as specified in the quality statement. They are of three types:

- *Input:* what must be in place for the desired care to be provided (e.g. physical resources, human resources, policies, guidelines),
- *Output:* whether the desired process of care was provided as expected
- *Outcome:* the effect of the provision and experience of care on health and people-centered outcomes



Figure 2: Structure of standards

Scope and use of standards and quality statements

The standards of care cover the routine care and management of complications occurring in women at preconception, women and their babies during the antenatal period, during labour, childbirth and the early postnatal period, including those in small babies during the first week of life. They are centered on the woman, the newborn and the family and are applicable to all health facilities that offer antenatal and maternity services. They are in line with national guidelines for maternal and newborn health and designed to address the specific priorities identified for reducing maternal and neonatal mortality.
The standards of care provide a basis for what is expected and required, support the monitoring and measurement of performance against measures of best practice in order to identify priorities for improvement and provide information on how best practice can be used to support high-quality care or service delivery. They define priorities for improving the quality of maternal and newborn care for use by planners, managers and health care providers to:

- Prepare evidence-based national and subnational standards of care to ensure high-quality, effective maternal and neonatal health services around the time of childbirth;
- Introduce the expected standards of care and delivery services in order to identify the components of care that require improvement to ensure high-quality service;
- Use available resources to achieve optimal health care outcomes and improve the use by and satisfaction of individuals, families and communities with maternal and neonatal health services;
- Monitor service improvements, show that high-quality maternal and newborn care or services are being provided and highlight areas for improvement; and
- Provide a benchmark for national health facility audits, accreditation and rewards for provider performance.

Using quality measures

Health facility teams can use the quality measures to identify gaps in the quality of care and to improve the provision and experience of care according to the standard and the relevant quality statement. Health facility leaders, planners, managers and providers can use them to assess and monitor the availability of resources, the performance of processes, areas that require improvement and the impact of interventions, hence driving quality improvement. The measures in this document have been adapted to the Kenyan context. However, the standards must be implemented consistently to ensure quality improvement.

The quality measures include input, output/process and outcome measures. Input measures include physical resources, human resources, policies, protocols and guidelines. Output measures include coverage of key practices and most are expressed as proportions, such as *"The proportion of all women who gave birth in the health facility whose urinalysis result was appropriately recorded during labour, childbirth and the early postpartum period."* The outcome measures include people centered and health outcomes.

Most quality statements are followed by measures that are highly specific to that statement; however, some measures might be relevant to more than one statement, especially with regard to physical resources.

For standard 2, some are annotated with 'a' if they cover only the woman, 'b' if they cover the baby and 'c' if they cover both the mother and the baby.
This was an exercise designed to adopt and streamline the WHO standards for MNCH within the national quality of care strategies and frameworks for the delivery of maternal and newborn health services to ensure that the services provided are of high quality.

MEASURES FOR QUALITY STATEMENTS

STANDARD 1 Every woman in the reproductive age receives routine evidence based care and management of complications before and during pregnancy.

Quality Statement 1.1:

Every woman planning a pregnancy should receive appropriate pre-conception care to enable her plan her family with a healthy pregnancy and fetal outcome

Rationale

Preconception care consists of interventions that identify and modify biomedical, behavioral, and social risks to a woman's health and future pregnancies. It includes health promotion, prevention of poor outcomes and management of any preexisting conditions; by emphasizing health issues that require action before conception or very early in pregnancy for maximal impact. It aims at improving the health status of mother and child.

The target population for pre-conception care is women of reproductive age (WRA) 15 to 49 years. Men are also targeted by several components of pre-conception care. (WHO, 2013)

Quality Measures

Input

1. The health facility provides for a Preconception wellness program that will cover issues related to hygiene, nutrition and supplementation (folate) and counselling and screening services, a positive lifestyle and pregnancy expectation as the mother prepares for conception.
2. The health facility has displayed written, up-to-date clinical protocols for pre-conception care.
3. Health-care staff in the MCH/FP clinics and OPD receive regular in service training and refresher sessions on pre-conception care at least once every 12months.
4. The health facility has adequate health care providers with the skills and competency to empower the woman in reproductive health rights and gender based violence.
5. The health facility educates and provides women with a variety of family planning options/ contraception care to encourage planned families.
6. Women receive folic acid prior to conception
7. The health facility provides support for women with difficulty in conceiving and early (1st trimester) pregnancy losses.
8. The health facility provides sufficient space, teaching aids and equipment for the pre-conception care clinic.
9. Women are screened, counseled on pre-existing conditions as appropriate.
10. Women with pre-existing diseases and conditions are managed pre-conceptually as appropriate.

Output/process

1. The proportion of women who received folic acid prior to conception.
2. The proportion of women screened for each of the following: HIV, Tuberculosis, Diabetes, Hypertension, Sickle Cell, Rhesus factor, Anemia and Other Genetic conditions for various underlying health conditions prior to conception.

Outcome

1. Proportion of women whose medical conditions were well controlled prior to conception.

Quality statement 1.2:

All pregnant women are supported to access quality antenatal care services within 12 weeks of pregnancy

Rationale

Antenatal care provides an integrated platform for the delivery of several cost effective evidence based health care interventions that are necessary for saving the lives of mothers and newborns. These include: health promotion, early detection and management of pregnancy related complications and preexisting diseases, and complication readiness, individualized birth planning, PMTCT, counseling on nutrition, healthy timing and spacing of pregnancy, and gender based violence amongst others.

The ANC platform is also pivotal for increasing access to critical high impact interventions for the prevention and management of anemia, HIV/AIDS, tuberculosis, and malaria.
Antenatal care should be woman centered, safe, and accessible. Women are more likely to seek and return for services if they feel cared for and respected by health care providers. This personalized approach requires health care providers to use excellent interpersonal skills since listening to client's concerns is just as important as giving advice. It respects clients' right to dignity, privacy, confidentiality, full and accurate information.

Inputs

1. The health facilities have written, up-to-date clinical protocols for antenatal care services
2. Health care providers receive in-service training and regular refresher sessions in the management of ANC services at least once every 12 months
3. The health care providers are able to obtain comprehensive history from the client (personal, medical, surgical and social/family, obstetric/gynae).
4. The health care providers conduct systematic physical examination in a private and confidential environment
5. The health care provider counsels mothers on hygiene, nutrition, safe sex, future family planning options, newborn care, breastfeeding and wellness in pregnancy.
6. The health facility has the capacity to perform ANC profiles.
7. The health facility facilitates the mother to form mother to mother support groups to encourage clinic attendance.
8. The health facility has a mechanism for tracing of ANC defaulters.
9. The health facility has a mechanism to do follow up of mothers.
10. The facility conducts Maternity open days and facilitates dialogue between facility and community.

Outcomes

1. Proportion of women who had comprehensive antenatal profile done during 1st visit (All ANC Profile Tests)
2. Proportion of women who received IFAS
3. Proportion of women screened for HIV
4. Proportion of women screened for syphilis
5. Proportion of women who attended ANC in 1sttrimester (12 weeks).
6. Proportion of women who completed ANC as outlined in the national guidelines i.e. completed scheduled visits.

STANDARD 2

Every woman and newborn receives routine evidence-based care and management of complications during labour, childbirth and the early postnatal period according to the national guidelines.

Quality statement 2.1a:

Women are assessed routinely on admission, during labour, childbirth and are given timely appropriate care.

Rationale:

Assessment of women and regular monitoring on admission, during labour and child birth are critical to ensure essential care that is appropriate to the woman's needs, to prevent the onset of complications and to identify risks or complications that require urgent action or referral for better outcomes of pregnancy and labour for both the mother and the newborn.

On admission, women undergo a full review of their antenatal care records, pregnancy and labour history, a vaginal examination and confirmation of labour. The fetal heart rate, fetal lie, position and presentation, blood pressure, pulse and temperature are determined and recorded. Blood group and Rhesus typing, haemoglobin, urine protein and glucose, and HIV status, if appropriate, are tested and recorded.

The progress of labour is monitored with a partograph/labor care guide; blood pressure, pulse, temperature and fetal heart rate are assessed regularly. Pain relief is offered, and the mother's choice is respected. Spontaneous vaginal birth is supported and guided by the mother's urge to push. The third stage of labour is managed actively, with intravenous or intramuscular Uterotonic given immediately after the birth (Uterotonic - oxytocin, Carbetocin, Ergometrine).
Any complications at admission and during labour and birth are rapidly identified and appropriately managed.

Quality measures

Input measures

1. The health facility has the basic essential equipment and supplies for routine care and detection of complications (thermometers, sphygmomanometers, fetal stethoscopes, urine dipsticks) available in sufficient quantities at all times in the areas of the maternity unit for labour and childbirth.
2. The health facility has written, up-to-date clinical protocols for assessing Intrapartum care and action in the labour and childbirth areas of the maternity unit that are consistent with national guidelines and accessible within maternity.
3. Health-care Providers in the labour and childbirth areas of the maternity unit receive in-service training, scheduled CME sessions on handling obstetric emergencies once every month and regular refresher sessions at least once every 12 months in the identification and management of obstetric emergencies during labour and childbirth.
4. The health care staffs receive mentorship sessions/supportive supervision quarterly.
5. The health facility has written, up-to-date clinical protocols for pain management during labor.

Output/process measures

1. The proportion of all women who gave birth in the health facility whose blood pressure, pulse and temperature were appropriately recorded during labour, childbirth and the early postpartum period.
2. The proportion of all women who gave birth in the health facility who received oxytocin within 1 minute of birth of the baby.

3. The proportion of all women who gave birth in the health facility whose progress in labour was correctly monitored and documented with a Partograph/labor care guide.
4. The proportion of all women who gave birth in the health facility whose urinalysis and hemoglobin levels result was appropriately recorded during labour and childbirth.
5. The proportion of all women who gave birth in the health facility who received any option for pain relief during labour and childbirth.

Outcome measures

1. The health facility perinatal mortality rate [number of fetal deaths (stillbirths) and early neonatal deaths / the total number of births of babies weighing at least 1000 g or of 28 weeks' gestation (stillbirths + live births) x 1000]
2. Intrapartum stillbirth rate (number of stillbirths occurring during the intrapartum period per 1000 births).
3. The proportion of all women admitted to the health facility in active labour who gave birth within 12 hours.

Quality statement 2.1b

(I): Newborns receive routine care immediately after birth.

Rationale:

Routine care of newborns immediately after birth facilitates adaptation of the newborn to the new environment, meets his or her immediate needs in the best possible way and avoids preventable complications.

Immediately after birth, newborns are dried thoroughly and placed in skin-to-skin contact with the mother for at least 1 hour. Clamping of the umbilical cord is delayed until 1–3 min after birth, and breastfeeding is supported in the first hour after birth. Any complications are identified and managed appropriately.

Quality measures

Input

1. The health facility has written, up-to-date, clinical protocols for essential newborn care that are consistent with national guidelines and are available in the labour and childbirth areas of the maternity unit.
2. Health-care staff in the labour and childbirth areas of the maternity unit receive in-service training or regular refresher sessions in essential newborn care and breastfeeding support at least once every 12 months
3. The health facility has supplies of sterile cord ties (or clamps) and scissors (or blades), vitamin K, 1% tetracycline eye ointment and 7.1% chlorhexidine for cord care available in sufficient quantities at all times for the expected number of births
4. The health facility has supplies of clean towels in the labour and childbirth areas for immediate drying of newborns, available in sufficient quantities at all times for the expected number of births.
5. The health facility has arrangements for alternative feeding methods, including cup, cup and spoon feeding (according to the national guidelines)
6. In the extreme cases where infant formula is needed, the health facility ensures that feeding of infant formula is demonstrated to mothers and family members of newborns only when needed, with a full explanation of the hazards of improper use.

Output/process

1. The proportion of all newborns who were dried immediately and thoroughly at birth.
2. The proportion of all newborns that were kept in skin-to-skin contact (with body and head covered) with their mothers for at least 1 hour after birth.

3. The proportion of all newborns who were breastfed within 1 hour of birth.
4. The proportion of all newborns whose umbilical cord was clamped 1–3 min after birth.
5. The proportion of all newborns who received all four elements of essential newborn care: immediate and thorough drying, immediate skin-to-skin contact, delayed cord clamping and initiation of breastfeeding in the first hour

Outcome

1. The proportion of all newborns who had a normal body temperature (36.5–37.5 °C) at the first complete examination (60-120 minutes after birth).

Quality statement 2.1b

(ii): Newborns who are not breathing spontaneously receive appropriate stimulation and resuscitation with a bag-and-mask within 1 minute of birth, according to the national guidelines.

Rationale:

Birth asphyxia is one of the leading causes of neonatal deaths within the first week of life and is also responsible for long-term neurological disability and impairment. It can be prevented by appropriate, effective resuscitation of newborns who are not breathing at birth.

For newborns who are not breathing spontaneously after thorough drying and stimulation, immediately clamp and cut the cord and resuscitate. . Suction is used only if the newborn had meconium stained liquor or if secretions are present in the mouth or nose. Positive-pressure ventilation with a self-inflating bag-and-mask is initiated within 1 minute of birth, with air for newborns >32 weeks' gestation and with 30% oxygen for preterm babies at < 32 weeks' gestation. The adequacy of ventilation is monitored by measuring the heart rate, chest movement and pulse oximetry (if available). A higher oxygen concentration is given only if the heart rate is < 60/min after 60 seconds of resuscitation.

Quality measures

Input

1. The health facility has written, displayed, up-to-date clinical protocols for managing newborns who are not breathing spontaneously in the childbirth areas of the maternity unit that are consistent with the national guidelines.
2. Health care staff in the childbirth and neonatal areas of the maternity unit receive in-service training and regular refresher sessions in basic newborn resuscitation at least once every 12 months.
3. Health care staff in the childbirth and neonatal areas of the maternity unit receive monthly drills or simulation exercises and supportive supervision in basic newborn resuscitation.
4. The health facility has a suction device, at least two sizes of neonatal mask and a self-inflating bag (500mls) in the childbirth and neonatal areas of the maternity unit.
5. Health-care Providers providing care for pregnant and postpartum women and newborns in the health facility are skilled in basic newborn resuscitation, as demonstrated by simulating positive pressure ventilation with a bag-and-mask on a manikin

Output/process

1. The proportion of all newborns who were not breathing spontaneously after drying and stimulation at the health facility who were resuscitated with a bag-and-mask within 1 min of birth.
2. The proportion of all newborns who were not breathing spontaneously after additional stimulation at the health facility who were resuscitated with a bag-and-mask but died.

Outcome

1. The proportion of all live babies born at term (≥ 37 weeks) with no major congenital malformations in the health facility who died within 7 days of birth (early neonatal mortality)

Quality statement 2.1c:
Mothers and newborns receive routine postnatal care

Rationale:
Routine postnatal care represents the use of best practices for prevention, early detection and treatment of complications in the mother and baby and counseling of mothers on how best to take care of themselves and their newborns.

Postnatal care, the individualized care provided to a mother and her baby after childbirth should address any variation from the expected normal recovery after birth such as excessive vaginal bleeding, altered level of consciousness, severe headache and difficulty in breathing. Blood pressure, temperature, bleeding and urine voiding are monitored frequently during the first 48 hours after childbirth. Complications are identified and managed, and exclusive breastfeeding is supported. Mothers are counseled on the following; danger signs (mother and baby), birth spacing and family planning methods.

Newborns receive a complete physical assessment, are kept in skin-to-skin contact with the mother and given eye and umbilical cord care. Bathing is delayed for 24 hours, Vitamin K and vaccines (BCG and birth Polio) are given as per the national guidelines, temperature is monitored, and complications are identified and managed. Low-birth weight and preterm babies are given additional care as needed.

Quality measures
Input

1. The health facility has written, up-to-date clinical protocols for postnatal care in the maternity and/or postnatal care areas of the maternity unit that are consistent with the national guidelines.
2. The health facility has a written breastfeeding policy that is routinely communicated to all healthcare providers and visibly displayed in all MNH service delivery areas.
3. The health facility has well displayed job-aids for management of post-partum complications e.g. post-partum hemorrhage, pre-eclampsia, eclampsia, and maternal sepsis.
4. The health facility practices and enables rooming-in to allow mothers and babies to remain together 24 hours a day.
5. Health-care staff in the maternity unit receive in-service training and refresher sessions in postnatal care and breastfeeding at least every 12 months.
6. The health facility has arrangements to ensure that every mother knows when and where post-natal care for herself and newborn will be provided after discharge from hospital (link with community referral standards).
7. Clients are counselled to come back for post-natal checkup at 10-14 days, 4-6wks and at 4-6 months (mother and baby) and also to come back anytime when they experience danger signs in her and baby.

Output/process

1. The proportion of all newborns on postnatal care wards or areas in the health facility who received Vitamin K, 1% tetracycline eye ointment, 7.1% chlorhexidine for cord care and Vaccination.
2. The proportion of all stable newborns in the health facility who are fed exclusively on breast milk from birth to discharge.
3. The proportion of all women in postnatal care wards who have documentation of blood pressure, pulse rate, lochia loss and breastfeeding.
4. The proportion of all newborns in the health facility who received a full clinical examination before discharge.
5. The proportion of all healthy mothers and newborns who received care for at least 24 hours after an uncomplicated vaginal birth in a health facility.

6. The proportion of all newborns on postnatal care wards or areas in the health facility for whom there is documented information on the newborn body temperature, respiratory rate, feeding behavior and the absence or presence of danger signs.
7. The proportion of all healthy mothers on postnatal wards or areas in the health facility who received breastfeeding counseling and support from a skilled health care provider.
8. Proportion of all postpartum women taught on danger signs of baby and mother
9. The proportion of all postpartum women in the health facility who were offered post-natal checkup within 48hrs, before discharge.
10. The proportion of all postpartum women in the health facility who were offered counseling on the importance of post-natal checkup within 48 hrs,2weeks and 6weeks, birth spacing and family planning methods before discharge.
11. The proportion of the ten steps in the baby friendly initiative implemented in the health facility.

Outcome

1. The proportion of all newborns in the health facility who were exclusively breastfed at the time of discharge from hospital.
2. The proportion of all postpartum women in the health facility who have taken up a family planning method before discharge.

Quality statement 2.2a:

Women with pre-eclampsia or eclampsia promptly receive appropriate interventions.

Rationale:

Pregnancy-induced hypertension, pre-eclampsia and eclampsia are major causes of maternal mortality, stillbirth and neonatal mortality. Prevention, early diagnosis and timely appropriate treatment can drastically reduce the associated mortality and morbidity.

Women with severe pre-eclampsia are immediately given intravenous or intramuscular magnesium sulfate and an antihypertensive, as appropriate. A pre-referral loading dose of magnesium sulphate should be given if the woman is to be transferred. Signs of organ dysfunction and other danger signs (blood pressure, respiratory rate, fluid balance, urine output, tendon reflexes and foetal heart rate) are monitored. Laboratory testing (Complete Blood Count, liver function test and kidney function tests) determine the progression of disease. If the woman has tremors, has signs of organ dysfunction or has intrauterine foetal death, labour is induced or caesarean section is performed, as appropriate. Appropriate foetal monitoring is mandatory. For preterm pregnancies, proactive management with corticosteroids with close monitoring of the mother is undertaken if the condition is stable.

Quality measures

Input

1. The health facility has written, displayed, up-to-date clinical protocols on the management of pre-eclampsia/eclampsia that are available in the gynaecological, antenatal, labour, childbirth and postnatal areas of the maternity unit and are consistent with the national guidelines (strictly available in all areas).
2. Health-care staff in gynaecological, antenatal, labour, childbirth and postnatal areas receive monthly mentorship sessions or simulation exercises and supportive supervision in the management of pre-eclampsia and eclampsia.
3. The health facility has pharmaceuticals, supplies and equipment available in sufficient quantities at all times in the gynaecological, antenatal, labour, childbirth and postnatal areas of the maternity unit. (Strictly available in all areas).
4. Health-care staff in the gynaecological, antenatal, labour, childbirth and postnatal areas receive CME sessions

Output/process

1. The proportion of all women with severe pre-eclampsia or eclampsia in the health facility who received the full dose of magnesium sulphate (loading dose for level 2 and 3).
2. The proportion of all women with pregnancy-induced hypertension in the health facility who received the recommended antihypertensive.
3. The proportion of women with pre-eclampsia or eclampsia who have had appropriate diagnostic tests.

Outcome

1. The proportion of all women with pre-eclampsia or eclampsia in the health facility that died as a result of pre-eclampsia or eclampsia.
2. The proportion of all women with pre-eclampsia or eclampsia that arrived at the health facility with a live foetus whose baby died in the perinatal period (stillbirths or early neonatal deaths).
3. The proportion of all women with pre-eclampsia or eclampsia in the health facility who experienced maternal near-misses due to pre-eclampsia or eclampsia.
4. The proportion of all women with pre-eclampsia in the health facility whose condition progressed to eclampsia.

Quality statement 2.3a:

Women with postpartum haemorrhage promptly receive appropriate interventions.

Rationale:

Postpartum haemorrhage is the leading cause of preventable maternal mortality, most deaths occurring in the first 24–48 hours of delivery. Early diagnosis and timely, adequate management are the basis for effectively reducing mortality.

Postpartum bleeding is monitored routinely. If haemorrhage occurs, it should be promptly managed with intravenous oxytocin and other Uterotonic, uterine massage, manual removal of retained placenta as appropriate, temporizing measures or surgical interventions when indicated. Continued blood loss, pulse rate and blood pressure are closely monitored, and shock is managed with immediate resuscitation with intravenous fluid and blood transfusion, if indicated.

Quality measures

Input

1. The health facility has written, displayed, up-to-date clinical protocols for postpartum haemorrhage management that are available in the childbirth and postnatal care areas and are consistent with the national guidelines.
2. Health-care staff in the labour, childbirth and postnatal care areas of the maternity unit receive in-service training and regular refresher sessions in the management of postpartum haemorrhage at least once every 12 months.
3. Health-care staff in the maternity unit receive monthly mentorship sessions or simulation exercises and supportive supervision in the management of postpartum haemorrhage.
4. The health facility has Uterotonic drugs, Antifibrinolytic, supplies for intravenous fluids and blood administration and equipment for management of PPH is available in sufficient quantities at all times in the childbirth and postnatal care areas.
5. A functional blood transfusion service and theatre is available in the health facility at all times.

Quality statement 2.3b:

Women who have gone into hypovolemic shock receive appropriate interventions according to the national guidelines.

Rationale:
Shock is a life threatening condition that is characterized by failure of the circulatory system to maintain adequate perfusion of the vital organs. It requires immediate and intensive treatment. The main causes of obstetric shock are severe haemorrhage and sepsis.

Quality measures

Input

1. The Facility has well displayed protocols for management of hypovolemic shock.
2. The health care providers can identify a patient in shock using AVPU mnemonic and call for help.
3. The health facility has wide bore cannulas adult sizes, oxygen mask, adult ambu bags, group and cross match bottles, IV fluids – ringers lactate and normal saline, Vital signs monitoring charts and fluid input and output monitoring charts.
4. The health care providers are able to apply ABC approach in management of a patient with hypovolemic shock.
5. The health facility has the capacity to carry out lab Investigations e.g. group and cross match, full blood count etc.

Output/process

1. The proportion of all women with postpartum haemorrhage in the health facility who received therapeutic Uterotonic drugs.
2. The proportion of women who developed hypovolemic shock who were managed successfully.
3. The proportion of all women in the health facility with postpartum haemorrhage due to a retained placenta for whom manual removal of the placenta was performed by a skilled birth attendant.
4. The proportion of all women in the health facility with postpartum haemorrhage due to tears that received appropriate management.
5. The proportion of all women in the health facility with postpartum haemorrhage due to Disseminated Intravascular Coagulation (DIC) that received appropriate management.

Outcome

1. The proportion of all women who gave birth in the health facility who had severe postpartum haemorrhage (abnormal bleeding of >500 mls post SVD and 1,000 mls post C/S or any bleeding with hypotension or alters the hemodynamic status of the mother or requiring blood transfusion) and were not transfused.
2. The proportion of women who were diagnosed with PPH and referred within 30 mins to a higher level for transfusion.
3. The proportion of all women who had postpartum haemorrhage in the health facility who died as a result of postpartum haemorrhage.

Quality statement 2.4a:

Women whose progress in labour is delayed or whose labour is obstructed receive appropriate interventions according to the national guidelines.

Rationale:
Obstructed labour is a major cause of both maternal and newborn morbidity and mortality. Undiagnosed obstructed labour can lead to a ruptured uterus, vesico-vaginal fistula or recto-vaginal fistula in the mother and higher risks for stillbirth, neonatal asphyxia, meconium aspiration syndrome and other conditions. Proper monitoring of labour to avoid prolongation and its complications and early detection and timely management of obstructed labour can decrease the incidence of these complications.
Monitoring and management for prolonged labour include partograph charting/labour care guide monitoring, checking for cephalopelvic disproportion, assessing and managing the woman's hydration. Intravenous oxytocin (and with amniotomy if the membranes are not ruptured) is used if there is delay in the first stage with no cephalopelvic disproportion. Prolonged second stage of labour is treated by

appropriate use of instrumental delivery (vacuum)) or by caesarean section if there is evidence of foetal compromise or signs of obstruction of labour.

Note: Augmentation should be used only in confirmed prolonged labour after exclusion of cephalopelvic disproportion and in facilities capable of close, regular monitoring of the foetal heart rate and the pattern of uterine contraction and can manage any adverse effects.

Quality measures

Input

1. The health facility has written, up-to-date clinical protocols for preventing and managing prolonged labour, which are available in the labour and childbirth areas and are consistent with the national guidelines.
2. Health-care staff in the labour and childbirth areas of the maternity unit receive in-service training and regular refresher sessions (every 12 months) in managing prolonged and obstructed labour.
3. The health facility has the essential supplies and equipment for assisted vaginal delivery, including newborn resuscitation equipment, available in sufficient quantities at all times in the childbirth area of the maternity unit.
4. The health facility has staff who are trained in the use of vacuum delivery kit
5. The health facility has an adequately equipped operating theatre close to the childbirth area of the maternity unit.
6. If the health facility does not have an operating theatre, it has an appropriate referral system to a facility that has this service.
7. The health facility has an adequate number of staff skilled in performing caesarean section, 24 hours a day.
8. Health Care Staff in labour ward are able to interpret the partograph/labor care guide to diagnose obstructed labour and take necessary action.

Output/process

1. The proportion of all women in the health facility with prolonged and/or obstructed labour who gave birth by caesarean section.
2. The proportion of all women who gave birth in the health facility who underwent assisted vaginal birth (vacuum) for delayed second stage of labour.
3. The proportion of women with prolonged or obstructed labour who underwent emergency caesarean section within 30 minutes of the decision to perform caesarean section.

Outcome

1. The proportion of all women who gave birth in the health facility whose uterus ruptured during labour.
2. The proportion of all perinatal deaths that occurred in the health facility after prolonged or obstructed labour.
3. The proportion of women with obstructed labour who died during labour and delivery.

Quality statement 2.5a:

Women in preterm labour receive appropriate interventions for both themselves and their babies, according to national guidelines.

Rationale:

Preterm labour (before 37 completed weeks of pregnancy) can result in numerous health risks to the baby: which increase the earlier the baby is delivered. Prevention of preterm labour and appropriate management of imminent preterm labour are imperative to reduce the associated risks to the baby, prevent avoidable complications and improve the outcome and survival of preterm babies.

Women in preterm labour are admitted to a facility that has the capacity to manage preterm babies and their complications, conduct a thorough assessment and evaluation to confirm gestational age by ultrasound or date of the last menstrual period, assess them for signs and symptoms of infection and evaluate whether birth is imminent or can be delayed.

Antenatal corticosteroids are given, after ruling out chorioamnionitis, for imminent risk of preterm birth at 24–34 weeks of gestation, with tocolytics as appropriate. Antenatal magnesium sulphate is given for preterm labour at < 32 weeks of gestation to protect the foetus from neurological complications. Women with confirmed preterm pre-labour rupture of membranes are routinely given antibiotics.

Quality measures

Input

1. The health facility has written, up-to-date clinical protocols for the management of preterm labor in the childbirth areas of the maternity unit that are consistent with the national guidelines.
2. Health-care staff in the maternity unit receive in-service training and regular refresher sessions in the management of preterm labour at least once every 12 months.
3. Health-care staff in the maternity unit receive monthly mentorship sessions, drills or simulation exercises, CMEs and supportive supervision in the management of preterm labour.
4. Health care staff have the capacity to identify/diagnose women with preterm labour through history taking.
5. The healthcare provider performs investigations to ascertain the cause of pre-term labour
6. The health facility has supplies of antenatal corticosteroids (dexamethasone or betamethasone), antibiotics and magnesium sulphate available in sufficient quantities at all times to manage preterm birth in accordance with the national guidelines.
7. Women in preterm labour receive appropriate interventions for both the woman and the baby according to evidence-based guidelines including use of antenatal corticosteroids for eligible mothers.

Output/process

1. The proportion of all preterm newborns born between 24 and 34 weeks of gestation in the health facility whose mothers received at least one dose of antenatal corticosteroids when indicated.
2. The proportion of all preterm newborns born before 32 weeks of gestation in the health facility whose mothers received magnesium sulphate during the active phase of labour to protect their baby from foetal neurological complications.
3. The proportion of all women with preterm pre-labour rupture of membranes who gave birth in the health facility who received prophylactic antibiotics.

Outcome

1. The proportion of all women with preterm labour rupture of membranes who gave birth in the health facility who developed chorioamnionitis.
2. The proportion of all babies at risk for birth in the health facility at 24 to < 34 weeks of gestation who developed Respiratory Distress Syndrome.

Quality statement 2.5b:

Women with Ante partum Haemorrhage (APH) receive appropriate interventions according to evidence-based guidelines.

Rationale:

Haemorrhage is the leading direct cause of maternal mortality accounting for 34 % of all maternal deaths in Sub-Saharan Africa. APH complicates 2 to 6 percent of all pregnancies. Death may occur in about 10 hours after the onset of APH. Anaemia in pregnancy is common in Africa and bleeding in pre-existing anaemia increases the risk of death. Appropriate care in pregnancy and labour includes detection,

correction and prevention of anaemia, care by skilled attendant, recognition and early management of complications.

Quality measures

Input

1. The health care providers can identify and diagnose a patient with APH
2. The healthcare provider performs speculum examination to rule out other causes of bleeding
3. Women with ante partum hemorrhage (APH) managed according to current evidence based protocols.

Output/process

1. The proportion of women with APH who were managed successfully.

Outcome

1. The proportion of women with APH who died

Quality statement 2.5c:

Preterm and small babies receive appropriate care, according to national guidelines.

Rationale:

Preterm and small babies are at much greater risk for death during the neonatal period and for long-term health problems and lifelong disabilities. They should be cared for in well-equipped neonatal units with well-trained staff present round the clock.

Preterm and low-birth-weight babies (< 2500 g) are kept warm at all times and closely monitored for complications; their mothers are given support in providing exclusive breastfeeding or alternative feeding (expressed breast milk, donor breast milk or formula). Clinically stable preterm newborns weighing ⩽ 2000 g are given kangaroo mother care. Those who are unstable are cared for in a clean incubator or under a radiant warmer, and their temperature is closely monitored. The risks for common complications (hypothermia, feeding problems, apnea, respiratory distress syndrome and infections) are assessed, monitored, recognized early and appropriately managed. Antibiotics, safe oxygen therapy, continuous positive airway pressure and surfactant replacement are given as appropriate.

Quality measures

Input

1. The health facility has written, up-to-date clinical protocols for the care of small and preterm babies in the childbirth areas of the maternity unit that are consistent with the national guidelines.
2. Health care staff in the health facility who work in MNH service delivery points receive in-service training and regular refresher sessions in appropriate care of preterm and low birth-weight babies at least once every 12 months.
3. The health facility has supplies and materials to provide optimal thermal care to stable and unstable preterm babies.
4. The health facility has drugs and equipment necessary for the care of pre-term baby.
5. The health facility has the supplies and materials to provide optimal feeding to preterm babies and support for breastfeeding or alternative feeding.
6. All pre-term and low birth weight neonates receive additional care.

Output/process

1. The proportion of all low-birth-weight newborns born in the health facility with a birth weight ⩽ 2000 g who received at least 20hrs kangaroo mother care in the first week of life.

2. The proportion of all unstable low-birth-weight newborns weighing ⩽ 2000 g who could not receive kangaroo mother care in the health facility who were cared for in a thermo-neutral environment, either under radiant warmers or in incubators.
3. The proportion of all low-birth-weight newborns born in the health facility whose mothers received additional support to exclusively breastfeed the baby.

Outcome

1. The proportion of all preterm babies (< 28 weeks, 28–31 weeks and 32–37 weeks of gestational age) born in the health facility who died within the first 7 days of life.
2. The proportion of all low-birth-weight newborns born in the health facility who were exclusively fed on their mother's milk during their stay in the health facility.
3. The proportion of all live preterm babies born in the health facility who had severe neonatal morbidity (respiratory distress syndrome, intraventricular haemorrhage, necrotizing enterocolitis).
4. The proportion of low-birth-weight baby deaths in the facility attributed to possible serious bacterial infection or sepsis.

Quality statement 2.6a:

Women with or at risk for infection during labour, childbirth or the early postnatal period promptly receive appropriate interventions, according to national guidelines.

Rationale:

Puerperal sepsis is one of the leading causes of maternal mortality and can also cause early-onset sepsis in newborns. The prevention of predisposing factors, aseptic precautions in all interventions and procedures; early, accurate diagnosis and use of appropriate antibiotics for treatment of maternal infection will reduce the occurrence of both maternal and neonatal sepsis and the associated morbidity and mortality.

Women at risk for infection are given prophylactic antibiotics if they are undergoing elective or emergency caesarean section, in protracted labour with pre-labour rupture of membranes, in cases of retained placental products, with third- or fourth-degree perineal tears or before manual removal of the placenta. Specimens are obtained for culture and sensitivity before starting antibiotic treatment. Women with signs and symptoms of infection (fever > 38 °C before delivery or during labour, membranes ruptured ⩾18 h before birth, foul-smelling or purulent amniotic fluid and abdominal pain and/or offensive vaginal discharge in the postnatal period) are treated with antibiotics and monitored closely, and their management is assessed regularly.

Quality measures

Input

1. The health facility has written, up-to-date clinical protocols for the treatment of women with, or at risk for, infections during labour, childbirth and the early postnatal period in the childbirth and postnatal care areas of the maternity unit that are consistent with the National guidelines.
2. Health care staff in the health facility who deal with pregnant and postpartum women receive in-service training and regular refresher sessions in the recognition and management of maternal peri-partum infections at least once every 12 months.
3. Health care providers are able to correctly diagnose women with or at risk for infection during labour, childbirth and the early postnatal period.
4. Health care providers are able to manage women with infections.
5. The health facility has supplies of oral and injectable first and second-line antibiotics available in sufficient quantities at all times for the expected case load.
6. The health facility has capacity to perform lab investigations for clients with infections.
7. If the health care facility has no capacity to manage women with infections it correctly identifies indications for referral and refer according to referral protocols.

Output/process

1. The proportion of all women who underwent caesarean section in the health facility who received prophylactic antibiotics before caesarean section.
2. The proportion of all women who gave birth in the health facility with term pre-labour rupture of membranes for more than 18 hours who received antibiotics.
3. The proportion of all women who gave birth in the health facility who had a temperature of > 38˚C or other signs of infection (uterine tenderness, foul-smelling or purulent lochia, high WBC count) after childbirth.

Outcome

1. The proportion of all women who underwent caesarean section in the health facility who had severe systemic infection or sepsis after the caesarean section.
2. The proportion of all women who gave birth in the health facility who had severe systemic infection or sepsis in the postpartum period.
3. The proportion of all women who gave birth in the health facility who died from severe systemic infection or sepsis.

Quality statement 2.6b:

Newborns with suspected infection or risk factors for infection are promptly given antibiotic treatment; according to the national guidelines (these include jaundice, convulsions).

Rationale:

Newborns are at higher risk for infection because of their immature immune system. Infections in newborns can lead to death or to long-term disabilities in survivors. Good hand hygiene, cord care and other appropriate aseptic precautions, screening of neonatal sepsis according to the presence of one or more risk factors, early diagnosis of signs and symptoms of neonatal sepsis and appropriate treatment with antibiotics are essential to prevent sepsis and the associated morbidity and mortality.

Newborns with risk factors for infection or with signs of infection are given antibiotic treatment according to the national guidelines. Risk factors for infection are maternal fever (> 38 °C) before delivery or during labour, membranes ruptured ⩾ 18 h before birth and foul-smelling or purulent amniotic fluid. Newborns with signs of serious bacterial infection present with inability to feed (or have stopped feeding well), convulsions, fast breathing (> 60 breaths/min) severe chest in-drawing, fever (⩾ 38 °C) or low body temperature (< 35 °C), lethargy, movement only when stimulated or no movement at all. A blood culture is obtained before the initiation of antibiotics in newborns at risk or with signs of infection. They are treated with an empirical injectable antibiotic for sepsis or suspected sepsis and closely monitored for reassessment of their management. Culture reports are the basis for deciding any change in antibiotics and the duration of treatment.

Quality measures

Input

1. The healthcare facility has a written, up-to-date clinical protocol for early diagnosis and management of neonatal infection in the childbirth areas of the maternity unit that is consistent with the national guidelines.
2. The health care providers have the capacity to manage or refer for further management a newborn with signs of complications according to referral protocol.
3. The health facility has supplies of injectable antibiotics (at least first-line; benzyl penicillin and gentamicin) and second-line (cefuroxime and amikacin) antibiotics for neonatal sepsis and infections) available in sufficient quantities at all times for the expected case load.
4. Health care staff in the health facility who care for pregnant and postpartum women and newborns receive in-service training and regular refresher sessions in the recognition and management of suspected newborn infections at least once every 12 months.

Output/process

1. The proportion of all newborns in the health facility with signs of infection who received injectable antibiotics.

Outcome

1. The proportion of all severe neonatal morbidity in the health facility that was due to neonatal sepsis.
2. The proportion of newborns treated for sepsis in the health facility who died (case fatality rate).
3. The proportion of all neonatal deaths in the health facility that were due to sepsis.

Quality statements 2.7:

All women and newborns receive care according to standard precautions for preventing hospital-acquired infections.

Rationale:

Hospital-acquired infections increase morbidity and mortality, the cost of care and the duration of stay in hospital. Standard precautions as articulated in the national infection prevention guidelines and protocols are essential to prevent hospital-acquired infections.

Standard precautions are observed at all times, including hand hygiene with soap and water or alcohol-based hand rub before and after examining a woman or newborn, and appropriate use of gloves, safe storage and disposal of infectious waste and sharps, safe handling of equipment for patient care and soiled linen, sterilization and disinfection of instruments and the childbirth area.

Quality measures

Input

1. The health facility has written, up-to-date policy guidelines for standard infection prevention control and precautions for transmission (including microbial surveillance and stewardship)
2. The health facility has a reliable water source on site with running water, soap and disposable towels or alcohol-based hand rub for hand hygiene in all service delivery areas.
3. Health care staff in MNH service delivery points receive training/continuous medical education on standard infection control and precautions for transmission of infection and appropriate use of the autoclave machine at least once every 12 months.
4. The health facility ensures safe handling, storage and final disposal of infectious and contaminated waste.

