



Quality improved.

Lessons learned from a quality improvement program for private maternity care facilities in India



MSD for mothers
Committed to Saving Lives



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MSD for Mothers

This program was developed and is being implemented in collaboration with *MSD for Mothers*, MSD's 10-year, \$500 million initiative to help create a world where no woman dies giving life. *MSD for Mothers* is an initiative of Merck & Co., Inc., Kenilworth, NJ, USA.

Jhpiego

Jhpiego is a nonprofit global leader in the creation and delivery of transformative health care solutions that save lives.

In partnership with national governments, health experts and local communities, we build health providers' skills, and we develop systems that save lives now and guarantee healthier futures for women and their families. Our aim is revolutionizing health care for the planet's most disadvantaged people.

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The Federation of Obstetric and Gynaecological Societies of India (FOGSI) is the professional organization representing practitioners of obstetrics and gynecology in India. With 241 member societies and over 33,000 individual members spread over the length and breadth of the country, FOGSI exists to encourage and disseminate knowledge, education and research in the field of obstetrics and gynecology, to pilot and promote preventive and therapeutic services related to the practice of obstetrics and gynecology for betterment of the health of women and children in particular and the wellbeing of the community in general, to advocate the cause of reproductive health and rights and to support and protect the interest of practitioners of obstetrics and gynecology in India.

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Executive summary

India continues to struggle with a high maternal mortality rate. Although an increasing number of women are giving birth in health care facilities, maternal deaths are not declining at a corresponding pace, largely due to insufficient quality of care. Among private maternity providers, quality of care is inconsistent and there is no clear consensus on quality standards. In addition, India has no national system to ensure quality among private providers.

With support from *MSD for Mothers*, and in partnership with the Federation of Obstetric and Gynaecological Societies of India (FOGSI), Jhpiego developed a quality improvement (QI) model that resulted in improved care practices in 140 private, for-profit facilities in Jharkhand and Uttar Pradesh. Through a program that included skills training, drills, standardized data collection tools, peer assessments, and formal recognition, providers were motivated to participate in activities designed to help their facilities achieve and maintain quality standards.

The Jhpiego-FOGSI Private Sector Quality Improvement (PSQI) program was unique in demonstrating a potential mechanism for measuring and benchmarking quality and objectively linking it to quality improvement. PSQI program staff worked directly with facilities to assess the quality of care provided; identify gaps in skills, practices, and procedures, and other reasons for a facility's non-adherence to quality standards; develop action plans and implement strategies to address those gaps; and measure improvement and determine level of compliance, tracking progress over time. By the end of the implementation period, the proportion of

participating facilities able to meet at least 70% of quality standards rose from less than 3% to 88%.

Based on this successful implementation experience, we recommend the following strategies for private sector QI initiatives in India and similar settings:

- 1 Recognize the role of medical professional associations. This program succeeded in large part due to its ability, with FOGSI's help, to engage private maternity providers in quality management and improvement.
- 2 Leverage nurses and paramedics as drivers of change.
- 3 Consider the needs of private providers and adjust training approaches accordingly, by using modular content and flexible scheduling.
- 4 Provide post-training support and on-the-job mentoring to ensure the sustainability of quality improvements.
- 5 Leverage the potential of formal recognition systems (such as a quality seal or certification by an accrediting body) to support sustained quality in private health facilities.

Looking forward, Jhpiego, FOGSI, and *MSD for Mothers* will work to bring this QI model to a growing number of private providers and explore ways to ensure and sustain quality over time.

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Introduction

Research shows that better care during labor and delivery and immediately after childbirth could avert up to 1.49 million maternal and newborn deaths (including stillbirths) annually worldwide by 2025.¹ Yet despite the evidence, progress on reducing maternal mortality fell short of global targets for 2015, and it remains off pace to meet **the new Sustainable Development Goal set for 2030** (a maternal mortality ratio of less than 70 deaths per 100,000 live births).