Output/process

1. The percentage of health care staff in the health facility who observe the "5 moments for hand hygiene".
2. The percentage of staff members in the health facility who meet biosafety standards when administering parenteral drugs

Outcome

1. The proportion of all neonates born in the health facility who had hospital-acquired infections.

Quality statement 2.8:

No woman or newborn is subjected to unnecessary or harmful practices during labour, childbirth and the early postnatal period.

Rationale:

Unnecessary and harmful practices can lead to complications and harm mothers and their newborns. They should be avoided and replaced with evidence-based health practices.

Unnecessary or harmful practices are not used or practiced. These practices include; routine enemas and pubic or perineal shaving before vaginal birth, fundal pressure to facilitate the second stage of

labour, augmentation of labour with oxytocin before confirmation of delayed labour, episiotomy (unless indicated), uterine packing to control bleeding (unless indicated), instrumental vaginal childbirth (unless indicated), caesarean section (unless indicated) and suctioning of a newborn (unless indicated), immediate bathing of the baby, keeping well babies in the nursery away from the mother, denying mothers food, advertising and promotion of breastfeeding substitutes and bottle-feeding, and applying substances to the cord.

Quality measures

Input

1. The health facility has written up-to-date guidance on harmful practices and unnecessary interventions during labour, childbirth and the early postnatal period.
2. Health care staff in the facility receive in-service training and regular refresher sessions on harmful practices and unnecessary interventions at least once every 12 months.
3. The health facility does not display infant formula or bottles and teats, including on posters or placards
4. The health facility does not give newborns food or drink other than breast milk, unless medically indicated, and does not give pacifiers (also called "dummies" or "soothers") to breastfeeding babies.
5. The health facility does not promote infant formula in the wards, and samples are not distributed to mothers or staff.
6. Health-care staff in the health facility receive monthly supportive supervision and mentoring on harmful practices and unnecessary interventions.

Output/process

1. The proportion of women who underwent unnecessary caesarean section in the health facility contrary to indications in National Guidelines.
2. The proportion of all newborns born within the health facility who had any substance other than 7.1 % chlorhexidine applied to the cord

STANDARD 3

The health information system enables the use of data to ensure early, appropriate action to improve the care of every woman and newborn.

Quality statement 3.1:

Every woman and newborn has a complete, accurate and standardized medical record during the antenatal period, labour, childbirth and the early postnatal period.

Rationale:

Complete, accurate medical recording during labour is important for documenting care, clinical follow-up, accurate hand-over, early detection of complications and health outcomes provides information for identifying areas for improvement. Standardized patient care registers and clinical records for mothers and newborns from admission to discharge are in place and are accurate, complete and legible. Continuity of care records are available (e.g. referral notes, records of antenatal intrapartum and postnatal care). Demographic data, times of admission, childbirth and discharge, progress of labour, actions taken and the outcome of childbirth, including stillbirths, are appropriately recorded. Details of newborns, including identification, gestational age, birth weight and examination findings, are recorded in a system that allows linkage of women and their newborns in all records. The International Classification of Diseases (ICD) is used to code diagnoses.

Quality measures

Input

1. The health facility has necessary basic MNH data for collection tools, forms, the clinical and observation charts in place at all time for routine recording and monitoring of all care processes for women and newborns.
2. The health care facility has a system that ensures that patient management and interventions are clearly documented and signed by the relevant personnel with clear identification of name
3. The health facility has a birth and death registration system in place that is linked to the national vital registration system at all times.
4. The health facility has a system for classifying diseases and birth outcomes, including death, which is aligned with the International Classification of Diseases. 11
5. The health facility has the capacity to upload data on the KHIS as per national policy requirements.
6. The health facility has a policy/system in place to ensure that records and information are protected from loss, destruction, tampering and unauthorized access or use.

Output/process

1. The proportion of newborns currently in the health facility who have a patient identifier and individual clinical medical record.
2. The proportion of newborns discharged from the health facility within the past 24 hours who had an accurately completed record of processes of care, treatments, outcomes and diagnoses.
3. The proportion of women discharged postpartum within the past 48 hours who had an accurately completed record of processes of care, treatments, outcomes and diagnoses.
4. Proportion of documents correctly filled with the health care provider's name and signature.

Quality statement 3.2:

Every health facility has a mechanism for data collection, analysis and feedback as part of its activities for monitoring and improving performance around the time of the antenatal, childbirth and postnatal period.

Rationale:

The purpose of data collection is to provide information that can be analyzed and used appropriately to provide feedback and improve health outcomes. Data are collected, verified, analyzed and used routinely to make clinical and management decisions for planning and improving clinical services. They are available to, and used by, the facility staff for continuous improvement of processes of care and used by health care providers to plan and improve activities and clinical services. Accurate, complete data are submitted to the appropriate levels in a timely manner and are used for periodic reviews of mortality and morbidity in order to improve quality.

Quality measures

Input

1. The health facility notifies all maternal deaths within 24 hrs. Perinatal deaths within 72hours and uploads data to the KHIS within 7 days.
2. The health facility has a functional MPDSR committee with well-defined Terms of Reference (TORs).
3. Facility MPDSR committee meets monthly to review maternal deaths, perinatal deaths and near misses and has a mechanism for implementing the recommendations of the reviews.
4. The health facility has standard operating procedures and protocols in place at all times for checking, validating and reporting data.
5. The health facility has a data system for collecting and analyzing relevant health outcome indicators and can produce visual outputs and timely reporting on paper or digitally at all times.
6. Managers and health care workers in the health facility met at least once a month within the past six months to review process and outcome data.
7. Managers and health care workers in the health facility use the recommendations in reviews of data for decision-making and for monitoring improved performance within the past six months.

Output/process

1. The proportion of all perinatal deaths occurring in the health facility that were notified within 72hours
2. The proportion of all maternal deaths occurring in the health facility that were notified within 24 hours
3. The proportion of all maternal deaths occurring in the health facility that were reviewed within 7 days
4. The proportion of all perinatal deaths occurring in the health facility that were reviewed within 7 days

Outcome

1. Proportion of facility recommendations of death reviews made in the previous three months that have been acted upon

STANDARD 4

Every woman and newborn with condition(s) that cannot be managed effectively with the available resources is appropriately referred.

Quality statement 4.1:

Every woman and newborn is appropriately assessed in the antenatal period, admission, during labour and in the early postnatal period to determine whether referral is required, and the decision to refer is made without delay.

Rationale:

A referral system can be defined as a process in which a health worker at one level of the health system, having insufficient resources (drugs, equipment, skills) to manage a clinical condition, seeks the assistance of a better or differently resourced facility at the same, lower or higher level to assist in, or take over the management of, the client's case. It is vital to recognize cases that require referral rapidly in order to ensure that every patient receives timely, appropriate care and to avoid unnecessary complications.

Up-to-date referral protocols and guidelines are in place, are accessible and reflect the health facility's capacity and resources.

There is a triage system at admission, and a mechanism on the wards to identify, assess, and respond to emergencies immediately. Facilities are able to provide pre-referral stabilization care and treatment.

Quality measures

Input

1. The health facility has written, up-to-date clinical protocols, SOPs and guidelines for the identification, management (including pre-referral care) and referral of women with complications related to pregnancy, labour, and childbirth and post-partum period.
2. The health facility has written, up-to-date clinical protocols, SOPs and guidelines for the identification, management (including pre-referral care) and referral of newborns with complications.
3. The health facility is equipped with appropriate medicines and medical supplies for stabilization and pre-referral treatment for referred women and newborns.
4. Health care staff in the maternity unit receive in-service training and regular refresher sessions in referral protocols and guidelines at least once every 12 months.
5. The health facility has mechanisms in place to ensure that patients are referred in a timely manner to the appropriate health facility/specialist while ensuring continuity of care and patient safety.
6. The facility has the referral protocol well displayed at all points of care and relevant offices e.g. telephone office, driver's office or ambulance etc.

Output/Process

1. The proportion of women and newborns seen in the health facility in the past three months who fulfilled the facility's criteria for referral who were actually referred.
2. The proportion of all pregnant or postpartum women who could not be managed at the health facility and were referred for childbirth or further management without delay, accompanied by a health care professional and a completed standardized referral note.
3. The proportion of all sick, preterm or small newborns who could not be managed at the health facility who were referred within 30 minutes of a decision, accompanied by a health care professional and a completed standardized referral note.

Outcome

1. The proportion of women seen in the health facility in the past three months who fulfilled the facility's criteria for referral who were actually referred.
2. The proportion of newborns seen in the health facility in the past three months who fulfilled the facility's criteria for referral who were actually referred.
3. The proportion of pregnant women who could not be managed at the health facility and were referred for further management.
4. The proportion of postpartum women who could not be managed at the health facility and were referred for further management
5. The proportion of sick, preterm or small newborns who could not be managed at the health facility and were referred within 30 minutes of a decision, accompanied by a health care professional and a completed standardized referral note.

Quality statement 4.2:

For every woman and newborn who requires referral, the referral follows a pre-established plan that can be implemented without delay at any time.

Rationale:

A pre-established plan for referral expedites the process, prevents unnecessary delay and results in better, more timely care for patients.

Availability of adequately equipped transport services that operate 24 hours a day, 7 days a week, to transport women and newborns as necessary, a list of known network facilities and their telephone numbers is in place. The referral system is supervised and accountable, with a policy that protects women from financial barriers to referral, and there is a procedure to monitor and evaluate the system.

Quality measures

Input

1. The health facility has ready access to a functioning ambulance or other vehicle for emergency transport of women and newborns to referral facilities 24hours a da y, 7 days a week.
2. There is an up-to-date list of network facilities in the same geographical area that provide referral care for women and children.
3. The health facility has local arrangements to ensure that women and newborns who cannot be managed at the health facility are referred to an appropriate level of care without delay, 24 h a day, 7 days a week by strengthening mutually beneficial referral systems among public, private, and faith-based and mission hospitals
4. The facility audits and gives recommendations of maternal and newborn deaths (on patients for whom decision has been made to refer) occurring before or during referral monthly.

Output/process

1. The proportion of newborns who died due to delayed (after 30 minutes of decision) transfer to a higher-level facility for further management.
2. The proportion of pregnant or postpartum women who died (before or during transfer) to a higher level facility for further management after decision made
3. The proportion of pregnant and postpartum women and newborns who were referred without appropriate emergency transport

Quality statement 4.3:

For every woman and newborn referred within or between health facilities, there is appropriate information exchange and feedback to relevant health care staff.

Rationale:

Appropriate information exchange and feedback within and between health facilities improves patient care, increases the motivation of health care workers, helps learning from experience and leads to improved patient care.

A functioning communication system (e.g. radio, telephone) within the referral network operates at all times, and formal agreements and arrangements for communication and consultations are in place. Information exchange and feedback protocols on referral and standardized referral and counter-referral forms are available when needed.

Quality measures

Input

1. The health facility has a standardized referral form to document relevant demographic and clinical information, which includes clinical findings, diagnosis, pre-referral interventions or treatment given and reason for referral.
2. The health facility has reliable communication methods, including a mobile phone, land line or radio, which is functioning at all times, for referrals and consultation on complicated cases.
3. Evidence that the health facility has formal agreements, communication arrangements and a feedback system with referral Centre(s).
4. The health facility has embraced e-health, such as telemedicine, e-referrals, and e-mail to improve the referral system between facilities, within and outside the country.
5. Data on referrals/transfers is collected and used to continuously improve patient care and strengthen the referral system.
6. The facility has counter-referral feedback mechanism

Output/process

1. The proportion of women referred with completely filled referral forms.
2. The proportion of referred women with communication before referral.

STANDARD 5

Communication with women and their families is effective and responds to their needs and preferences.

Quality statement 5.1:

All women and their families receive information about their care and have effective interactions with staff.

Rationale:

Effective communication with women and their families helps them feel more involved in their care, avoids unnecessary anxiety, misunderstanding and wrong expectations and gives them control of their condition, which contributes to a positive experience.

Health care staff have interpersonal communication and counselling skills and are readily approachable. They have a positive attitude, use simple, clear language that women and their families can understand and recognize the communication needs and preferences of all women under their care.

Quality measures

Input

1. The health education materials in written/pictorial format or electronic format are available, well displayed and accessible by the clients served by the health facility.
2. Health care staff in MNH service areas (antenatal, labour, post-natal) are oriented and receive in-service training at least once every 12 months to improve their interpersonal communication and counseling skills
3. The health facility has written, up-to-date mechanism (protocols, guidelines, checklist, SOPs) that outline clear goals, operational plans and monitoring to promote the interpersonal communication and counseling skills of health care staff.
4. Health care staff in the MNH service areas (antenatal, labour, post-natal) receive support supervision in interpersonal communication and counseling at least once every three months.
5. The health facility offers daily group education sessions on MNH to the clients.
6. The health facility has staff trained to handle clients with special needs.
7. The health facility has clear and visible signage and service charter in every MNH area.
8. The health facility has a functional feedback mechanism.

Output/process

1. The proportion of all women attending MNH service areas (antenatal, labour, post-natal) in the facility who received information and counseling on the specific services i.e. those in the Mother Child Handbook
2. The proportion of all women who gave birth in the health facility who reported that they were given the opportunity to discuss their concerns and preferences.
3. The proportion of health care staff in the health facility that are trained/orientated on interpersonal communication and counseling skills to support women and their families.
4. The proportion of staff who have skills to handle clients with special needs, for example hearing, per shift.

Outcome

1. The proportion of all women attending ANC in the health facility who felt that they were adequately informed by the care provider(s) about the examinations, actions and decisions taken for their care.

2. The proportion of all women who attended ANC in the health facility who reported that their needs and preferences were taken into account.
3. The proportion of all women who gave birth in the health facility who felt that they were adequately informed by the care provider(s) about the examinations, actions and decisions taken for their care.
4. The proportion of all women who gave birth in the health facility who reported that their needs and preferences were taken into account during labour, childbirth and postnatal care.
5. The proportion of all women who gave birth in the health facility who reported that they were satisfied with the health education and information they received from the care providers.

Quality statement 5.2:

All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals.

Rationale:

Coordinated care and accurate hand-over of information among health care providers is essential to maintain continuity in patient care and to avoid unnecessary delays in treatment.

A standard format is used for information exchange between care providers (e.g. during staff shift changes and referrals, with social care services, sending laboratory results), and effective verbal and/or telephone communication is used among caregivers involved in the hand-over of care. There is timely reporting of the results of critical diagnostic tests.

Quality measures

Input

1. The health facility has a standard form for clinical progress notes and monitoring events during the antenatal, labour/delivery and postnatal period. (Mother-child booklet, Partograph, files, cardex and registers) to facilitate written hand-over.
2. The health facility has written, up-to-date protocols for verbal and written hand-over of women and newborns at shift changes, during intra-facility transfer, on referral to other facilities and at discharge.
3. Health-care staff in the MNH service delivery areas are oriented and receive in-service training and regular refresher sessions at least once every 12 months in the clinical hand-over policy and communication of important information for hand-over, referral or discharge.
4. The health facility has a functioning, reliable communication system for information exchange among relevant service providers (e.g. telephones, internet)

Output/process

1. The proportion of women attended to during antenatal, labour /delivery, and postnatal period for whom the relevant tools (mother-child booklet, Partograph, file) have been appropriately completed.
2. The proportion of all women who gave birth in the health facility who reported that health care staff introduced themselves and showed good knowledge of the women's history and the care that had been given to date.

Outcome

1. The proportion of health Care providers, by cadre, and social professionals who were satisfied with the communication during clinical hand-over among members of the health care team in the health facility.WHO. (2013).

Preconception Care,Policy Brief. Department of Maternal, Newborn, Child and Adolescent Health. https://www.researchgate.net/profile/Kathleen_Brandert/publication/5369556_Integrating_Preconception_Health_into_Public_Health_Practice_A_Tale_of_Three_Cities/links/5b993eb2a6fdcc59bf8d7787/Integrating-Preconception-Health-into-Public-Health-Practice-A-Tale-of-Three-Cities.pdf

STANDARD 6

Women and newborns receive care with respect and preservation of their dignity.

Aim:

The aim of this standard is to give total respect and to preserve the dignity of all women throughout their stay in the health facility. Their privacy and confidentiality should be respected at all times, and any kind of mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services, should be avoided.

Quality statement 6.1:

All women and newborns have privacy during antenatal, labour/childbirth, and postnatal care and their confidentiality is respected.

Rationale:

Privacy and confidentiality of information make women and families feel respected at all times, protect them from any stigma associated with their problems and build trust in health care providers.

Health care staff respect the privacy and confidentiality of care and information. Linen, curtains, partitions and screens are available to ensure privacy. Verbal and written records of women and newborns' conditions are kept confidential.

Quality measures

Input

1. The physical environment of the health facility allows privacy and the provision of respectful, confidential care, including the availability of curtains, screens, partitions and sufficient bed capacity.
2. The health facility ensures privacy and confidentiality for all women and newborns.
3. The health facility has accountability mechanisms for redress in the event of violations of privacy, confidentiality or consent.
4. The health facility has written accountability mechanisms for redress in the event that women are denied informed choice
5. Woman's consent is obtained for attendance of any people to be present other than needed staff (i.e., students)
6. The health facility has a standard informed consent form that is easily accessible to the health care staff
7. The health facility has a mechanism to educate and communicate clients' rights to clients attending the facility.

Output/process

1. The proportion of procedures in the health facility that require written consent for which there is an associated record of consent signed by the woman or a family member i.e. caesarean section
2. The proportion of all women undergoing examinations or procedures in the health facility who reported that their permission was sought before the examination or procedures were performed
3. The proportion of staff working in MNH service areas trained on respectful maternity care

Outcome

1. The proportion of all women who gave birth in the health facility who were satisfied with the degree of privacy during their stay and care in the labour and childbirth areas.

Quality statement 6.2:
No woman or newborn is subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.

Rationale:
Every woman has the basic human right to the highest attainable standard of health care without discrimination or maltreatment.

Health care staff treat all women with kindness, compassion, courtesy, respect, understanding and honesty and preserve their dignity. Women are free to complain without fear of repercussions, and there is no restriction on their movement into or out of the health facility.

Quality measures

Input

1. The health facility has written up-to-date, zero-tolerance non-discriminatory policy with regard to mistreatment of women and newborns and has mechanisms for redress.
2. The health facility has a system whereby the mothers of sick newborns can be close to and nurse their babies.
3. MNH Services are affordable, accessible and equitable (NB. Free in public health facilities)
4. The health facility has a written protocol/policy and mechanism to receive and address women's and families' complaints about the care received (e.g. a suggestion box, contact number, hotline, and an office).
5. The health facility has a complaints box, which is easily accessible to women and their families.
6. Health care staff in the MNH service areas receive supportive supervision monthly, and training/ mentorship at least every 12 months in Respectful Maternity Care and accountability mechanisms are in place.
7. The health facility has mechanisms to prevent and deter extortion, corruption and abuse (e.g.; CCTV, and a well displayed service charter).
8. The health facility has a written protocol/policy against the inappropriate use of the social media by the health workers against women and their newborns e.g. taking snap shots and posting on social media.
9. The facility has an ethics committee that meets regularly.

Output/process

1. The proportion of all women who gave birth in the health facility who reported physical, verbal or sexual abuse, to themselves or their newborns.
2. The proportion of women who gave birth in the health facility who were satisfied that the facility met their religious and cultural needs.
3. The proportion of women who gave birth in the health facility who were aware of the existence and location of a complaints box and other feedback mechanisms.

Outcome

1. The proportion of all women who gave birth in the health facility who reported having been treated with respect and their dignity preserved.
2. The proportion of all women in the health facility who made complaints that were acted upon without repercussions.
3. The proportion of all complaints made anonymously in the health facility that were acted upon.

Quality statement 6.3:
All women can make informed choices about the services they receive, and the reasons for interventions or outcomes are clearly explained.

Rationale:
It is essential that women feel involved in their treatment and care and can make informed choices in order to improve their compliance and satisfaction with the treatment.

Women are informed about their rights and options for care and encouraged to ask questions. They are supported in making decisions about all aspects of their care and treatment; their personal values and beliefs are respected, and their consent is obtained before procedures are carried out.

Quality measures

Input

1. The health facility has a written procedure for obtaining informed consent from women before examinations and procedures (including; minors, persons with special needs etc.)
2. Health care staff in the health facility receives supportive supervision monthly and in-service training at least once every 12 months, in effective informed consent procedures and in women's right to choose care at childbirth. Orientation is provided for new staff.

Output/process

1. The proportion of procedures in the health facility that require written consent for which there is an associated record of the woman's consent.
2. The proportion of women who received care in the health facility who were aware that they had the right to accept or refuse treatment.

Outcome

1. The proportion of women who gave birth in the health facility by caesarean section who were aware of the reason for the caesarean section.
2. The proportion of women who gave birth in the health facility who felt that they participated in decisions about their labour, birth and postnatal care.

STANDARD 7

Every woman and her family or the companion of her choice are given emotional support that is sensitive to their needs and strengthens the woman's capability.

Aim:
Emotional support is an essential component of the experience of care. Having the birth companion of her choice helps a woman to go through childbirth more confidently. Every woman receives support that strengthens her own capability during childbirth.

Quality statement 7.1:
Every woman is offered the option to experience labour and childbirth with the companion of her choice.

Rationale:
Birth companions provide physical, emotional and spiritual support to women during labour and delivery and thus have a positive impact on the women and improved birth outcomes.

Women are allowed and encouraged to choose a companion to be present during their labour and childbirth. The companion is oriented in supporting the woman during labour, childbirth and the post-natal period and both the woman and her companion are encouraged to participate actively in the woman's care.

Quality measures
Input
1. The labour and childbirth areas are organized in such a way as to allow physical adequate private space for the woman and her companion at the time of birth.
2. The health facility has a written, up-to-date protocol, which is explained to women and their companions, to encourage all women to have at least one person of their choice, as culturally appropriate, with them during labour, childbirth and the immediate postnatal period.
3. Health care staff in the health facility are oriented and receive mentoring /training sessions at least once every 12 months on the positive impact of the presence of a chosen companion during labour, childbirth and the postnatal period.

Output/process
1. Proportion of women and their companions who have had the above protocol explained to them during labour, childbirth and the immediate postnatal period.
2. Proportion of health care staff who have been oriented and received mentoring/ training sessions in the past 12 months on the positive impact of the presence of a chosen companion during labour and birth.
3. The proportion of all women who gave birth in the health facility who had a companion of their choice during labour and childbirth.

Outcome
1. The proportion of all women who gave birth in the health facility who expressed satisfaction with the health services.
2. The proportion of all companions who were satisfied with the orientation given on their role during labour and childbirth.

Quality statement 7.2:
Every woman receives support to strengthen her capability during childbirth and the post-natal period.

Rationale:
Every woman should be given emotional support to improve her mental health, give her a positive outlook and improve the overall health outcomes of the mother and baby.

Care at the facility optimizes biological, psychological, social and cultural well-being. Women are encouraged to adopt the position of their choice during labour, to walk around freely during the first stage and to eat and drink enough to ensure adequate nutrition and hydration. Women with complex emotional needs (e.g. previous newborn death, experience of gender-based violence, rape, and mental health problems) are identified and supported. Grief support is provided to families if the mother or baby dies.

Input
1. Health care workers in the labour and childbirth areas of the maternity unit are oriented in non-pharmacological and pharmacological pain relief and received training/mentoring sessions at least once in the preceding 12 months.
2. The health facility has written, up-to-date information, which is explained to women and their families/companions, to minimize unnecessary interventions, support normal labour and strengthen the woman's capability, so that she feels in control of her childbirth experience. (dos and don'ts)
3. Health care staff in the labour and childbirth areas of the maternity unit are oriented and receive training / mentorship sessions at least once in 12 months to strengthen clients and families emotional

STANDARD 8

For every woman and newborn, competent, motivated staff are consistently available to provide routine care and to manage complications.

Quality statement 8.1:

Every woman and newborn has access at all times to at least one skilled birth attendant and assistant for routine care and management of complications.

Rationale:

The availability of health care staff around the clock is essential for optimal routine and emergency care of patients and timely management of complications.

A health facility staffing policy is in place, reviewed regularly and updated as necessary, which specifies the number, types and necessary competence of staff to ensure an adequate number and skill mix of health care staff for the volume of work, 24 hours a day, 7 days a week. Clinical and non-clinical staff are oriented to their specific roles and responsibilities in the facility or unit to which they are assigned. A staff roster listing duties and the times staff will be on duty is always updated and on display. Written information is available on how to access services, and signs indicate key service areas (e.g. emergency department) and what to do in case of an emergency. Women are triaged to prioritize emergency conditions.

Quality measures

Input

1. The health facility has skilled birth attendants/emergency obstetric newborn care available at all times, in sufficient numbers to meet the anticipated work load of each cadre as per HRH standards
2. The health facility has a written, up-to-date staffing policy, listing the numbers, types and competence of staff, that is reviewed continuously according to the level.
3. The health facility has a roster that is displayed in all service areas, giving the names of staff on duty, the times of their shifts and their specific roles and responsibilities
4. The health facility has a written, up-to-date policy on triage and waiting times for emergency and non-emergency consultations and treatment
5. The health facility has clear communication channels to reach staff on duty at all times

Output /process

1. Proportion of skilled staff (doctors, clinical officers, nurses and midwives) with competence to provide MNH services 24 hours in the facility.
2. The proportion of staff who have been oriented to their functions, roles and responsibilities in the facility or unit to which they are assigned
3. The proportion of women who attended the health facility who reported receiving attention within the appropriate time for their condition as per the service charter on triage and waiting time

Outcome

1. The proportion of women and their newborns in the health facility who were attended to by a skilled birth attendant (as per the definition) during and after childbirth.

Quality statement 8.2:

The skilled birth attendants and other healthcare providers have appropriate competence and skills to meet requirements during labour, childbirth and the early postnatal period.

Rationale:

Qualification, certification, training and orientation of health care staff improve their performance of their roles and responsibilities.

All staff have a job description that lists the necessary competence, roles and responsibilities, supported by the desired qualifications and other requirements. The education, licensure or registration and other credentials required by law or regulation are verified for all health care staff and kept current. There are established programs for recruitment, retention, professional development and continuing education of all staff.

All staff receive continuing orientation on protocols and responsibilities, supportive supervision and professional development activities, with an annual performance appraisal and recognition of good performance. Effective, efficient case management systems are in place to ensure that patients receive adequate, safe, timely care, and health care staff can demonstrate appropriate competence in providing routine care and managing complications for mothers and newborns.

Quality measures

Input

1. The health facility has an annual training program for continuing professional and skills development for all skilled birth attendants and other health care providers.
2. The health facility has standard procedures and plans for recruitment(where applicable), orientation and deployment
3. The health facility periodically appraises all staff and has a mechanism for staff motivation, recognition, reward scheme and retention strategies in place for recognizing good performance
4. The health facility has sufficient numbers of educated, competent, licensed, motivated, regulated skilled birth attendants with an appropriate skills mix, working in multidisciplinary teams.
5. The health facility provides an enabling, supportive environment for professional staff development, with regular supportive supervision and mentoring
6. The health facility facilitates inter-professional collaborative practice and induction with clear roles and responsibilities based on the professional scope of practice and care needed throughout the continuum of care
7. The facility has functional Quality Improvement Teams(QITs), Work Improvement Teams(WITs) and Safety Improvement Teams (SITs) that meet regularly

Output/process

1. The proportion of skilled birth staff at the health facility who received a written job description on deployment to the facility.
2. The proportion of skilled birth attendants (MNH staffing) at the health facility who received in-service training, a refresher session or mentoring within the past 12 months within the facility.
3. The number of supervisory visits to support clinical competence and performance improvement (in the past three months) within the facility.
4. The proportion of staff at the health facility who were assessed (post training follow up) by the trainer at least once in the preceding 12 months within the facility.
5. The number of Work Improvement Teams (WIT) meetings held per month to review competence and quality improvement activities within the facility.
6. The number of interactions per month with professional mentors to ensure clinical competence and improve performance within the facility.

7. The proportion of all staff at the health facility who were engaged in at least two active quality improvement team meetings and participated in quality improvement activities in the preceding 6 months.

Outcome

1. The proportion of all women who gave birth at the health facility who were satisfied with the care and support from facility staff.
2. The proportion of skilled birth attendants and health care providers at the health facility whose preceding performance appraisal was satisfactory.
3. The proportion of all staff at the health facility who reported being "highly satisfied" with their job.
4. The proportion of all staff at the health facility who were actively considering looking for a new job/ transfer.
5. The proportion of all staff at the health facility who could identify and report on at least one quality improvement activity in which they were personally involved in the past six months.

Quality statement 8.3:

The managerial and clinical leadership of every health facility is collectively responsible for creating and implementing appropriate policies and fosters an environment that supports facility staff in continuous quality improvement.

Rationale:

Good managerial and clinical leadership improve performance by showing direction and inspiring employees and create an environment of support for staff in undertaking continuous quality improvement.

There is managerial and clinical leadership, collective responsibility, appropriate government policies and procedures and an environment that supports staff in undertaking continuous quality improvement. There is a defined leadership structure and authority, lines of accountability and a defined quality improvement team with resources. Staff collectively develop and implement quality improvement and patient safety programs and receive support supervision and mentoring.
A policy and plan are in place to manage financial risks, and the facility undertakes regular audits (maternal and perinatal deaths and near-misses), with recommendations for improving quality. A system is in place for regular review of the data collected and reporting and communication of quality management matters to guide decision-making and monitor performance. Patient care and satisfaction are reviewed regularly, and the status of quality improvement is documented.

Quality measures

Inputs

1. The health facility has a written, up-to-date plan for improving the quality of care and a patient safety program, which is reviewed annually.
2. The health facility has a written, up-to-date leadership structure, with defined roles and responsibilities and lines of accountability for reporting.
3. The health facility has adequate anesthetist/anaestheologist as per facility level of care in accordance to current national human resource norms and standards.
4. The health facility has a mechanism for regular collection of information on patient and provider satisfaction.
5. The health facility holds at least one monthly meetings to review data, monitor quality improvement performance and make recommendations to address any identified problems.
6. The health facility standard governing procedures (policies and protocols) are in place and accessible to all relevant staff.

7. The health facility holds at least two annual meetings with stakeholders (e.g. the community, service users, partners) to review its performance, identify problems and make recommendations for joint actions to improve quality.
8. The facility has written protocol/SOP in place for staff to provide feedback on progress of quality improvement activities to the facility management.

Output Process

1. The proportion of Health facility leaders who communicated the performance of the facility through established mechanisms for monitoring (e.g. a dashboard of key metrics) to all relevant staff.
2. The proportion of all health facility leaders who were trained in quality improvement and leading change (use of information, enabling behaviors, continuous learning).
3. The proportion of all health facility leaders who were trained in leadership and management skills.
4. The proportion of monthly meetings on the quality of care that were actually held in the preceding 12 months.

Outcome

1. The proportion of chosen indicators that showed improved performance of the system (according to the facility dashboard)

Quality statement 8.4:

Health workers receive emotional support and respect required to have a fulfilling professional life to provide support to the women and newborns

Rationale:

Health care provision is a stressful job that places a large physical and emotional burden on the health care worker.

Working hours are long and the number of patients to be attended to is usually large. Health care workers are often faced with disrespect and hostility from patients and relatives which expose them to the risk of physical and emotional abuse without adequate redress and support from the health system. Health workers also may make mistakes that lead to unpleasant consequences for the patient and self-blame for the health worker.

Many a times health workers experience depression and burn out which unfortunately often goes unnoticed. It's therefore important to have a system that protects the health worker from overwork and quickly recognizes and deal with emotional problems in the health worker.

Input

1. The health facility provides training on work related stress management at least once every 12 months.
2. The health facility has a conducive working environment for health care staff in the MNH areas.
3. Health care staff in the MNH areas receive regular supportive supervision and feedback
4. The facility has adequate staffing according to the current human resource for health norms and standards.
5. The health facility has adequate stock of medicines and supplies
6. The health facility has adequate provision of basic staff welfare scheme and infrastructural needs for MNH staff e.g. toilet, tea room, shower, staff call-room and staff changing room
7. The health facility provides training on psychological support for supervisors at least once every 12 months.

Output/process

1. The proportion of shifts with the recommended nurse to patient ratio according to MOH guidelines.
2. The Proportion of stock out days of essential drugs e.g. oxytocin, IV fluids, magnesium sulphate and antibiotics.
3. Proportion of health care staff who are able to identify symptoms of stress and burn out in themselves and in others.
4. Proportion of health care staff with stress and burn out who have received support.
5. Proportion of health care staff reporting satisfaction in terms of supplies, staffing and resources available.
6. Proportion of supervisors who have received training on psychological support.
7. Proportion of staff who have received training on work related stress.

Outcome

1. The proportion of health workers who report having emotional support and respect required to have a fulfilling professional life.

STANDARD 9

The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and the management of complications

Quality statement 9.1:

Water, energy, sanitation, hand hygiene, and waste disposal facilities are functioning, reliable, safe and sufficient for the needs of staff, women and their families.

Rationale:

A safe, clean, hygienic environment with continuous supply of clean water and electricity, good sanitation and safe waste disposal are the basis of appropriate care of patients, for carrying out all procedures and interventions and for controlling infection.

A consistent supply of safe water is available on site at all times for drinking, cleaning and hand-washing in all clinical areas and MNH delivery points including labour ward, childbirth and newborn areas and operating theatres. Sanitation services are available, clearly separated by gender and accessible to all women, their families and staff. The health facility and its ancillary facilities (e.g. staff quarters) have reliable access to a source of electricity (e.g. solar, generator or grid) at all times. A mechanism for segregation, collection, transport, treatment and safe disposal of waste is in place. The facility has a budget and protocol for the operation and maintenance of energy, safe water and sanitation services.

Quality measures

Input

1. The health facility has infrastructure that supports client safety and quality of care
2. The health facility infrastructure is designed, constructed and maintained to facilitate proper cleaning and drainage, infection prevention and control and pest, rodents and scavenger control.
3. The health facility has written, up-to-date policy guidelines for standard infection prevention control and precautions for transmission (including microbial surveillance and stewardship)
4. The facility has an functional multi-disciplinary IPC committee with terms of reference and a champion/focal person
5. The health facility has a functioning source of safe water located on the premises that is adequate to meet all demands for drinking, personal hygiene, medical interventions, cleaning, laundry, cooking, for use by staff, women, newborns and their families.
6. The health facility ensures safe handling, storage and final disposal of infectious and contaminated waste
7. The health facility has leak-proof, covered, labelled waste bins and impermeable sharps containers available in every treatment area, to allow segregation of waste into four categories: sharps, no sharps, infectious waste, general non-infectious waste (e.g. food, packaging) and anatomical waste (e.g. placenta).
8. The health facility has at least one functioning hand hygiene station per 10 beds, with soap and water or alcohol-based hand rub, in all wards.
9. The health facility has health personnel trained on IPC
10. The health facility has housekeeping personnel trained on IPC
11. The health facility has energy infrastructure (e.g. solar, generator, grid) that can meet all the electricity demands of the facility and associated infrastructure at all times, with a back-up power source.
12. The health facility has in place a mechanism to reduce wastage of water and energy (e.g. general maintenance of plumbing, switching off lights)

13. The health facility has well displayed awareness-raising (IEC) materials on infection prevention and control including menstrual hygiene management in all service delivery points
14. The health facility has sanitation facilities on premises that are usable, appropriately illuminated at night, accessible to people with limited mobility and separated by gender for staff and patients; meets the needs for menstrual hygiene management, with hand washing stations and soap and water (at least 1 latrine per 20 users for inpatient settings)
15. The health facility has adequate precautions to ensure the security of its premises, staff, patients and visitors
16. The heath facility has a fuel management plan and local buffer stock, supported by an adequate budget for all the fuel needs for vehicles, cooking and heating, as relevant and as required, at all times.
17. The health facility has in place measures to facilitate emergency preparedness, disaster management and risk reduction
18. The health facility has handwashing protocols that are well displayed in all service delivery areas:
19. The health facility has a reliable water source on site with running water, soap and disposable towels or alcohol-based hand rub for hand hygiene in all service delivery areas
20. The health facility has a Central Sterilizing Unit

Outcome

1. The proportion of women and their families who attended the health facility who were satisfied with the water, sanitation and energy services including lighting and would recommend the health facility to friends and family.
2. The proportion of all health care staff at the health facility who were satisfied with the water, sanitation and energy services and considered that these services contribute positively to providing high-quality care.

Quality statement 9.2:

Areas for labour, childbirth and postnatal care are designed, organized and maintained so that every woman and newborn and their families can be cared for according to their needs in private, to facilitate the continuity of care.

Rationale:

To facilitate provision of optimal quality care, the infrastructure of the health facility should be adequate and well maintained, with basic services, good ventilation, a power source and hygiene.

The general infrastructure should be organized into dedicated service areas close to the labour and childbirth areas or rooms (reception, triage and assessment area, immediate postnatal high care area, rooming-in postnatal wards or rooms, newborn corners, sick newborn ward, kangaroo mother care ward, neonatal intensive care unit, theatre for performing caesarean sections) and adequately equipped for effective, consistent provision of optimal care. The service areas should be clean, well ventilated and illuminated, particularly at night, and conducive to privacy (e.g. curtain, wall); adequate, safe, clean, well-maintained basic facilities (beds, mattresses, bed linen, washing and bathing facilities, toilet) are in place.

Quality measures

Input

1. The areas for labour, childbirth and postnatal care are planned, designed and organized as per set MOH standards and complies with applicable guidelines and policies,
2. The health facility has a dedicated area in the labour and childbirth area for resuscitation of newborns, which is adequately equipped with a resuscitaire e.g. radiant warmer, light and appropriate resuscitation equipment and supplies.
3. The health facility has maintenance mechanism for rehabilitation, improvement and continuous operation and maintenance of water sanitation and hygiene and health care waste services.

4. The health facility has clean, appropriately illuminated, well-ventilated labour, childbirth postnatal areas and neonatal areas, and surroundings that allow for privacy and are adequately equipped, regularly cleaned and maintained.
5. The facility has adequate number of birthing rooms or areas for the estimated number of births in the service area.
6. The health facility has adequate infrastructure to cater for rooming in, kangaroo mother care and breastfeeding in the postnatal unit.
7. The health facility has a labour and childbirth area or room with a functional, clean and accessible bathroom or shower room with warm water and toilet for use only by women in labour and after childbirth
8. The health facility has a dedicated ward/area for admitting sick and unstable small babies
9. A facility offering surgical services has an adequately equipped operating theatre located close to and easily accessible from the labour and childbirth areas
10. The facility has a dedicated recovery room or area for care of women with complications

Output/process

1. The proportion of all pregnant women who attended the health facility who reported that it has a clean physical environment conducive for childbirth.

Outcome

1. The proportion of all women who gave birth in the health facility who were satisfied with the environment of the MNH Service areas.

Quality statement 9.3:

Adequate stocks of medicines, supplies and equipment are available for routine care and the management of complications.

Rationale:

Available, adequate essential medicines, equipment and other supplies are critical for provision of optimal quality care.

There is a list of essential medicines and supplies (e.g. laboratory reagents) and their uses and orderly, clean, secure storage for these items, with an efficient system to avoid stock-outs. All suitable medicines are available in the clinical areas (e.g. magnesium sulfate in the labour and childbirth areas). Essential equipment is available in the right places, at all times, with a system for regular maintenance and guidelines for appropriate use of the equipment. Laboratory tests are available (e.g. haemoglobin, blood group, urine protein) for routine use and management of complications. Blood is available for transfusion services, and an uninterrupted supply of oxygen is available in the labour and neonatal areas.