Progress has been particularly slow in resource-constrained settings in countries such as India.^{2,3} While national schemes such as *Janani Suraksha Yojana* have successfully increased the number of women delivering in facilities, the expected impact of higher institutional delivery rates on maternal mortality has failed to materialize; maternal deaths have declined only slightly in some regions, and in others not at all.^{4,5} Similarly, while the overall infant mortality rate is declining, the early neonatal mortality rate—a main indicator of intrapartum and perinatal care quality—has remained virtually unchanged in the last decade.⁶

These trends strongly suggest that the problem in India is quality of care; that improving care quality needs to be made a priority; and that greater efforts must be made to bridge the gap between research-supported knowledge and clinical practice.⁷

Focus on private maternity providers

In recent years, considerable efforts in India to improve the quality of institutional care during the antenatal, delivery, and postpartum periods have favored public health care facilities, largely excluding private ones. This has been the case despite the fact that private providers in India account for up to 30% of institutional deliveries in rural areas and up to 52.5% of institutional deliveries in urban areas, and despite evidence suggesting that quality of care is an issue for both sectors.⁸ A recent study conducted in Delhi, for example, found widespread non-adherence to evidence-based practices during childbirth among both public and private health facilities.⁹

Quality improvement (QI) and quality assurance among private maternity providers are particularly challenging due to:

- A widespread lack of technical resources;
- Insufficient training and other opportunities for nurses and paramedics to update their skills and knowledge, leading to continued use of outdated, ineffective, and sometimes harmful practices;
- Weak incentives for private maternity providers to invest in quality improvement, because efforts typically do not immediately translate into an increased client base; and
- Limited capacity (if not total absence) of systems to measure and monitor the quality of private providers' services.

Additional external challenges make it difficult to standardize quality of care across private maternity providers. Specifically:

- The private health sector is largely unorganized and unregulated.
- There has been no unifying or guiding voice driving QI activities in the past, professional associations did not play this role.
- There are no established benchmarks or standards for measuring care quality in the private sector, and thus there is a corresponding lack of accountability for performance.
- Government resources are allocated solely to public sector QI efforts.

With these challenges in mind, Jhpiego and FOGSI, with support from *MSD for Mothers*, designed and implemented the Private Sector Quality Improvement (PSQI) program to demonstrate a replicable model for improving quality of care in the private sector in India, while also working to develop standards that can be used to assess the content of maternity care delivered. In designing both the standards and the QI models, Jhpiego leveraged its expertise in implementing quality improvement in the public sector as well as its previous experience working with the private sector. In addition, Jhpiego and FOGSI forged a critical partnership, which proved to be central to the program's success. The following sections cover the objectives, implementation activities, and key findings of this QI program, along with lessons learned and suggested strategies for continued success.

The program: Leveraging private enterprise

The PSQI program was implemented over 3 years (2013–2016) in 11 large cities in the states of Jharkhand and Uttar Pradesh: Agra, Allahabad, Bokaro, Dhanbad, Giridih, Jamshedpur, Kanpur, Lucknow, Meerut, Ranchi, and Varanasi.

The PSQI program invited 149 facilities offering maternity care to participate. These 149 facilities were selected from a group of 200 identified during initial landscaping and outreach supported by FOGSI. Selection criteria included a delivery load of approximately 50–100 deliveries per month and the ability to meet basic infrastructure requirements for safe care practices. Facilities had an average of 24 beds and ranged from single obstetrician-led practices to corporate hospitals. The program's objectives were to **improve the quality of care** provided by private maternity providers through implementation of quality standards, and **strengthen the clinical competency** of private maternity providers in high-quality, evidence-based maternal and newborn health and family planning practices.

Quality improvement approach

Jhpiego modified its Standards-Based Management and Recognition® standards and used them as the foundation for the QI model, working in close consultation with FOGSI members and state government officials to prioritize and streamline them to satisfy the providers' need for a simple approach. Jhpiego's original list of standards was pared down to 27 (see Figure 1; complete list in Appendix A), and these became the targets for the QI efforts. Each standard was assigned a set of verification criteria for assessing adherence to that practice. Appendix B is an example of a standard and its verification criteria.

Details about the standards and the QI approach were disseminated to more than 200 private providers, including those selected for program implementation, during state- and city-level workshops conducted by the program in close coordination with local FOGSI chapters.

Figure 1. Performance standards for quality improvement

S.No.	Areas	Number of Standards
1.	Normal labor and delivery, including immediate newborn care (NLD)	13
2.	Management of complications during labor and delivery (MCLD)	5
3.	Postnatal care for the mother and newborn— inpatient (PNC)	5
4.	Postpartum family planning/PPIUCD counseling and insertion skills	4
TOTAL		27

Quality improvement implementation

Key QI implementation activities, also shown in Figure 2, included the following:

- 1 Conducting baseline readiness assessments** of participating private health facilities using performance standards to identify gaps and develop action plans, and **periodic follow-up assessments** to ensure progress;
- 2 Prioritizing resources** (equipment, drugs, and supplies) that are essential for adherence to recommended practices, and supporting facilities to ensure their availability;
- 3 “Upskilling” health workers** in key areas where performance was found to be lacking;
- 4 Improving compliance through post-training onsite mentoring** and troubleshooting support (including drills), and applying the Safe Childbirth Checklist; and
- 5 Improving the use of data** to drive action and increase accountability for the provision of high-quality care, via standardized data collection tools.

Figure 2. Implementation of performance standards



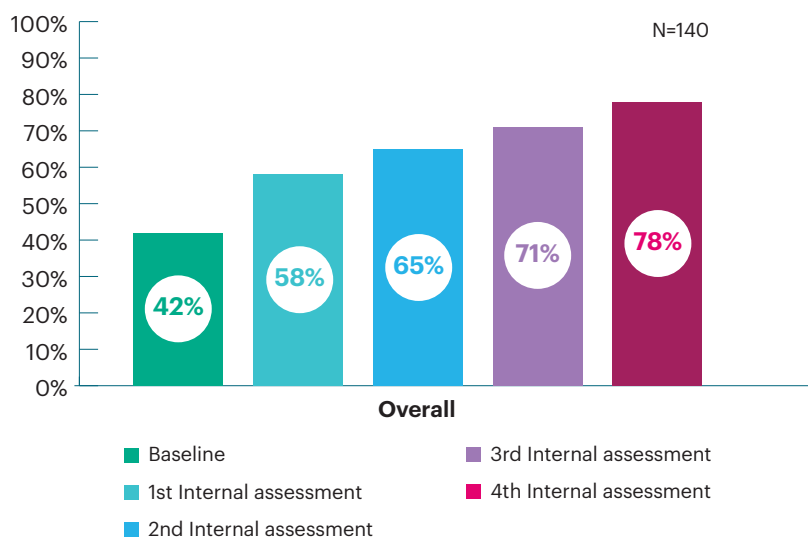
Conducting facility assessments

Facility readiness assessments were important for providing an initial overview of the quality of care the facility staff was prepared to offer. During assessments, PSQI program staff conducted direct observations of provider-patient interactions to assess compliance with verification criteria governing each performance standard. Unmet verification criteria were noted and incorporated into action plans.

At baseline, facilities demonstrated, on average, compliance with about 40% of the 27 performance standards. The goal was for all facilities to achieve compliance with at least 19 of the 27 standards—a 70% compliance score—by project's end, in order to be considered a facility offering high-quality maternity care.

The action plans typically included upskilling activities for health workers and updating facility practices and protocols. Efforts were made to include key personnel, such as obstetricians, nursing in-charges, and facility managers, in the assessment process.

Figure 3. Average scores on performance standards during internal assessments



Following the initial baseline assessment, facilities were instructed to conduct self-assessments every 6 months and update their action plans accordingly. These internal assessments were an opportunity for facility staff to work together to devise locally appropriate improvement strategies. Separate external assessments were conducted with support from PSQI program staff. **The 140 facilities that completed the program underwent five rounds of internal assessments at 6-month intervals**, including at baseline. Progress was recorded and collated to measure overall achievement. **The results of the internal assessments were found to be reliable during external assessments by Jhpiego and FOGSI.** Jhpiego conducted these external assessments as part of the routine quality



“After five rounds of assessments, 122 out of 140 participating facilities (87%) achieved a 70% score or better, compared to only 3% of facilities at baseline.”



improvement support visits to the facilities, and FOGSI's peer obstetricians from other cities conducted more formal, external assessments. The comparability of internally and externally assessed scores is reflected in the fact that out of 97 facilities scoring over 70% in internal assessments, only eight scored less than 70% in external peer assessments by FOGSI.

Assessing compliance with standards

Each standard contained a set of verification criteria that must be followed in order to meet the standard. Each verification criterion was triangulated through either direct observation of care provided to clients, observation of provider demonstration on models, or review of case records, provider interviews, or mothers' interviews, and through physical verification of the instrument(s)/equipment(s) required to perform the practice. A facility was considered compliant with a standard only when all of its verification criteria were met. Even one unmet verification criterion meant noncompliance with that standard.

The average facility adherence score on standards increased from 42% at baseline to 78% in the fourth internal assessment, reflecting facilities' adherence to standards defined in the program (Figure 3). After five rounds of assessments, **122 out of 140 participating facilities (87%) achieved a 70% score or better**, compared to only 3% of facilities at baseline.