Quality measures

Input

1. The health facility has supplies of antihypertensive agents, magnesium sulfate and antidotes (calcium gluconate) in sufficient quantities, available at all times, in antenatal, labour, childbirth and postnatal areas for the management of women with pre-eclampsia and eclampsia.
2. The health facility has Uterotonic drugs and supplies for intravenous infusion (syringes, needles, infusion sets, intravenous fluid solutions and blood) available in sufficient quantities at all times in the childbirth and postnatal care areas for the management of women with postpartum haemorrhage.
3. The health facility has supplies of antenatal corticosteroids (dexamethasone or betamethasone), antibiotics and magnesium sulfate available in sufficient quantities at all times to manage preterm births.

4. The health facility has supplies of first- and second-line injectable antibiotics and other essential medicines available at all times for the management of mothers and newborns with, or at risk for, infections during labour, childbirth and the early postnatal period.
5. The health facility has a safe, uninterrupted oxygen source and delivery supplies available at all times in labour, childbirth, neonatal areas and the operating theatre where theatre is available.
6. The health facility has an on-site pharmacy and a medicine and supplies stock management system managed by a trained pharmacist or pharmaceutical technologist.
7. The health facility has functioning essential equipment and supplies for the detection of complications in sufficient quantities at all times in the labour and childbirth areas of the maternity unit.
8. The health facility has essential supplies and functioning equipment available in sufficient quantities at all times in the labour and childbirth areas.
9. The health facility has supplies and functioning equipment for emergency care and resuscitation of newborns available all times in areas designated for labour, childbirth and neonatal care.
10. The health facility has supplies and functioning equipment for the emergency care and resuscitation of women available in sufficient quantities at all times in areas designated for labour, childbirth and postnatal care.
11. The health facility has a functioning diagnostic ultrasound machine and trained health staff who can conduct a basic obstetric ultrasound examination to determine viability, the number of fetuses' present, gestational age, prenatal diagnosis of fetal anomalies or early diagnosis of placental insufficiency.
12. The health facility has a dedicated budget for essential medicines, equipment (and its maintenance) and medical supplies for maternal and newborn care

Outcomes

1. The proportion of all women who had severe pre-eclampsia or eclampsia in the health facility who did not receive the full dose of magnesium sulphate because of a stock-out.
2. The proportion of all women who gave birth in the health facility who purchased gloves and other necessary items
3. The proportion of mothers with obstetric complications who were managed according to protocol
4. The proportion of newborns with neonatal complications who were managed according to protocol.
5. The proportion of women referred for caesarean section as a result of lack of supplies/equipment or staff trained to conduct caesarean section.

Quality statement 9.4:

The laboratory has adequate infrastructure and capacity to perform tests required for maternal and newborn health

Rationale:

The availability of a functional lab is essential in maternal and newborn care. This is because many laboratory tests are essential for the pre-conception, ante natal, delivery and post-natal period. Blood transfusion is often required and is usually lifesaving in many of the complications in maternal and newborn care.

Quality measures

Input

1. The health facility has laboratory infrastructure which is designed, constructed and provides a conducive working environment for staff
2. The health facility has laboratory that is staffed with qualified lab personnel
3. The health facility has essential laboratory reagents and supplies for tests to support the management of women and newborns
4. The health facility has adequate supply of blood and blood products which are released in a timely manner

5. The health facility has a mechanism for screening and testing blood and its products to provide safe blood for transfusion.
6. The facility has blood that is correctly labeled and is properly stored at the correct temperature
7. The facility has a blood bank that operates 24 hours a day
8. The health facility has mechanisms and protocols for the right processes of bleeding and transfusion of blood and blood products
9. General biosafety and IPC practices are followed in the laboratory

Output/process

1. The proportion of women requiring blood transfusion who received blood

Outcome

1. The proportion of women requiring blood transfusion who died before receiving the blood transfusion

STANDARD 10 Safe obstetric anaesthetic care and surgery

Statement 10.1:
Every woman who requires surgical intervention should receive timely and efficient care in a safe environment.

Rationale:
Safe and efficient anaesthesia in obstetric surgery results will lower maternal and neonatal morbidity and mortality. Successful obstetric surgical intervention requires efficient anesthesia service in a safe environment, which is in turn dependent on the availability of adequate technical resources including equipment, drugs and well trained and highly motivated anesthesia providers. Safe anaesthesia requires that we conform to the minimum standards for anaesthesia as prescribed by the Kenya Society of Anesthesiologist (KSA), The World Federation of Societies of Anesthesiologists (WFSA) and the World Health Organization (WHO).

Every mother requiring surgery should receive timely, quality and safe anaesthetic care in a health facility that has an adequately equipped and functional operating theatre and Post Anaesthesia Care Unit (PACU) facility, with an adequate number of skilled staff to monitor them throughout their stay in theatre and manage any complications that may arise. They should also conduct regular reviews of all mortalities and near misses in theatre.

Quality measures

Input

1. The health facility has an adequately equipped and functional operating theatre and Post Anaesthetic Care Unit (PACU) facilities to offer emergency obstetric care and obstetric anaesthesia as per the national anaesthesia guidelines.
2. The health facility has adequate number of skilled staff to provide surgical and anaesthetic services for caesarean section and management of the patient in the post anaesthetic care unit, 24hrs a day.
3. The health facility has registers and anaesthetic charts in place at all times for the routine recording and monitoring of all care processes of the anaesthetised woman.
4. The health facility conducts reviews of all mortalities and near misses in theatre and has a mechanism for implementing the recommendation of the reviews.
5. The health facility has supplies of sterile packs, non-pharmaceuticals and pharmaceuticals required for spinal anaesthesia available at all times in sufficient quantities for the expected number of operations.
6. The health facility has essential drugs and supplies for the provision of obstetric anaesthesia and the management of complications according to national anaesthesia guidelines and available in sufficient quantities at all times in theatre.
7. The health facility has arrangements with other facilities and a mechanism to cater for the critically ill woman or any woman with post anaesthetic complications requiring escalation of care.
8. The health facility theatre staff adhere to IPC guidelines and protocols
9. The health facility has Housekeeping personnel in theatre who wear personal protective equipment

Output/process

1. The proportion of fully equipped and functional operating rooms as per the national anaesthesia guidelines.

2. The proportion of functional operation tables to recovery beds in the post anaesthesia care unit (PACU) as per national anaesthesia guidelines

Outcomes

1. Proportion of patients referred from theatre to an ICU or another health care facility for escalated care.
2. The proportion of women who died during or after exposure to anaesthesia
3. The proportion of anaesthetic related deaths that have been reviewed and recommendations for improvement made in the last 12 months.
4. The proportion of recommendations made for anaesthesia care implemented within the stipulated time frame.

Quality statement 10.2:

Every woman who requires surgical intervention will receive prompt and safe anaesthetic care from a formally trained, certified and registered anaesthesia service provider.

Rationale

While the presence of a functional theatre is key in provision of Safe and efficient anaesthesia in obstetric surgery, it is highly dependent on the presence of a well-trained and competent anaesthetic team comprising of an anaesthetist and an anaesthetic assistant.

Every anaesthesia provider must be formally trained and registered to provide anaesthesia in Kenya; they are also required to participate in various continuous professional development activities to improve their knowledge and competencies.

The anaesthesia provider will ensure that the patient is adequately prepared for theatre and discuss with the patient / guardian the relevant aspects of anaesthetic care, as they develop an individualized peri-operative anaesthetic plan.

Input

1. The anesthetists/anaestheologists reviews every woman before surgery to ensure that they are appropriately prepared for the surgery and are informed on the options and risk of the anaesthetic procedure.
2. The anesthetists/anaestheologists provides individualized intra-operative care as recommended by national anaesthesia guidelines.
3. The anesthetists/anaestheologists engage in continuous professional development activities as dictated by their regulatory body and receive updates and refresher courses on the management of obstetric emergencies at least every 12months.
4. The anesthetists/anaestheologists clearly documents all the anaesthetic processes from pre anaesthetic review to reversal of anaesthesia including any incidents that may have occurred.
5. The anaesthetist/ anesthesiologist uses the anaesthesia chart in the patient file to monitor anaesthetic care.
6. The health facility provides for adequately trained support staff such as anaesthetic assistant at all times in theatre to assist the anaesthesia service provider in the provision of anaesthetic services.

Output/process

1. Proportion of fully filled anaesthetic charts.
2. The proportion of anaesthetists who have participated in obstetric and newborn refresher courses in the last 12 months.
3. Proportion of files with documented pre-anaesthetic review.

Outcomes

1. Proportion of women who were aware of the options of anaesthesia.
2. Proportion of women who were aware of the risk of anaesthesia.
3. Proportion of caesarean sections that had a turnaround (decision to operation time) time of 1hour or less.
4. Proportion of poor neonatal outcomes (fresh still birth, severe asphyxia) after caesarean section.
5. The proportion of women exposed to anesthesia who were transferred for ICU care or died on the theatre table.

STANDARD 11

Every community member is empowered to realize their rights to quality, equitable and dignified Maternal and Newborn Health Services (Kenya Community Health Strategy goal)

Rationale:

Community health forms the basis for addressing delays to the uptake and utilization of maternal and newborn health services, as well as defining what quality means, contextual to their community. Communities have largely been passive recipients of health services, despite evidence showing that involvement of community members increases the uptake and utilization of Maternal and Newborn Health services.

Community involvement leads to awareness, increased demand for health rights and quality services from the link health facilities, and accountability for the efficiency and effectiveness of health services. The community members should be empowered with the necessary information and education, which will enable them to actively participate and make informed decisions regarding maternal and newborn care.

Quality Statement 11.1:

All women, their families and the general community are sensitized and educated on maternal and newborn health

Quality Measures

Inputs

1. Regular education and sensitization sessions on Maternal and Newborn Health are conducted at the health facility and at the community level.
2. Informational materials (written, pictorial & audio-visual) on health rights are available and accessible to all the women and the community
3. Community Health Extension Workers (CHEWs), in conjunction with the link facility health care providers, facilitate trainings to empower women and community members to demand for their rights and entitlements

Output/process

1. The proportion of health education sessions held at the facility in the last 3 months
2. Number of dialogue sessions conducted at the community level over the last 3 months
3. Proportion of women who report availability of audio-visual materials on maternal and newborn health services at the community e.g. Chief's office, schools, churches and market places
4. Proportion of community members who are aware of their rights and entitlement.

Quality statement 11.2:

The community has confidence in the health care system delivery of maternal and newborn health services.

Quality Measures

Inputs

1. There is a feedback mechanism between the community and the healthcare facility regarding maternal and newborn health services.
2. Community Health Extension Workers (CHEWs) hold regular and effective dialogue meetings with the community on maternal and newborn health care.

3. The community members are sensitized on what to expect from the health care facilities in terms of quality, equitable and dignified maternal and newborn care services.

4. There is a well-functioning social accountability mechanism where communities effectively participate in the improvement of the management and delivery of MNH services (Community score-card).

Outputs

1. Number of feedback meetings held between the community and the health care facility regarding maternal and newborn health services in the last 12 months
2. The number of meetings held with the community on improvement of the management and delivery of MNH services (community score-card) in the last 12 months.
3. Number of action days held in the community health units with reports in the last 12 months
4. Number of social accountability meetings held in the last 12 months
5. Number of maternity open days held in the facility in the last 12 months

REFERENCES

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7. Ministry of health, Core standards for quality health care Kenya, Quality Model for Health
8. Ministry of health, Kenya Referral Strategy 2014 – 2018
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14. Standards for Improving Quality of Maternal and Newborn Care in Health Facilities – WHO 2016
15. Strategy for Community Health 2014 – 2019 (http://guidelines.health.go.ke/#/category/12/90/meta)
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17. WHO recommendations Intrapartum care fora positive childbirth experience

SECTION B



REPUBLIC OF KENYA



MINISTRY OF HEALTH

MATERNAL NEWBORN HEALTH QUALITY OF CARE ASSESSMENT AND QUALITY IMPROVEMENT TOOL

A Preparations for the Quality Assessment

How to prepare for the assessment

1. Make a plan for logistics
   - Number of facilities to assess
   - Identify members to conduct QA
   - Dates to conduct QA visits
   - Official request to County/facilities
2. State an agenda for the visit
3. Identify and communicate to the stakeholders involved
4. Remind facilities of the intended visit
5. Print copies of the tool or have the electronic version ready

Check lists of Guidelines and policies that should be reviewed before assessment exercise

No	Document	Yes	No		Document	Yes	No
1	Kenya Health Policy 2014-2030			6	Post Natal Care Guideline		
2	Kenya Health Sector Strategic and Investment plan, 2018-2023			7	National Quality Obstetric and Pediatric Care Guidelines (NQOPC), 2021-2025		
3	Human Resource for Health Norms and standards guideline for the health sector			8	Kenya Health Sector Referral Strategy		
4	Kenya Quality Model for health Quality Standards for community health Services			9	All appropriate protocols as mentioned in the document		
5	PAC hand Book			10	Helping Baby Breath 2nd Edition		

Who should/can do the assessment?

- National Teams providing technical assistance
- County/Sub county Health Management Teams
- Facility Quality Improvement teams

B. During the Assessment

How teams can organize themselves

Teams to work with all cadres whose work revolves around maternal and newborn heath

1. Obstetrician /Gynecologists, Medical doctors, Pediatricians
2. Anesthetist/anaesthesiologist
3. Clinicians with RH training
4. Nurses/midwives
5. Lab Technicians/Technologists
6. Health Records and Information Officer (HRIO)

C. Post assessment – What needs to be done?

Debriefing meetings

- Meeting by the team who conducted the assessment to debrief
- Give facility in charge/team result and share the documented results
- Facility teams to develop action plan for identified gaps
- Get a copy of the plan
- Compile and analyze results
- Send scoring sheet to MOH
- Set a date for the next assessment

Facility Details

Date of assessment ☐ (captured by system)

Facility Name ☐

Facility Level ☐ Level 2 ☐ Level 3 ☐ Level 4 ☐ Level 5 ☐ Level 6 (indicate)

Facility ownership ☐ ☐ GOK ☐ FBO ☐ PRIVATE

Facility MFL code ☐

County ☐

Sub County ☐

Accreditation ☐ ISO ☐ Safe Care ☐ Slamta ☐ (Others ☐)

Date of last inspection of the facility by a regulatory body ☐ NHIF ☐ Joint Health Inspection
☐ Health Provider Inspection ☐ Oversight Authority ☐ (Others ☐)

Assessment Type ☐ Internal Assessment ☐ External Assessment

Assessor's Name ☐

Assessor's Registration No. ☐

Registration Body. ☐

Assessors telephone no: ☐

Facility in-charge's name: ☐

Facility in-charge's telephone number: ☐

Does this facility have the following units?

	Yes	No
Preconception Clinic		
Antenatal ward		
Labor ward		
Postnatal ward		
Combined antenatal and postnatal ward		
Newborn unit		
Kangaroo mother care (KMC) area/room		
Laboratory		
Pharmacy		
Theater		
MCH		

How to use this tool:

This tool is designed:

- For self-assessment by Quality Improvement Teams (QITs) within health facilities;
- For peer assessments by Quality Improvement Teams from different facilities;
- For external assessment by County, National Supervisors or Quality Improvement Teams (QITs) who should provide support to ensure compliance with basic standards

This tool is divided into several parts; it has 11 Standards. The standards are divided into Quality Statements which are further divided into Quality Measures.

- The quality measures include input, output/process and outcome measures
- The input influences the process and outcome measures
- Each input has one or more components and each component scores "1" for "Yes" and "0" for "No" and Not Applicable (N/A)
  - "Yes" refers to where the procedure is expected and available at that level of care,
  - "No" to where the procedure is expected and not available
  - "Not Applicable" is where the procedure is not expected at that level
- Calculate and write the percentage of inputs achieved per quality statement and in total
- Summarize the results using the "Summary of results" form.
- The output/process and outcome measures are reported as proportions.
- Information is collected for the previous three months i.e. quarterly
- The denominator will be for the services or clients seen in the specific area of assessment in the previous three months/number of files sampled.
- The sampling size is determined by the number of deliveries in the facility in that quarter.

Sample size Table

Population Size	Sample size for a 95% CI to have width of 0.16	Population Size	Sample size for a 95% CI to have width of 0.16
Less than 20	all	180-199	86
20-29	26	200-249	94
30-39	32	250-299	101
40-49	38	300-349	106
50-59	43	350-399	110
60-69	48	400-499	113
70-79	53	450-499	116
80-89	57	500-749	127
90-99	61	750-999	131
100-119	67	1000-4999	146
120-139	73	5000 or more	150
140-159	78	140-159	78
160-179	82	160-179	82

Sources of information

1) **Case observations:** For clinical case management, this is the preferred source of information, and should be used as much as possible. The care for new arrivals and admitted patients to the hospital should be observed first hand without interference from the assessors. This is complemented by discussion of the case with staff, review of the case records and monitoring charts, and interviewing the caregivers.

If there are not enough cases for direct review of case management, simulated cases are presented to staff to assess clinical case management.

2) **Records:** Assessors obtain information on the quality of care for admitted and recently discharged patients by checking records. If there are not sufficient patients for direct case observations, assessors should ask staff if it is possible to review records.

3) **Interviews:** There are 2 structured questionnaires to be administered during the assessment visit. These questionnaires are designed to capture additional information on access to the facility, perception of care provided and services received. This is assessed from both the provider and the patient's perspective. These can be self-administered or via interview from caregivers, patients and clients. The following are the interview questionnaires in this section:
    a) Exit interview with new mother
    b) Interview of health professionals

SCORING

- Every quality statement will be scored as per the number of elements achieved in all the inputs over the total number of the elements in the quality statement.
- The quality standard score is achieved by averaging all the scores for the quality statements in that standard.

$$\text{Quality statement score} = \frac{\text{Total components achieved}}{\text{Total components in the quality statement}} \times 100$$

$$\text{Quality standard score} = \frac{\text{Total of all the quality statement percentage scores in the standard}}{\text{Number of quality statements in the standard}}$$

INTERPRETATION OF SCORES

Standards score	Risk category	Compliance category	Remarks
0-24 % absence of standards	Very High Risk	Non-Compliant	No documented/observable effort of compliance .Need for immediate action by Quality Improvement team
25-49-Standards minimally adhered to	High Risk	Minimally compliant	Standard is minimally met, there is need for improvement. State areas for improvement under remarks. Identify the quality gaps and start implementing QI activities and review within 1-3 months
50-74 Standards partially adhered to	Imminent high risk	Partially Compliant	(Standard is not fully met, there is need for improvement. State areas for improvement under remarks) Identify the quality gaps and work towards reaching the desired goal within 3 months
75-100 % Most standards adhered to	Low Risk	Fully Compliant	Met Target. Continuously supervise for maintenance of the satisfactory quality ratings

Adapted from MOH-KQMH Hospital Checklist 2018 & Joint Health Inspection Checklist 2015

STANDARDS	NUMBER OF QUALITY STATEMENTS	PERCENTAGE SCORE FOR EACH QUALITY STATEMENT		AGGREGATE SCORE FOR EACH STANDARD
Standard 1: Every woman in the reproductive age receives routine evidence based care and management of complications before and during pregnancy	2	QS1		
		QS2		
Standard 2: Every woman and newborn receives routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period, according to the national guidelines.	13	QS 2.1a		
		QS 2.1b (i)		
		QS 2.1b (ii)		
		QS 2.1c		
		QS 2.2a		
		QS 2.3a		
		QS 2.4a		
		QS 2. 5a		
		QS 2. 5b		
		QS 2. 5c		
		QS 2. 6a		
		QS 2. 6b		
		QS 2. 7		
		QS 2. 8		
	2	QS 3.1		

STANDARDS	NUMBER OF QUALITY STATEMENTS	PERCENTAGE SCORE FOR EACH QUALITY STATEMENT		AGGREGATE SCORE FOR EACH STANDARD
Standard 3: The health information system enables the use of data to ensure early, appropriate action to improve the care of every woman and newborn.		QS 3.2		
Standard 4: The health information system enables the use of data to ensure early, appropriate action to improve the care of every woman and newborn.	3	QS 4.1		
		QS 4.2		
		QS 4.3		
Standard 5: Communication with women and their families is effective and responds to their needs and preferences.	2	QS 5.1		
		QS 5.2		
Standard 6: Women and newborns receive care with respect and preservation of their dignity.	3	QS 6.1		
		QS 6.2		
		QS 6.3		
Standard 7: Every woman and her family or the companion of her choice are given emotional support that is sensitive to their needs and strengthens the woman's capability.	2	QS 1		
		QS 2		
Standard 8: For every woman and newborn, competent, motivated staff are consistently available to provide routine care and manage complications.	4	QS 8.1		
		QS 8.2		
		QS 8.3		
		QS 8.4		
Standard 9: The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and management of complications	4	QS 9.1		
		QS 9.2		
		QS 9.3		
		QS 9.4		
Standard 10: Safe obstetric anaesthetic care and safe surgery	2	QS 1		
		QS 2		
Standard 11: Every community member is empowered to realize their rights to quality, equitable and dignified Maternal and Newborn Health Services	4	QS 11.1		
		QS 11.2		
		QS 11.3		
		QS 11.4		

Antenatal Care and Preconception Care

STANDARD 1 — **Every woman in the reproductive age receives routine evidence based care and management of complications before and during pregnancy.**

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
1.1 Every woman planning a pregnancy should receive appropriate pre-conception care to enable her plan her family with a healthy pregnancy and fetal outcome	**Inputs** **For this part the assessment to be in MCH and OPD where there is a dedicated Preconception Care Clinic** 1. The health facility provides for a preconception wellness program that will cover issues related to Information, education and counseling on • Hygiene • Nutrition and supplementation (folic acid) • Promotion of exercises • Screening for pre-existing medical conditions like anemia, diabetes mellitus, TB, STIs/HIV, hypertension • Management of pre-existing medical care- diabetes mellitus, hypertension, anemia, thyrotoxicosis, asthma, cardiac conditions • Assessment for: - immunization status – (tetanus, diphtheria hepatitis B, Rubella) • Assessment for genetic conditions • Assessment for medication use, • Assessment for drug use • Assessment for Intimate partner violence • Mental status assessment (tool is available)	Verify presence from protocols	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Assessment for genetic conditions • Assessment for medication use, • Assessment for drug use • Assessment for Intimate partner violence • Mental status assessment (tool is available)		☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	2. The health facility has displayed, up-to-date clinical protocols for pre-conception care	Check for availability of pre-conception care clinical protocols	☐	☐	☐		
	3. Health-care staff in the MCH/FP clinics and OPD receive regular in-service training and refresher sessions on pre-conception care at least once every 12month • The facility has an annual staff training plan and on job training program • The facility has an active continuous medical education program in place–rota available • The facility has an accessible resource center in place • Attendance list of trained staff is available • Staff training logs are available • Functional mentorship program in place	Verify from training database	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has adequate health care providers with the skills and competency to empower the woman in reproductive health and rights and gender-based violence. Staff have received training on the following in the last 12 months • Sexual gender-based violence, trauma counseling and Psychosocial care and support • Respectful maternity care • Antenatal and pre-conception care	Verify from training database	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	5. The health facility educates and provides women with a variety of family planning options/contraception care to encourage planned families • Intra uterine devices • Implants • Oral contraceptives • Injectable contraceptives • Male Condoms • Female condoms • Cycle beads • Calendar	Check if the services and FP commodities are available	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	6. Women receive folic acid prior to conception • Protocol available • Folic acid available	Check protocol, Verify availability of folic acid	☐ ☐	☐ ☐	☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	7. The health facility provides information, education and counseling for women with difficulty in conceiving and early (1st trimester) pregnancy losses • The facility has a functional infertility clinic • The facility has a referral system for couples with infertility • Facility has services for management of habitual abortions • Facility has a referral system for women with habitual abortions	Check for availability, sample 5 client files, clients attendance register available	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	8. The health facility provides preconception care • Adequate space for examination which is well lit, ventilated, privacy (audio and visual). • Well displayed teaching aids on the following: - Nutrition -Breast examination -STIs/HIV materials -Exercises -Family planning	Observe Check for physical presence of teaching aids	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	• Functional equipment to include: - Examination couch - Blood pressure machine - Glucometer - Portable light - Clinical thermometers - Stethoscope - Weighing - Height scale - Intra uterine device trays - Implants-insertion/removal kits	Verify functionality of equipment	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Supplies to include the following: - Family planning commodities, anti-helminthes, iron and folate supplements, other micronutrient supplements. - Pregnancy test kits - Long lasting insecticidal nets(malaria endemic areas) - Urinalysis strips - Rapid diagnostic test kits (for malaria endemic areas)	Verify availability	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	• The facility has the capacity to do the following - HIV/VDRL testing - Blood group and cross matching test - Hemoglobin levels testing, - Malaria test - Urinalysis test - Pregnancy test	Observe/Ask/ sample five client files	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	9. Women Are Screened, Counseled On pre-existing conditions as appropriate • Blood Pressure • Temperature • Weight • Rhesus Incompatibility • Hemoglobin Levels • Blood Sugar • HIV/Syphilis • Tuberculosis • Malaria (Endemic Area) • Genetic Conditions E.G. Sickle Cell • Hepatitis B	Sample five client files	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	10. Women with pre-existing diseases and conditions are managed pre-conceptually as appropriate. • Hypertension • Hepatitis B • Febrile disease • Anemia • Rhesus incompatibility • HIV/syphilis/tuberculosis • Diabetes mellitus • Malaria (endemic area) • Genetic conditions e.g. Sickle cell • Others (specify)	Sample five client files	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	Output/process 1. The proportion of women who received folic acid prior to conception 2. The proportion of women screened for each of the following: HIV, Tuberculosis, Diabetes, Hypertension, Sickle Cell, Rhesus factor, Anemia and Other Genetic conditions for various underlying health conditions prior to conception.	Check records Check case files					
	Outcomes 1. The proportion of women whose medical conditions were managed prior to conception.	Verify from case files					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
1.2. All pregnant women are supported to access quality antenatal care services within 12 weeks of pregnancy	**Inputs** 1. The health facilities have written, up-to-date clinical protocols for antenatal care services	Check for presence of protocol	☐	☐	☐		
	2. Health care providers receive in-service training and regular refresher sessions in the management of ANC services at least once every 12 months • Antenatal care • Emergency obstetric newborn care training • Family planning (long- and short-term methods • Post abortion care training • Adolescent and sexual reproductive health • Respectful maternity care • Sexual gender-based violence • Reproductive health cancers screening (Breast and cervical) • PMTCT • Post Natal Care • Maternal Perinatal Death Surveillance and Response	Check training data base	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	3. The health care providers are able to obtain comprehensive history from the client (Personal, Medical, Surgical and Social/ Family, Obstetric/Gynae).	Observe and sample five mother child booklet (MOH 216)/sample five client files	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health care providers conduct systematic physical examination in a private and confidential environment	Observe for privacy (screens, curtains, doors, lockable cabinets and drawers for files)	☐	☐	☐	☐	
	5. Pregnant women receive health education in the following: - • Targeted individual care • Health education on:_ - Individual birth plan (IBP) - Danger signs - Hygiene - Nutrition - Safer sex - HIV management if positive - Signs of labour - Future family planning options - Newborn Care, - Breastfeeding - Wellness in pregnancy	Sample and Verify five Mother child booklets/ client files Observe the health worker counsel the mother on IBP Ask five clients on the services received	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. The health facility has the capacity to perform ANC profiles; • Hemoglobin • Syphilis screening • Urinalysis • Blood grouping • Rhesus factor • HIV testing • Hepatitis B • Malaria (in endemic areas) • Random Blood sugar	Check from Register sample and Verify five mother child booklets/ client files	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	7. The health facility facilitates the mother to form mother to mother support groups to encourage clinic attendance	Verify from quality improvement team meeting minutes Ask and verify from five clients	☐	☐	☐		
	8. The health facility has a mechanism for tracing of ANC defaulters	Verify the presence of defaulter tracing diaries Ask two CHVs (if available) if they are involved in ANC defaulter tracing	☐	☐	☐		
	9. The health facility has a mechanism to do follow up of mothers	Verify from ANC register	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	10. The facility • Conducts maternity open days to orientate the expectant mother and birth partner on the environment of the hospital • Facilitates dialogue between facility and community	Ask and verify from existing records, chalkboards and minutes Ask two CHVs (if available) if they conduct maternity open and dialogue days	☐ ☐	☐ ☐	☐ ☐		
	Outcomes (Check for 3 months' data) 7. Proportion of women who had comprehensive antenatal profile done during 1st visit (All ANC Profile Tests) 8. Proportion of women who received IFAS 9. Proportion of women screened for HIV 10. Proportion of women screened for syphilis 11. Proportion of women who attended ANC in 1st trimester (12 weeks). 12. Proportion of women who completed ANC as outlined in the national guidelines i.e. completed scheduled visits.	Verify from MOH 711 Verify from KHIS					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 2

Every woman and newborn receives routine evidence-based care and management of complications during labour, childbirth and the early postnatal period according to the national guidelines.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.1a Women are assessed routinely on admission, during labour, childbirth and are given timely appropriate care	**Inputs** 1. The health facility has the basic essential equipment and supplies for routine care and detection of complications available in sufficient quantities at all times in the areas of the maternity unit for labour and childbirth: • Full delivery set (tray 10x14 inches, large kidney dish 10inches, 2 bowls 6 inches, gallipot, gauze, cotton wool, cord ligatures, 2 artery forceps 8inches, 6 towels, needle holder 7 inches, 1 cord scissors, episiotomy scissors) • Thermometer • Sphygmomanometer • Stethoscope • Fetoscope • Urine dipstick • Clean dry towels • Heat source • Rescuscitairre • Suction device and assorted suction tubes • Neonatal masks 2 sizes (pre-term and term)	Observe for availability of sufficient quantities at all times for the expected number of births	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Ambu bag (500ml) • Sterile cord ties (or clamps) • Scissors (or blades) • Oxytocin • Vitamin k • 1% tetracycline eye ointment • 7.1% chlorhexidine		☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	2. The health facility has, up-to-date clinical protocols for intrapartum care and action in the labour and childbirth areas of the maternity unit that are consistent with national guidelines and accessible within maternity	Verify presence of protocols	☐	☐	☐		
	3. Training . Health care providers at the facility received the following in obstetric emergencies and complications and essential newborn care including resuscitation and breastfeeding in the last 12 months • Monthly CME sessions • In service training yearly • Refresher sessions yearly/drills	Verify from training database	 ☐ ☐ ☐	 ☐ ☐ ☐	 ☐ ☐ ☐		
	4. The health care Provider receive mentorship sessions/support supervision quarterly	Verify from mentorship/ support supervision reports	☐	☐	☐		
	5. Availability of a written up-to-date protocol on pain management during labour	Verify presence of protocols	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. The health care providers do the following: • Counsel client on post-partum family planning • Counsel client on HIV testing • Ensures privacy during the entire process of provision of care • Explains each step of the examination to the woman using easy-to-understand language and encourages her to ask questions • Takes vital signs (temperature, Pulse Rate, BP)	Observe	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	7. The pregnant woman's general condition (labour and stage confirmed) and emergency signs are assessed immediately upon arrival and documented • The pregnant woman's general condition is assessed within the first 30 minutes of arrival in the health facility • The health care provider trained in obstetric triage conducts an assessment of the woman's general condition and emergency signs (triage) • The following assessment findings are documented by a skilled birth attendant (SBA): -All vital signs (BP, Pulse rate, Respiratory rate, Temperature) -Foetal heart sounds -Rupture of membranes -Contractions -Cervical dilatation -Fetal presentation -Severe abdominal pain and tenderness	Observe / Verify from a sample of 5 medical records Exit interview Observe / Verify from a sample of 5 case files	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	8. The progress of labour is regularly monitored using a Partograph: - Are partographs/labour care guides filled out completely and correctly? Check for: • Blood pressure every 4hours • Foetal heart rate checked ½ hourly • Uterine contractions assessed every half hourly • Cervical dilatation every 4 hours • Descent • Moulding • State of membranes or colour of the liquor • Outcome of the baby • Any medication or fluid given recorded • Was the partograph/labour care guide started when the cervix was ⩾ 5 cm? (source: WHO INTRAPARTUM CARE 2018)	Sample 5 partographs/ labour care guides from women actively in labour Ask 2health workers to demonstate how to chart partograph by giving a case scenario Sample and check records of 5 clients who delivered	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	9. The health care provider uses partograph/ labour care guide to make decisions	Verify if partograph/ labour care guide was used to make decision for c/s or augmentation of labour or referral	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	10. Facility offers pain relief to women in labour (pharmacological or non-pharmacological)	Observe or Verify through client interview	☐	☐	☐		
	11. Clients get information on how their labour is progressing?	Verify through client interview	☐	☐	☐		
	12. Health facility allows mothers in labour to have birth companions	Observe/client interview	☐	☐	☐		
	13. Health facility allows women to deliver in positions preferred by the client	Observe/client interview	☐	☐	☐		
	14. Does the facility have the capacity to provide the EMONC signal functions? • Caesarian Section (CEMONC) • Blood Transfusion (CEMONC) • Parenteral Uterotonics • Parenteral Antibiotics • Parenteral Anticonvulsants • Manual Removal of Retained Products • Manual Removal of Placenta • Assisted Vaginal Delivery • Neonatal Resuscitation	Observe	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	15. Health care providers skillfully completes 2nd stage of labor • The health provider prepares to assist the birth. • An assistant should be available • Child birth area has a documented room temperature in the labour room and temp is ⩾25C and free from draught • Availability of delivery kit	Observe a delivery or Provide a case scenario	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Availability of infection prevention materials, buckets and supplies including running water and personal protective equipment • Availability of basic equipment to perform resuscitation of the newborn • The health provider explains to the woman how to manage the bearing down process • The health provider allows the woman to bear down during contractions (when she feels the desire) • Health care provider constantly monitors foetal heart rate every five minutes or when there is no contraction. • Performs an episiotomy only if necessary (Breech, shoulder dystocia, vacuum extraction, poorly healed 3rd or 4th degree tear or fetal distress) • The health care provider allows the head to crown spontaneously. • The health provider gently delivers the baby		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	16. Every woman receives Uterotonic:- Oxytocin/ Carbetocin within one minute after birth of the baby, as part of Active Management of Third Stage of Labour according to protocol	Observe administration of Uterotonic within one minute Use simulation or ask health care provider to explain.	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	17. Health care provider performs active management of third stage	Observe for removal of placenta using CCT (controlled cord traction), uterine massage and expulsion of clots Use simulation or ask health care provider to explain	☐	☐	☐		
	18. The Facility provides clients with hot drinks after delivery	Verify through client interview	☐	☐	☐		
	19. 4th stage – Cleaning of mother, emptying of bladder, half hourly check of vital signs within the first 2 hours, Monitor for excessive bleeding, uterine contraction	Observe Verify sampled medical records of 5 patients	☐	☐	☐		
	20. The Facility provides women with a warm bath after delivery when stable	Verify through client interview	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process measures 1. The proportion of all women who gave birth in the health facility whose Blood Pressure, Pulse and Temperature were appropriately recorded during labour, childbirth and the early postpartum period.	Sample and check files					
	2. The proportion of all women who gave birth in the health facility who received oxytocin within 1 min of the birth of their baby	Sample and check heck files					
	3. The proportion of all women who gave birth in the health facility whose progress in labour was correctly monitored and documented with a partograph/ labour care guide.	Sample and check heck files					
	4. The proportion of all women who gave birth in the health facility whose urinalysis and hemoglobin levels result was appropriately recorded during labour and childbirth.	Sample and check heck files					
	5. The proportion of all women who gave birth in the health facility who received any option for pain relief during labour and childbirth.	Sample and check heck files Clients interview in postnatal ward					
	Outcome measures (in the last 3 months) 1. The health facility perinatal mortality rate [number of foetal death (stillbirths) and early neonatal deaths / the total number of births of babies weighing at least 1000 g or of 28 weeks' gestation and above (stillbirths + live births) x 1000	Sample and check heck facility records					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. Intrapartum stillbirth rate (number of stillbirths occurring during the intrapartum period per 1000 births).	Sample and check facility records					
	3. The proportion of all women admitted to the health facility in active labour who gave birth within 12 hours.	Sample and check file					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.1b (i): Newborns receive routine care immediately after birth.	**NEWBORN ROUTINE CARE** **Input** 1. The health facility has written up-to-date, clinical protocols for essential newborn care that are consistent with national guidelines and are available in the labour and childbirth areas of the maternity unit.	Observe for presence of protocols	☐	☐	☐		
	2. Health-care staff in the labour and childbirth areas of the maternity unit receive in-service training or regular refresher sessions in essential newborn care and breastfeeding support at least once every 12 months	Verify from training data base	☐	☐	☐		
	3. The health facility has supplies of - Sterile cord ties (or clamps) - Cord scissors, - Vitamin K,	Physical check in the ward	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	- 1% tetracycline eye ointment - 7.1% chlorhexidine for cord care available in sufficient quantities at all times for the expected number of births		☐ ☐	☐ ☐	☐ ☐		
	4. The health facility has supplies of clean towels in the labour and childbirth areas for immediate drying of newborns, available in sufficient quantities at all times for the expected number of births.	Check for presence	☐	☐	☐		
	5. Observe care at birth (the health care provider performs the following: • Delivers baby to mother's abdomen (skin to skin if mother is in a stable state) • Delays cord clamping for 1-3 mins after birth • Applies 7.1% Chlorhexidine on the umbilical stump • Ensures the baby is kept warm in skin-to-skin contact on the mother's chest and covers the baby with a cloth or blanket including the head (with a hat) • Ensures the baby has begun to suckle within an hour of birth • Performs head to toe exam at the baby within 24 hrs. • Routinely administers VIT.K injection to newborns • Documents the baby's particulars in register/ mother's file(mother's full name, sex, date and time of delivery birth, weight, Apgar score)	Observe	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. The health facility has arrangements for alternative feeding methods, including cup, cup and spoon feeding (according to the national guidelines)	Ask and observe	☐	☐	☐		
	7. In the extreme cases where infant formula is needed, the health facility ensures that feeding of infant formula is demonstrated to mothers and family members of newborns only when needed, with a full explanation of the hazards of improper use.	Verify through client interview from mothers whose babies are on formula feeding - NBU & PNC ward	☐	☐	☐		
	Output/process 1. The proportion of all newborns who were dried immediately and thoroughly at birth.	Observe during delivery – No. of newborns dried immediately divided by the total observed					
	2. The proportion of all newborns that were kept in skin-to-skin contact (with body and head covered) with their mothers for at least 1 hour after birth	Observe during delivery					
	3. The proportion of all newborns who were breastfed within 1 hour of birth.	Observe during delivery					
	4. The proportion of all newborns whose umbilical cord was clamped 1–3 min after birth.	Observe during delivery					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The proportion of all newborns who received all four elements of essential newborn care: immediate and thorough drying, immediate skin-to-skin contact, delayed cord clamping and initiation of breastfeeding in the first hour	Observe during delivery					
	Outcome 1. The proportion of all newborns who had a normal body temperature (36.5–37.5 °c) at the first complete examination (60-120 minutes after birth).	Observe/ check files					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.1b (ii): Newborns who are not breathing spontaneously receive appropriate stimulation and resuscitation with a bag-and-mask within 1 minute of birth, according to the national guidelines.	1. The health facility has written, displayed, up-to-date clinical protocols for managing newborns who are not breathing spontaneously in the childbirth areas of the maternity unit that are consistent with the national guidelines.	Check for presence of protocols	☐	☐	☐		
	2. Health care staff in the childbirth and neonatal areas of the maternity unit receive in-service training and regular refresher sessions in basic newborn resuscitation at least once every 12 months.	Verify from the training data base	☐	☐	☐		
	3. Health care staff in the childbirth and neonatal areas of the maternity unit receive monthly drills or simulation exercises and supportive supervision in basic newborn resuscitation.	Verify from the training data base	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has a suction device, at least two sizes of neonatal mask (sizes 1 and 2) and a self-inflating bag (500mls) in the childbirth and neonatal areas of the maternity unit.	Verify for presence	☐	☐	☐		
	5. Health-care workers providing care for pregnant and postpartum women and newborns in the health facility are skilled in basic newborn resuscitation, as demonstrated by simulating positive pressure ventilation with a bag-and-mask on a manikin	Simulation or observe a resuscitation	☐	☐	☐		
	6. Observe the following: - If baby does not begin breathing (not crying) or gasping, asks for assistance, rapidly cuts and ties the cord, dries the baby and initiates resuscitation according to protocol	Observe or simulation	☐	☐	☐		
	7. Dries the baby- ensures head is dried, but if meconium stained, sucks first before drying the baby	Observe or simulation	☐	☐	☐		
	8. Wraps the baby to keep it warm	Observe or simulation	☐	☐	☐		
	9. Quickly suctions the baby's mouth and then nose to remove any secretions	Observe or simulation	☐	☐	☐		
	10. Correctly positions the head of the baby in a sniffing position to prevent airway blockage	Observe or simulation	☐	☐	☐		
	11. If the baby does not breathe quickly initiates ventilation • Correctly positions head and applies correct mask • Ventilates 30-50 times per minute for 1 minute • Pauses and determines whether the baby is breathing spontaneously or not	Observe or simulation	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	12. If the baby is breathing and there is no sign of respiratory difficulty (intercostal retractions or grunting), places the baby in skin-to-skin contact with mother	Observe or simulation	☐	☐	☐		
	13. If baby is breathing and has a heart rate of <60 beats per min; • Starts cardiopulmonary resuscitation, 3 cardiac compressions to 1 ventilation until the heart rate reaches 100 beats per min • If there is no breathing after 20 minutes of ventilation or gasping type of breathing for 30 minutes -Suspends resuscitation and records the time of death -Provides emotional support to mother/ parents and family members	Observe or simulation Observe or simulation	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	14. Essential medicines available in the department Medicines; • Crystalline penicillin/Ampicillin • Gentamicin • Multivitamins • Iron syrup • Vitamin K • Tetracycline Eye Ointment • I.V. Fluids • 10% dextrose • Normal Saline • Oxygen • 7.1% chlorhexidine • Nevirapine • Adrenaline • Phenobarbitone	Check for availability in the ward	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of all newborns who were not breathing spontaneously after additional stimulation at the health facility who were resuscitated with a bag-and-mask within 1 min of birth.	Observe – No. of newborns resuscitated with a bag-and-mask within 1 min of birth /Total observed					
	2. The proportion of all newborns who were not breathing spontaneously after additional stimulation at the health facility who were resuscitated with a bag-and-mask but died.	Observe/ Sample maternity files/register					
	Outcome 1. The proportion of all live babies born at term (⩾ 37 weeks) with no major congenital malformations in the health facility who died within 7 days of birth (early neonatal mortality)	Check record/ Sample maternity files/register					