Prioritizing resources

Before the initiation of training and related activities, program staff prepared a list of essential resources for meeting performance standards, such as magnesium sulfate, functional blood pressure apparatus, and basic infrastructure for newborn resuscitation areas (see Appendix C). The QI team shared the list with facilities and visited the facilities to encourage facility leadership to procure any missing resources. In many instances, the program staff helped facilities reorganize so that resources were more readily available, and advised facilities to maintain stocks of essential items to prepare for sudden complications. Facilities bore the costs for ensuring the availability of resources. Following the initial prioritization of resources, Jhpiego and FOGSI assessed the availability of resources/supplies during mentoring visits.

Strategic skills building

Health workers in private facilities, mostly paramedic staff and, in some cases, doctors, are often not up-to-date on the latest evidence-based practices, due to the absence of a robust system of continuing medical education and no mandatory training for retaining registration to practice.

To address this issue, the program staff trained private providers on key competencies required to implement high-impact, evidence-based clinical





standards. FOGSI local champions helped organize training sessions and often participated as trainers. The program developed a 2-day training curriculum to refresh providers' skills to perform key lifesaving practices during childbirth. Focusing on key lifesaving practices made training more time- and resource-efficient.

Separate training curricula were prepared for obstetricians and their facility staff to ensure that each type of private provider was exposed to content relevant to his/her level of expertise. Furthermore, the training curricula were designed to be customizable to suit individual scheduling routines and time constraints. Sensitization/orientation sessions were conducted both onsite and offsite; 62 centralized offsite training batches and 87 onsite training batches were organized, and more than 95% of providers (more than 1,300) from targeted facilities underwent clinical skills standardization training. To further improve access to high-quality postpartum family planning services, the program held an additional 22 centralized offsite trainings and 13 onsite trainings with approximately 500 providers.

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Post-training onsite mentoring support

Once a majority of a facility's staff had completed skills-building training, program staff followed up with periodic mentoring and support visits designed to ensure that health workers were putting their new skills into practice. Jhpiego had learned from its previous QI program experience that it is essential to provide this kind of follow-up support in the health workers' own facilities. The PSQI program used a set of standard operating procedures to govern these mentoring and support visits. Between September 2014 and December 2016, program staff conducted more than 1,900 visits, with an average of 14 visits per facility.

Priority activities during the mentoring and support visits included observing clinical performance; correcting mistakes and facilitating changes in protocols and practices; and helping staff complete important records. Program staff also facilitated the use of the **Safe Childbirth Checklist**, a reference tool developed by the World Health Organization, which contains detailed guidance on key evidence-based, lifesaving clinical practices targeting the major causes of maternal and neonatal mortality.^{7,10}

By the end of the implementation period, 79% of participating facilities were using the Safe Childbirth Checklist consistently during deliveries. The mentoring and support visits also provided an opportunity to conduct specialized team-centric activities in the form of emergency preparedness drills. During these drills, a “client”—a member of the staff wearing a delivery simulator—would receive care from the facility team, providing scripted responses to questions, while a drill director assessed team performance.

The drills were a welcomed opportunity for facility teams to practice identifying and managing obstetric complications, and for program staff to assess their level of preparedness and capacity to handle such complications. The drills covered the following scenarios: a healthy mother with a normal delivery; a case of pregnancy-induced hypertension with related complications; a normal delivery resulting in postpartum hemorrhage; and a vaginal delivery with newborn asphyxiation. This intervention began in the last year of the program; by program’s end, 148 successful drills were conducted at 54 facilities.

Improving the use of data for action and accountability

SMART (specific, measurable, attainable, relevant, and time-bound) indicators were effective for improving the quality of care and accountability for quality in facilities. As a first step toward meaningful use of data, the program introduced a **standardized labor room register**. This tool, endorsed by FOGSI, enables facilities to capture case details and track the frequency of certain practices during labor and delivery, such as measuring blood pressure, using a partograph, and administering oxytocin to prevent or treat postpartum hemorrhage.

Designated personnel from each facility team participated in a workshop on data handling to learn how to use the register and to compile monthly reports on service statistics, complications, and key practices. The workshop lessons were reinforced with some handholding by program staff during follow-up mentoring site visits.