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Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
POST-NATAL CARE							
2.1c: Mothers and newborns receive routine postnatal care	**Inputs** 1. The woman remains in the facility for at least 24 hours after delivery for normal births and 72 hours for C/ Section births (See Annex 15 for Post-Partum Care for both mother and baby)	Sample and verify from records of 5 patients for normal and 5 for C/section	☐	☐	☐		
	2. The health care provider conducts post-natal care (for mother and baby) checkup within 48 hours before discharge	Verify from patients file, register, and MCH handbook.	☐	☐	☐		
	3. Women are counselled on neonatal danger signs before discharge	Verify from MCH handbook. ,PNC register, Client interview	☐	☐	☐		
	4. Clients are counselled on postpartum danger signs before discharge	Client interview, Verify from MCH handbook, maternity files	☐	☐	☐		
	5. Clients are counselled to come back for post-natal checkup at 10-14 days at 4-6wks at 4-6 months (mother and baby) and also to come back anytime when they experience danger signs in her and baby	Client interview	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. The health facility has written, up-to-date clinical protocols for postnatal care in the maternity and/or postnatal care areas of the maternity unit that are consistent with the national guidelines.	Observe for presence of protocols	☐	☐	☐		
	7. The health facility has a written breastfeeding policy that is routinely communicated to all healthcare providers and visibly displayed in all MNH service delivery areas	Observe for presence and display	☐	☐	☐		
	8. The health facility has well displayed job-aids for management of post-partum complications e.g. post-partum hemorrhage, pre-eclampsia, eclampsia, maternal sepsis	Observe/ check for presence	☐	☐	☐		
	9. The health facility practices and enables rooming-in to allow mothers and babies to remain together 24 hours a day.	Observe	☐	☐	☐		
	10. Health-care staff in the maternity unit receive in-service training and refresher sessions in postnatal care and breastfeeding at least every 12 months.	Check training data base, registers	☐	☐	☐		
	11. The health facility has arrangements to ensure that every mother knows when and where Post-natal care for herself and newborn will be provided after discharge from hospital (link with community referral standards)	Check records/ Observe	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Counsel on the following before discharge: - • A Complication readiness plan (Danger signs, Fund, Transport) developed • Routine newborn care (breast feeding, hygiene, thermal protection, immunization and use of mosquito nets) • Initiation of coitus post-delivery, safer sex, personal hygiene and clean chain, nutrition, danger signs, 12. Offer family planning and other services accordingly prior to discharge • The health facility's offer PPFP	Check records Exit Interview Check MCH handbook Exit interview Check a sample of records/ Observe	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	13. Health Care staff observe IPC – observe decontamination, waste segregation and hand washing	Observe	☐	☐	☐		
	Output/process 1. The proportion of all newborns in postnatal care wards or areas in the health facility who received • Vitamin K, • 1% tetracycline eye ointment • 7.1% chlorhexidine for cord care 14. Vaccination	Verify from records Verify from discharge file Exit questionnaire	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	2. The proportion of all stable newborns in the health facility who are fed exclusively on breast milk from birth to discharge						

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The proportion of all women in postnatal care wards who have documentation on • Blood pressure • Pulse rate • Lochia loss Breastfeeding.	Verify from records					
	4. The proportion of all newborns in the health facility who received a full clinical examination before discharge.	Verify from records/ observe					
	5. The proportion of all healthy mothers and newborns who received care for at least 24 hours after an uncomplicated vaginal birth in a health facility.	Verify from records/ observe/ Exit interview					
	6. The proportion of all newborns on postnatal care wards or areas in the health facility for whom there is documented information on the newborn • Temperature • Respiratory rate • Feeding behavior The absence or presence of danger signs.	Sample discharge files discharge files					
	7. The proportion of all healthy mothers on postnatal wards or areas in the health facility who received breastfeeding counseling and support from a skilled health care provider.	Sample files of mothers in the ward Exit interview					
	8. Proportion of all postpartum women taught on danger signs of baby and mother	Exit interview					
	9. The proportion of all postpartum women in the health facility who were offered post-natal checkup within 48hrs, before discharge	Exit interview					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	10. The proportion of all postpartum women in the health facility who were offered counseling on the importance of post-natal checkup within 48 hrs,2 weeks and 6 weeks, birth spacing and family planning before discharge.	Exit interview Verify from records					
	11. The proportion of the ten steps in the Baby Friendly Initiative (BFI) implemented in the health facility	Verify from records (See Annex 16)					
	Outcome The proportion of all newborns in the health facility who were exclusively breastfed at the time of discharge from hospital.	Verify from clinical notes/ cardex Exit interview					
	1. The proportion of all postpartum women in the health facility who have taken up a family planning method before discharge.	Exit interview					

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MANAGEMENT OF COMPLICATIONS							
Quality Statement	**Quality Measures**	**Assessment Methodology**	**Y**	**N**	**N/A**	**Score**	**Comments**
2.2a: Women with pre-eclampsia or eclampsia promptly receive appropriate interventions	**Severe pre-eclampsia or eclampsia.**						
	Input						
	1. The health facility has written, displayed, up-to-date clinical protocols on the management of pre-eclampsia/eclampsia that are available in the gynaecological, antenatal, labour, childbirth and postnatal areas of the maternity unit and are consistent with the national guidelines (strictly available in all areas).	See walls for display See for records of protocols	☐	☐	☐		
	2. Health-care staff in gynaecological, antenatal, labour, childbirth and postnatal areas receive monthly mentorship sessions or simulation exercises and supportive supervision in the management of pre-eclampsia and eclampsia.	Check training log books and training registers	☐	☐	☐		
	3. The health facility has pharmaceuticals, supplies and equipment available in sufficient quantities at all times in the gynaecological, antenatal, labour, childbirth and postnatal areas of the maternity unit. (Strictly available in all areas. • Nifedipine • Hydralazine • Labetalol • Methyldopa • I.V fluids; ringers lactate • Magnesium sulphate • Calcium gluconate • Phenytoin (epanutin) • Diazepam	Check for availability of supplies in the MNH pharmacy and check for functionality emergency kits and equipment	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• IV giving sets • Blood Giving sets • Branulas of adult sizes • Syringes and needles all sizes • Specimen bottles • Patella hammer • BP machine • Stethoscope • Urine dipsticks	Check for availability of supplies in the MNH pharmacy and check for functionality emergency kits and equipment	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	4. Health-care staff in the gynaecological, antenatal, labour, childbirth and postnatal areas receive CME sessions in • The use of antihypertensive agents, • Intravenous infusion • Calcium gluconate • Magnesium sulfate for treating preeclampsia and eclampsia at least once every 12 months	Check training log books and training registers	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	5. Health-care staff in the gynaecological, antenatal, labour, childbirth and postnatal areas are able to identify a client with pre/eclampsia	Ask/ Simulate/ interview/ demonstration -Ask Health care Provider (HCP) to mention some cardinal signs e.g. headache, vision disturbance, oedema,	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
		Mental confusion, convulsion/ fits, upper abdominal pain, reduced fetal movements, nausea and vomiting, decreased urinary output, proteinuria					
	6. Health-care staff in the gynaecological, antenatal, labour, childbirth and postnatal areas are able to manage a client with pre/eclampsia.	Ask the HCP to explain steps in management of pre-eclampsia/ eclampsia Provide a simulation (Use annex 3)	☐	☐	☐		
	7. Parenteral magnesium sulphate is administered for signs of pre-eclampsia and eclampsia according to current evidence-based protocol.	Sample a few patients' files and verify	☐	☐	☐		
	8. The facility has a special room for Nursing patients with eclampsia according to National guidelines	Observe/ Physical verification	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	9. The facility carries out lab investigations to rule out end organ involvement • Full haemogram • Urinalysis – proteinuria • Liver function test. • Urea, electrolyte, creatinine • Coagulation profile • Uric acid levels	Sample a few patients' files and verify	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	10. The facility has radiological investigations: • Ultrasonography • Fetal doppler	Check from maternity ward/ radiology dept.	☐ ☐	☐ ☐	☐ ☐		
	Output/process 1. The proportion of all women with severe pre-eclampsia or eclampsia in the health facility who received the full dose of magnesium sulphate (loading dose for level 2 and 3)	See records					
	2. The proportion of all women with pregnancy-induced hypertension in the health facility who received the recommended antihypertensives.	See records in patients files					
	3. The proportion of women with pre-eclampsia or eclampsia who have had appropriate diagnostic tests.	See records in files					
	Outcome 1. The proportion of all women with pre-eclampsia or eclampsia in the health facility that died as a result of pre-eclampsia or eclampsia.	See MPDSR records					
	2. The proportion of all women with pre-eclampsia or eclampsia that arrived at the health facility with a live foetus whose baby died in the perinatal period (stillbirths or early neonatal deaths).	See maternity inpatient file					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The proportion of all women with pre-eclampsia or eclampsia in the health facility who experienced maternal near-misses due to pre-eclampsia or eclampsia.	See near-miss/MPDSR meetings minutes					
	4. The proportion of all women with pre-eclampsia in the health facility whose condition progressed to eclampsia.	See patients' files					

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Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.3a: Women with postpartum haemorrhage promptly receive appropriate interventions	**Postpartum Haemorrhage (PPH)**						
	Input 1. The health facility has written, displayed, up-to-date clinical protocols for postpartum haemorrhage management that are available in the childbirth and postnatal care areas and are consistent with the national guidelines.	Observe for existence and display on walls	☐	☐	☐		
	2. Health-care staff in the labour, childbirth and postnatal care areas of the maternity unit receive in-service training and regular refresher sessions in the management of postpartum haemorrhage at least once every 12 months.	See training database and training registers	☐	☐	☐		
	3. Health-care staff in the maternity unit receive monthly mentorship sessions or simulation exercises, CMEs and supportive supervision in the management of postpartum haemorrhage.	See training log books and training registers	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has uterotonics drugs, antifibrinolytics, supplies for intravenous fluid and blood administration and equipment for management of PPH is available in sufficient quantities at all times in the childbirth and postnatal care areas. • Oxytocin with proper storage or Heat stable Carbetocin (Pabal) • Prostaglandin analogues e.g. -Ergometrine -Misoprostol • Antifibrinolytics e.g. Tranexamic acid	See records in MNH pharmacy and emergency tray Physical check for availability and functionality	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	5. The health facility has supplies for intravenous fluid and blood administration and equipment for management of PPH available in sufficient quantities at all times in the childbirth and postnatal care areas: • IV Giving Sets. • Blood Giving Sets • Large Bore Cannulas • Strapping • Sterile and Non- Sterile Gloves, • Gynaecological Gloves • Needles and Syringes all sizes • Lidocaine 0.5% • Specimen Bottles • Standard Lab Request Forms • IV Fluid Charts • Heaters • Clean Linen • Sterile VE Packs • Speculum Packs	See MNH pharmacy and supplies cupboard/ availability in wards Physical check	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Stitching Packs and Suture • Delivery Bed with Stirrups • Urinary Catheter and Urine Bags • BP machine • Thermometer • SPO2 Monitor • Oxygen • Adult Size Ambu Bags and baby size ambu bags • Ventilators and Monitors • UBT KIT • Non-Pneumatic Anti shock Garment(NASG)	Physical check	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	6. Availability of a functional blood transfusion service Availability of the following blood products: • Packed Red Blood Cells. • Fresh Frozen Plasma • Platelets • Whole Blood	Observe for availability in the laboratory	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	7. Health facility has a theatre available at all times.	Visit theatre and verify	☐	☐	☐		
	8. Health care providers are able to correctly diagnose PPH or client records have sufficient information to support diagnosis of PPH (this is blood loss in excess of 500mls following vaginal delivery or 1000mls following caesarean section or any bleeding that alters the hemodynamic status of the mother)	Verify by direct observation, interview or clinical records review	☐	☐	☐		
	9. The health care providers are able to detect the 4T's (Tone, Trauma, Tissue, Thrombin) and upon diagnosis, immediately call for help/notify the theatre	Ask the HCP to explain the causes of PPH	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	10. .Health care providers effectively manage patients with PPH to prevent shock (See Annex 4)	Verify by direct observation, interview or clinical records review whether the provider properly manages PPH	☐	☐	☐		
	11. Availability of emergency preparedness	Check for PPH box and updated emergency tray	☐	☐	☐		

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Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.3b. Women who have gone into hypovolemic shock receive appropriate interventions according to the national guidelines	Hypovolemic shock. 1. The Facility has well displayed protocols for management of hypovolemic shock	Verify presence of protocols	☐	☐	☐		
	2. The health care providers can identify a patient in shock using AVPU mnemonic and call for help	Ask HCP to explain the signs of hypovolemic shock or simulate (See annex 5)	☐	☐	☐		
	3. The health facility has the following: • Wide bore Cannulas adult sizes • Oxygen mask • Adult Ambu bags • Grouping and Cross Match bottles • IV fluids – ringers lactate and normal saline • Vital signs monitoring charts • Fluid input and output monitoring charts		☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	4. The health care providers are able to apply ABC Approach in management of a patient with hypovolemic shock	Assess the management of hypovolemic shock by interviewing or observing a provider who works in the maternity ward or in the emergency room Or give a simulation. (See annex 5)					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The health facility has the capacity to carry out the following lab Investigations: - Grouping and Cross Match - Full Blood Count - Urea, Electrolytes, Creatinine- Liver Function Tests	Verify in the laboratory	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	Output/process 1. The proportion of all women with postpartum haemorrhage in the health facility who received therapeutic uterotonic drugs	See clinical records					
	2. The proportion of women who developed hypovolemic shock who were managed successfully	See clinical records					
	3. The proportion of all women in the health facility with postpartum haemorrhage due to a retained placenta for whom manual removal of the placenta was performed by a skilled birth attendant.	See clinical records					
	4. The proportion of all women in the health facility with postpartum haemorrhage due to tears that received appropriate management	See clinical records					
	5. The proportion of all women in the health facility with postpartum haemorrhage due to Disseminated Intravascular Coagulation (DIC) that received appropriate management	See clinical records (See annex 17)					
	Outcome 1. The proportion of all women who gave birth in the health facility who had severe postpartum haemorrhage (abnormal bleeding of >500 mls post SVD and 1,000 mls post C/S or any bleeding with hypotension or requiring blood transfusion) and were not transfused.	See clinical records					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The proportion of women who were diagnosed with PPH and referred within 30 mins to a higher level for transfusion	See clinical records					
	3. The proportion of all women who had postpartum haemorrhage in the health facility who died as a result of postpartum haemorrhage	See MPDSR meetings minutes					

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Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.4a: Women whose progress in labour is prolonged or whose labour is obstructed receive appropriate interventions according to the evidence based national guidelines	**Input:** 1. The health facility has written, up-to-date clinical protocols for preventing and managing prolonged labour, which are available in the labour and childbirth areas and are consistent with the national guidelines.	Observe Physical verification	☐	☐	☐		
	2. Health-care staff in the labour and childbirth areas of the maternity unit receive in-service training and regular refresher sessions (every 12 months) in managing prolonged and obstructed labour.	See training register/ training data base	☐	☐	☐		
	3. The health facility has the essential supplies and equipment for assisted vaginal delivery • Vacuum delivery kit, • I.V fluids, • Newborn resuscitation Available in sufficient quantities at all times. (all supplies for normal labour to be available)	Check for functionality. Verify that there is – vacuum extractor, resuscitaire,	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
		and ambu bag and mask (adult and neonatal).					
	4. The health facility has staff who are trained in the use of vacuum delivery kit	Check from training log	☐	☐	☐		
	5. The health facility has an equipped operating theatre close to the childbirth area of the maternity unit.	Verify availability of theatre	☐	☐	☐		
	6. If the health facility does not have an operating theatre, it has an appropriate referral system to a facility that has this service.	See referral protocol	☐	☐	☐		
	7. The health facility has an adequate number of staff skilled in performing caesarean section, 24 hours a day.	See rota and verify using the national human resource norms and standards	☐	☐	☐		
	8. Health Care Staff in labour ward are able to interpret the partograph/labour care guide to diagnose obstructed labour and take necessary action	Sample a few files of post C/S patients and check reasons for C/S Ask health care provider how to use the partograph to identify obstructed labour	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of all women in the health facility with prolonged and/or obstructed labour who gave birth by caesarean section.	See files					
	2. The proportion of all women who gave birth in the health facility who underwent assisted vaginal birth (vacuum or forceps delivery) for delayed second stage of labour.	See delivery records / files					
	3. The proportion of women with prolonged or obstructed labour who underwent emergency caesarean section within 30 minutes of the decision to perform caesarean section.	See records in nursery/ maternity					
	Outcome 1. The proportion of all women who gave birth in the health facility whose uterus ruptured during labour.	See records / Check from Maternity Register					
	2. The proportion of all perinatal deaths that occurred in the health facility after prolonged or obstructed labour.	See records/ Check from Maternity Register					
	3. The proportion of women with obstructed labour who died during labour and delivery.	See MPDSR minutes					

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Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.5a: Women in preterm labour receive appropriate interventions for both themselves and their unborn babies, according to national guidelines.	**Input** 1. The health facility has written, up-to-date clinical protocols for the management of preterm pre-labour in the childbirth areas of the maternity unit that are consistent with the national guidelines	Check for presence	☐	☐	☐		
	2. Health-care staff in the maternity unit receive in-service training and regular refresher sessions in the management of preterm labour at least once every 12 months.	Check training database	☐	☐	☐		
	3. Health-care staff in the maternity unit receive monthly mentorship sessions, drills or simulation exercises, CMEs and supportive supervision in the management of preterm labour.	Check training log Observe/ check records/ simulate	☐	☐	☐		
	4. Health care staff have the capacity to identify/ diagnose women with preterm labour through history taking	Ask the healthcare provider to give signs/ symptoms of pre-term labour (labour pains before 37 completed weeks) Vaginal speculum assessment /digital examination the cervix is dilated	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The healthcare provider performs the following investigations to ascertain the cause of pre-term labour • Blood slide for malaria parasites (in malarial endemic areas). • Urine for microscopy culture and sensitivity • High vaginal swab for gram stain and culture • Ultrasound for foetal assessment if indicated.		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	6. The health facility has the following supplies available in sufficient quantities to manage preterm birth in accordance with the national guidelines: • Antenatal corticosteroids (dexamethasone or betamethasone) • Antibiotics • Tocolytics (Magnesium sulphate, Nifedipine, Salbutamol).	Check for stock outs for the last three months from pharmacy	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	7. Women in preterm labour receive appropriate interventions for both the woman and the baby according to evidence-based guidelines including use of antenatal corticosteroids for eligible mothers Conservative Management: • Bed rest if less than 34 weeks gestation. • Administration of corticosteroids Betamethasone or Dexamethasone • Administer tocolytics drugs e.g. IV Salbutamol can also give Magnesium Sulphate and Nifedipine) • Treat any underlying cause(s)		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of all preterm newborns born between 24 and 34 weeks of gestation in the health facility whose mothers received at least one dose of antenatal corticosteroids when indicated.	Check file					
	2. The proportion of all preterm newborns born before 32 weeks of gestation in the health facility whose mothers received magnesium sulphate during the active phase of labour to protect their baby from foetal neurological complications.	Check file					
	3. The proportion of all women with preterm pre-labour rupture of membranes who gave birth in the health facility who received prophylactic antibiotics.	Check file					
	Outcome 1. The proportion of all women with preterm pre-labour rupture of membranes who gave birth in the health facility who developed chorioamnionitis.	Check file					
	2. The proportion of all babies at risk for birth in the health facility at 24 to < 34 weeks of gestation who developed Respiratory Distress Syndrome.	Check file					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.5b. Women with Ante partum Haemorrhage (APH) receive appropriate interventions according to evidence-based guidelines	**Inputs** 4. The health care providers can identify and diagnose a patient with APH	Ask the health care provider for the signs of APH (see annex 18)	☐	☐	☐		
	5. The healthcare provider performs speculum examination to rule out other causes of bleeding	Observe / Simulate	☐	☐	☐		
	6. Were women with ante partum hemorrhage (APH) managed according to current evidence based protocols? • Vaginal examination is not performed. • Assess the amount of bleeding • Restore blood volume - An IV line is inserted and intravenous fluids are administered rapidly -Ensure availability of blood if required for transfusion or the patient is immediately referred where blood transfusions can be given safely. -If bleeding is heavy deliver as soon as possible	Medical record review Case scenarios Document review: perinatal mortality audits to assess action taken. Referral records	 ☐ ☐ ☐	 ☐ ☐ ☐	 ☐ ☐ ☐		
	Output/process 1. The proportion of women with APH who were managed successfully	Check file					
	Outcome 1. The proportion of women with APH who died	Check file					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.5c: Preterm and small babies receive appropriate care, according to national guidelines.	**Pre-term and small for gestational age babies** **Input** 1. The health facility has written, up-to-date clinical protocols for the care of small and preterm babies in the childbirth areas of the maternity unit that are consistent with the national guidelines. • Basic Paediatric Protocols • Neonatal Protocols	Verify presence of protocols	☐ ☐	☐ ☐	☐ ☐		
	2. Health care staff in the health facility who work in MNH service delivery points receive in-service training and regular refresher sessions in appropriate care of preterm and low birth-weight babies at least once every 12 months.		☐	☐	☐		
	3. The health facility has supplies and materials to provide optimal thermal care to stable and unstable preterm babies, including: • Kangaroo Mother Care • Support Binders • Baby Cap • Socks • Nappy/Diapers • Kangaroo Mother Care Implementation Guideline • Clean Incubators • Radiant Warmers	Verify through observation and physical check	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has drugs and equipment necessary for the care of pre-term baby Supplies: - • Antibiotics: - Ampicillin or Crystalline Penicillin - Cefotaxime/ Ceftriaxone/Ceftazidime - Gentamicin - Vancomycin • I.V Fluids: - 10%Dextrose - Normal saline - 15% Potassium chloride (KCL) • CNS Drugs: - Phenobarbital - Phenytoin • Respiratory Drugs: - Caffeine Citrate - Surfactant • Miscellaneous Drugs: - Sodium Bicarbonate - Chlorhexidine 7.1% - Tetracycline Eye Ointment - Nevirapine - AZT - Naloxone • Vitamins/Minerals (as multivite): - Vitamin K - Vitamin D - Ferrous Sulphate syrup • Vaccines: - BCG - Polio	Verify through physical check And ask for stock out in the last three months	☐ ☐	☐ ☐	☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Equipment: - Phototherapy Lamps - Ambu Bag - Oxygen Supply/Concentrator - Appropriate Sized Face Masks Size 0 And 1 - CPAP Systems - Multi-Function Monitors - Pulse Oximeters - Micro Droppers - Exchange Transfusion Kit - Stethoscope - Glucometers - Suction Apparatus - Thermometers - Weighing Scale		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	5. The health facility has the supplies and materials to provide optimal feeding to preterm babies and support for breastfeeding or alternative feeding: • Feeding Cups • Milk-Storage Facilities • Milk Banks • Nasogastric Tubes • Syringe Drivers • Infant Formula • Breast Pumps	Verify through physical check	 ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. All pre-term and low birth weight neonates receive additional care. • Kangaroo mother care is initiated early in the first week of life for babies with birth weight <2000 g and clinically stable according to protocols • The infant is kept skin-to-skin with the mother in kangaroo position • The infant is supported for feeding breast milk • The mother receives supportive environment (shown how to express, counselling on breastfeeding, expressing implements, psychological support and nutrition for the mother) to establish breastfeeding • Guidelines are available for use of oxygen in pre-term babies • Specific feeding needs of low birth weight and other sick newborns are taken care of • All pre-term and low birth weights weighing ⩽ 2000g are admitted for monitoring • Mother's milk is given to low birth weights as much as possible • Frequent feeding (at least 8 feeds per day) are provided to low birth weight babies and intake is monitored • Babies unable to feed are given expressed milk by spoon/cup or fed by NG-tube according to age and weight (intake is monitored)	Observe or interview the health Care provider	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Room temperature is kept at between 25-28°C. • Baby is weighed on alternate days • Oxygen need is routinely assessed using a pulse oximeter • Pre-term babies on oxygen therapy have oxygen saturations monitored		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	The discharge protocol for a preterm is followed • The pre-term is able to breastfeed • Continuous weight gain of at least 15g/kg per day for 3 consecutive days. • Has regained birth weight and has a minimum weight of 2000gms. • Able to breastfeed and/or feed well by cup. • The overall condition is stable (Temperature, Respiration, feeding, no signs of infection or danger signs). • All pre-terms of gestation less than 34weeks are discharged on; iron and Vitamin D supplements • Follow up by a Paediatric RCO/Doctor is arranged • The referral protocols for those needing specialized care to appropriate facilities are available • Those needing specialized care are referred to appropriate facilities.	Observe baby chart Check files Check for protocols Interview staff Discharge summary	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	Output/process 1. The proportion of all low-birth-weight newborns born in the health facility with a birth weight ⩽ 2000 g who received at least 20hrs kangaroo mother care in the first week of life.	Check records					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The proportion of all unstable low-birth-weight newborns weighing ⩽ 2000 g who could not receive kangaroo mother care in the health facility who were cared for in a thermo-neutral environment, either under radiant warmers or in incubators.						
	3. The proportion of all low-birth-weight newborns born in the health facility whose mothers received additional support to exclusively breastfeed the baby.						
	Outcome 1. The proportion of all preterm babies (< 28 weeks, 28–31 weeks and 32–37 weeks of gestational age) born in the health facility who died within the first 7 days of life.						
	2. The proportion of all low-birth-weight newborns born in the health facility who were exclusively fed on their mother's milk during their stay in the health facility						
	3. The proportion of all live preterm babies born in the health facility who had severe neonatal morbidity (respiratory distress syndrome, intraventricular haemorrhage, necrotizing enterocolitis).						

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The proportion of low-birth-weight baby deaths in the facility attributed to possible serious bacterial infection or sepsis						

TOTAL NUMBER OF COMPONENTS ACHIEVED	
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PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

2.6a: Women with or at risk for infection during labour, childbirth or the early postnatal period promptly receive appropriate interventions, according to national guidelines.	**Inputs** 1. The health facility has written, up-to-date clinical protocols for the treatment of women with, or at risk for, infections during labour, childbirth and the early postnatal period in the childbirth and postnatal care areas of the maternity unit that are consistent with the National guidelines.	Verify presence of protocols	☐	☐	☐		
	2. Health care staff in the health facility who deal with pregnant and postpartum women receive in-service training and regular refresher sessions in the recognition and management of maternal peri-partum infections at least once every 12 months	Verify from the training database	☐	☐	☐		
	3. Health care providers are able to correctly diagnose women with or at risk for infection during labour, childbirth and the early postnatal period	Ask the HCP to state signs of infection	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. Health care providers are able to manage women with infections as follows: • Vital signs (T, PR, BP and RR) • IV fluids infusion / Fluid balance • Uterus involution checked • Parenteral Broad spectrum antibiotics administration • Perineal care • Removal of retained POCs • Drainage of pelvic abscess if any • Early ambulation initiation • Documentation of all information on care and treatment provided	Observe or determine from the records whether a case of puerperal sepsis was managed as per treatment protocols. If no case was reported ask the health care provider to take you through the management process	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	5. The health facility has supplies of oral and injectable first- and second-line antibiotics available in sufficient quantities at all times for the expected case load. • Ampicillin or penicillin • Gentamicin • Clindamycin • Cephalosporin • Metronidazole • Amoxicillin Clavulanate	Observe availability in MNH pharmacy	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. The health facility has capacity to perform the following lab investigations for clients with infections: • Full blood count • High vaginal swab for wet preparation microscopy and culture and sensitivity • Urinalysis, - Microscopy, - Culture and sensitivity • Blood for culture and sensitivity - or can refer specimens for the same	Observe, interrogate or review records	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	7. If the health care facility has no capacity to manage women with infections it correctly identifies indications for referral and refer according to referral protocols	Check from referral notes and referral protocols	☐	☐	☐		
	Output/process 4. The proportion of all women who underwent caesarean section in the health facility who received prophylactic antibiotics before caesarean section.	Check files of women who underwent C/S					
	5. The proportion of all women who gave birth in the health facility with term pre-labour rupture of membranes for more than 18 hours who received antibiotics.	Check file					
	6. The proportion of all women who gave birth in the health facility who had a temperature of > 38°C or other signs of infection (uterine tenderness, foul-smelling or purulent lochia, high WBC count) after childbirth.	Check file					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Outcome 1. The proportion of all women who underwent caesarean section in the health facility who had severe systemic infection or sepsis after the caesarean section.	Check file					
	2. The proportion of all women who gave birth in the health facility who had severe systemic infection or sepsis in the postpartum period.	Check file					
	3. The proportion of all women who gave birth in the health facility who died from severe systemic infection or sepsis.	Check MPDSR reports/ minutes					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.6b: Newborns with suspected infection or risk factors for infection are promptly given antibiotic treatment, according to the national guidelines (these include jaundice, convulsions).	**Neonatal sepsis** **Input** 1. The healthcare facility has a written, up-to-date clinical protocol for early diagnosis and management of neonatal infection in the childbirth areas of the maternity unit that is consistent with the national guidelines	Verify presence of protocol in the unit	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• The Health care providers have capacity to diagnose and investigate babies for Neonatal sepsis.	Check records	☐	☐	☐		
	Signs of newborn sepsis: -Difficulty feeding -Hypothermia -Lethargy -Fever	Ask a health care provider to list some signs of newborn sepsis & investigations	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	• Investigations: -Urine microscopy -Blood culture -Lumbar puncture - to rule out or confirm meningitis		☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	2. Antibiotics are administered according to a current evidence-based protocol for management of suspected newborn sepsis	Verify from treatment sheet	☐	☐	☐		
	3. The health care providers have the capacity to manage or refer for further management a newborn with signs of complications according to referral protocol.	-Check records -Verify presence of					
	• Antibiotics - according to age and weight of the baby	guidelines on antibiotics	☐	☐	☐		
	• Monitoring and recording of clinical status in observation chart or Critical Care Pathway(CCP) form	-Observe for presence of observation chart or Critical Care Pathway (CCP) form and clinical notes	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has supplies of injectable antibiotics (at least first-line (Benzyl penicillin and gentamicin) and second-line (cefuroxime and amikacin) antibiotics for neonatal sepsis and infections) available in sufficient quantities at all times for the expected case load	Check pharmacy records or S11 If there has been any stock out in the last 3 months	☐	☐	☐		
	5. Health care staff in the health facility who care for pregnant and postpartum women and newborns receive in-service training and regular refresher sessions in the recognition and management of suspected newborn infections at least once every 12 months.	Verify from training database	☐	☐	☐		
	6. The health care workers are able to identify/ diagnose and treat neonates with jaundice. • All neonates are examined for jaundice • Phototherapy and guidelines when to use it are available. • Procedures are in place to check the bilirubin level • Phototherapy lamps are checked regularly for correct functioning -The use of the machines is tracked and the lights are replaced after 2000hrs. • There are guidelines for referring severe jaundiced neonates with severe jaundice	Check records Check file and interview health Care provider Verify for machine checkup guideline or timer or ask HCP Check for guideline	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	7. The health care providers are able to identify diagnose and treat children with convulsions • Guidelines on how to manage convulsions are available in the ward • Glucose is checked and corrected • Convulsions are treated with appropriate anti-convulsants • Central nervous system infections are ruled out	Check records	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	8. The health care workers provide appropriate feeding/IV fluids for sick neonates. • Guidelines for recognition and treatment of hypoglycaemia are available, known and used by staff • Neonates unable to breastfeed are given expressed breast milk by cup or fed by naso-gastric tube in adequate amounts according to age. Intake is monitored • If IV fluids are given, they are recorded and precautions are taken to prevent fluid overload	Check for guidelines Observe Verify feeding chart Check records/fluid chart	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	9. Health care providers provide appropriate care of Sick Neonates: • Sick neonates are kept in a separate unit or room from healthy neonates • Sick neonates delivered outside of the facility are kept in a separate room from other neonates delivered in the facility • At the time of admission, a monitoring plan is made according to the severity of the neonate's condition	Observe / Physical check Ask HCP Observe/ Check files	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	10. Nursing care plans available for all sick neonates • Key risk signs are monitored and recorded by a nurse • Dosages and time are recorded for every neonate receiving medications and IV fluids by a nurse. • Additional special monitoring is performed and recorded appropriately to follow the progress of particular conditions (Babies with asphyxia, meningitis, severe sepsis; e.g. tone, reflexes, AVPU	Check records Check records	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	11. Sick neonates are routinely monitored by doctor/ clinician • Seriously ill neonates are assessed by a doctor/clinical officer upon admission and reviewed twice daily until improved. • Sick neonates or new admissions are also reviewed by a doctor/clinical officer seven days a week including weekends and holidays	Check records	☐ ☐	☐ ☐	☐ ☐		
	12. Follow Up of neonates from the newborn unit: • Counselling is offered to mothers /care takers on importance of follow up before discharge • Follow up is arranged before discharge in the health facility closest to the patient's home that can provide the necessary follow up treatment. • All mothers/caretakers of admitted neonates receive a discharge note explaining their condition and providing information for the staff at the follow up facility.	Exit interview Check records Check for duplicate in the patients file	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• The referral protocols for those needing specialized care to appropriate facilities available • Those needing specialized care are referred to appropriate facilities.	Check for availability of protocols	☐ ☐	☐ ☐	☐ ☐		
	Output/process 1. The proportion of all newborns in the health facility with signs of infection who received injectable antibiotics.	Check records					
	Outcome 1. The proportion of all severe neonatal morbidity in the health facility that was due to neonatal sepsis.	Check records					
	2. The proportion of newborns treated for sepsis in the health facility who died (case fatality rate).	Check records					
	3. The proportion of all neonatal deaths in the health facility that were due to sepsis.	Check records					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

2.7: All Women and newborns receive care according to standard precautions for preventing hospital-acquired infections.	**Inputs** 1. The health facility has written, up-to-date policy guidelines for standard infection prevention control and precautions for transmission (including microbial surveillance and stewardship)	Verify	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The facility has an IPC functional multi-disciplinary committee with terms of reference and a champion/focal person	Verify availability of TORs IPC Committee Minutes	☐	☐	☐		
	3. The health facility has handwashing protocols that are well displayed in all service delivery areas:- • MCH clinic • Maternity unit: -Antenatal room -Labour ward -Post-natal ward • New born unit/newborn areas • Gynaecological wards • Theatre/operating unit • Central sterilizing unit	Observe	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	4. The health facility has a reliable water source on site with running water, soap and disposable towels or alcohol-based hand rub for hand hygiene in all service delivery areas • MCH clinic • Maternity unit: -Antenatal room -Labour ward -Post-natal ward • New born unit/newborn areas • Gynaecological wards • Theatre/operating unit • Central sterilizing unit	Verify Observe	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The health facility staff perform hand hygiene as per handwashing protocols/procedure and national guidelines 5 moments of hand washing: • Before touching a patient, • Before clean/aseptic procedures, • After body fluid exposure/risk, • After touching a patient, • After touching patient surroundings.	Observe and interview the staff	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	6. The health facility has a cleaning protocol known by all cleaning staff	Observe and interview the staff	☐	☐	☐		
	7. The health facility is clean, there is absence of dust, blood, trash and cobwebs in the all service delivery areas: • MCH clinic • Maternity unit: -Antenatal room -Labour ward -Post-natal ward • New born unit/newborn areas • Gynae wards • Theatre/operating unit	Observe and interview the staff Observe	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	8. Health care staff in the childbirth and neonatal areas of the maternity unit receive training/ continuous medical education in standard infection control and precautions for transmission of infection and appropriate use of the autoclave machine at least once every 12 months	Verify from training database	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	9. The health facility has a well displayed waste management and disposal protocol in maternity unit	Observe	☐	☐	☐		
	10. The health facility ensures safe handling, storage in puncture resistant containers and final disposal of sharps waste • Is there a sharp container in all maternal, newborn service delivery areas • Is the sharp container in all maternal, newborn service delivery areas closed when ¾ full and removed	Verify availability of sharp containers, Ask when sharp containers are closed and removed	☐ ☐	☐ ☐	☐ ☐		
	11. The health facility has appropriate sterilizing facilities and disinfectants for instruments. • Autoclave • 0.1%Chlorine • Enzymatic solution • 2-4% glutaraldehyde • 8% Formaldehyde • Ethylene Oxide Others----------comment	Verify/ Observe	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	12. The health facility has instrument processing mechanism in place • Three buckets are used for processing instruments • 0.5% chlorine • Enzymatic solution	Observe	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	13. Antiseptics, disinfectants and other supplies are available in amounts sufficient for three months of operation • Alcohol (spirit), 60–90% • Ethyl, isopropyl alcohol (60%–90%)or • Chlorhexidine gluconate (2%–4%)or • Hibitane solution or • Iodine preparations (1%–3%) (E.g. Povidone iodine, betadine solution, etc.) • Enzymatic solution • Chlorine solution	Ask	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	14. There is a designated instrument cleaning area with controlled traffic flow to avoid cross-contamination well ventilated and illuminated	Observe	☐	☐	☐		
	15. The health facility has an SOP on instrument processing	Observe	☐	☐	☐		
	16. The decontamination of instruments and other articles (immediately after use and before cleaning) is performed according to national IPC guidelines:	Observe Interview HCP	☐	☐	☐		
	17. The process of packaging of instruments and other items to be sterilized is performed according to the national IPC guidelines	Check for packaging protocols	☐	☐	☐		
	18. The sterilization process is performed according to protocol and manufacturer's instructions based on the type of sterilization	Check for availability of protocols, Verify from register	☐	☐	☐		
	19. The processed instruments are recorded	Check register	☐	☐	☐		
	20. The processed instruments are labeled and stored in a safe, clean environment to ensure that the instrument remain sterile	Observe/ verify	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	21. High level disinfected or chemical sterilized instruments and other items are stored dry in containers without antiseptics	Observe/ Verify	☐	☐	☐		
	22. The health facility has a functioning and appropriate mechanism for disposal and treatment of waste e.g. • Incinerator • Placenta macerator • Composite pit • Placenta pit or other well secured area free from pests, rodents, animals & community • Microwave	Verify availability and functionality	 ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐		
	23. Health care staff observe biosafety in administration of parental drugs (See annex 9)		☐	☐	☐		
	24. Injection safety	See annex 19	☐	☐	☐		
	Output/process 1. The percentage of health care staff in the health facility who observe the "5 moments for hand hygiene".	Observe					
	2. The percentage of staff members in the health facility who meet biosafety standards when administering parenteral drugs	Observe					
	Outcome 1. The proportion of all neonates born in the health facility who had hospital-acquired infections.	Records					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
2.8: No Woman or Newborn is subjected to unnecessary or harmful practices during Labour, Childbirth and the early postnatal period	**Input** 1. The health facility has written up-to-date guidance on harmful practices and unnecessary interventions during labour, childbirth and the early postnatal period. • Perineal/pubic shaving prior to vaginal birth • Enema on admission for inducing labour • Routine clinical pelvimetry on admission in labour • Indiscriminate use of medical induction on normal healthy pregnancies at term i.e. oxytocin augmentation or caesarean section before a cervical dilatation of 4cm when the fetal and maternal conditions are reassuring. • The use of fundal pressure in second stage of labour. • Routine use of episiotomy for women undergoing vaginal birth • Routine suctioning of newborns • Routine suctioning of nose and mouth in neonates born through clear amniotic fluid who start breathing on their own • Routine antibiotic prophylaxis for women with uncomplicated vaginal birth/episiotomy • Routine packing of the uterus to control bleeding after delivery • Immediate bathing of the baby • Keeping well babies in the nursery away from the mother. • Advertising and promotion of breastfeeding substitutes and bottle feeding • Applying substances to the cord other than 7.1% chlorhexidine	Verify	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Mothers are denied food for more than 6 hours after Caesarean Section under Spinal Anaesthesia		☐	☐	☐		
	2. Health care staff in the facility receive in-service training and regular refresher sessions on harmful practices and unnecessary interventions at least once every 12 months.	Verify from training logs	☐	☐	☐		
	3. The health facility does not display infant formula or bottles and teats, including on posters or placards	Observe	☐	☐	☐		
	4. The health facility does not give newborns food or drink other than breast milk, unless medically indicated, and does not give pacifiers (also called "dummies" or "soothers") to breastfeeding babies.	Observe/ask	☐	☐	☐		
	5. The health facility does not promote infant formula on the wards, and samples are not distributed to mothers or staff.	Observe/ Exit interview	☐	☐	☐		
	6. Health-care staff in the health facility receive monthly supportive supervision and mentoring on harmful practices and unnecessary interventions.	Verify from supervision log	☐	☐	☐		
	Output/process 1. The proportion of women who underwent unnecessary caesarean section in the health facility contrary to indications in National Guidelines.	Verify from records See Annex 20					
	2. The proportion of all newborns born within the health facility who had any substance other than 7.1 % chlorhexidine applied to the cord.	Exit Interview of mother					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 3

The health information system enables the use of data to ensure early, appropriate action to improve the care of every woman and newborn.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
3.1: Every woman and newborn has a complete, accurate, standardized medical record during the antenatal, labour, childbirth and the early postnatal period.	1. The health facility has necessary basic MNH data collection tools, forms, the clinical and observation charts in place at all time for routine recording and monitoring of all care processes for women and newborns. • Mother Child Booklet ☐ • ANC registers ☐ • Child Welfare Register ☐ • Immunization Register ☐ • Immunization Summary Sheet ☐ • Immunization Tally Sheet ☐ • PMTCT Register ☐ • Family Planning Register ☐ • Gender Based Violence Register ☐ • Post Rape Care Form ☐ • Post Natal Care Register (MCH and PNC ward) ☐ • Adolescent and Youth Sexual Reproductive Health Register ☐ • Cervical Cancer Screening form ☐ • Reproductive Health System cancer screening registers ☐	Check/ Verify					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	-Prostate,	Observe	☐	☐	☐		
	-Cervical cancer register		☐	☐	☐		
	• Post Abortion Care Register		☐	☐	☐		
	• Partograph		☐	☐	☐		
	• Patients File- Observation Charts, Treatment Sheet, Care Plans, Discharge Summary, Consent Form, Surgical Notes, Pre Medication Notes, Anaesthetic Notes		☐	☐	☐		
	• Delivery Register		☐	☐	☐		
	• Birth Notification		☐	☐	☐		
	• Newborn File		☐	☐	☐		
	• Newborn Register		☐	☐	☐		
	• Kangaroo Mother Care Register		☐	☐	☐		
	• MPDSR Tools:-						
	-Maternal death Notification forms		☐	☐	☐		
	-Perinatal death notification forms		☐	☐	☐		
	-Maternal death review forms		☐	☐	☐		
	-Perinatal death review forms		☐	☐	☐		
	-Verbal Autopsy forms		☐	☐	☐		
	• Gynae Outpatient Clinic Files		☐	☐	☐		
	• MOH 100(Referral form)		☐	☐	☐		
	• 513(Household register)		☐	☐	☐		
	• 514(service delivery logbook)		☐	☐	☐		
	• 515(chew summary)		☐	☐	☐		
	• 516(chalk board)		☐	☐	☐		
	• Summary Tool 711(Integrated RH/MCH summary)		☐	☐	☐		
	• Theatre Register		☐	☐	☐		
	B. Check if the tools above are updated at every visit,						
	Monthly summary sheets completed		☐	☐	☐		
	Reports uploaded in the KHIS		☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The health facility has a system that ensures that patient management and interventions are clearly documented and signed by the relevant personnel with clear identification of name - Data quality committees in place - Continuous medical education on documentation - Mentorship on documentation		☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	3. The health facility has a birth and death registration system in place that is linked to the national vital registration system at all times.	Verify from the registration books	☐	☐	☐		
	4. The health facility has a system for classifying diseases and birth outcomes, including death, which is aligned with the International classification of diseases 11	Verify records department	☐	☐	☐		
	5. The health facility has the capacity to upload data on the KHIS as per national policy requirements. • Human resource capacity • Computers/laptops • Rights to view or key in data • Passwords	Observe Interview staff	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	6. The health facility has a policy/system in place to ensure that records and information are protected from loss, destruction, tampering and unauthorized access or use. • The facility has a system in place to ensure safety, confidentiality and retrieval of patient information • Storage space • Computers with passwords • Databases with passwords	Ask Verify by observation Interview staff	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Inter connectivity inter-operability system • Data repository • Internet connection or Airtime • Standard operating procedures • Offline capability system for data entry		☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	Outputs 1. The proportion of newborns currently in the health facility who have a patient identifier and individual clinical medical record.	Check ward files or Newborn records					
	2. The proportion of newborns discharged from the health facility within the past 24 hours who had an accurately completed record of processes of care, treatments, outcomes and diagnoses.	Check files (Newborn unit)					
	3. The proportion of women discharged postpartum within the past 24 hours who had an accurately completed record of processes of care, treatments, outcomes and diagnoses.						
	4. Proportion of documents correctly filled with the health care provider name and signature.	Verify from patient's files, registers, prescriptions and request forms verify from CME mentorship Rota					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
3.2: Every health facility has a mechanism for data collection, analysis and feedback as part of its activities for monitoring and improving performance around the time of antenatal, childbirth and postnatal period	**Input** 1. The health facility: • Notifies maternal deaths within 24hours • Notifies perinatal deaths within 72hours • Uploads data to the KHIS monthly	Verify notification forms Check in the system	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	2. The health facility has a functional MPDSR committee with well-defined terms of reference (TORs).	Verify written terms of reference, appointment letter, schedules of meetings, files with confirmed minutes	☐	☐	☐		
	3. Facility MPDSR committee meets monthly to review maternal deaths, perinatal deaths and near misses and has a mechanism for implementing the recommendations of the reviews.	Verify filed action plans in place, verify from the minutes if previous recommendations have been acted upon	☐	☐	☐		
	4. The health facility has Standard Operating Procedures and Protocols in place at all times for checking, validating and reporting data	Verify a facility data quality committee, verify the minutes	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
		of their meetings, observe availability and display of SOPs					
	5. The health facility has a data system for collecting and analyzing relevant health outcome indicators and can produce visual outputs and timely reporting on paper or digitally at all times.	Verify presence of the data system, verify data presentation mechanisms like score cards, dashboards, graphs and charts displayed	☐	☐	☐		
	6. Managers and health care workers in the health facility met at least once a month within the past six months to review process and outcome data.	Verify file confirmed minutes	☐	☐	☐		
	7. Managers and health care workers in the health facility use the recommendations in reviews of data for decision-making and for monitoring improved performance within the past six months.	Verify quality improvement plans, verify performance of indicator plan, verify evidence of actions taken on the basis of information	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of all perinatal deaths occurring in the health facility that were notified within 72hours	Verify notification forms Check in the system					
	2. The proportion of all maternal deaths occurring in the health facility that were notified within 24hours	Verify notification forms Check in the system					
	3. The proportion of all maternal deaths occurring in the health facility that were reviewed within 7 days	Verify notification forms Check in the system					
	4. The proportion of all perinatal deaths occurring in the health facility that were reviewed within 7 days	Verify notification forms Check in the system					
	Outcome 1. Proportion of facility recommendations of death reviews made in the previous three months that have been acted upon	Check MPDSR minutes					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 4

Everywoman and newborn with condition(s) that cannot be managed effectively with the available resources is appropriately referred.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
4.1: Every woman and newborn is appropriately assessed in the antenatal period, admission, during labour and in the early postnatal period to determine whether referral is required, and the decision to refer is made without delay	**Input** 1. The health facility has written, up-to-date clinical protocols, SOPs and guidelines for the identification, pre-referral management and referral of women with complications related to pregnancy, labour, childbirth and post-partum period.	Verify presence	☐	☐	☐		
	a) Antenatal period- SOPs guidelines and protocols for identification, management(pre-referral) and referral of the following: • Ante partum hemorrhage • Pre mature labour • Pre-eclampsia and post-eclampsia • Anaemia • Abnormal lie (after 36 weeks) • Febrile conditions • Deep venous thrombosis • Chronic medical conditions like cardiac diseases, asthma, diabetes, sickle cell anemia	Verify presence	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	b) During labour and childbirth SOP guidelines and protocols for identification and pre referral management of the following: • Ante partum hemorrhage • Prolonged/ obstructed labour • Fetal distress/ cord accidents • Pre-eclampsia and post-eclampsia • Anaemia • Deep venous thrombosis • Maternal sepsis • Febrile conditions • Chronic medical conditions like cardiac diseases, asthma, diabetes, sickle cell anemia		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	c) Post -partum period SOP guidelines and protocols for identification and pre referral management of the following: • Post-partum hemorrhage • Post-partum sepsis • Postpartum psychosis • Pre or eclampsia • Deep venous thrombosis		☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	2. The health facility has written up-to-date clinical protocols, SOPs and guidelines for the identification, pre-referral management and referral of newborns with complications. • Pre maturity • Low birth weight • Convulsions • Asphyxia • Congenital malformations • Macrosomic babies	Verify presence	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The health facility is equipped with appropriate medicines, equipment and supplies for stabilization and pre-referral treatment for referred women and newborns. A. Medicines • Phenobabitone • Adrenaline • Oxytocin/misoprostol/Ergometrine • Oxygen • Hydralazine • Magnesium sulphate • Calcium gluconate • Parenteral antibiotics (broad spectrum) • Intravenous fluid	Verify	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	Medical equipment • Ambubag (neonatal and adult) • Assisted vaginal delivery kit • Suction machine, penguin sucker • Manual vacuum aspiration kit • Oxygen concentrator/oxygen • Oral pharyngeal airways • Stethoscopes • Sphygmomanometer(BP Machine) • Thermometer • Fetoscope • Delivery trays • Cut down tray • Ultrasound machine • Doppler machine • Pulse oximeters • Source of warmth	Verify presence	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Ultrasound machine • Doppler machine • Pulse oximeters • Source of warmth	Verify presence	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	Medical supplies • Gloves • Sterile dressings • Cotton wool • Cannulas(assorted) • Surgical blades • Linen(assorted) • Dry towels • Portable incubator	Verify presence	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	4. Health care staff in the maternity unit receive in-service training in emergency obstetric and neonatal response and have regular refresher sessions on referral protocols and guidelines at least once every 12 months.	Verify availability of continuous medical education plan, rotas, content and lists of topics Database of trained staff-/ Register in service, mentorship and on job training	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The health facility has mechanisms in place to ensure that patients are referred in a timely manner to the appropriate health facility/ specialist while ensuring continuity of care and patient safety. • Drugs, equipment supplies, and patients conditions • Continuous Patient Monitoring • Designated ambulance clinical/paramedical staff for referral • Communication mechanism for referral e.g. Cell phones • Referral register/forms	Check from and ambulance Verify presence Interview the providers	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	6. The facility has the referral protocol well displayed at all points of care in relevant offices e.g. in-charge's office, telephone office, driver's office or ambulance etc.	Verify presence	☐	☐	☐		
	Output/process 1. The proportion of women and newborns seen in the health facility in the past three months who fulfilled the facility's criteria for referral who were actually referred.	Interview staff Check from admission register and referral form/ Register					
	2. The proportion of pregnant or postpartum women who could not be managed at the health facility and referred for further management:- • Without delay/timely(within 30 mins of review) • Accompanied by a health care professional • Completed standardized referral note	Check files Register Referral form					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The proportion of sick, preterm or small newborns who could not be managed at the health facility and were referred within 30 minutes of a decision, accompanied by a health care professional and a completed standardized referral note.	Verify Check files Register Referral Form					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

4.2: For every woman and newborn who requires referral, the referral follows a pre-established plan that can be implemented without delay at any time.	**Input** 1. The health facility has ready access to a functioning ambulance or other vehicle for emergency transport of women and newborns to referral facilities 24hours a day, 7 days a week.	Check referral plan/ask	☐	☐	☐		
	2. There is an up-to-date list of network facilities in the same geographical area that provide referral care for women and children.	Check referral plan/ask Verify from the referral strategy	☐	☐	☐		
	3. The health facility has local arrangements to ensure that women and newborns who cannot be managed at the health facility are referred to an appropriate level of care without delay, 24 hours a day, 7 days a week by strengthening mutually beneficial referral systems among public, private, and faith-based hospitals	Ask Memorandum of understanding in place	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The facility audits and gives recommendations of maternal and newborn deaths (on patients for whom decision has been made to refer) occurring before or during referral monthly.	Verify minutes and action plan -verify presence of review forms	☐	☐	☐		
	Output/process 1. The proportion of newborns who died due to delayed (after 30 minutes of decision) transfer to a higher-level facility for further management.	Check files/ registers					
	2. The proportion of pregnant or postpartum women who died (before or during transfer) to a higher level facility for further management after decision made	Check files/ registers					
	3. The proportion of pregnant and postpartum women and newborns who were referred without appropriate emergency transport	Referral register/form Patients files					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
4.3: For every woman and newborn referred within or between health facilities, there is appropriate information exchange and feedback to relevant health care staff.	**Input** 1. The health facility has a standardized referral form to document relevant demographic and clinical information, which includes clinical findings, diagnosis, pre-referral interventions or treatment given and reason for referral.	Verify availability of referral form	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The health facility has reliable communication methods, including a mobile phone, land line or radio, which is functioning at all times, for referrals and consultation on complicated cases.	Verify any of the above	☐	☐	☐		
	3. The health facility has formal agreements, communication arrangements and a feedback system with referral Centre(s)	Verify availability of strategy, policy, memorandum of understanding with public-private partnership	☐	☐	☐		
	4. The health facility has embraced e-health, such as telemedicine, e-referrals, and e-mail to improve the referral system between facilities, within and outside the country.	Verify above	☐	☐	☐		
	5. Data on referrals/transfers is collected and used to continuously improve patient care and strengthen the referral system.	Check from minutes work/quality improvement teams					
	6. The facility has counter-referral feedback mechanism	Interview staff					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of women referred with completely filled referral forms.	Check file/ referral booklet					
	2. The proportion of referred women with communication before referral.	Check referral book and cardex (referral form)					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 5

Communication with women and their families is effective and responds to their needs and preferences.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
5.1: All women and their families receive information about their care and have effective interactions with staff	**Inputs** 1. The health education materials in written/ pictorial format or electronic format are available, well displayed and accessible by the clients served by the health facility.	Observe IEC materials displayed	☐	☐	☐		
	2. Health care staff in MNH service areas (antenatal, labour, post-natal) are oriented and receive in-service training at least once every 12 months to improve their interpersonal communication and counseling skills	Check training database/ register	☐	☐	☐		
	3. The health facility has written, up-to-date mechanism (protocols, guidelines, checklist, SOPs) that outline clear goals, operational plans and monitoring to promote the interpersonal communication and counseling skills of health care staff.	Observe for written protocols, guidelines and SOPs	☐	☐	☐		
	4. Health care staff in the MNH service areas (antenatal, labour, post-natal) receive supportive supervision in interpersonal communication and counseling at least once every three months.	Check for supportive supervision books	☐	☐	☐		
	5. The health facility offers daily group education sessions on MNH to the clients.	Check health for education register/ schedule	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. A. The health facility has a system in place to enable communication with the following clients: • Visually impaired • Speech impaired • Hearing impaired • Mentally challenged B. The health facility has staff trained to handle clients with special; • Visual, • Speech • Hearing • Mentally challenged	Check for systems in place Inquire from the in charge/HR department	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	7. The health facility has clear and visible signage and service charter in every MNH area: • Labour ward • Newborn unit • Maternity/postnatal wards • MCH	Observe signage and service charter	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	8. The health facility has a functional feedback mechanism, such as: • Customer care desk • Complaint/complement books • Suggestions boxes, • Maternity open days • Official social media pages.	Observe the customer care desk and suggestion box Inquire records from the in charge	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of all women attending MNH service areas (antenatal, labour, post-natal) in the facility who received information and counseling on the specific services i.e. those in the Mother Child Handbook						
	2. The proportion of all women who gave birth in the health facility who reported that they were given the opportunity to discuss their concerns and preferences.						
	3. The proportion of health care staff in the health facility that are trained/orientated on interpersonal communication and counseling skills to support women and their families.						
	4. The proportion of staff who have skills to handle clients with special needs, for example hearing per shift.						
	Outcome 1. The proportion of all women attending ANC in the health facility who felt that they were adequately informed by the care provider(s) about the examinations, actions and decisions taken for their care.						
	2. The proportion of all women who attended ante natal care in the health facility who reported that their needs and preferences were taken into account.						
	3. The proportion of all women who gave birth in the health facility who felt that they were adequately informed by the care provider(s) about the examinations, actions and decisions taken for their care.						

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The proportion of all women who gave birth in the health facility who reported that their needs and preferences were taken into account during labour, childbirth and postnatal care.						
	5. The proportion of all women who gave birth in the health facility who reported that they were satisfied with the health education and information they received from the care providers.						

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
5.2: All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals	**Inputs** 1. The health facility has a standard form for clinical progress notes and monitoring events during the antenatal, labour/delivery and postnatal period (mother-child booklet, partograph, files, cardex and registers) to facilitate written hand-over.	Check for records	☐	☐	☐		
	2. The health facility has written, up-to-date protocols for verbal and written hand-over of women and newborns at shift changes, during intra-facility transfer, on referral to other facilities and at discharge.	Check for protocol	☐	☐	☐		
	3. Health-care staff in the MNH service delivery areas are oriented and receive in-service training and regular refresher sessions at least once every 12 months in the clinical hand-over policy and communication of important information for hand-over, referral or discharge.	Check training log	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has a functioning, reliable communication system for information exchange among relevant service providers (e.g. telephones, internet)	Check for availability of these	☐	☐	☐		
	Output/process 1. The proportion of women attended to during antenatal, labour /delivery and postnatal period for whom the relevant tools (mother-child booklet, partograph file) have been appropriately completed.	Check the records i.e. Case files, ANC profile, Vital signs on admission, PNC check-ups, Partograph, Vital signs within 6hours after delivery, Lochia loss					
	2. The proportion of all women who gave birth in the health facility who reported that health care staff introduced themselves and showed good knowledge of the women's history and the care that had been given to date	Exit interview					
	Outcome 1. The proportion of health care staff, by cadre, and social professionals who were satisfied with the communication during clinical hand-over among members of the health care team in the health facility.						

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 6

Women and newborns receive care with respect and preservation of their dignity.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
6.1. All women and newborns have privacy during antenatal, labour/childbirth, and postnatal care and their confidentiality is respected.	**Inputs** 1. The physical environment of the health facility allows privacy and the provision of respectful, confidential care, including the availability of curtains, screens, partitions and sufficient bed capacity. • Women's privacy is respected with a single room for labour and birth, or curtains/screens are available if there is more than one woman per room • Bed is positioned away from doors or windows (not in front of them) • Availability and use of curtains, screens, partitioned rooms/cubes or other visual barrier to protect woman during examinations, birth and procedures • Uses drapes or covering appropriate to protect woman's privacy • Appropriate spacing of beds (4 ft.) • One woman- one bed- no sharing of beds • Patient files are stored in locked cabinets with limited access	Verify by direct observation, interview or records review	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The health facility ensures privacy and confidentiality for all women and newborns.	Observe and interview	☐	☐	☐		
	3. The health facility has accountability mechanisms for redress in the event of violations of privacy, confidentiality or consent.	Ask/Confirm availability of protocol Check for documenta-tion of redress Check Alternative Dispute Resolution minutes	☐	☐	☐		
	4. The health facility has written accountability mechanisms for redress in the event that women are denied informed choice	Check and Confirm availability of protocol	☐	☐	☐		
	5. Woman's consent is obtained for attendance of any people to be present other than needed staff (i.e., students)	Exit interview	☐	☐	☐		
	6. The health facility has a standard informed consent form that is easily accessible to the health care staff	Check and confirm availability of consent forms in the unit	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	7. The health facility has a mechanism to educate and communicate clients' rights to clients attending the facility. - Responds to questions with promptness, politeness and truthfulness	Verify by direct observation, confirm presence of clients rights displayed Exit interview	☐	☐	☐		
	Output/process 1. The proportion of procedures in the health facility that require written consent for which there is an associated record of consent signed by the woman or a family member i.e. caesarean section	Check by sampling 5 files of women who have undergone surgical procedure					
	2. The proportion of all women undergoing examinations or procedures in the health facility who reported that their permission was sought before the examination or procedures were performed	Exit interview					
	3. The proportion of staff working in MNH service areas trained on respectful maternity care	Check training database for past 3 months					
	Outcome 1. The proportion of all women who gave birth in the health facility who were satisfied with the degree of privacy during their stay and care in the labour and childbirth areas.	Exit interview					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
6.2. No woman or newborn is subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.	1. The health facility has written up-to-date, zero-tolerance non-discriminatory policy with regard to mistreatment of women and newborns and has mechanisms for redress.	Verify presence of policy and Alternative Dispute Resolution ADR) book/register	☐	☐	☐		
	• Well displayed service charter on clients rights and mechanisms of reporting abuse/ discrimination/neglect/extortion or denial of services	Observe, verify by checking records from GBV register	☐	☐	☐		
	• Health care provider speaks to the woman in a language and at a language-level that she understands	Exit interview and observe	☐	☐	☐		
	• Health care provider does not make insults, intimidation, threats, or coerces woman or her companion	Observe/Exit interview	☐	☐	☐		
	• Health care provider does not use physical force or abrasive behavior with the woman, including slapping or hitting	Observe/Exit interview	☐	☐	☐		
	2. The health facility has a system whereby the mothers of sick newborns can be close to and nurse their babies.	Observe	☐	☐	☐		
	• Never separates woman from her baby unless medically necessary	Observe	☐	☐	☐		
	• Encourages woman to ask questions regarding her babies' condition	Observe/Exit interview/Ask	☐	☐	☐		
	• Women encouraged to actively participate in the care of their sick newborns	Exit interview/ Ask	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. MNH Services are affordable, accessible and equitable (NB. Free in public health facilities)	Observe	☐	☐	☐		
	4. The health facility has a written protocol/policy and mechanism to receive and address women's and families' complaints about the care received (e.g. a suggestion box, contact number, hotline, and an office).	Verify by checking presence	☐	☐	☐		
	5. The health facility has a complaints box, which is easily accessible to women and their families,	Check for availability	☐	☐	☐		
	• The suggestion/complaints box is periodically emptied, and the contents reviewed	Ask and verify by sampling 5 complains/ suggestions and reviews	☐	☐	☐		
	• The health facility has evaluation forms filled by clients on discharge regarding care received.	Verify presence	☐	☐	☐		
	• The facility has documentation of the recommendations and actions taken to address complaints	Verify documenent-ation	☐	☐	☐		
	• The facility has a functional hotline number to facilitate quick response	Ask/verify	☐	☐	☐		
	• The facility has a dedicated office to receive and handle complaints	Ask/verify	☐	☐	☐		
	6. Health care staff in the MNH service areas receive supportive supervision monthly, and training at least every 12 months in Respectful Maternity Care and accountability mechanisms are in place. Orientation is provided for new staff.	Check/verify CME/training register	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	7. The health facility has mechanisms to prevent and deter extortion, corruption and abuse (e.g.; CCTV, and a well displayed service charter). • Display of a comprehensive service charter at the entrance of the health facility • A functional CCTV. • Functional hotline • An office that addresses corruption • Use of suggestion box	Verify presence	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	8. The health facility has a written protocol/policy against the inappropriate use of the social media by the health workers against women and their newborns e.g. taking snap shots and posting on social media.	Exit interview	☐	☐	☐		
	9. The facility has an ethics committee that meets regularly.	Check minutes	☐	☐	☐		
	Output/process 1. The proportion of all women who gave birth in the health facility who reported physical, verbal or sexual abuse, to themselves or their newborns.						
	2. The proportion of women who gave birth in the health facility who were satisfied that the facility met their religious and cultural needs.						
	3. The proportion of women who gave birth in the health facility who were aware of the existence and location of a complaints box and other feedback mechanisms.						

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Outcome 1. The proportion of all women who gave birth in the health facility who reported having been treated with respect and their dignity preserved						
	2. The proportion of all women who gave birth in the health facility who made complaints that were acted upon without repercussions.						
	3. The proportion of all complaints made anonymously in the health facility that were acted upon.						

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
6.3. All women can make informed choices about the services they receive, and the reasons for interventions or outcomes are clearly explained.	**Inputs** 1. The health facility has a written procedure for obtaining informed consent from women before examinations and procedures (includ	Verify presence					
	2. Health care staff in the health facility receives supportive supervision monthly and training at least once every 12 months, in respectful maternal care. Orientation is provided for new staff.	Check training register					
	Process/outputs 1. The proportion of procedures in the health facility that require written consent for which there is an associated record of the woman's consent.	Verify from files					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The proportion of women who received care in the health facility who were aware that they had the right to accept or refuse treatment.	Exit interview					
	Outcome 1. The proportion of women who gave birth in the health facility by caesarean section who were aware of the reason for the caesarean section.	Exit interview					
	2. The proportion of women who gave birth in the health facility who felt that they participated in decisions about their labour, birth and postnatal care	Exit interview					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 7

Every woman and her family or the companion of her choice are given emotional support that is sensitive to their needs and strengthens the woman's capability.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
7.1. Every woman is offered the option to experience labour and childbirth with the companion of her choice.	**Input** 1. The labour and childbirth areas are organized in such a way as to allow physical adequate private space for the woman and her companion at the time of birth.	Observe labour ward for the recommended requirements	☐	☐	☐		
	2. The health facility has a written, up-to-date protocol, which is explained to women and their companions, to encourage all women to have at least one person of their choice with them during labour, childbirth and the immediate postnatal period	Check for the written protocols	☐	☐	☐		
	3. Health care staff in the health facility are oriented and receive orientation at least once every 12 months on the positive impact of the presence of a chosen companion during labour, childbirth and the postnatal period.	Check facility training data base/ Individual CPD record book	☐	☐	☐		
	Output/process 1. Proportion of women and their companions who have had the above protocol explained to them during labour, childbirth and the immediate postnatal period.	Exit interview					
	2. Proportion of health care staff who have received orientation in the past 12 months on the positive impact of the presence of a chosen companion during labour and birth.	Training data base					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Outcome 1. The proportion of women who expressed that the presence of the companion had a positive effect on their labour and delivery.	Exit interview					
	2. The proportion of all companions who were satisfied with the explanation given on their role during labour and childbirth	Exit interview					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
7.2. Every woman receives support to strengthen her capability during childbirth and the post-natal period.	**Inputs** 1. A) Health care workers in the labour and childbirth areas of the maternity unit are trained on non-pharmacological and pharmacological pain relief and received training/ mentoring sessions at least once in the preceding 12 months. • Pharmacological ways of pain management o Analgesics o Anesthesia • Non pharmacological ways of pain management in labour o Hydrotherapy o Patterned breathing o Focus and distraction o Massage o Superficial heat or cold	Verify from the individual CPD record book. Training data base Check records Observe/ check records	 ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	B. Clients in the labour and childbirth areas of the maternity unit are provided with pharmacological pain relief drugs or taught on non-pharmacological pain relief methods.	Verify from client exit questionnaire	☐	☐	☐		
	2. The health facility has written, up-to-date information, which is explained to women and their families/companions, to minimize unnecessary interventions, support normal labour and strengthen the woman's capability, so that she feels in control of her childbirth experience. (dos and don'ts) Verify if the following has been explained to the mother: • Avoid unnecessary drugs • Encourage mobility • Change of position (helps the mother to cope better with her labour) • Rest between contractions • Breathing exercises • Drinking fluids • Bladder care (pass urine at least once every 2 hours • Position during delivery	Verify from the cardex and the Client exit questionnaire	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	3. A) Health care staff in the labour and childbirth areas of the maternity unit are oriented and receive training / mentorship sessions at least once in 12 months to strengthen clients and families emotional support. • Psychosocial support on bereavement • Postpartum depression	Verify from the individual CPD book Check records	 ☐ ☐	 ☐ ☐	 ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	B. Clients and families are provided with grief support and psychosocial support during bereavement	Verify from clients records Confirm from the client exit interviews	☐	☐	☐		
	4. The health facility has a referral mechanism for women and families with complex emotional needs, and refers them for specialized care.	Check records and referral forms	☐	☐	☐		
	Output/process 1. Proportion of women and their companions who have had the birth process explained to them during labour, childbirth and the immediate postnatal period.	Exit interview					
	2. Proportion of health care workers trained on non-pharmacological and pharmacological pain relief and received training /mentorship sessions at least once in the past 12 months.	Training data base					
	3. Proportion of health care workers trained and received training / mentoring sessions on psychosocial support on bereavement and on postpartum depression in the last 12 months.	Training data base					
	4. Proportion of all women with complex emotional (depression, anxiety neuroses, psychosis) needs who were referred for specialized care.	Check files/ maternity register					
	5. The proportion of all women undergoing bereavement or an adverse outcome who received additional emotional support from health facility staff.	Exit interview					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. The proportion of all women who gave birth in the health facility who did so in the labour position of their choice.	Exit interview					
	7 .The proportion of all women who gave birth in the health facility who reported having sufficient food and drink during labour	Exit interview					
	8. The proportion of all women who gave birth in the health facility who were ambulatory during the first stage of labour.	Exit interview					
	Outcome 1. The proportion of all women who gave birth in the health facility who expressed satisfaction with the health services.	Exit interview					
	2. The proportion of all women who gave birth in the health facility who would recommend childbirth in that facility.	Exit interview					
	3. The proportion of all women who gave birth in the health facility who reported a positive birth experience.	Exit interview					
	4. The proportion of all women who gave birth in the health facility who were satisfied that their choices and preferences were respected	Exit interview					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 8

For every woman and newborn, competent, motivated staff are consistently available to provide routine care and to manage complications.

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
8.1: Every woman and newborn has access at all times to at least one skilled birth attendant and assistant for routine care and management of complications	**Quality measures** **Inputs** 1. A. The health facility has skilled birth attendants/ emergency obstetric newborn care available at all times, in sufficient numbers to meet the anticipated work load of each cadre as per HRH standards • Obstetrician Gynecologist • Paediatrician • Anesthesiologist or RCO/Nurse Anesthetist • Medical Officers • Midwives/Nurses • Clinical Officers, with Reproductive Health • Theater Nurse B. The health facility has staff available in MNH service delivery areas at all times, in sufficient numbers to meet the anticipated work load of each cadre as per HRH standards • Laboratory Technologist/Technician, • Pharmacy Technologist • Registered Clinical officers • Health Records Officers • Nutritionist	Verify using (See annex 1)	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Social Worker • Public health officer/technician • Health promotion officers • Cleaning staff • Maintenance Staff	Verify using (See annex 1)	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	2. The health facility has a written, up-to-date staffing policy, listing the numbers, types and competence of staff, that is reviewed continuously according to the level.	Verify availability of a written, up-to-date staffing policy according to norms and standards (neonatal care nurse, midwife, theatre nurse)	☐	☐	☐		
	3. The health facility has a roster that is displayed in all service areas, giving the names of staff on duty, the times of their shifts and their specific roles and responsibilities	Verify availability of a roster and duty allocation	☐	☐	☐		
	4. The health facility has a written, up-to-date policy on triage and waiting times for emergency and non-emergency consultations and treatment Maternal e.g. bleeding (APH/PPH), Sepsis, Cord prolapse, PROM, Premature Labour, Pre-eclampsia, eclampsia, Neonatal – Convulsions, Sepsis, Hypothermia, Asphyxia, Prematurity	Verify written, up-to-date policy on triage emergencies specifying maternal/ neonatal emergencies	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The health facility has clear communication channels to reach staff on duty at all times • Displayed duty roster with the phone numbers • Phone with airtime • Radio call • Standby vehicle with fuel	Verify	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	Outputs 1. Proportion of skilled staff (doctors, nurses and midwives) with competence to provide MNH services 24 hours in the facility.						
	2. The proportion of staff who have been oriented to their functions, roles and responsibilities in the facility or unit to which they are assigned						
	3. The proportion of women who attended the health facility who reported receiving attention within the appropriate time for their condition as per the service charter on triage and waiting time						
	Outcome 1. The proportion of women and their newborns in the health facility who were attended to by a skilled birth attendant (as per the definition) during and after childbirth.						