Each facility reported its monthly data to Jhpiego, and the Jhpiego Monitoring and Evaluation (M&E) team validated the data (Appendix D shows the reporting template). The rare discrepancies were addressed with a site visit, during which the M&E team would check the data against the labor room register and review the use of recording and reporting formats with staff as needed. Providers also reported monthly progress data, often using the mobile phone application WhatsApp to do so. The state M&E team would then compile a monthly program report for each facility, and respective dashboards and feedback were shared with the facility during the next follow-up visit.

More than 90% of facilities involved in the program used standardized registers and reported quality data at least once during the program period; 70% shared it monthly for more than 6 consecutive months, mainly via email. The facilities monitored their dashboard indicators on an ongoing basis. The regular follow-up and feedback proved vital in strengthening data recording and reporting practices.

Facility achievement recognition

Peer recognition emerged as one of the biggest motivations for private maternity providers to engage in QI programs. Private maternity providers also indicated that formal certification of the achievement of standards and recognition by FOGSI would be a suitable and powerful reward mechanism.

FOGSI assessed compliance with standards. To prepare local FOGSI chapter members to assess adherence to standards, Jhpiego developed an objective quality assessment methodology. FOGSI teams (composed of an external FOGSI assessor from a different city, an internal FOGSI assessor from the same city, and a Jhpiego facilitator) assessed compliance with standards of care using methods such as personnel interviews, physical verification, client interviews, record reviews, demonstration of key skills on anatomic models, and simulation drills. Upon achieving more than 70% of standards, facilities received FOGSI certification and a quality of care seal. By program's end, FOGSI assessed 97 of 140 facilities, and 89 scored more than 70%. FOGSI did not assess adherence to standards in the remaining 43 facilities because of the program's shift in focus from FOGSI certification to third-party accreditation.

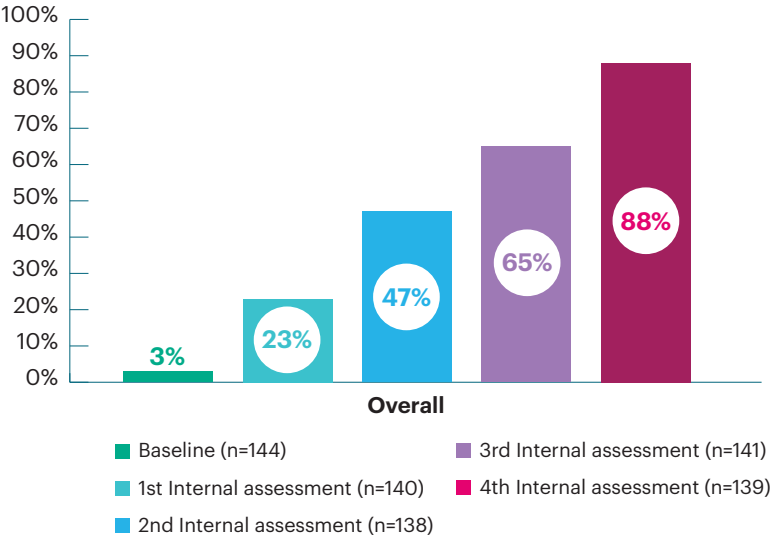
Facilities that did not achieve certification received recommendations from FOGSI assessors to improve adherence to standards.

Key program findings

The findings from periodic facility assessments indicate that the programmatic approach was successful in improving the quality of care during childbirth in the target facilities. Key results and lessons learned include the following:

- 1 **Improved adherence to safe care practices, described in the form of simple, objective standards of care, was achievable within a 3-year time frame.** Over the life of the program, 88% of facilities achieved the desired scores on performance standards (Figure 4).

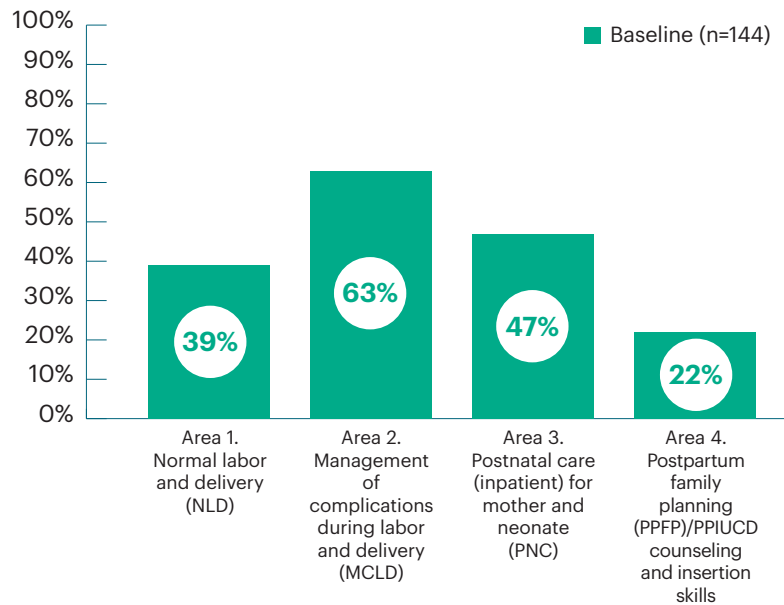
Figure 4. Facility scores on successive assessments