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
8.2: The skilled birth attendants and other healthcare providers have appropriate competence and skills to meet requirements during antenatal care labour, childbirth and the early postnatal period.	**Inputs** 1. The health facility has an annual training program for continuing professional and skills development for all skilled birth attendants and other health care providers Staff have received any RH training in the last one year • Essential obstetric care • Essential newborn care • Post abortion care • Family planning • Long term FP methods • Comprehensive reproductive health • Adolescent sexual and reproductive health • ANC, MIP/TB • Post rape trauma counseling • RT cancer screening (cervix/prostate) • EMONC • Cardiopulmonary resuscitation • Haemovigilance updates • MPDSR, • Respectful maternal care • Quality improvement • Leadership and management skills	Check training data base, Individual CPD	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	2. The health facility has standard procedures and plans for recruitment(where applicable), orientation and deployment	Verify presence of the plans	☐	☐	☐		
	3. The health facility periodically appraises all staff and has a mechanism for staff motivation, recognition, reward scheme and retention strategies in place for recognizing good performance	Check the performance appraisal files	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has sufficient numbers of educated, competent, licensed, motivated, regulated skilled birth attendants with an appropriate skills mix, working in multidisciplinary teams.	Verify the licenses	☐	☐	☐		
	5. The health facility provides an enabling, supportive environment for professional staff development, with regular supportive supervision and mentoring	Check the support supervision book if signed and mentorship program	☐	☐	☐		
	6. The health facility facilitates inter-professional collaborative practice and induction with clear roles and responsibilities based on the professional scope of practice and care needed throughout the continuum of care	Check for the documented staff job description and induction program	☐	☐	☐		
	7. The facility has functional Quality Improvement Teams(QITs), Work Improvement Teams(WITs) and Safety Improvement Teams(SITs) that meet regularly	Check for the minutes	☐	☐	☐		
	Output/process 1. The proportion of skilled birth staff at the health facility who received a written job description on deployment to the facility.	Check the employment file					
	2. The proportion of skilled birth attendants (MNH staff) at the health facility who received in-service training, refresher session or mentoring within the past 12 months within the facility.	Check the training database					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The number of supervisory visits to support clinical competence and performance improvement (in the past three months) within the facility.	Check for internal support supervision book					
	4. The proportion of staff at the health facility who were assessed (post training follow up) by the trainer at least once in the preceding 12 months within the facility.	Check training register/data base					
	5. The number of Work Improvement Teams (WIT) meetings held per month to review competence and quality improvement activities within the facility.	Check minutes					
	6. The number of interactions per month with professional mentors to ensure clinical competence and improve performance within the facility.	Check mentoring log					
	7. The proportion of all staff at the health facility who were engaged in at least two quality improvement team meetings and participated in quality improvement activities in the preceding 6 months	Staff Interview					
	Outcome 1. The proportion of all women who gave birth at the health facility who were satisfied with the care and support from facility staff.	Client exit questionnaire					
	2. The proportion of skilled birth attendants and health care providers at the health facility whose preceding performance appraisal was satisfactory	Verify from staff appraisal file					
	3. The proportion of all staff at the health facility who reported being "highly satisfied" with their job.	Staff questionnaire					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The proportion of all staff at the health facility who were actively considering looking for a new job/transfer.	Staff questionnaire					
	5. The proportion of all staff at the health facility who could identify and report on at least one quality improvement activity in which they were personally involved in the past six months	Staff questionnaire					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

8.3: The managerial and clinical leadership of every health facility is collectively responsible for creating and implementing appropriate policies and fosters an environment that supports facility staff in continuous quality improvement	1. The health facility has a written, up-to-date plan for improving the quality of care and a patient safety program, which is reviewed annually.	Verify presence of plan	☐	☐	☐		
	2. The health facility has a written, up-to-date leadership structure, with defined roles and responsibilities and lines of accountability for reporting.	Check for the organogram	☐	☐	☐		
	3. The health facility has adequate anaesthesia providers as per facility level of care in accordance to current national human resource norms and standards. • Anaesthesiologist, ☐ • Clinical officer anaesthetists ☐ • Anaesthetists nurse ☐	See annex 1		☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has a mechanism for regular collection of information on patient and provider satisfaction	Check for the suggestion box Check for customer satisfaction book	☐	☐	☐		
	5. The health facility (various committees/Teams) holds at least one monthly meeting to - Review data - Monitor quality improvement performance - Make recommendations to address any identified problems	Check for evidence of reviewed relevant data (reports and recommend-ations) e.g. hand washing, maternal/ neonatal death, neonatal/ postnatal sepsis, Documentat-ion of implemented recommenda-tions	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	6. The health facility standard governing procedures (policies and protocols) are in place and accessible to all relevant staff. • Reproductive health policy • Current Annual Work Plan (including Reproductive Health activities) is available, accessible to all staff and is being implemented.	Check for availability	☐ ☐	☐ ☐	☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Neonatal child and adolescents health policy • Immunization policy • Logistics management protocol, • Procurement policy, • Communication protocol, • Referral protocol, • Reporting protocol	Check for availability	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	7. The health facility holds at least two annual meetings with stakeholders (e.g. the community, service users, partners) to review its performance, identify problems and make recommendations for joint actions to improve quality.	Check for minutes of the meetings					
	8. The facility has written protocol/SOP in place for staff to provide feedback on progress of quality improvement activities to the facility management.	Verify availability of SOPs and evidence of documentati-on					
	Output process 1. The proportion of health facility department heads who communicated the performance of the facility through established mechanisms for monitoring (e.g. a dashboard of key metrics) to all relevant staff	Verify through the dashboard					
	2. The proportion of all health facility department heads who were trained in quality improvement and leading change (use of information, enabling behaviors, continuous learning).	Verify from the training database the training needs assessment, the training done on QI					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The proportion of all health facility department heads who were trained in leadership and management skills.	Verify from the training data base					
	4. The proportion of monthly meetings on the quality of care that were actually held in the preceding 12 months.	Verify from the minutes of the meetings					
	Outcome 1. The proportion of chosen indicators that improved performance of the system (according to the facility dashboard)	Verify from the dashboard					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

8.4: Health workers receive emotional support and respect required to have a fulfilling professional life to provide support to the women and newborns	**Input** 1. The health facility provides training on work related stress management at least once every 12 months. • Self-awareness • Psychological counselling • Life skills	Verify if the staff have trainings through interview and Training data base	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	2. The health facility has a conducive working environment for health care staff in the MNH areas. • Spacious, well-lit and ventilated consultation room(s) • Rooms designed to provide visual and audio privacy for clients/patients • Designated waiting area for clients/patients with seats	Verify by physical check Observation	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• The rooms are furnished • Adequate and reliable water supply • Running water and hand washing facility • Staff room/nurses room/changing room	Verify by physical check Observation	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	3. Health care staff in the MNH areas receive regular supportive supervision and feedback	Verify from support supervisory book	☐	☐	☐		
	4. The facility has adequate staffing according to the current human resource for health norms and standards.	Verify staffing according to human resource for health norms and standards.	☐	☐	☐		
	5. The health facility has adequate stock of medicines and supplies	Verify essential medicines using stock cards and antibiotics register, KEMSA order list	☐	☐	☐		
	6. The health facility has adequate provision of basic staff welfare scheme and infrastructural needs for MNH staff e.g. toilet, tea room, shower, staff call-room and staff changing room	Verify availability of staff welfare scheme ,staff room, clean staff toilet,	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
		well ventilated tea room, availability of shower, and staff call room					
	7. The health facility provides training on psychological support for supervisors at least once every 12 months. • Case studies, difficult situations, real life experience, • Support supervision for counsellors • Balancing family and work related life • Dealing with burn out	Verify from training database Staff Interview	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	Output/process 1. The proportion of shifts with the recommended nurse to patient ratio according to MOH guidelines.	Verify availability of the following staff ratio according to human resource for health services.					
	2. The proportion of stock out days in the last 3 months of essential drugs: - Uterotonic e.g. - Oxytocin, - IV fluids, - Magnesium Sulphate - Antibiotics.	Verify from antibiotics register, Logistic management information system order forms, drugs register, patient treatment sheets					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. Proportion of health care staff who are able to identify symptoms of stress and burn out in themselves and in others.	Staff questionnaire					
	4. Proportion of health care staff with stress and burn out who have received support.	Staff questionnaire Staff register					
	5. Proportion of health care staff reporting satisfaction in terms of supplies, staffing and resources available.	Staff Questionnaire Check equipment inventory Ordering file for supplies Duty roster/ allocation					
	6. Proportion of supervisors who have received training on psychological support.	Staff questionnaire training database					
	7. Proportion of staff who have received training on work related stress.	Staff questionnaire training database					
	Outcome 1. The proportion of health workers who report having emotional support and respect required to have a fulfilling professional life.	Staff questionnaire					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 9

The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and the management of complications

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
9.1: Water, energy, sanitation, hand hygiene, and waste disposal facilities are functioning, reliable, safe and sufficient for the needs of staff, women and their families	**Inputs** Physical Infrastructure 1. The health facility has infrastructure that supports client safety and quality of care • Clear signage directing clients to the facility and various service delivery points • Well displayed service charter • Fire extinguishers /fighting apparatus in place • The design approved by the ministry of public works and NEMA (evidence certificates/ valid, title deed) • Well maintained building (floors, walls, windows ceilings and other related structures etc.) • Adjustable beds with rails • Non-slippery floors • Two doors for entry and exit • The health facility is clean there is absence of dust, blood, trash and cobwebs in all service delivery areas:	Verify through observation Check smooth, slanting hard, easily cleanable surfaces (floors, labour ward floor, walls, ceilings, external surfaces etc.	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	2. The health facility infrastructure is designed, constructed and maintained to facilitate proper cleaning, drainage, infection prevention and control, pest, rodents and scavenger control.	Check for smooth slanting floor (labour ward)	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• The health facility has adequate connected drainage system for sewerage and water run-off. • The health facility has pest rodents and scavenger control mechanism in place	Verify pest rodents and scavenger control mechanism is in place	☐ ☐	☐ ☐	☐ ☐		
	3. The health facility has written, up-to-date policy guidelines for standard infection prevention control and precautions for transmission (including microbial surveillance and stewardship)	Check for access to current policy guidelines and standards for IPC and Anti-Microbial Resistance (AMR)	☐	☐	☐		
	4. The facility has an functional multi-disciplinary IPC committee with terms of reference and a champion/focal person	Check for Minutes and TORs Verify if there is an IPC focal person	☐	☐	☐		
	5. The health facility has a functioning source of safe water located on the premises that is adequate to meet all demands for drinking, personal hygiene, medical interventions, cleaning, laundry, cooking, for use by staff, women, newborns and their families	Observe the availability of covered tanks with sieves for harvesting rain water, boreholes, tap / piped water	☐	☐	☐		
	6. The health facility ensures safe handling, storage and final disposal of infectious and contaminated waste	Verify					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Waste segregations practice in place • Waste storage mechanism in place • Waste transportation mechanism in place • Waste treatment in place • Functional waste/compost pit in place • Functional placenta pit and a clean surrounding environment • Functional incinerator available		☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	7. The health facility has leak-proof, covered, labeled waste bins and impermeable sharps containers available in every treatment area, to allow segregation of waste into four categories: sharps, non-sharps, infectious waste, general non-infectious waste (e.g. food, packaging) and anatomical waste (e.g. placenta). • Availability of colour coded bins with liners and practice of waste segregation • Puncture proof container for sharp disposal available • All waste is collected and removed from the room in closed, leak proof containers with bin liners • Puncture-resistant and leak proof containers are closed and removed when three quarters full • Waste management is done according to an Orientation Guide for health workers in o Health Care Waste Management, o Health Care health management plan o Health Care Waste Management Policy	Observe and check for availability of the Policy guidelines	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	8. The health facility has at least one functioning hand hygiene station per 10 beds, with soap and running water or alcohol-based hand rub, towels in all wards.	Verify availability of running	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
		water and soap for hand washing/hand rub					
	9. The health facility has health personnel trained on IPC • Health personnel use appropriate PPEs • Health personnel observe IPC protocols	Verify from training data base Observe	☐ ☐	☐ ☐	☐ ☐		
	10. The health facility has housekeeping personnel trained on IPC • The housekeeping personnel uses the proper protective equipment. Eyewear / goggles/ Face, Mask, Utility gloves, plastic apron, Gumboots, Head gear where appropriate • Soiled linen is disinfected before being taken to laundry • Blood and body spills are mopped with disinfectant and the area is cleaned with water • All surfaces that have come in immediate contact with a patient and body fluids is disinfected by a disinfectant and rinsed with clean water • The delivery bed, mattress pads, instrument trolleys, baby scales and resuscitation equipment are disinfected using a disinfectant and rinsed with clean water • Floors / hallways are damp mopped at least daily (and whenever they are soiled) with a disinfectant cleaning solution	- Observe - Verify Check for availability of each protective gear Check for protocols for disinfection Ask housekeeping staff	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Sinks are scrubbed daily and as necessary with a separate mop, cloth or brush with a disinfectant cleaning solution • Bathrooms, toilets and latrines are cleaned daily and as necessary with separate mop, cloth or brush with a disinfectant cleaning solution as per cleaning schedule • Table tops are disinfected, and sides, base and legs are wiped with a damp cloth and disinfectant cleaning solution	Check for cleaning schedule	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	11. The health facility has energy infrastructure (e.g. solar, generator, grid) that can meet all the electricity demands of the facility and associated infrastructure at all times, with a back-up power source.	Verify availability of power source and back up	☐	☐	☐		
	12. The health facility has in place a mechanism to reduce wastage of water and energy (e.g. general maintenance of plumbing, switching off lights)	Verify availability of maintenance log Observe Check for signage on turning off the taps and switching off lights after use	☐	☐	☐		
	13. The health facility has well displayed awareness-raising (IEC) materials on infection prevention and control including menstrual hygiene management in all service delivery points	Check for availability of relevant IEC materials	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	14. The health facility has; • Sanitation facilities on premises that are usable • Appropriately illuminated at night • Accessible to people with limited mobility • Separated by gender for staff and patients; • Meets the needs for menstrual hygiene management in all service delivery points • Adequate latrines /toilets with hand washing stations and liquid soap and running water (at least 1 latrine per 20 users for inpatient settings)	Verify the availability of sanitation facilities Check for ramps and toilet rails Verify sanitary pad bucket Verify availability of latrines/toilets with washing	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	15. The health facility has adequate precautions to ensure the security of its premises, staff, patients and visitors.	Check for availability of trained security guards or watchmen, perimeter wall, availability of 24 hours surveillance i.e. CCTV	☐	☐	☐		
	16. The heath facility has a fuel management plan and local buffer stock, supported by an adequate budget for all the fuel needs for vehicles, cooking and heating, as relevant and as required, at all times.	Check for the plan and the budget	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	17. The health facility has in place measures to facilitate emergency preparedness, disaster management and risk reduction. Availability of: • trained personnel in disaster management • functional ambulance • Referral directory/network • Emergency box • Blood and blood products • Fuel logs and cards	Check training database for trained personnel, Check for functional ambulance, availability of fuel logs/ cards, check completeness of emergency box, verify availability of blood and blood products	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	18. The health facility has hand washing protocols that are well displayed in all service delivery areas: - • Administrative Offices • Waiting areas • Laboratory • Pharmacy • Wards • Central sterilizing unit	Observe	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	19. The health facility has a reliable water source on site with running water, soap and disposable towels or alcohol-based hand rub for hand hygiene in all service delivery areas • Administrative Offices • Waiting areas • Laboratory • Pharmacy • Wards • Central sterilizing unit	Observe	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	20. The health facility has a Central Sterilizing Unit/ equivalent with: • Containers for high level disinfection • Autoclave (high-pressure steam • Hot air oven • Steam sterilizers • E.T.O machine	Verify availability and functionality	☐	☐	☐		
	Outcome 1. The proportion of women and their families who attended the health facility who were satisfied with the water, sanitation and energy services including lighting and would recommend the health facility to friends and family.	Verify with the annual customer satisfaction report					
	2. The proportion of all health care staff at the health facility who were satisfied with the water, sanitation and energy services and considered that these services contribute positively to providing high-quality care.	Verify with the annual staff satisfaction report					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
9.2: Areas for labour, childbirth and postnatal care are designed, organized and maintained so that every woman and newborn and their families can be cared for according to their needs in private, to facilitate the continuity of care	1. The areas for labour, childbirth and postnatal care are planned, designed and organized as per set MOH standards and complies with applicable guidelines and policies,	Verify with MOH infrastructural norms (available in the MOH website)	☐	☐	☐		
	2. The health facility has a dedicated area in the labour and delivery room for resuscitation of newborns, which is adequately equipped with the following: • Resuscitaire • Radiant warmer • Reliable source of light • Complete set of functional resuscitation equipment and supplies.	Verify availability of a functional resuscitation equipment and supplies using the annexed checklist	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	3. The health facility has maintenance mechanism for rehabilitation, improvement and continuous operation and maintenance of water sanitation and hygiene and health care waste services.	Verify for water storage facility and maintenance schedule (register) -Verify for availability of mechanism for waste management	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	4. The health facility has labour, childbirth postnatal and neonatal areas, and surroundings that are; • Adequately equipped • Regularly cleaned • Regularly maintained • Appropriately illuminated • Well-ventilated • Allows for privacy (partitioned by screen/ curtains)	Check for signed cleaning schedule. Check for maintenance schedule Check for screens and curtains	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	5. The facility has adequate number of birthing rooms or areas for the estimated number of births in the service area.	Verify as per estimated monthly facility deliveries	☐	☐	☐		
	6. The health facility has adequate post-natal unit infrastructure to cater for: • rooming in, • kangaroo mother care • Breastfeeding.	Observe	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	7. The health facility has a labour and childbirth area or room with a functional, clean and accessible • bathroom with warm water • toilet for use only by women in labour and after childbirth	Observe	☐ ☐	☐ ☐	☐ ☐		
	8. The health facility has a dedicated ward/area for admitting sick and unstable small babies	Verify if there is a designated ward/area	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	9. A facility offering surgical services has an adequately equipped operating theatre located close to and easily accessible from the labour and childbirth areas	Verify location and proximity	☐	☐	☐		
	10. The facility has a dedicated recovery room or area for care of women with complications	Verify and observe	☐	☐	☐		
	Output/process 1. The proportion of all pregnant women who attended the health facility who reported that it has a clean physical environment conducive for childbirth	Verify with the customer satisfaction report					
	Outcome 1. The proportion of all women who gave birth in the health facility who were satisfied with the environment of the MNH service areas.	Verify with the customer satisfaction report					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

9.3: Adequate stocks of medicines, supplies and equipment are available for routine care and management of complications.	**Inputs** 1. The health facility has supplies of antihypertensive agents, in sufficient quantities, available at all times, in antenatal, labour, childbirth and postnatal areas for the management of women with pre-eclampsia and eclampsia • Hydralazine • Methyldopa • Nifedipine • Magnesium sulfate • Calcium gluconate		☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The health facility has Uterotonic drugs and supplies for intravenous infusion available in sufficient quantities at all times in the childbirth and postnatal care areas for the management of women with postpartum hemorrhage • Oxytocin • Ergometrine • Misoprostol • Tranexamic Acid • Carbetocin (Heat Stable) • Syringes • Needles • Infusion Sets • Intravenous Fluid Solutions • Blood	Verify availability of Uterotonic in the drug cupboard	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	3. The health facility has supplies of antenatal corticosteroids (dexamethasone or betamethasone) and antibiotics available in sufficient quantities at all times to manage preterm births • Dexamethasone or Betamethasone • Crystalline Penicillin/Ampicillin • Gentamicin • Ceftriaxone • Augmentin • Chloramphenicol • Intravenous Flucloxacillin	Verify from pharmacy/ drug store	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	4. The health facility has supplies of first- and second-line injectable antibiotics and other essential medicines available at all times for the management of mothers and newborns with, or at risk for, infections during labour, childbirth and the early postnatal period	Verify from pharmacy/ drug store					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Crystalline Penicillin/Ampicillin • Gentamicin • Ceftriaxone • Amoxicillin Clavo Chloramphenicol • Intravenous Flucloxacillin • Clindamycin • Vancomycin • Parenteral Metronidazole		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	5. The health facility has a safe, uninterrupted oxygen source and delivery supplies available at all times in labour, childbirth, neonatal areas and the operating theatre where theatre is available • Full oxygen cylinders • Oxygen concentrator • Oxygen masks different sizes • Nasal prongs different sizes • Catheters and masks • Nasal prongs for continuous positive airway pressure (CPAP)	Verify availability and functionality	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	6. The health facility has an on-site pharmacy and a medicine and supplies stock management system managed by a trained pharmacist or pharmaceutical technologist.	Verify from pharmacy and HR records	☐	☐	☐		
	7. The health facility has functioning essential equipment and supplies for the detection of complications in sufficient quantities at all times in the labour and childbirth areas of the maternity unit • Thermometers • BP Machine/Sphygmomanometers • Foetol Stethoscopes/Foetol scope	Verify availability and functionality	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Urine Dipsticks • Pulse Oximeter • Glucometer • Doppler monitor • RDT for malaria (malaria endemic areas)		☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	8. The health facility has essential supplies and functioning equipment available in sufficient quantities at all times in the labour and childbirth areas • Childbirth Beds • Vacuum Extractor • Delivery Set (At Least 5 Per Room) • Incubators • Rescuscitairre • Weighing Machine • Sterile Gloves • Room Heaters • Suction Machine • Mucus Extractors • Intravenous Fluids • Intravenous Giving Sets • Branulla All Sizes	Verify availability and functionality	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	9. The health facility has supplies and functioning equipment for emergency care and resuscitation of newborns available all times in areas designated for labour, childbirth and neonatal care. • Rescuscitairre • Well-stocked neonatal resuscitation trolley • Neonatal ambu bags 500ml, suction tubes of assorted sizes • Neonatal face masks: term and pre-term • Warmer	Verify availability	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Suction device • Pulse oximeter • Laryngoscope • Oxygen source • Nasal prongs/ non reservoir mask		☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		
	10. The health facility has supplies and functioning equipment for the emergency care and resuscitation of women available in sufficient quantities at all times in areas designated for labour, childbirth and postnatal care. • Well-stocked resuscitation trolley • Suction device • Pulse oximeter • Airway • Laryngoscope • Endotracheal tubes • Adult bag valve masks • Infusion sets • Intravenous fluids • Drip stand • PPH box • Pre-eclampsia box	Verify availability and functionality	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	11. The health facility has a functioning diagnostic ultrasound machine and trained health staff who can conduct a basic obstetric ultrasound examination to determine viability, the number of fetuses' present, gestational age, prenatal diagnosis of fetal anomalies or early diagnosis of placental insufficiency • Ultrasound machine	Verify availability and functionality Verify from HR records Verify with training data base	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	12. The health facility has a dedicated budget for essential medicines, equipment (and its maintenance) and medical supplies for maternal and newborn care	Check availability of current annual work plan and budget					
	Outcomes 1. The proportion of all women who had severe pre-eclampsia or eclampsia in the health facility who did not receive the full dose of magnesium sulphate because of a stock-out.	Check from maternity register and files					
	2. The proportion of all women who gave birth in the health facility who purchased gloves and other necessary items	Client satisfaction report					
	3. The proportion of mothers with obstetric complications who were managed according to protocol	Check register/ patient notes					
	4. The proportion of newborns with neonatal complications who were managed according to protocol.	Summate data from std 2					
	5. The proportion of women referred for caesarean section as a result of lack of supplies/equipment or staff trained to conduct caesarean section.	Check from theater register, admission					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
9.4: The laboratory has adequate infrastructure and capacity to perform Tests required for maternal and new-born health	**Inputs** 1. The health facility has laboratory infrastructure which is designed, constructed and provides a conducive working environment for staff • Waiting area with adequate space • Work tables with flat and washable surfaces • Chairs /stools • Storage shelves /cabinets • Wash basin with faucet (stopper) • Running water and soap • Good lighting and ventilation • Sharps containers • Waste disposal containers with color coded plastic liners • Wall clock with second hand in every testing point/area • Laboratory request forms • Standard operating procedures /manuals • Laboratory register • The laboratory has a special receiving area for the samples and registration • The laboratory has lockable doors and cupboards for the storage of the reagents • Separate sinks for hand-washing and disposal of body fluids and other chemicals	Observe	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	2. The health facility has laboratory that is staffed with qualified lab personnel • Certified laboratory technologists and technicians	Verify with HR and training database	☐	☐	☐		
	3. The health facility has essential laboratory reagents and supplies for the following tests to support the management of women and newborns • Bacteriology (culture) • Bacterioscopy (smear)	Check for the availability of tests and reagents	☐ ☐	☐ ☐	☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Bilirubin • Blood culture • Blood glucose • Blood group • Blood typing and RH factor tests • Clinical chemistry • Coagulation tests • Cross-matching • Urea, creatinine and electrolytes • Full blood count • Haematocrit determination • Haemoglobin determination • Hepatitis B • HIV testing • Liver function tests • Platelet count • Random blood sugar • Syphilis tests • Urinalysis • Peripheral blood film • Acid Alcohol Fast Bacillus (AAFB) • Portable cool boxes	Check for the availability of tests and reagents	☐ ☐	☐ ☐	☐ ☐		
	4. The health facility has adequate supply of blood and blood products which are released in a timely manner • Whole blood • Fresh frozen plasma • Platelets • Packed cells • Cryoprecipitate	Verify from laboratory availability of blood and blood products verify with the register (blood dispatch register)	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	5. The health facility has a mechanism for screening and testing blood and its products to provide safe blood for transfusion. • ABO blood grouping and RH typing • Screening of donor blood for HIV • Screening of donor blood for Hepatitis B Surface Antigen (HBSAG) and Hepatitis C (HCV) • Tests for syphilis (VDRL or RPR)	Verify availability of equipment and review of records	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	6. The facility has blood that is correctly labeled and is properly stored at the correct temperature • Name of the blood product • Date blood was drawn and expiration date • Blood type(ABO) and RH factor • Refrigerator is used at all times for storing blood • Temperature is kept between 2-6°C for whole blood • Temperature is recorded and monitored regularly according to protocol	Sample 3 blood pints and check for expiry Verify from lab register Verify from temperature monitor chart	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	7. The facility has a blood bank that operates 24 hours a day • Cross matching and providing blood for transfusion is available 24 hours a day • ABO and RH typing is available 24hours a day • There are at least 2 units of type O negative blood for obstetric emergencies	Verify from the duty roster Verify from Lab register	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	8. The health facility has mechanisms and protocols for the right processes of bleeding and transfusion of blood and blood products • National blood transfusion protocol • Hospital transfusion committee • Staff are trained on haemovigilance	Observe for availability of protocols Verify from minutes Verify from training database	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	9. General biosafety and IPC practices are followed in the laboratory	Check for biosafety /IPC SOPs in the lab Observe staff (See Annex 8)	☐	☐	☐		
	Output/process 1. The proportion of women requiring blood transfusion who received blood	Check from maternity register and patients file					
	Outcome 1. The proportion of women requiring blood transfusion who died before receiving the blood transfusion	Check monthly MPDSR reports					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 10 Safe obstetric anaesthetic care and surgery

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments

10.1: Every woman who requires surgical intervention should receive timely and efficient care in a safe environment.	**Inputs:**
	The health facility has an adequately equipped and functional operating theatre and Post Anaesthetic Care Unit (PACU) to offer emergency obstetric care and anaesthesia as per the National Anaesthesia guidelines.
	• Availability of functional operating theatre
	• Availability of operating table in working condition
	• Availability of functional surgical lamp
	• Availability of functional mayo trolley
	• Availability of functional instrument trolley
	• Availability of full caesarean section set
	  • 5 Ramp leys sponge holding forceps
	  • 2 Mayo scissors curved
	  • 2 Mayo scissors straight
	  • Carless ligature scissors
	  • 6 x 10" Chances artery forceps
	  • 10 green Armitage forceps
	  • 6 Spencer Wells artery forceps
	  • 6 cross section towel clips
	  • 2 Bard Parker handles no. 4
	  • Bard Parker handle no. 3
	  • 2 Trevor dissecting forceps toothed
		The observe to verify by observation or examination
		Verify if it is movable and adjustable
		Verify if Mayo's trolley is adjustable, has mobile wheels and free from rust and dents
		Verify if the instrument trolley has mobile wheels and free from rust and dents
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Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• 2 Trevor dissecting forceps non-toothed • 15 Dunhill's artery forceps • 4 Allis tissue forceps • 4 Little wood forceps • Sims needle holder • Doyen's retractor • Lange bag retractor • 2 Lanes tissue forceps • Abdominal packs • Raytex gauze for theatre	Verify valve is in working condition presence of suitable mask for neonate and mother (size 0, 1, 4,5)	☐	☐	☐		
	• Functional suction apparatus - calibrated bottle	Verify availability	☐	☐	☐		
	• Functional, manual bag/valve /self-inflating resuscitation bag(2 sizes, (for neonate and mother)		☐	☐	☐		
	• Available protective gear (Mackintosh apron, gloves, masks, eye shields):		☐	☐	☐		
	• Do staff use the necessary Personal Protective Equipment		☐	☐	☐		
	• The Personal protective equipment is put in a readily accessible place for all staff	Observe	☐	☐	☐		
	• A functional stethoscope is available for every anaesthetic machine available in PACU	Verify availability and functionality	☐	☐	☐		
	• A functional patient monitor is in place condition by verifying that: - • A working pulse oximeter probe for every monitor • Appropriate size of blood pressure cuffs (small medium large)		☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Electrocardiograph leads are readily available • The patient on the table is being monitored by ECG, SPO2, BP • The theater has appropriate airway management instruments and accessories: range of oropharyngeal airways (size 00, 0, 1, 4, 5,) • Laryngoscope lights up • An appropriate range of laryngoscope blades (size, 0, 1, 4, 5,) • Availability of the Magill's forceps is available	verify that there are ECG, SPO2, BP monitors	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	• The patient on the table has a HME (heat moisture exchange) filter • Routine servicing of equipment is done:- the anaesthetic machine and operating bed • Operating table is in working condition the bed can move up, down and into Trendelenburg position and head down. • A copy of protocol for checking the anaesthesia machine or a similar document is available on each anaesthesia delivery system • PACU has space allocated specifically for PACU (1.5 bed per operating table) that is easily accessible to the operating room	Verify/Check for records Verify that there is a sticker that clearly indicates the date of last service and the date for next service	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	PACU has the following for use only by PACU • Water point and sink • Nursing station /desk space • Wall clock • Trolley for emergency drugs and acute pain management and non-pharmaceuticals (for dressing, airway management and circulation management) • Functional portable procedure lamp • Fully stocked resuscitation trolley and defibrillator	Verify/ observe Verify availability and functionality	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		
	Each bed space has • Has electrical socket that are one meter from the floor • Oxygen source, • Functional suction apparatus • Appropriate manual bag valve/self-inflating resuscitation bag for mother) with suitable mask (size 4,5) • A working stethoscope is available • The patient monitor is in working condition • A working pulse oximeter probe for every monitor • With appropriate size of blood pressure cuffs (small medium large) • Electrocardiograph leads are readily available • The patient on the table is being monitored by ECG, SPO2, BP • The floor of the theatre is slanting and allow good drainage of the theatre refuse	Verify availability and functionality Verify availability and functionality	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. The health facility has adequate number of skilled staff to provide surgical and anaesthetic services for caesarean section and management of the patient in the post anaesthetic care unit, 24hrs a day. • There is staff allocated as follows per shift: - Anaesthesist - Anaesthetic assistant - Obstetrician - Surgical assistant - Medical officers - A team leader/ overseer - One scrub nurse per theater - A circulating nurse per theater - A nurse to receive the baby - 1 PACU nurse per 2 beds • An updated rota, well written and displayed, with contacts • Verify if there is staff allocated on duty (not on call) to cover for emergency obstetric cases at night	Verify availability Verify if there is a working rota for all the listed staff with contacts well updated for all shifts	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	3. The health facility has registers and anaesthetic charts in place at all times for the routine recording and monitoring of all care processes of the anaesthetised woman • The presence of theater lists for elective and emergency case scheduled • The patients register is fully filled with the following information: - Patients name and age - Diagnosis - Procedure - Anaesthesia provider	The observer will verify that there are registers for all theatres; available, up to date and complete Verify availability	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	- Anaesthesia method - Time in - Time out - Outcome • Monthly summary • Printed copies of the anaesthesia chart are available • There is a board clearly indicating the current operation details that is visible to theatre staff (patient details, operation, surgeon, anaesthetist, scrub nurse, gauze count, start and end time)	Verify availability	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	4. The health facility conducts reviews of all mortalities and near misses in theatre and has a mechanism for implementing the recommendation of the reviews. • All mortalities and referrals from theatre are reviewed by theatre user committee • The recommendations made during the meeting have been implemented by talking to the staff and observing any relevant changes made.	Verify from the minutes Sample 2 reco-mmedation in the minutes and check implementat-ion status	☐ ☐	☐ ☐	☐ ☐		
	5. The health facility has supplies of sterile packs, non-pharmaceuticals and pharmaceuticals required for spinal anaesthesia available at all times in sufficient quantities for the expected number of operations.	Observe and verify availability	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	6. Pharmaceutical in the theater • Plain lidocaine • 0.5% heavy/plain bupivacaine • Ephedrine or phenylephrine • IV fluids Pharmaceuticals in the theater: • Sterile spinal packs adequate to the expected case for that day • Verify that the sterile spinal packs contain: - Draping - Draping with hole - Kidney dish - Gallipot - Sponge holder - Sterile gauze swaps - Spinal needles (size 22, 25, or 27 only).	Observe and verify availability Check for expiry dates Check for completeness of the packs	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	7. The health facility has essential drugs and supplies for the provision of obstetric anaesthesia and the management of complications according to national anaesthesia guidelines and available in sufficient quantities at all times in theatre. Pharmaceuticals: • Magnesium sulphate • Naloxone • Antibiotics – ceftriaxone, augmentin • Hydralazine • Flumazenil • Adrenaline • Diazepam • Midazolam • Calcium gluconate • Tranexamic aci	Verify availability and expiry dates	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Lasix • Plasil • Chlorpheniramine • Nitrous oxide • Halothane • Ketamine • Suxamethonium • Sodium thiopental • Local anaesthetic agents • Atropine • IV infusion sets • Blood giving sets • Cannulae (assorted sizes) • Needles and syringes (assorted sizes) • Urethral catheters • Urine bags • Gauze • Cotton wool		☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	8. The health facility has arrangements with other facilities and a mechanism to cater for the critically ill woman or any woman with post anaesthetic complications requiring escalation of care. • A working ICU in the hospital • Displayed protocol for referral and contact information for referral facility • Availability of register of patients for escalated care from theater to ICU in same hospital • Availability of referral forms of patients for escalated care from theater to ICU in another facility	Observe and Verify contacts list displayed Confirm from referral register	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• **Infection Prevention and control** The health facility theatre staff adhere to IPC guidelines and protocols • The staff observe hand hygiene • The staff use protective equipment during procedures • Instruments are processed before sterilization • Waste is segregated and managed according to waste management protocols • Soiled linen is decontaminated before cleaning • The floor is cleaned as per cleaning protocols • The Theatre has a designated area for cleaning used instruments and linen	Check for availability of running water, liquid soap and hand washing protocols Observe Verify availability of Protocols for instrument processing, waste management, colour coded ,buckets with bin liners and cleaning policy guidelines	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	9. Housekeeping personnel in theatre wear personal protective equipment during cleaning • Protective eye wear(goggles) • Mask • Utility/heavy duty gloves • Plastic apron • Gum boots • Head gear	Verify availability of PPEs Observe	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of fully equipped and functional operating rooms as per the national anaesthesia guidelines.	Verify Observe					
	2. The proportion of functional operation tables to recovery beds in PACU as per national anaesthesia guidelines	Verify from PACU Observe					
	Outcomes 1. Proportion of patients referred from theatre to an ICU or another health care facility for escalated care.	Verify from Theatre register, Verify from Referral Register					
	2. The proportion of women who died during or after exposure to anaesthesia	Verify from Theatre register Verify from postnatal register Check in MPDSR reports					
	3. The proportion of anaesthetic related deaths that have been reviewed and recommendations for improvement made in the last 12 months.	Check in MPDSR reports					
	4. The proportion of recommendations made for anaesthesia care implemented within the stipulated time frame.	Check in MPDSR reports					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
10.2: Every woman who requires surgical interventions will receive prompt and safe anaesthetic care from a formally trained, certified and registered anaesthesia service provider.	**Inputs** 1. The anaesthesia service provider reviews every woman before surgery to ensure that they are appropriately prepared for the surgery and are informed of the options and risks of the anaesthetic procedure The following are done: • Client is reviewed by the anaesthetist • Client is aware of the various anaesthetic options available for their surgery • Client is aware of the anaesthetic risks and benefits • Does the client know what the planned anaesthesia method	Verify from client file	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐		
	2. The anaesthetist provides individualized pre and intraoperative care as recommended by national anaesthesia guidelines. • informs the client on key findings after the pre-anesthetic review • client understands why the anaesthesia method is most suitable for her • pre-anaesthetic review has a plan of management for the client and highlights the expected challenges (difficult intubation, back deformity)	Client interview Verify from file	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	3. The anesthetists/anaestheologists engage in continuous professional development activities as dictated by their regulatory body and receive updates and refresher courses on management of obstetric emergencies at least every 12months	Verify from CME/training log					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• The anaesthesia provider is a formally trained anaesthesiologist/anesthetist • Retention / license is up to date • Confirm refresher courses attended by anaesthesiologist/ anesthetist	Training data base Verify from HR department	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐		
	4. The anaesthetist/ anesthesiologist/ clearly documents all the anaesthetic processes from pre-anaesthetic review to reversal of anaesthesia including any incidents that may have occurred. • Diagnosis and indication for surgery • Woman's baseline vital signs measurement, blood pressure, pulse, respiratory rate • The woman's results of investigations done • Comprehensive physical examination • Previous anaesthetic exposure and surgical history • Medical history – presence of allergies, chronic illness or regular drug use • Airway, assessment and examination, assesses adequacy of mouth, chin, jaw and neck for endotracheal intubation if needed • The anaesthesia impression which includes the ASA classification (see annex 12) • Proposed anaesthetic technique to be used	Observe Review the pre-anesthetic review notes and confirm if the anaesthetist/ anesthesiol-ogist has recorded	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
	5. The anaesthetist/ anesthesiologist uses the anaesthesia chart in the patient file to monitor anaesthetic care • Records client's name, age and hospital number • Records the diagnosis and planed surgery, name of surgeon, anaesthetist, assistant surgeon and scrub nurse	Verify from 5 patient files Review the anaesthetic chart	☐ ☐	☐ ☐	☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	• Records date and time of start and end of surgery and anaesthesia • Records type of anaesthesia given • Records every 15 minutes: maternal pulse, blood pressure, and SPO2 • Records estimated blood loss • Records reversal procedure • Records immediate post-operative management • Records any drugs and IV fluids given during the period they are under anaesthesia.	Verify from 5 patient files Review the anaesthetic chart	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐		
	6. The health facility provides for adequately trained support staff such as anaesthetic assistant at all times in theatre to assist the anaesthesia service provider in the provision of anaesthetic services. • The anaesthetic assistant knows what preparations are done before intubation • The anaesthetic assistant knows what complications are expected during extubation	Observe Verify from training data base Check rota Interview anesthetic assistant Use annex 14	☐ ☐	☐ ☐	☐ ☐		
	Output/process 1. Proportion of fully filled anaesthetic charts.	Review file					
	2. The proportion of anaesthetists who have participated in obstetric emergency refresher courses in the last 12 months.	Training data base					
	3. Proportion of files with documented pre-anaesthetic review.	Review files					
	Outcomes 1. Proportion of women who were aware of the options of anaesthesia.	Pre/Post-operative Client interview					

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. Proportion of women who were aware of the risk of anaesthesia.	Pre/Post-operative Client interview					
	3. Proportion of caesarean sections that had a turnaround (decision to operation time) time of 1hour or less.	Review file					
	4. Proportion of poor neonatal outcomes (fresh still birth, severe asphyxia) after caesarean section.	Review file Perinatal death review reports					
	5. The proportion of women exposed to anesthesia who were transferred for ICU care or died on the theatre table.	Verify from MPDSR reports / referral register/ ICU register					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

STANDARD 11

Every community member is empowered to realize their rights to quality, equitable and dignified Maternal and Newborn Health Services (Kenya Community Health Strategy goal)

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
11.1: All Women, their families and the general community are sensitized and educated on Maternal and Newborn Health	**Inputs** 1. Regular education and sensitization sessions on Maternal and Newborn Health are conducted at • The health facility • The community level	Verify- minutes and reports from maternity open days and community dialogue days, MCH micro-teaching schedules and health education reports by CHEW Ask 5 women whether they have been sensitized on MNH	☐ ☐	☐ ☐	☐ ☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	2. Informational materials (written, pictorial & audio-visual) on health rights are available and accessible to all the women and the community.	Verify from the walls, flyers, brochures, roll up banners, television screens/ CD DVDs, billboards, continuous electronic messaging. (Written in at least two languages used in the community).	☐	☐	☐		
	3. Community health extension workers (CHEWs), in conjunction with the link facility health care providers, facilitate trainings to empower women and community members to demand for their rights and entitlements.	Verify -invitation letters, attendance lists , reports, and, data base Ask 5 women whether they have been sensitized on their rights and entitlements	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	Output/process 1. The proportion of health education sessions held at the facility in the last 3 months	Health Education Records book and chalkboard					
	2. Number of dialogue sessions conducted at the community level over the last 3 months	Check from CHEW's record book					
	3. Proportion of women who report availability of audio-visual materials on maternal and newborn health services at the community e.g. Chief's office, schools, churches and market places	Client Exit Interview					
	4. Proportion of community members who are aware of their rights and entitlement.	Ask 5 community members					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
11.2: The community has confidence in the health care system delivery of maternal and newborn health services.	**Inputs** 1. There is a feedback mechanism between the community and the healthcare facility regarding maternal and newborn health services.	Verify -suggestion box content review minutes, customer care desk with register, designated telephone line and register of complaints, maternity open days and dialogue days reports and minutes, community score card	☐	☐	☐		
	2. Community health extension workers (CHEWs) hold regular and effective dialogue meetings with the community on maternal and newborn health care.	Schedules of dialogue/ maternity open days Minutes/ reports of dialogue and maternity open days Action plans implemented reports) from community dialogue and maternity open days	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
	3. The community members are sensitized on what to expect from the health facilities in terms of quality, equitable and dignified maternal and newborn care services.	Report on training of CHEWs and CHVs on Respectful Maternity Care (RMC), Reports on sensitization of the community on RMC Ask 5 community members	☐	☐	☐		
	4. There is a well-functioning social accountability mechanism where communities effectively participate in the improvement of the management and delivery of MNH services (community score-card).	Verify-community score card/ chalkboard findings disseminat-ion/ reports and implemented action plans. Social accountability service charter. Social accountability committee meetings minutes.	☐	☐	☐		

Quality Statement	Quality Measures	Assessment Methodology	Y	N	N/A	Score	Comments
		Confirmed minutes and action plans. Minutes of Verbal Autopsy. Ask 5 community members about their participation					
	Outputs 1. Number of feedback meetings held between the community and the health care facility regarding maternal and newborn health services in the last 12 months	Check minutes / reports Check scorecard					
	2. The number of meetings held with the community on improvement of the management and delivery of MNH services (community score-card) in the last 12 months.	Check minutes / reports					
	3. Number of action days held in the community health units with reports in the last 12 months	Check minutes / reports					
	4. Number of social accountability meetings held in the last 12 months	Check records					
	5. Number of maternity open days held in the facility in the last 12 months	Check minutes / records					

TOTAL NUMBER OF COMPONENTS ACHIEVED	
TOTAL COMPONENTS IN THE QUALITY STATEMENT	
PERCENTAGE SCORE FOR THE QUALITY STATEMENT	

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97.	Welling Khamadi	U.O.N

ANNEXES



Annex 1: Exit questionnaire for mothers/clients on discharge after delivery

1. How were you received in the facility?
☐ Very well
☐ Well
☐ Not well

2. How do you find our delivery services?
☐ Easily accessible
☐ Equitable to all
☐ Cost effective (e.g. could use NHIF)

3. Did you receive a postpartum-family planning method before discharge? (Std 1 and 2)

4. Did the health care provider encourage you to ask questions regarding your baby's condition? (Std 2 and 6)

Standard 1

5. During ANC in the health facility were you adequately informed by the healthcare provider(s) about the examinations, actions and decisions taken for their care?
☐ Yes
☐ No

6. Did you receive any health education on:
   - Avoiding unnecessary drugs
   - Mobility
   - Change of position
   - Rest between contractions
   - Breathing exercises
   - Drinking fluids
   - Bladder care (pass urine at least once every 2 hours
   - Position during delivery

Standard 2

7. Did you receive information or counseling on the health service you received?
   A. Yes
   B. No

8. Were you given information on how your labour was progressing?
   A. Yes
   B. No

9. Were you offered pain relief?
   A. Yes
   B. No

10. (a). Which was your preferred birth position?
   - Lithotomy
   - Lateral
   - Squatting
   - Others specify

(b). Was your preferred position allowed?
A. Yes
B. No

11. Were you given information and counseling on the specific services (antenatal, labour, postnatal)?

12. Were you educated on non-pharmacological and pharmacological pain relief methods?

13. Were you informed about danger signs for your baby and yourself and emergency preparedness?

14. Was your baby fed exclusively on breast milk from birth to discharge?

15. Were you offered infant formula in the wards or were any samples distributed to you?

16. If infant formula was used, were you shown how to use and informed of the hazards?

17. Did your baby receive a bath within 24 hours of birth?

18. Were you allowed to room in with your baby for 24 hours a day?

19. Were you offered counseling on the importance of post-natal checkup within 48 hrs, 2 weeks and 6 weeks, birth spacing and family planning methods?

20. Have you taken up a family planning method?

21. In the Post Natal ward did you receive breastfeeding counseling from a skilled health provider?

22. Did you receive additional support to establish breastfeeding (for a mother of a low birth weight baby)?

23. Are you satisfied with the water, sanitation and energy services and consider that these services contribute positively to providing high-quality care?

Standard 3

24. After how long were you discharged?

Standard 5

25. Were you adequately informed by health care staff regarding decisions taken about your care?
- ☐ Yes
- ☐ No

26. Were you given the opportunity to discuss your concerns or preferences with health care service providers during antenatal, childbirth and post partum care?
- ☐ Yes
- ☐ No

27. Were your needs and preferences met during the antenatal, child birth and post-partum period?
- ☐ Yes
- ☐ No

28. Did the health care staff introduce themselves and show good knowledge of your history and the care that had been given to date?

Standard 6

29. Were you communicated to in easy to understand language?

- ☐ Yes
- ☐ No

30. Did the staff respond to your questions with promptness, politeness and truthfulness?

- ☐ Yes
- ☐ No

31. Were the services equitably delivered to you/to your baby with no discrimination and mistreatment?

- ☐ Yes
- ☐ No

32. Did you experience any physical force like slapping or hitting or any abrasive verbal abuse from the staff?

- ☐ Yes
- ☐ No

33. Did the health care staff seek your permission before any examination or procedures performed on you?

34. Were any photographs taken of you and your baby without your permission/consent?

35. Were you aware of the right to accept or refuse treatment?

36. Were your religious and cultural needs met?

37. Were you aware of the existence and location of a complaints box and other feedback mechanisms?

38. What do you apply on the cord?

39. Did the health care provider make insults, intimidation, threats, or coerces to you or your companion?

40. Were you treated with respect and your dignity preserved?

41. Were your complaints acted upon without repercussions?

42. Was your consent obtained for attendance of any people to be present other than needed staff (i.e., students)?

43. Were you educated and communicated to on your rights on attending the facility.

44. Were you aware of the reason for the caesarean section?

Standard 7

45. Were you given the opportunity to have a companion of your choice during labour and child birth?

- ☐ Yes
- ☐ No

46. Were you given provided with grief and psychosocial support during the time of bereavement (applicable for bereaved mothers)?

- ☐ Yes
- ☐ No

47. Did the health facility provide you with sufficient food and drink during labour?

48. Were you ambulatory during the first stage of labour?

Standard 8

49. How long did it take for you to be attended to?
- ☐ Less than 5 minutes
- ☐ 10-minutes
- ☐ 30 minutes
- ☐ I hour or more

50. Were you satisfied with the health care you received?

51. Were you satisfied with the care and support from facility staff?

52. Were you satisfied with the health services at the facility?

Standard 9

53. Were you satisfied with the water, sanitation and energy services including lighting and would recommend the health facility to friends and family?

54. Did the health facility have clean physical environment conducive for childbirth?

Standard 10: FOR THOSE WHO UNDERWENT ANAESTHESIA

55. Were you reviewed by the anesthetist before surgery?

56. Did the anaesthetist inform you of the key findings after the preanesthetic review?

57. Did the anaesthetist inform you of the various anaesthetic options available for your surgery?

58. Did the anaesthetist inform you of the anaesthetic risks and benefits?

59. Did you understand why the anaesthesia method was most suitable for you?

Standard 11

60. Were you provided with informational materials (written, pictorial & audio-visual) on your health rights?

Staff Interview/Questionnaire

Standard 2

1. Are any samples of formula distributed to you in the wards?

2. Are you satisfied with terms of supplies, staffing and resources available?

Standard 3

3. Please report on at least one quality improvement activity in which you were personally involved in the past six months.

Standard 5

4. Have you been oriented to your functions, roles and responsibilities in the facility or unit to which you are assigned?

5. Are you satisfied with the communication during clinical hand-over among members of the health care team in the health facility? Doctors, RCOs, Nurses?

Standard 8

6. Have you received training on work related stress?
7. What are the signs and symptoms of burn out and stress?
8. Do you have the emotional support and respect required to have a fulfilling professional life?
9. Are you able to identify symptoms of stress and burn out in yourself and in others?
10. If you suffered from stress and burn out did you receive support?
11. Have you received training on psychological support?
12. Are you highly satisfied with your job?
13. Are you actively looking for a new job?

Community Interview / Questionnaire

1. Are you aware of your rights and entitlement as concerns health services?
2. Are you satisfied with maternal and newborn health services provided by CHWs?
3. Are you provided with informational materials (written, pictorial & audio-visual) on health rights at the community CHW office?
4. Are you provided with audio-visual materials on maternal and newborn health services at the community e.g. Chief's office, schools, churches and market places?

Annex 2: Distribution of staffing norms by level of care

Table 1: Section B: Distribution of Staffing Norms

Staff Category	Sub categories	Regional (2ndary referral) hospital -L5	County (primary) hospital -L4	Health Centre L3	Dispen-sary L2	Commu-nity Unit L1
Medical Officers & Specialists	Medical Officers	50	16	2	-	-
	Anesthesiologist	6	2	-	-	-
	Oromaxillofacial Anesthesiologist	1	-	-	-	
	Cardiologist	2	-	-		
	General Surgeon	4	2			
	Orthopaedic Surgeon	2	1			
	Cardiothoracic Surgeon	1				
	Critical Care Physician	1				
	ENT surgeon	2	1			
	Gastroentologist	2				
	Obs/Gyne Specialist	3	2			
	Palliative Care Specialist	2				
	Neonatologist	2	1			
	Nephrologist	2	1			
	Neurologist	1	1			
	Plastic Surgeon(Reconstructive Surgeon	1				
	Neuro-Surgeons	1				
	Oncologist	4				
	Ophthalmologist	2	1			
	Optometrist	1	1			
	Dermatologists	1	1			
	Paediatric Endocrinologist	1				
	Paediatric Nephrologist	1				
	Paediatric Neurologist	1				
	Paediatric Surgeon	1				
	Paeditrician	4	2			
	Pathologist	2	1			
	Psychiatrist	4	2			
	Radiologists	4	2			
	Rheumatologist	1				
	Specialist Physician(Internist)	4	2			

Staff Category	Sub categories	Regional (2ndary referral) hospital -L5	County (primary) hospital -L4	Health Centre L3	Dispen-sary L2	Commu-nity Unit L1
	Medical Endocrinologist	1				
	Public Health Physician	2	1			
	Urological Surgeon	1				
	Child & Adolescent Psychiatrist	1				
	Community Psychiatrist	1				
	Forensic Psychiatrist	1				
Clinical Officers	General Clinical Officers(Diploma)	44	30	6	2	1
	Graduate Clinical Officers	7	14	1		
	Specialised Clinical Officers	4	2	1		
	Clinical Officer ENT/ Audiology					
	Clinical Officer Lung & Skin	2	4	1		
	CO Ophthalmology/ Cataract Surgery	2	4			
	CO Paediatrics	6	2	1		
	CO Reproductive Health	2	2	1		
	CO Dermatology/ Venereology	2	1	-	-	
	CO Orthopaedics	2	1	-	-	
	CO Anaesthetists	15	6			
	CO Psychiatry/Mental Health	2	1			
	CO Oncology/ Palliative Care	2	1			
Nurses and specialist	BSN Nurse	12	4			
	Cardiology Nurse	2				
	Critical Care Nursing	20				
	Dental Nurse	8	8	2		
	Forensic Nurse	2				
	Kenya Enrolled Community Health Nurse	250	100	12	4	1
	Kenya Registered Community Health Nurse	260	50	8	2	1
	Kenya Registered Nurse	80	20	2		
	Enrolled Nurse	10	6	4	2	
	Nephrology Nurse	10				

Staff Category	Sub categories	Regional (2ndary referral) hospital -L5	County (primary) hospital -L4	Health Centre L3	Dispen-sary L2	Commu-nity Unit L1
	Oncology Nurse	10	2			
	Ophthalmic Nurse	6	2			
	Paediatric Nurse	10	2			
	Palliative Care Nurse	6	4			
	Psychiatrist Nurse	20	6			
	Registered Midwives	60	20	6		
	Sign Language Nurse	2	1	1		
	Theater Nurses	60	10			
	Anaesthetist Nurse	4	6			
	Accidents & Emergency Nurse	10	10			
Pharmacy Staff	Pharmacist	6	4	1		
	Clinical pharmacist	4	2			
	Oncology Pharmacist	1				
	Pharmaceutical Technologist	10	8	4	1	
Plaster Staff	Plaster Technicians/ Technologists	6	4	2		
Rehabilitative staff	Orthopaedic Technologist	6	3	1	1	
	General Physiotherapist	12	6	3	1	1
	BSc Physiotherapy	2	1			
	Specialized Physiotherapists	3	2			
	Occupational Therapist	12	10	3	2	1
Clinical psychologists	Clinical psychologists	2	1			
Dental staff	Dental Officers	10	4	1		
	Oromaxillofacial Surgeon	2	1			
	Paediatric Dentist	6	2			
	Orthodontist	2	1			
	Dental Technologists	10	6	2		
	Community Oral Health Officers		2	4	2	1
	General Radiographer	10	6	2		
	Ultra sonographer	2	1			
	Mammography	1				
Diagnostics &	CT Scan /MRI Radiographer	3				
	Dental Radiographer	2	1			
	Therapy Radiographer	2				

Staff Category	Sub categories	Regional (2ndary referral) hospital -L5	County (primary) hospital -L4	Health Centre L3	Dispen-sary L2	Commu-nity Unit L1
	Nuclear Medicine Technologist	2				
	Radiation Monitoring & Safety Officer	1				
Health Promotion Officers	Health Promotion Officers	6	4	4	2	2
Medical Social Work	Medical Social Work	8	6	2	1	1
Health Administrative staff	Medical Superintendent	1	1			
	Health Administrative Officers	2	2	1		
	Human Resource Management Officer	2	2			
	Clerks	20	10	4	2	
	Secretaries	2	1			
	Accountants	6	2			
	Supply Chain Assistant	6	4	1		
	Supply Chain Officer	2	2			
Health Information	Health Records Information Management Officers-HRIMO	12	8	4	1	
	ICT Officer	4	2	1		
Medical Engineering Staff	Medical Engineers	2				
	Medical Engineering Technologists	8	5			
	Medical Engineering Technician	6	2	2		
Medical Laboratory Scientists	Medical Laboratory Technologists	50	40	10	2	
Nutrition staff	Nutrition & Dietetic Officer	20	10	2		
	Nutrition & Dietetic Technologist	12	8	4	2	1
	Nutrition & Dietetic Technician	4	4	2	1	1
	Cateress	2	2			
Environmental Health Staff	Public health Officers	4	4	2	1	2
	Public Health Technician			2	2	4

Staff Category	Sub categories	Regional (2ndary referral) hospital -L5	County (primary) hospital -L4	Health Centre L3	Dispen-sary L2	Commu-nity Unit L1
Community Health Service Staff	Community Health Service Personnel(CHSP)					5
	Community Health Volunteers(CHV)					10
Support staff	Cooks	20	10	2		
	Drivers	15	12	4		
	Support Staff	60	40	10	4	
	Mortuary Attendant	10	6	2		
	Security	16	10	4	2	

The Kenya Health Strategic and Investment Plan, 2014 - 2018

Annex 3: The WHO Robson classification system

The WHO Robson classification system

A caesarean section is a life-saving surgical procedure in preventing maternal and perinatal morbidity and mortality. The use of C/S has been increasing at an alarming rate hence in 2015, WHO developed a tool to be used to compare caesarean sections in stratified groups in the same setting over time or between different settings. This is aimed to measure the trend and implement changes to ensure that the C/S is not used unnecessarily.

Robson classification system

Group 1 

Group 1: Nulliparous women with a single cephalic pregnancy, ⩾37 weeks' gestation in spontaneous labour

Group 2 

Group 2: Nulliparous women with a single cephalic pregnancy, ⩾37 weeks' gestation who either had labour induced or were delivered by Caesarean Section before labour

2a: Induced labour
2b: Caesarean Section before labour

Group 3 

Group 3: Multiparous women without a previous uterine scar, with a single cephalic pregnancy, ⩾37 weeks' gestation in spontaneous labour

Group 4 

Group 4: Multiparous women without a previous uterine scar, with a single cephalic pregnancy, ⩾37 weeks' gestation who either had labour induced or were delivered by Caesarean Section before labour

4a: Induced labour
4b: Caesarean Section before labour

Group 5 

Group 5: All multiparous women with at least one previous uterine scar, with a single cephalic pregnancy, ⩾37 weeks' gestation

Group 6 

Group 6: All nulliparous women with a single breech pregnancy

Group 7 

Group 7: All multiparous women with a single breech pregnancy, including women with one or more previous uterine scars

Group 8



Group 8: All women with multiple pregnancy, including women with one or more previous uterine scars

Group 9



Group 9: All women with a single pregnancy with a transverse or oblique lie, including women with one or more previous uterine scars

Group 10



Group 10: All women with a single pregnancy <37 weeks' gestation including women with one or more previous uterine scars

Reference

Robson Classification: Implementation Manual. Geneva: World Health Organization; 2017

Annex 4: Management of pre-eclampsia/eclampsia

MANAGEMENT OF PRE-ECLAMPSIA/ECLAMPSIA

- Hydralazine
- Labetalol
- Methyldopa
- I.V fluids
- Magnesium sulphate and calcium gluconate
- Phenytoin/diazepam
- Giving sets
- Branulla of all sizes
- Specimen bottles

For mild pre-eclampsia.

The information to support fluid eclampsia is included and checked on card

Mild Pre-eclampsia e.g. with BP 140/90 with Proteinuria trace or 1+ do the following:

- Do lab investigations to rule out end-organ involvement (CBC.UECr.LFT).
- Establish if the mother can rest at home
- Advise patient and relatives on importance of bed rest
- Give oral antihypertensive (alpha methyl dopa 250mg three times daily) Maintain diastolic BP at 90-100 mmHg
- Monitor maternal and foetal condition weekly.
- Admit if coming too far away from hospital,
- Advise on worsening signs of the condition, and the need to report if any signs of severe pre- eclampsia are present.
- Advise mother to take a diet, which is rich in protein, fibre and vitamins but low in carbohydrate and salt.
- Deliver after 37weeks (expectant management with corticosteroids for fetal lung maturity as needed.)
- If the mother shows no improvement and facilities /skills to manage severe eclampsia are lacking, refer to higher level.
- Nutrition information, importance of bed rest, worsening signs.

For severe eclampsia and eclampsia

- The information to support the diagnosis of severe pre-eclampsia or eclampsia such as 20 weeks of gestation or more, Diastolic BP 110 mmHg or more, convulsions has been Included and clearly recorded.

Healthcare provider takes history on the following:

- Headache
- Vision disturbance
- Edema including face and hands
- Upper abdominal pain
- Fetal movements
- Nausea and vomiting
- Decreased urinary output
- Mental confusion
- Convulsion/fits

1. Drowsiness/altered level of consciousness/confusion
2. Edema
3. Jaundice
4. Abdominal examination (obstetric, Ascites, Hepatomegaly).
5. Fundoscopy.
6. Input-output assessment.
7. Check for hyperreflexia/clonus
8. Seizures.
9. Focal neurological deficits

Observe or check records for Laboratory investigations:

- Urinalysis - proteinuria
- CBC
- Liver function test.
- Urea, electrolyte, creatinine
- Coagulation profile
- Uric acid levels

Radiological investigations:
Ultrasonography
Fetal Doppler

Management

- Admit patient
- Monitor vital signs every 15- 30 minutes
- Start MgSO4 regime
- Consider timing and mode of delivery
- Closely monitor fluid intake and urine output
- Do blood chemistry (liver enzymes and creatinine)
- If the diastolic blood pressure is 110 mm Hg or more, start antihypertensive drugs, e.g. Hydralazine: Give 5mg IV slowly over 10 mins if BP > or =160/110mm Hg; repeat 5 mg q20min to maximum of 20 mg
- If labetolol is not available, give Hydralazine or Nifedipine.
  Labetolol : Give 20mg bolus, subsequently give doses of 40mg followed by 80mg IV at 10- 20 min intervals to achieve BP control to a maximum of 300 mg. Lebatolol may also be administered by continuous IV infusion at 1mg/kg/hr.

Nifedipine: Initial dosage is 10 mg orally of BP > or = 160/110 mm hg. One may repeat after 30 minutes as needed

- Give MgS04.

Loading Dose.

- Magnesium sulphate 20% Solution, 4g IV over 5 minutes
- Follow promptly with 10g of 50% magnesium sulphate solution, 5g in each buttock as deep IM injection with 1mL of 2% lignocaine in the same syringe
- Ensure that aseptic technique is practiced when giving magnesium sulphate deep IM injection. Warn the woman that a feeling of warmth will be felt when magnesium sulphate is given.
- If convulsions occur after 15 minutes, give 2g magnesium sulphate (50% solution) IV over 5 minutes

Maintenance Dose

- Give 5g magnesium sulphate (50% solution) + 1 mL lignocaine 2% IM every 4 hours into alternate buttocks. Continue treatment with magnesium sulphate for 24 hours after delivery or the last convulsion, whichever occurs last.
- If 50% solution is not available, give1g of 20% magnesium sulphate solution IV every hour by continuous infusion(
- CLOSELY MONITOR THE WOMAN FOR SIGNS OF TOXICITY

Before repeat administration, ensure that:

- Respiratory rate is at least 16 per minute.
- Patellar reflexes are present.
- Urinary output is at least 30 ml per hour over preceding four hours

WITHHOLD OR DELAY DRUG IF:

- Respiratory rate falls below 16 per minute Patellar reflexes are absent
- Urinary output falls below 30ml per hour over the preceding 4 hours withhold MgSo4 and infuse patient with I.V fluids over 8hours with monitoring for pulmonary edema.
- Administers Furosemide I.V 40mg single dose in case of pulmonary edema.

Keep antidote ready:

- In case of respiratory arrest:
- Assist ventilation (mask and bag, anaesthesia apparatus, intubation)
- Give Calcium gluconate 1g (10mL of 10% solution) IV slowly until calcium gluconate begins to antagonise the effects of magnesium sulphate and respiration begins.
- If no improvement, refer to comprehensive centre accompanied by trained nurse.

Follow-up:

- Hourly monitoring of toxicity until the patient improves.
- Performance and evaluation of coagulation screen. Fetal heart rate (if patient has not yet delivered)
- Signs and symptoms of complication

Consider delivery as follows:

- Gestation ⩾34weeks
- Maternal end-organ involvement
- Fetal compromise.
- Expectant management with corticosteroids for fetal lung maturity as needed.

- Delivery in eclampsia should occur regardless of Gestational age within 12 hours from first fit (eclampsia is not an indication for C/S).

In Eclampsia vaginal delivery is recommended:

- If the cervix is favourable (soft, dilated, effaced), rupture the membranes and induce labour using oxytocin
- If there is no absolute indication for Cesarean section
- If safe anaesthesia is not available for C/section or if the foetus is dead or too premature for survival: If the cervix is unfavourable (firm, thick, closed), ripen the cervix using prostaglandins or a Foley catheter.

In Eclampsia caesarean section should be done:

- If vaginal delivery is not anticipated within 12hours (for eclampsia) or 24 hours (for severe pre- eclampsia), deliver by C/section
- If there are foetal heart rate abnormalities (< 100 or > 180 beats / minute)
- If the cervix is unfavourable (firm, thick, closed) and the foetus is alive,

For Eclamptic Fits

Management of fitting patient:

- Patient should be put in semi prone position so that mucous and saliva can drain out.
- Tight fitting dresses around the neck should be loosened or removed.
- No attempt should be made to insert any instrument into the mouth.
- Administer magnesium sulphate (or diazepam) as per regime to control fits.
- Aspirate secretions from the mouth and nostrils as necessary.
- Give Oxygen continuously during fit and for 5 minutes after each fit (if available).
- Fitting should be allowed to complete its course without restraining the patient.
- Privacy and dignity of patient must be observed - pull screens around her.

Post-natal care for Severe Pre-eclampsia and Eclampsia.

- Continue anticonvulsive therapy for 24 hours after delivery or last convulsion, whichever occurs last.
- Continue antihypertensive therapy as long as the diastolic pressure is ⩾110 mmHg
- Continue to monitor urine output. If urine output is less than 500 ml in 24 hours, limit the amount of fluid intake to 500 mls per 24 hour + an amount equal to the amount of urine passed
- Watch carefully for the development of pulmonary oedema.
- Monitor carefully for life threatening complications until the patient is clearly recovering.
- Consider referral/consultation of women who have:
  - Oliguria (less than 500 ml urine output in 24 hours) that persists for 48 hours after delivery.- refer to renal unit
  - Coagulation failure (e.g. coagulopathy or haemolysis, elevated liver enzymes and low platelets (HELLP) syndrome)
  - Persistent coma lasting more than 24 hours after convulsion.

Annex 5: Management of PPH

Service provider can correctly diagnose PPH or client records have sufficient information to support diagnosis of PPH (This is blood loss in excess of 500mls following vaginal delivery or 1000mls following caesarean section)

1. The health care provider looks out for the 4T's (Tone, Trauma, Tissue, Thrombin)
   Upon diagnosis, immediately calls for help/notify the theatre then measures the vital signs (PR BP RR,)
   - Determines Level of consciousness
   - If there is shock or suspicion of shock based on the assessment continue management as above
   - Covers the woman and starts oxygen at 6–8 L/minute
   - Starts two IV lines using 16- or 18-gauge wide bore needle
   - Takes a blood sample for hemoglobin, cross-matching, and clotting test
   - Initiates IV infusion with normal saline or Ringer's lactate
   - Infuses 1000 mL in each line over a 15–20-minute period
   - Administers at least two additional litres of solution during the first hour
   - Continues to replace volume IV according to blood loss
   - Monitors vital signs every 15 minutes
   - Performs bladder catheterization
   - Monitors fluid intake and output every 30 minutes

IF bleeding is due to retained placenta:

- Confirms that there's no second baby then administers oxytocin 10 IU IM
- Gives analgesia e.g. morphine, tramadol or anesthesia.
  Attempts placental extraction by applying controlled cord traction (with counter tractions on uterus), asking the woman to bear down(repeat the CCT with contraction)
- If this maneuver fails, performs manual removal of placenta (MROP) using sterile techniques
- Administers single dose of antibiotics e.g. crystapen, or penicillin 5 million IU IV PLUS metronidazole 500 mg IV (single dose)
- Makes sure that bladder is empty
- Procedure for MROP:
  - Holds the umbilical cord with a clamp and pulls the cord gently.
  - Inserts the other hand into the uterine cavity and locate the placenta
  - Provides counter-traction abdominally
  - Detaches the placenta by slowly working around the placental bed until the whole placenta is separated from the uterine wall.
  - Hold placenta in hand, removes it and inspects for completeness
  - Arranges for transfer of the woman for further surgical management or hysterectomy in case of placenta accreta, increta or percreta

If bleeding is due to uterine atony:

- Explains to the woman and what she is going to do, then
- Performs vigorous uterine massage
  Expel clots
- Administers oxytocin 20 IU in 1 L of saline solution at 60 drops/minute, and ergometrine 0.2 mg IM or IV (if the woman is not hypertensive)
- Continues to administer oxytocin 20 IU in 1 L of saline solution, 40 drops/ minute, up to a maximum of 3 L of solution with oxytocin, if necessary, and ergometrine 0.2 mg IM (or IV over 15 minutes) every four hours, up to three times if necessary (if the woman is not hypertensive)
- If hemorrhaging continues, performs bi-manual uterine compression using sterile techniques
  - Inserts fist into anterior vaginal fornix and applies pressure against anterior wall of uterus

- Places the other hand on the abdomen behind the uterus, presses the hand deeply into the abdomen, and applies pressure against the posterior wall of the uterus
- Maintains compression until bleeding is controlled and the uterus contracts.

If this procedure fails, performs aortic compression

- Applies downward pressure by placing a closed fist just above the umbilicus and slightly to the left over the abdominal aorta directly through the abdominal wall do insert uterine balloon tamponade as you wheel to theatre or as you transfer to the next level of care.
- Doctor in theatre or within reach must have skills on B-lynch, Uterine Artery Ligation and Hysterectomy

If bleeding is due to retained placental parts:

- Tells the woman what the problem is and explains what she is going to do
- Performs manual vacuum aspiration or instrumental extraction of remains under sterile procedure
- If removal of retained placenta fails take for examination under anaesthesia and further
- Management in case it is placenta accrete, increta, percreta

IF bleeding is due to perineal or cervical tears:

- Explains the problem and intervention to a woman
- Administers 1%Lidocaine to affected area
- Sutures the tears using appropriate suturing material

If bleeding is due to coagulopathy:

- Check coagulation laboratory results or findings(bedside clotting time)
- Transfuse with fresh frozen plasma/platelets/blood or refer as appropriate.
- Infuse 40IU of oxytocin in saline (Note if blood is clotted).
- Monitors uterine contraction, vital signs, and bleeding every 15 minutes during the first two hours and every half hour for the 3rd hour

Performs uterine massage and extraction of clots as needed
Measures fluid intake and urinary output hourly
Performs coagulation screen /clotting test if hemorrhage persists
Replaces volume and transfuses if necessary
Manages coagulopathy as appropriate

- Measures hematocrit or hemoglobin 24 hours after hemorrhage has been controlled
- If hematocrit is less than 33% or hemoglobin less than 11g/dl, prescribes120 mg of iron sulfate and 400 mcg of folic acid orally for a period of three months or provides blood transfusion as indicated

Enquires about the status of the baby and manages accordingly: safe and comfortable
Records all information including the care provided clearly and completely
Refers as appropriate

Annex 6: Hypovolemic shock

Ensure the provider assesses and notes the following:

- Pulse weak and fast (>110, ⩽60beats/minute)
- BP low (systolic <90 mmHg)
- Pallor
- Sweatiness or cold and clammy skin
- Rapid breathing (rate of 30 breaths per minute or more)
- Anxious, confused or Unconscious
- Scanty urine output (less than 30 mls/Hr)

What is the immediate treatment to be given?

- Call for help
  ABC of life described, simulated or provided based on the need
- Assess the woman Using A V P U mnemonic: (i.e. is the patient ALERT, responding to VOICE, only responding to PAIN or UNRESPONSIVE)
- If she is unconscious turn her on to her side to minimise the risk of aspiration in case she vomits and to ensure that the airway is open.
  - Maintains airways: put oxygen mask
  - Administers oxygen to the woman, 6–8 L/minute by cannula or mask
  - Starts two IV lines using a 16- or 18-gauge/ wide bore needle
- Takes a blood sample for haemoglobin, coagulation screen and blood group and Rhesus (cross-matching) and Requests for blood accordingly
- Keep the woman warm but do not overheat her, as this will increase peripheral circulation and reduce blood supply to the vital centres

Replaces fluids:

- 1 L saline or Ringer's solution over a 15–20-minute period
- Correctly Labels IV bags with: medications added and starting time
- Administers at least two additional litres of this solution during the first hour (two or three times the estimated blood loss) (1litre in 30minutes at 30ml/minute).
- Assesses woman's need for transfusion based upon signs and symptoms of shock or impending shock and amount of blood lost
- Performs bladder catheterization using indwelling catheter
- Avoid using plasma Substitutes e.g. Dextran.
- Give at least 2L of IV fluids in the first hour. This is over and above fluid replacement for ongoing losses (Note: A more rapid rate of infusion is required in the management of shock resulting from bleeding. Aim to replace two to three times the estimated fluid loss)
- Do not give fluids by mouth to a woman in shock
- Reduce the infusion rate to: 3ml/minute (1 Litre in 6-8 hours) when pulse slows down to less than 100 beats/minute, systolic BP increases to 100 mmHg or higher
- 0.5 ml/minute if breathing difficulty or puffiness develops
- Give fluids at:
- Moderate rate if severe abdominal pain, dangerous fever or dehydration: infuse 1 Litre in 2-3 hours
- Slow rate if severe anaemia / severe pre-eclampsia or eclampsia: infuse 1 Litre in 6-8 hours
- Catheterise the bladder and monitor urine output
- Record time and amount of fluids given – always use a fluid balance sheet and monitoring chart

Response to the immediate treatment?

- Re-assesses the woman every 15 minutes:
  - Vital signs (BP, RR, PR, T) stabilizing pulse (90beats/minute or less)

- Increasing systolic blood pressure (100mmmhg or more)
- Mental state (confusion, consciousness)
- Fluid balance (input and output) - urine output 30ml/hour

What to do when the conditions improve?

- Adjusts IV infusion to 1000 mL over a six-hour period (60 drops/minute)
- Continues to monitor vital signs every 30 minutes
- Monitors any loss of blood every 30 minutes

What to do if the condition does not improve?

- Continues IV solution 1000 mL over a six-hour period (60 drops/minute)
- Continues to administer oxygen at 6–8 L/minute
  Continues to monitor vital signs and fluid balance
- Identifies and manages the specific cause of the shock according to Protocol
  - Pertinent History taking and Physical examination
  - Lab exams requested as needed
- Continuously communicates to the mother, partner and staff to allay any anxiety
- Records all information including the care provided clearly and completely.

Refer as needed.

- Availability of skilled staff in the facility to do:
- Venous cut-down to obtain IV access in case there is inability to get IV access.

Annex 7: Obstructed labour

For obstructed labour:

History

- Age, parity, gravidity
- History of previous operative delivery
- History of previous stillbirth
- Duration of previous labour and outcome
- Duration of current labour
- Duration of ruptured membranes

Physical Examination

- Signs of physical and mental exhaustion
- Dehydration- dry mouth,
- Acetone breath due to keto-acidosis.
- Fever
- Shock - rapid pulse, anuria or oliguria, cold extremities, pale complexion, low blood pressure.
- Shock may be due to a ruptured uterus or sepsis.

Abdominal examination

- The foetal head may be palpable above the pelvic brim
- There may be frequent and strong uterine contractions
- The uterus may have gone into tetanic contractions and sits tightly moulded around the foetus
- Bandl's ring may be evident.
- The uterus may stop contracting especially in primigravidas

Vaginal examination:

- Oedema of the vulva present,
- Foul smelling - meconium stained liquor
- Absence of amniotic fluid (fluid has already drained away)
- Concentrated or bloody urine

- Hot and dry vagina
- Oedema of the cervix.
- Incomplete dilatation of the cervix
- Large caput succedaneum can be felt
- Severely moulded head, or a shoulder presentation or prolapsed arm.

Partograph reading.

Examination of the partograph may reveal:
- Foetal heart rate of more than 160/minute or less than 120/minute indicating foetal distress
- Foul smelling meconium-stained liquor
- Severe moulding
- Severe caput formation
- The rate of cervical dilatation slow or remains static in spite of strong contraction
- Maternal tachycardia and pyrexia

Scanty urine with ketonuria
Prolonged labour
- No advance of the presenting part despite adequate contractions because of mechanical factors. Obstruction usually occurs at the brim but may occur in the mid cavity of pelvic outlet.
- Second/ third degree molding and caput

Determine whether there is information to include the following:
Re-hydrated the patient to maintain normal plasma volume and prevent or treat dehydration and ketosis
- Checked maternal vital signs (T, RR, BP, PR)
- Gave broad spectrum antibiotics to prevent puerperal sepsis
- Took blood for Hb, blood grouping and X-matching
- Performed bladder catheterization
- Decided on the mode of delivery (one hour of admission) in a timely fashion:
  - If the fetus is alive, the cervix is fully dilated and the head is at 0 station or below, deliver by vacuum extraction. If vacuum fails referral should be made immediately for delivery by caesarean section.
  - If the fetus is alive but the cervix is not fully dilated or if the fetal head is too high for vacuum extraction, referral should be made immediately for delivery by caesarean section.
  - Performed or referred for laparatomy in case of uterine rupture
  - Performed or referred for C/section in case fetus alive and normal,
  - Performed or referred for craniotomy or destructive operation by competent obstetrician in case of a dead fetus in cephalic presentation with fully dilated uterus and descent of 3/5 or more
- Foley Catheter inserted and retained for 10 to 14 days
- Broad spectrum antibiotics administered for 7 days:
- Mother and significant others counseled on the cause of her condition and any outcomes
- Emotional support provided for mother and relatives
- Records all information including the care provided clearly and completely

Annex 8: Decontamination o f Instruments

Observe during the packaging process if:
- The instruments are clean and dry

If packaging items to be sterilized through steam sterilization (autoclave):
- Linen items have been laundered, dried and are intact (have no holes)
- All jointed instruments are opened (or in unlocked position) and disassembled
- The types of materials used for wrapping are:
  - Cloth wraps, muslin, or cotton: double wrapping or
  - Paper (Kraft or other paper): double wrapping
- If using paper, it is used only once and discarded (it is not reused)
- Canvas or other waterproof material is never used for wrapping

AND/OR

If packaging items to be sterilized through dry heat:
- The types of materials used are:
  - Cloth wraps, muslin: double wrapping or Metal with lids containers

10. The process of loading the sterilizer is performed properly.
Observe during the loading process :

If using steam sterilization (autoclave):
- If the autoclave is vertical, it has one or two baskets or
- If the autoclave is horizontal, it has a cart or shelves
- There is at least 7–8 cm of space between the packages and the walls
- Packs , Bottles , solid metals , glass containers with dry materials, canister, utensils and treatment trays rest on their edge and side in loose contact and with enough space between each other
- Instrument trays (mesh or perforated bottom only) are placed flat on shelves or baskets
- Packs are within the size limit: maximum dimensions: 30 x 30 x 50 cm or 5 kg

AND/OR

If using dry-heat sterilization:
- There is at least 7–8 cm (3 inches) of space between the packages and the walls

11. The sterilization process is performed according to protocol and manufacturer's instructions based on the type of sterilizer.
Observe during the sterilizing cycle if the standard conditions listed below are followed:

If steam sterilization (autoclave):
- Packs (linen,) rest on their edge, in loose contact with each other
- Autoclave for 20 minutes for unwrapped items or 30 minutes for wrapped items at 121 ºC (250ºF) in a gravity-displacement sterilizer,

AND/OR
- Autoclave other items depending on the type, whether it is wrapped or unwrapped, and the type of sterilizer (according to the manufacturer's instructions)

AND/OR
If dry-heat sterilization:
- There is space between packs and containers
- Sterilize at 170 ºC (340 ºF) for 1 hour after achieving the desired temperature (total cycle between 2 and 2.5 hours),

AND/OR
- Sterilize at 160 ºC (320 ºF) for 2 hours after achieving the desired temperature (total cycle between 3 and 3.5 hours)

AND/OR
If chemical sterilization is used:
- Disassembled instruments are totally soaked for at least 10 hours in 2–4% Glutaraldehyde solution or for at least 24 hours in 8% formaldehyde solution
- There is a label on the container indicating the starting time of sterilization
- There is a label on the container indicating the date of reconstitution, and the solution is used within 14 days or less (if Glutaraldehyde) or 28 days or less (if formaldehyde)
- After 10 hours (if Glutaraldehyde) or 24 hours (if formaldehyde), instruments are removed with sterile gloves or forceps and rinsed with sterile water, dried and placed in a sterile container

12. The process of unloading the sterilizer is performed according to the national IP standards to avoid contamination of sterile items.
    Observe during the unloading process:

If using steam sterilization (autoclave):
- The door is open 12–14 cm (5–6 inches) after the sterilizing cycle has been completed, and the chamber pressure gauge reaches "0"
- 30 minutes are allowed before unloading the sterilizer, for pack and instruments to dry (not applicable if drying cycle is used)
- Packages are dry before unloading
- If a loading cart is used, the cart is removed from the sterilizer and placed aside until it is cool
- If the packs are loaded in baskets or are placed directly in the sterilizer, baskets and / or packs are laid out on a clean surface padded with clean paper or fabric, until they are cool
- Unnecessary handling of the packs is avoided
- When packs have cooled to room temperature, they are dispensed or placed in a sterile storage area

If using dry-heat sterilization:
- Packs/containers are laid out on a clean surface padded with clean paper or fabric, away from open windows or a fan until they are cool
- Packs/containers cool to room temperature before handling
- Unnecessary handling of the packs/containers is avoided
- When packs/containers have cooled to room temperature, they are dispensed or placed in a sterile storage area

13. The High Level Disinfection (HLD) process is performed according to national standards and method used.

Observe during the HLD cycle if the standard conditions listed below are followed:

If boiling is used:
- All cleaned, disassembled instruments are totally immersed in water before lid is closed
- The lid is closed
- Instruments are disinfected for 20 minutes starting from the time a rolling boil begins
- After 20 minutes, instruments are removed with HLD or sterile forceps, dried and stored in HLD containers

AND/OR

If chemical:
- Glutaraldehyde (2–4%), formaldehyde (8%), or 0.1% chlorine solution (prepared with boiled or sterile water):
- All cleaned, disassembled instruments are immersed in solution for 20 minutes in a container with a lid
- There is a label on the container indicating the starting time of HLD
- There is a label on the container indicating the date of reconstitution, (within 14 days if using Glutaraldehyde; 28 days if using formaldehyde or within 24 hours if using chlorine solution)
- After 20 minutes, instruments are removed with HLD or sterile forceps or gloves, rinsed with sterile or boiled water, dried and stored in HLD containers

Annex 9: IPC in the lab

Staff is forbidden to eat, drink or smoke in the laboratory
- It is forbidden to store food and beverages in refrigerators used for clinical specimens
- Specimen containers have lids
- Laboratory workers wear appropriate attire (lab coats) and examination gloves to receive and handle the specimens
- Specimens are placed in a container that prevents leakage during collection, handling, processing, storage or transportation
- Staff change gloves and wash hands between patients and procedures
- Staff record information, answer the phone, open doors without gloves

Annex 10: Puerperal sepsis

Diagnosis

Signs and symptoms such as Fever, Offensive lochia, Sub involution of the uterus, Headache and general malaise, purulent discharge from laceration, episiotomy or incision

Laboratory Investigations
- Full blood count- look for neutrophilia
- High vaginal swab or lochia swab, or swab of incision for culture and sensitivity
- Urine test for analysis, microscopy, culture and sensitivity

Management
- Checks Vital signs (T, PR, BP and RR)
- Infuses IV fluids / Fluid balance
- Checks uterus for involution
- Provides parenteral Broad spectrum antibiotics until patient is fever free for 48 hrs
- Encourages or provides Perineal care
- Removes digitally ant retained POCs
- Drains any pelvic abscess
- Encourages Early ambulation
- Records all information including the care provided clearly and completely

Annex 11: Biosafety in administration of parental drugs

- Perform hand hygiene.
- Introduce yourself to patient.
- Confirm patient ID using two patient identifiers (e.g., name and date of birth) AND check against medication administration record (MAR)
- Check MAR against doctor's orders.
- Check that the medication has not expired.
- Administer the medication. If inserting an intravenous cannula or giving an intramuscular injection make sure that the skin has been prepared with spirit.
- Perform hand hygiene.