- 2 **Periodic post-training mentoring visits were effective in helping facilities improve adherence to standards.** Only 3% of facilities achieved a score higher than 70% during the baseline assessment; but an additional 20%, 24%, 18%, and 23% of facilities achieved this level by the first, second, third, and fourth assessments, respectively. Thus, between each successive assessment, approximately 20% more facilities achieved the desired scores.

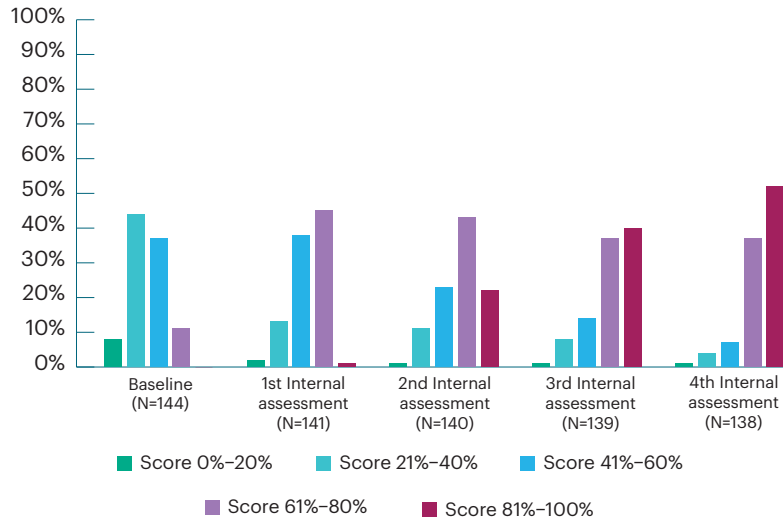
- 3 **At baseline, the private health care facilities fared better in management of complications than in routine care.** Average scores were 39% for normal labor and delivery, 63% for management of complications, and 47% for routine postnatal care (Figure 5). Given that ob-gyns tend to take the lead in managing complications, and that nurses and other paramedic staff typically lead in providing routine care, these scores show a need to strengthen the capacity of the latter group, in addition to standardizing care protocols.

Figure 5. Area-wise scores of facilities on performance standards



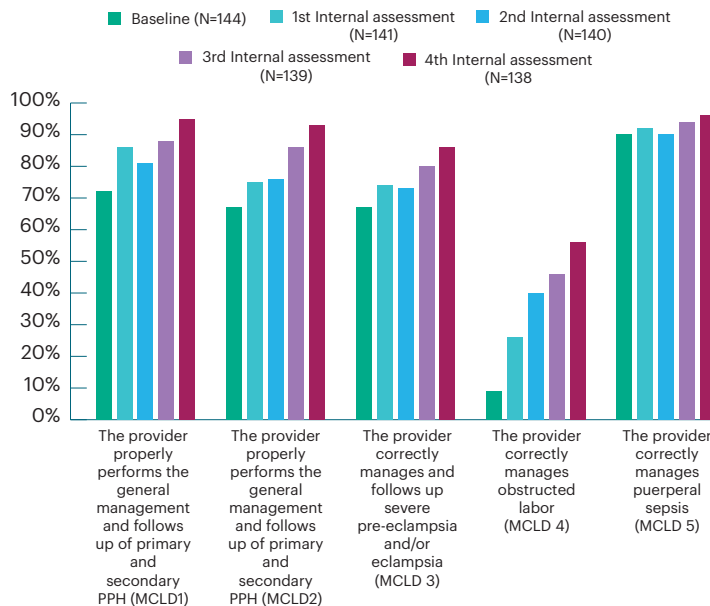
- 4 **Facilities made the greatest improvements between the baseline and first assessments.** On average, facility performance scores jumped by 16% in that time. Improvements continued thereafter, but at a more gradual pace, with scores rising an average of 7%, 6%, and 7% between the first and second, second and third, and third and fourth assessments, respectively. Changes in proportion of facilities in score quintiles also suggest a gradual change in adherence to performance standards (Figure 6). This indicates that the gap analyses conducted during the baseline assessments were useful in identifying basic protocol- and process-related issues that facilities could address internally. Subsequent, more incremental improvements were mostly skill and behavior related.
- 5 **Learning the basics can be challenging.** Facilities scored lowest at baseline on standards related to infection prevention, processing of instruments, and safe and sterile techniques. When providers had incorrect knowledge about a care practice (such as active management of the third stage of labor, or a vaginal exam), performance improved the fastest; progress was slower on standards that are skill intensive and dependent on health workers, such as newborn resuscitation and using a partograph to monitor the progress of labor.