Ánnex 12: Infection Control Standard precautions in health care –who

Table 2: Section B: Infection Control Standard Precautions in Health Care

AIDE-MEMOIRE

Infection control standard precautions in health care

Background

Standard precautions are meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used, as a minimum, in the care of all patients.

Hand hygiene is a major component of standard precautions and one of the most effective methods to prevent transmission of pathogens associated with health care. In addition to hand hygiene, the use of **personal protective equipment** should be guided by **risk assessment** and the extent of contact anticipated with blood and body fluids, or pathogens.

In addition to practices carried out by health workers when providing care, all individuals (including patients and visitors) should comply with infection control practices in health-care settings. The control of spread of pathogens from the source is key to avoid transmission. Among source control measures, **respiratory hygiene/cough etiquette**, developed during the severe acute respiratory syndrome (SARS) outbreak, is now considered as part of standard precautions.

Worldwide escalation of the use of standard precautions would reduce unnecessary risks associated with health care. Promotion of an **institutional safety climate** helps to improve conformity with recommended measures and thus subsequent risk reduction. Provision of adequate staff and supplies, together with leadership and education of health workers, patients, and visitors, is critical for an enhanced safety climate in health-care settings.

Important advice

- Promotion of a safety climate is a cornerstone of prevention of transmission of pathogens in health care.
- Standard precautions should be the minimum level of precautions used when providing care for all patients.
- Risk assessment is critical. Assess all health-care activities to determine the personal protection that is indicated.
- Implement source control measures for all persons with respiratory symptoms through promotion of respiratory hygiene and cough etiquette.

✔ Checklist

Health policy

- Promote a safety climate.
- Develop policies which facilitate the implementation of infection control measures.

Hand hygiene

- Perform hand hygiene by means of hand rubbing or hand washing (see overleaf for detailed indications).
- Hands should always be washed with soap and water if hands are visibly soiled, or exposure to spore-forming organisms is proven or strongly suspected, or after using the restroom. For other indications, if resources permit, perform hand rubbing with an alcohol-based preparation.
- Ensure availability of hand-washing facilities with clean running water.
- Ensure availability of hand hygiene products (clean water, soap, single use clean towels, alcohol-based hand rub). Alcohol-based hand rubs should ideally be available at the point of care.

Personal protective equipment (PPE)

- ASSESS THE RISK of exposure to body substances or contaminated surfaces BEFORE any health-care activity. **Make this a routine!**
- Select PPE based on the assessment of risk:
  - clean non-sterile gloves.
  - clean, non-sterile fluid-resistant gown.
  - mask and eye protection or a face shield.

Respiratory hygiene and cough etiquette

- Education of health workers, patients and visitors.
- Use of source control measures.
- Hand hygiene after contact with respiratory secretions.
- Spatial separation of persons with acute febrile respiratory symptoms.

World Health Organization

EPIDEMIC AND PANDEMIC ALERT AND RESPONSE

Table 3: Section B: Health Care facility recommendations for standard precautions

Health-care facility recommendations for standard precautions

KEY ELEMENTS AT A GLANCE

1. Hand hygiene[1]

Summary technique:

- Hand washing (40–60 sec): wet hands and apply soap; rub all surfaces; rinse hands and dry thoroughly with a single use towel; use towel to turn off faucet.
- Hand rubbing (20–30 sec): apply enough product to cover all areas of the hands; rub hands until dry.

Summary indications:

- Before and after any direct patient contact and between patients, whether or not gloves are worn.
- Immediately after gloves are removed.
- Before handling an invasive device.
- After touching blood, body fluids, secretions, excretions, non-intact skin, and contaminated items, even if gloves are worn.
- During patient care, when moving from a contaminated to a clean body site of the patient.
- After contact with inanimate objects in the immediate vicinity of the patient.

2. Gloves

- Wear when touching blood, body fluids, secretions, excretions, mucous membranes, nonintact skin.
- Change between tasks and procedures on the same patient after contact with potentially infectious material.
- Remove after use, before touching non-contaminated items and surfaces, and before going to another patient. Perform hand hygiene immediately after removal.

3. Facial protection (eyes, nose, and mouth)

- Wear a surgical or procedure mask and eye protection (face shield, goggles) to protect mucous membranes of the eyes, nose, and mouth during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

4. Gown

- Wear to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
- Remove soiled gown as soon as possible, and perform hand hygiene.

5. Prevention of needle stick injuries[2]

Use care when:

- handling needles, scalpels, and other sharp instruments or devices
- cleaning used instruments
- disposing of used needles.

6. Respiratory hygiene and cough etiquette

Persons with respiratory symptoms should apply source control measures:

- cover their nose and mouth when coughing/sneezing with tissue or mask, dispose of used tissues and masks, and perform hand hygiene after contact with respiratory secretions.

Health care facilities should:

- place acute febrile respiratory symptomatic patients at least 1 metre (3 feet) away from others in common waiting areas, if possible.
- post visual alerts at the entrance to health-care facilities instructing persons with respiratory symptoms to practise respiratory hygiene/cough etiquette.
- consider making hand hygiene resources, tissues and masks available in common areas and areas used for the evaluation of patients with respiratory illnesses.

7. Environmental cleaning

- Use adequate procedures for the routine cleaning and disinfection of environmental and other frequently touched surfaces.

8. Linens

Handle, transport, and process used linen in a manner which:

- prevents skin and mucous membrane exposures and contamination of clothing.
- avoids transfer of pathogens to other patients and or the environment.

9. Waste disposal

- Ensure safe waste management.
- Treat waste contaminated with blood, body fluids, secretions and excretions as clinical waste, in accordance with local regulations.
- Human tissues and laboratory waste that is directly associated with specimen processing should also be treated as clinical waste.
- Discard single use items properly.

10. Patient care equipment

- Handle equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of pathogens to other patients or the environment.
- Clean, disinfect, and reprocess reusable equipment appropriately before use with another patient.

[1] For more details, see: WHO Guidelines on Hand Hygiene in Health Care (Advanced draft), at: http://www.who.int/patientsafety/information_centre/ghhad_download/en/index.html.
[2] The SIGN Alliance at: http://www.who.int/injection_safety/sign/en/

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Annex 13: ASA Classification

Table 4: Section B: ASA Classification

American Society of Anesthesiologists®

ASA Physical Status Classification System

Committee of Oversight: Economics

(Approved by the ASA House of Delegates on October 15, 2014, and last amended on December 13, 2020)

The ASA Physical Status Classification System has been in use for over 60 years. The purpose of the system is to assess and communicate a patient's pre-anesthesia medical co-morbidities. The classification system alone does not predict the perioperative risks, but used with other factors (eg, type of surgery, frailty, level of deconditioning), it can be helpful in predicting perioperative risks.

The definitions and examples shown in the table below are guidelines for the clinician. To improve communication and assessments at a specific institution, anesthesiology departments may choose to develop institutional-specific examples to supplement the ASA-approved examples.

Assigning a Physical Status classification level is a clinical decision based on multiple factors. While the Physical Status classification may initially be determined at various times during the preoperative assessment of the patient, the final assignment of Physical Status classification is made on the day of anesthesia care by the anesthesiologist after evaluating the patient.

Current Definitions and ASA-Approved Examples

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:	Pediatric Examples, Including but not Limited to:	Obstetric Examples, Including but not Limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use	Healthy (no acute or chronic disease), normal BMI percentile for age	
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease	Asymptomatic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent diabetes mellitus, abnormal BMI percentile for age, mild/moderate OSA, oncologic state in remission, autism with mild limitations	Normal pregnancy*, well controlled gestational HTN, controlled preeclampsia without severe features, diet-controlled gestational DM.

ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents.	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity, malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation, brain/spinal cord malformation, symptomatic hydrocephalus, premature infant PCA <60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants <6 weeks of age.	Preeclampsia with severe features, gestational DM with complications or high insulin requirements, a thrombophilic disease requiring anticoagulation.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory distress, advanced oncologic state.	Preeclampsia with severe features complicated by HELLP or other adverse event, peripartum cardiomyopathy with EF <40, uncorrected/decompensated heart disease, acquired or congenital.

ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.	Uterine rupture.
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes			

** Although pregnancy is not a disease, the parturient' s physiologic state is significantly altered from when the woman is not pregnant, hence the assignment of ASA 2 for a woman with uncomplicated pregnancy.*
***The addition of "E" denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)*

Annex 14: Five (5) moments for hand hygiene

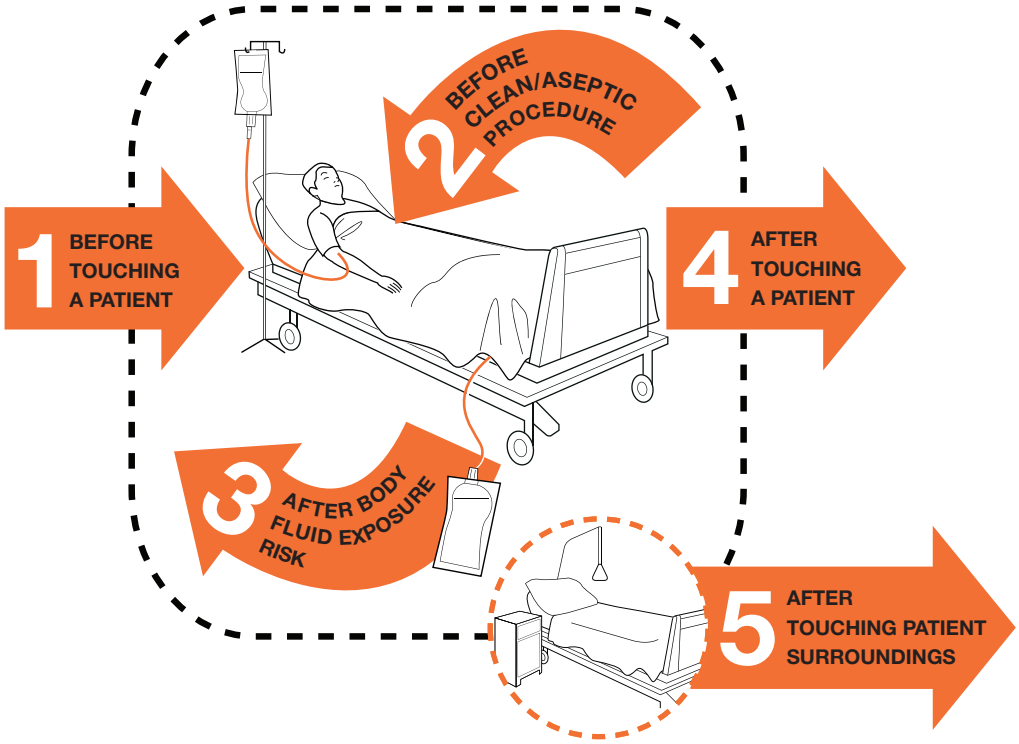
The 5 Moments for Hand Hygiene approach defines the key moments when health-care workers should perform hand hygiene.
This evidence-based, field-tested, user-centered approach is designed to be easy to learn, logical and applicable in a wide range of settings.

This approach recommends health-care workers to clean their hands

- **Before touching a patient,**
- **Before clean/aseptic procedures,**
- **After body fluid exposure/risk,**
- **After touching a patient, and**
- **After touching patient surroundings.**

Figure 3: WHO guidelines on hand hygiene in health care

Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.

World Health Organization | Patient Safety — A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

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WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

Annex 15: Endotracheal intubation guidelines (adults)

Background
Endotracheal intubation may be indicated but not limited to maintaining a patent airway, facilitating oxygenation and ventilation, reducing the risk of aspiration, and assisting in the removal of secretions.

Materials
The following materials should be during endotracheal tube placement:

1. Laryngoscope blades, appropriate size for the expected patient
2. Laryngoscope handle checked for sufficient battery power and working bulb
3. Endotracheal tube appropriate size for the expected patient plus a size above and a size below (2 to3 different sizes)
4. Syringe for inflation of the ETT cuff where necessary
5. Appropriate size oral airways
6. Oral suction apparatus
7. Appropriate size of suction catheter
8. Appropriate ETT securing device / materials

The assistant should also ensure that

1. There is an appropriately sized circuit, HME filter and mask connected and ready to use
2. End tidal CO2 connected to the circuit through the HME filter
3. There is appropriately sized hemodynamic and oxygen saturation monitoring equipment
4. There is Appropriate sedating, and muscles relaxants agents (as discussed with the anaesthetist)

The following should be accessible/ readily available in the theater in case anticipated difficult intubation or any other complications encountered during intubation

1. adjuncts– stylet, Appropriate size Laryngeal mask airway and /or nasopharyngeal airways
2. Resuscitation equipment– Ambu bag, face masks (2 to3 different sizes) Stethoscope

Annex 16: Postnatal care within 48 hours

Maternal care within 48 hours after uncomplicated vaginal delivery in health facility

General information

- Vigilance in period after delivery is critical to ensure early recognition of complications and prompt response
- If birth occurs at home, the first postnatal contact should be as early as possible within the first 24hours of birth

Recommendations:

- All postpartum women should have regular assessment during the first 24 hours as follows:
  - pulse rate 4 hourly until discharge
  - blood pressure should be measured shortly after birth
- If normal (100/60-140/90mm/hg), blood pressure should be taken every 4 hours until discharge
- excessive vaginal bleeding is indicated by presence of the following:
- pad soaked in less than five minutes
- increased pulse rate (pulse>100bpm)
- pallor (conjunctiva, palms)
- low blood pressure (BP<100/60mm/hg)
- shock index (Pulse rate/systolic BP) is greater than 0.7
  - uterine contraction
- uterus is hard and round
- fundal height should be below the umbilicus

- temperature should be normal (36.5 -37.2 degrees Celsius)
- Monitor temperature 4 hourly
- respiratory rates should be normal (18 to 24 breaths per minute)

- Woman should have passed urine within 6 hours
- Breastfeeding should be initiated within an hour after delivery progress should be assessed at each postnatal contact. Support offered as needed
  - there is no need to clean breast every time the baby feeds
  - daily bath is enough
- Maternity units should ensure some warm food and hot beverage is available for all postpartum especially those who deliver at night
- All HIV-infected women should be offered ART as per the Kenya ART guidelines
- HIV- infected women should
  - be counselled on importance of adherence to antiretroviral drugs
  - have viral load test if they have been on antiretroviral therapy for the past 6 months
- All women with unknown HIV status should be offered testing at delivery or soon as possible thereafter
- Women who tested HIV negative in the antenatal period should be offered repeat testing as per 2016 PMTCT guidelines
- All women should be offered syphilis test (RPR, VDRL or POC) if the test was not done during the antenatal visits
- Routine antibiotic prophylaxis following uncomplicated vaginal delivery is not recommended
- Prophylactic antibiotics are only recommended for women who have sustained third or fourth degree perineal tears
- Check for calf tenderness once a day until discharge
- Encourage male partner to support the women by:
  - allowing male partner free access to postnatal ward
  - involving men in care of the mother
  - providing privacy in the postnatal ward for male partners to stay with their spouses where possible
- Where it is feasible healthy mothers should receive care in the facility for at least 24 hours after an uncomplicated vaginal birth in a health facility
- Before discharge mother should be:
  - assessed for signs of high blood pressure
  - assessed for excessive vaginal bleeding
  - assessed for signs of infection
  - assessed for leakage of urine or faeces through the vagina
  - counselled on feeding, e.g. two extra meals and 2 snacks in addition to the 3 meals (for Example)
  - encouraged to use locally available and affordable foods and explained to about the need of extra food portions
  - assessed for mental or psychological wellness
- All women should be given information about the physiological process of recovery after birth
- All women should be advised to report any health concerns to a health care provider. In particular mothers educated on:
  - signs and symptoms of postpartum haemorrhage:
    - sudden and profuse blood loss or persistent increased blood loss
    - faintness
    - dizziness
    - palpitations/tachycardia
  - signs and symptoms of pre-eclampsia/eclampsia:
    - headaches accompanied by one or more of the symptoms of visual disturbances
    - nausea

        - vomiting
        - epigastric or hypochondriac pain
        - feeling faint
        - convulsions
    - signs and symptoms of infection:
        - fever
        - shivering
        - abdominal pain and/or
        - offensive vaginal discharge
    - signs and symptoms of thromboembolism:
- unilateral calf pain
- redness or swelling of calves
- shortness of breath or chest pain
- Adequate nutrition for the mother should be maintained to ensure the mother remains healthy and to enhance lactation performance and rapid recovery after delivery
- Women should be provided information on
    - their own nutrition
    - maintaining exclusive breastfeeding for the first 6 months
    - hygiene, especially hand washing
    - birth spacing and family planning
- health providers should discuss with the women about their contraceptive options
    - safer sex including use of condoms
- In malaria-endemic areas, mothers and babies should sleep under long lasting Insecticidal treated bed nets
- Women should be advised on importance of perineal hygiene. This includes:
    - frequent changing of sanitary pads
    - washing hands before and after changing pads
    - daily bathing or showering to keep their perineum clean
- Iron and folic acid supplementation should be provided for at least three months after delivery
- Signs of obstetric fistula- bleeding in urine, leakage of urine or faeces in vagina

Postnatal care following home delivery

- Women who deliver at home should be reviewed at a health facility as soon as possible and preferably within 24 hours after delivery
- Community health volunteer or community midwife should refer or accompany the mothers to the health facility
- At the facility the women should receive the standard package of postnatal care
- Haemoglobin levels determined, testing for HIV and syphilis, urinalysis done
- All women should be advised to report any health concerns to a health care professional

Maternal care within the first 48 hours after complicated vaginal delivery

Introduction

Complicated delivery refers to operative vaginal deliveries, caesarean sections, or women who were resuscitated, who had pre-eclampsia, eclampsia, and postpartum haemorrhage among others

Recommendation

- All women who had complicated deliveries should be managed according to relevant national guidelines and besides been offered the standard postnatal care
- women delivered by caesarean section should be assessed for signs of bleeding at the incision site and infection over and above post-surgical monitoring of the patient

Neonatal care within the first 48 hours

Introduction

Almost three fourths (74.3%) of the total deaths during the neonatal period occur in the first week of life. This include; almost all deaths (98.2%) due to asphyxia, about 40% deaths secondary to sepsis, and83.2% of deaths due to prematurity.

The first day (day 0) contributes to around 40% of these deaths.

Recommendations

- Where it is feasible, all healthy newborns should receive care in the facility for at least 24 hours after an uncomplicated vaginal birth
- Health care providers should always observe infection prevention and control measures when handling all infants
- All newborns should have:
  - immediate skin to skin contact before the umbilical cord is clamped
  - full clinical examination within an hour after birth and before discharge
- Initiation of breast feeding should be encouraged within the first 1 hour of birth
  - support with correct positioning and attachment
  - practice rooming in,
  - encouraging breastfeeding on demand
- Infants should be kept warm
  - room temperature should be 25- 28ºC
  - baby should be placed on the mother's abdomen or on a warm, clean and dry surface if the
  - mother is not there
  - use a radiant warmer if room not warm
  - kangaroo mother care for preterm infants (less than 37 weeks gestation) and low birth weight
  - (less than 2.5kg)
  - appropriate clothing of the baby for ambient temperature is recommended
- this means one to two layers of clothes more than adults and use of hats/caps
  - the mother and baby should not be separated and should stay in the same room 24 hours a day
- 1% tetracycline eye ointment should be administered to the infant for Opthalmia Neonatorum

Prophylaxis

- BCG and OPV vaccination should be administered as soon as possible after birth
- Vitamin K should be administered to all neonates
- Bathing should be delayed until after 24 hours of birth. If this is not possible, bathing should be delayed for at least six hours
- All mothers and care givers should be advised to observe hygiene at all times
- Infants and their mothers should sleep in long lasting insecticidal nets
- HIV exposed children (HEI) should be initiated on antiretroviral prophylaxis as per the Kenya PMTCT guidelines
- Birth notification form should be completed before discharge
- Communication and play with the newborn should be encouraged
- Health provides should enquire and assesses for signs and symptoms during each postnatal care contact:
  - fever (temperature >37.5 °C)
  - low body temperature (temperature <35.5 °C)
  - fast breathing (breathing rate >60 per minute)
  - severe chest in-drawing
  - swollen eyes, pus draining from eye or ear
  - any yellowness (jaundice) of the eyes, in first 24 hours of life, or yellowness of palms and

- soles at any age
- baby blue around the mouth
- redness of umbilical cord stump at the base
- not breastfeeding
- history of convulsions
- no spontaneous movement or baby lethargic

- The newborn should be referred for further evaluation if any of the signs or symptoms is present
- The mother or care giver should be counselled to seek health care promptly if they notice any of the above danger signs occurs in-between postnatal care visits

Home visits for postnatal care

Community health volunteers should conduct home visits as per the guidelines to assess mother and infant for danger signs and appropriate referral

Recommendation

- A home visit should be conducted in the first week after delivery
- Mothers should be counselled on the following:
  - Danger signs for maternal and newborn complications in postnatal period and encouraged
  - To promptly seek care in case of occurrence.
  - family planning individually or with her partner
  - personal hygiene
  - hand washing
  - breast care and exclusive breastfeeding
  - importance of adequate maternal nutrition

Annex 17: Ten steps in the baby friendly initiative

Ten steps in the baby friendly initiative

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in — allow mothers and infants to remain together — 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Annex 18: Coagulopathy (clotting failure)

Coagulopathy is both a cause and a result of massive obstetric haemorrhage.

It can be triggered by many causes, including:

- Abruption
- Sepsis
- Foetal death
- Eclampsia

- Amniotic fluid embolism.

The clinical picture ranges from major haemorrhage, with or without thrombotic complications, to a clinically stable state that can be detected only by laboratory testing. In many cases of acute blood loss, the development of coagulopathy can be prevented if blood volume is restored promptly by infusion of IV fluids.

Management is as follows:

- Treat the possible cause of coagulation failure.

- Give fresh whole blood, if available, to replace coagulation factors and red cells

If fresh whole blood is not available, choose one of the following based on availability:

- Fresh frozen plasma or cryoprecipitate for replacement of coagulation factors

- Packed red cells for red cell replacement

- Cryoprecipitate to replace fibrinogen

- Platelet concentrates (if bleeding continues and the platelet count is less than 20 000).

RUPTURED UTERUS

Bleeding from a ruptured uterus may occur vaginally unless the foetal head blocks the pelvis. Bleeding may also occur intra-abdominally. Rupture of the lower uterine segment into the broad ligament, however, will not release blood into the abdominal cavity.

Management is as follows:-

- Restore blood volume by infusing IV fluids (normal saline or Ringer's lactate) before surgery.

- When stable, immediately perform laparotomy and deliver the baby and placenta.

- Repair the uterus if the operative risk is less than what hysterectomy would entail and the edges of the tear are not necrotic. This takes a shorter time than hysterectomy and reduces blood loss.

- If the uterus cannot be repaired, perform subtotal hysterectomy. If the tears extends through the cervix and vagina, total hysterectomy may be required

- Because there is an increased risk of rupture with subsequent pregnancies, discuss the option of permanent contraception with the woman after the emergency is over.

Other important considerations for management of APH

When there is vaginal bleeding in pregnancy, the life of the mother and baby may be in danger:

1. *The delivery must always be in the hospital, even if the bleeding stops on its own.*

2. *Efficient referral systems must therefore be available at all levels and operational*

Annex 19: Antepartum Hemorrhage

Table 5: Section B: Diagnosis of APH
Diagnosis of APH

The table below outlines the presenting signs and symptoms of APH and differential diagnosis of ruptured uterus

Presenting signs and symptoms typically present	Signs and symptoms sometimes present	Probable Diagnosis
Bleeding after 28 weeks gestation	• Shock • Bleeding may be precipitated by intercourse • Foetal presentation not in lower uterine pole – feels empty • Relaxed uterus • Normal foetal condition	Placenta Praevia
• Bleeding (may be retained in the Uterus) after 28 weeks gestation • Intermittent or constant • Abdominal pain	• Shock • Tense tender uterus • Decreased foetal movements • Foetal distress or absence of foetal heart sounds	Abruptio placentae
• Bleeding (intra – abdominally and vaginally • Severe abdominal pain (may decrease after rupture	• Shock • Abdominal distension! • Free fluid • Abdominal uterine contour • Tender abdomen • Easily Palpable foetal parts • Absent foetal movements and heart sounds	Ruptured Uterus

The differential diagnosis of APH includes:

- Labour (bloody show)
- Cervical erosion
- Cervicitis
- Cervical polyp
- Carcinoma
- Trauma.

NOTE
Digital vaginal examination can cause severe bleeding, making the need for delivery urgent, so IN GENERAL IT SHOULD BE AVOIDED.

If it is absolutely necessary, it should be done under sterile conditions in the operating room and then only if preparations have been made for immediate blood transfusion and vaginal delivery or caesarean section (double setup)

MANAGEMENT OF APH

GENERAL MANAGEMENT

- **Shout for help. Urgently mobilize all available personnel**

- Make a rapid evaluation of the general condition of the woman including vital signs (pulse, blood pressure, respiration, temperature).

- If you suspect shock, begin treatment immediately.

- Start a rapid IV infusion (Normal saline or ringer's solution)

- Even if signs of shock are not present, keep shock in mind as you evaluate the woman further because her status may worsen rapidly

Management of PLACENTA PRAEVIA

Placenta praevia is implantation of the placenta at or near the cervix. If you suspect placenta praevia, do not perform a vaginal examination unless preparations have been made for immediate caesarean section

- Perform a careful speculum examination to rule out other causes of bleeding such as cervicitis, trauma, cervical polyps or cervical malignancy. The presence of these, however, does not rule out placenta praevia

- Assess the amount of bleeding.

- Restore blood volume by infusing IV fluids (normal saline or Ringer's lactate)

- If bleeding is heavy and continuous, arrange for caesarean delivery irrespective of foetal maturity
  If bleeding is light or if it has stopped and the foetus is alive but premature, consider expectant management until delivery or heavy bleeding occurs
  - Keep the woman in the hospital until delivery
  - Correct anaemia with oral iron therapy
  - Ensure that blood is available for transfusion, if required

- If bleeding recurs, decide management after weighing benefits and risks for the woman and foetus of further expectant management versus delivery.

Confirming the diagnosis of Placenta Praevia

- If a reliable ultrasound examination can be performed, localize the placenta.

- If placenta praevia is confirmed and the foetus is mature, plan delivery.

- If ultrasound is not available or the report is unreliable and the pregnancy is less than 37 weeks, manage as placenta praevia until 37 weeks.

- If ultrasound is not available or the report is unreliable and the pregnancy is 37 weeks or more, examine under double set-up to exclude placenta praevia, with the woman in the operating theatre with the surgical team present.

- National Guidelines for Quality Obstetrics and Perinatal Care

The double set-up prepares for either vaginal or caesarean delivery, as follows.

- Ensure IV lines are running and cross matched blood is available.
- Use a sterile vaginal speculum to see the cervix:
- If the cervix is partly dilated and placental tissue is visible, the diagnosis is confirmed; plan caesarean delivery

If the cervix is not dilated, cautiously palpate the vaginal fornices:

- If you feel spongy tissue, confirm placenta praevia and plan caesarean delivery
- If you feel a firm foetal head, rule out major placenta praevia and proceed to deliver by induction

If a diagnosis of placenta praevia is still in doubt, perform a cautious digital examination:

- If you feel soft tissue within the cervix, confirm placenta praevia and plan delivery
- If you feel membranes and foetal parts both centrally and marginally, rule out placenta praevia and proceed to deliver by induction.

If delivered by caesarean section and there is bleeding from the placental site:

  - Under-run the bleeding sites with sutures.
  - Infuse oxytocin 20 units in 1 L IV fluids (normal saline or Ringer's lactate) at 60 drops per minute.

Women with placenta praevia are at high risk for postpartum haemorrhage and placenta accreta/increta, a common finding at the site of a previous caesarean scar

Delivery is indicated if:

- Foetus is mature
- Foetus is dead or has anomaly not compatible with life
- Mother's life is at risk due to excessive blood loss

Rupture the membranes for vaginal delivery if:

- Minor degree of placentae praevia is suspected and / or detected
- Presentation is favourable for vaginal delivery
- Bleeding is light

Perform caesarean section if:

- Bleeding is heavy and continuous irrespective of gestational age
- Major degree of placenta praevia is suspected

A lower segment caesarean section is the treatment of choice for a major degree of placenta praevia

If placenta obstructs delivery, either incise it or deliver the baby around the placental edge. Prompt delivery will reduce maternal and foetal complications including mortality.

MANAGEMENT OF ABRUPTIO PLACENTAE

An abruptio placentae (placental abruption, retro placental bleed) is the detachment of a normally located placenta from the uterus before the foetus is delivered

Management is as follows:

- Assess clotting status using a bedside clotting test. Failure of a clot to form after 7 minutes or a soft clot that breaks down easily suggests coagulopathy.
- Ensure that blood is available for transfusion, if required
- If bleeding is heavy (evident or hidden), deliver as soon as possible
    - If the cervix is fully dilated, perform assisted vaginal delivery if there are no other Contraindications.
    - If vaginal delivery is not **imminent, deliver by caesarean section.**

If bleeding is light to moderate (the mother is not in immediate danger), the course of action depends on the foetal heart rate:

- If foetal heart rate is normal or absent, rupture the membranes with an amniotic hook or a Kocher's clamp
- If contractions are poor, augment labour with oxytocin
- If the cervix is unfavourable (firm, thick, closed), perform a caesarean section
- If the foetal heart rate is less than 100 or more than 180 beats per minute:
    - o Perform rapid vaginal delivery
    - o If rapid vaginal delivery is not possible, deliver by immediate caesarean section. In every case of abruptio placentae, be prepared for postpartum haemorrhage.

Management of accidental haemorrhage (Abruptio Placenta) of revealed type

- Consider conservative treatment if:
- Bleeding stops on admission or if it is minimal.
- There is a need to prolong the pregnancy
- Foetal condition is stable

If bleeding continues, however, examine the patient in an operating theatre, with trays at hand for both amniotomy for induction of labour or caesarean section, to decide/upon a further course of action.

Lower segment caesarean section in the management of APH is indicated in case of;
- Poor progress of labour
- Failure of the uterus to relax between contractions
- Foetal distress
- Increased bleeding

Annex 20: Injection Safety

Injection Safety

Sharps (needles, scalpels, etc.) must be handled with extreme caution to avoid injuries during use or disposal.

General Guidelines for Sharps
- Do not pick up a handful of sharp instruments simultaneously.
- Position the sharp end of instruments away from self and others.
- Exercise caution when rotating instruments are in use.
- Wear heavy-duty or strong utility gloves while decontaminating instruments.
- Dispose of used sharps immediately in designated puncture- and leak-proof containers labeled with a biohazard symbol.
- Prevent access to used needles , syringes and other sharps while awaiting transport for final disposal.
- If injured by sharps, contact the supervisor immediately.

Safe and Appropriate Injections and Use of Needles and Syringes

A safe injection is an injection that does not harm the recipient, does not expose the provider to any avoidable risk, and does not result in any waste that is dangerous for other people.

WHO estimates that at least 50 % of all injections are unsafe. This poses serious health risks to recipients, HCWs, and the public. In many developing countries, injection overuse and unsafe practices account for a substantial proportion of new infections with HBV, HCV, and HIV. In a national cross-sectional survey on injection-safety practices in Kenya in 2012, 40% of participants preferred an injection over oral medication.

Injections should be administered safely and only when they are medically indicated. Eliminating unnecessary injections is the best way to prevent injection-associated infections.

The following guidelines determined through scientific evidences or expert consensus should be adhered to effectively protect patients, providers, and communities.

- Use a sterile, single-use syringe and needle for each injection.
  - Auto-disable syringes are mandatory for all immunization injections.
  - For curative and other types of injections, syringes with reuse-prevention devices and syringes with safety features are recommended. Where these are not available (for example, 20-milliliter and 50-milliliter insulin syringes), standard disposable syringes can be used.
- Ensure that the syringe and needle are sealed and inspect the packaging for breaches in barrier integrity.
- Prevent contamination of injection equipment and medication
  - Reconstitute each unit of medication aseptically and separately using a single-use syringe and needle.

- Prepare each injection in a clean designated area where blood or body fluid contamination is unlikely.
- Use single-dose vials instead of multi-dose vials. If multi-dose vials must be used, always pierce the septum with a sterile needle and do not leave the needle in place in the stopper of the vial.
- Select pop-open ampoules instead of ampoules that require a metal file to open.
- Protect fingers with a clean barrier, such as a small gauze pad, when opening ampoules.

- Inspect for and discard medications with visible contamination or breaches of integrity, such as cracks or leaks in the container.
- Follow product-specific recommendations for using, storing, and handling equipment and medication.
- Swabbing new vial tops or ampoules with an antiseptic or disinfectant is unnecessary.
- Prepare patient's skin before injection:
  - Wash skin that is visibly soiled or dirty with soap and water.
  - If swabbing with an antiseptic use a clean, single-use swab and maintain the contact time that is specified for the product.
  - Do not use cotton balls that have been stored wet in a multi-use container.
  - Avoid giving injections on skin that has compromised integrity.
- Discard a needle that has touched any nonsterile surface.

Prevent Injuries to HCWs

Before administering an injection or any skin-piercing procedure, ensure that the following precautions are observed, depending on the types of procedure:

- Anticipate and take measures to prevent sudden patient movement during and after the injection
- Discard all used syringes and needles or any other sharps as a unit at the point of use in an enclosed sharps container that is puncture- and leak-proof, placed within arm's reach, and less than three-quarters full.
- Use disposable gloves only if excessive bleeding is anticipated.

Annex 21: Caesarean section

Outline:

- Definition
- Indications
- Types of C/ Section
- Patient evaluation
- The Caesarean section Procedure
- Post-operative care
- Complications of Caesarean Section

Definition

Caesarean section also C-section, etc., is a surgical procedure in which one or more incisions are made through a mother's abdomen (laparotomy) and uterus (hysterectomy) to deliver one or more babies, or, rarely, to remove a dead fetus. Surgical delivery of a pre-viable foetus using Caesarean section procedures is termed hysterotomy.

Indications for Caesarean Section:
These may be divided into maternal, foetal or combined.

Maternal Indications
1. Previous uterine scar
2. Previous Lower Uterine Segment C/S due to a recurring reason e.g. contracted pelvis or a previous scar with a concomitant obstetric complication

    - History of two (2) or more previous C/S
    - After High vertical /classical C/S
    - Previous ruptured uterus
    - Previous myomectomy

3. Severe Pre-eclampsia (PET) or eclampsia with unfavourable cervix

    - Life-threatening ante partum haemorrhage (APH) or Placenta praevia type II b-IV
    - Contracted pelvis (congenital, fracture)
    - Following repair of obstetric fistula (VVF, RVF)
    - Medical illness; severe heart or respiratory disease, severe hypertension, cerebral aneurysm, musculoskeletal disorders, severe neurological disorders (C/S is then safer than vaginal delivery).
    - Prolonged labour, uterine inertia, cervical dystocia and failed induction
    - Pelvic tumors obstructing labour (fibroids, entrapped ovarian tumor, genital warts)
    - Invasive carcinoma of the cervix
    - Infections: (HIV, active Herpes Simplex Virus II, Human Papilloma Virus, Hepatitis B Virus)

Relative indications
C/ Section may also be considered in the following conditions

- 1.Postdatism
- 2.Elderly primigravida
- 3.Prior infertility
- 4.Bad obstetric history

Foetal
- Foetal distress /Poor biophysical profile score
- Malpresentation and malposition;
- Cord presentation and/or cord prolapse
- Multiple pregnancy: (1st non-cephalic, retained 2nd twin, extreme prematurity, discordant foetal growth, single amniotic sac, conjoined twins, >2 foetuses)
- Foetal Macrosomia: estimated weight > 4000g
- Foetal anomalies: (e.g. hydrocephalus, sacral tumor, Conjoined twins)

- Others: (e.g. Intrauterine Growth Retardation, oligohydramnios)

Feto-maternal

1. Failure to progress in labour
2. Peri-mortem C/ Section
3. Lack of competency by service provider in assisted delivery techniques