Figure 6. Quintiles of scores on standards at successive assessments



6 Managing obstructed labor was the greatest challenge for many providers. In the management of complications section of the standards, facilities scored lowest on managing obstructed labor; at baseline, only 9% of facilities achieved this standard, primarily due to inappropriate use of the partograph (Figure 7).

Figure 7. Facility scores on standards related to management of complications



7 Postnatal care quality is also a challenge. In the postnatal care section, the standards regarding routine physical examination of the mother were adhered to the least; at baseline, only 13% of facilities achieved this standard.

“Partnership with FOGSI was a key driver of success in the program, mainly in helping with provider recruitment and retention.”





Engaging private maternity providers: Lessons learned and strategies for success

Implementation of this program showed that in order for private sector QI efforts to succeed, stakeholders must take into account both intrinsic and extrinsic factors that affect the private sector's capacity to achieve sustainable quality improvements. We found that **private maternity providers are willing and eager to engage in QI initiatives**. Of the 149 facilities selected, 140 completed all implementation activities; seven facilities were discontinued and two facilities voluntarily withdrew, for an overall dropout rate of just 6.4%. The discontinued facilities were mostly practices in which delivery loads became very low due to the leading obstetrician moving away or the facility changing its focus to streams other than obstetrics.

The program also showed that **private maternity providers are open to sharing data for quality monitoring purposes, as long as they have access to easy-to-use tools and as long as confidentiality of data is maintained**. During the 2-year implementation period, 94% of participating facilities deployed the data tools developed to support the process, and 96% shared quality data as required. A crucial factor was the availability of the standardized birth register, where collated information about various cases could be stored.

The following strategies are recommended for a private sector-focused QI program to succeed in India or similar settings:

Recognize the role of professional associations in engaging private health facilities

Partnership with FOGSI was a key driver of success in the program, mainly in helping with provider recruitment and retention. By participating in the development of clinical standards, FOGSI helped to ensure that providers felt ownership of them. In addition, FOGSI provided an essential platform for periodic program reviews and formal recognition. In contexts such as India, where there is still a significant number of small independent maternity units and a weak regulatory environment, medical professional associations can be the glue that binds various QI program components together.

Leverage nurses and paramedics as drivers of change

Private maternity providers frequently underestimated their need for additional training. The PSQI program intentionally focused on training nurses and paramedics as an entry point and as a way to motivate ob-gyns to participate. Seeing improvements in knowledge and skills among the nursing and paramedic staff prompted facility physicians to reconsider joining the program. In many cases, paramedic/nursing staff were able to convince the doctors of the benefits of the training and sensitization programs.

Use modular content and flexible scheduling for training

Private maternity providers are busy running their own businesses, which limits their availability for training. Conventional training programs typically take 2 to 3 consecutive days to complete and require participants to travel to centralized locations during routine working hours. This much time away from the business poses a risk to revenue and clientele. The PSQI program's training approach was more efficient. Content focused on specific gaps and poor practices and could be tailored to a specific facility; the 3.5 hour-long units could be completed during off hours. The approach resulted in high rates of training participation.

Provide post-training support and on-the-job mentoring

Centralized training programs help orient and educate providers on key areas, but it can be challenging for them to adapt their newly learned skills and knowledge to a specific environment. The PSQI program addressed this challenge by offering onsite follow-up support, by helping to ensure the availability of all required supplies, and by helping to reorganize client care flow protocols with adequately skilled staff to provide care at different stages.

Leverage the potential of formal recognition systems for sustaining quality

Financial incentives, such as improved cost-effectiveness, and formal recognition of achievements in QI are powerful motivators for private facilities to engage in QI in a sustainable way. Formal recognition improves providers' professional standing among their peers, improves brand recognition, and creates a general sense of pride among facility-based team members. The mechanism for peer assessment-based certification that FOGSI developed for this program is one that other medical professional associations could replicate.

Next steps

As this program ended, Jhpiego, working closely with the Programme for Accessible Health, Communication and Education (PACE), FOGSI, and the Association of Obstetricians and Gynecologists of Uganda, developed a set of universal standards for private maternity providers, which appear in the **Private Maternity Care Quality Toolkit**. This user-friendly toolkit was developed through a consultative process with dozens of stakeholders and *MSD for Mothers* partners, including representatives from the governments of India and Uganda. Partners field-tested the toolkit to ensure usability across a variety of private maternity care settings. The toolkit has the following features:

- **Distinct private care focus:** The toolkit aligns with World Health Organization quality standards, but it is streamlined to meet the needs of private maternity providers who might not have the time or staffing required to undertake complex quality management processes. It includes a concise set of prioritized standards as well as practical tools for easy data collection and informed decision-making.
- **Comprehensive yet customizable:** The standards and indicators target the most essential practices across the maternity care continuum, including antenatal, intrapartum, and immediate postpartum care.
- **Applicable to a range of providers and settings:** To ensure that the toolkit meets the needs of small, midwife-run health centers as well as large, obstetrician-run hospitals, partners solicited input from a range of providers in India and Uganda.
- **Useful for quality measurement, improvement, and assurance:** True quality management encompasses measurement, improvement, and assurance. The toolkit covers all three, making it useful for both self-assessment and external assessment. Providers and facility managers can use it for quality improvement, while accreditors and regulators can use it for quality assurance.

In India, FOGSI endorsed these **standards**, modifying them slightly for the Indian context.

Today, *MSD for Mothers* supports Jhpiego and FOGSI in scaling up and sustaining adherence to the FOGSI standards. Phase II of this program—called *Manyata*—is a comprehensive quality management program with two components:

- Scalable quality improvement support for private facilities, conducted by FOGSI using the Private Maternity Care Quality Toolkit; and
- Sustainable quality assurance once FOGSI-endorsed quality standards are met, indicated by certification from FOGSI on clinical standards and independent certification bodies such as the National Board of Hospitals and Healthcare Providers on overall quality of hospital care.

Currently, *MSD for Mothers* aims to reach close to 500 providers through this certification and aims for national reach within 5 years.

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Appendix A: List of standards

Area 1: Normal labor and delivery (NLD)

- | | |
|---------------|---|
| NLD 1 | The provider prepares equipment, supplies, and the environment for safe delivery.
NOTE: Total number of delivery trays readied depends on delivery load of site. |
| NLD 2 | The provider performs a quick check and rapid initial assessment of pregnant women in labor to identify complications and prioritize care. |
| NLD 3 | The provider ensures respectful and supportive care for women coming for delivery. |
| NLD 4 | The provider properly reviews and fills out the clinical history of women in labor. |
| NLD 5 | The provider properly conducts the lab and physical examination. |
| NLD 6 | The provider properly conducts a vaginal examination. |
| NLD 7 | The provider fills out the partograph correctly to monitor labor and makes adjustments to care. |
| NLD 8 | The provider assists the woman in having a safe and clean birth. |
| NLD 9 | The provider properly conducts a rapid initial assessment and provides immediate newborn care. |
| NLD 10 | The provider properly performs resuscitation of the newborn if the baby is not breathing normally. |
| NLD 11 | The provider adequately performs active management of the third stage of labor. |
| NLD 12 | The provider properly disposes of the used instruments and medical waste after assisting in the birth. |
| NLD 13 | The provider properly monitors the mother and newborn in the immediate postpartum period. |

Area 2: Management of complications during labor and delivery (MCLD)

- | | |
|---------------|---|
| MCLD 1 | The provider properly performs the general management and follow-up of primary and secondary PPH. |
| MCLD 2 | The provider properly performs the specific management of the cause of the PPH. |
| MCLD 3 | The provider correctly manages and follows up severe pre-eclampsia and/or eclampsia. |
| MCLD 4 | The provider correctly manages obstructed labor. |
| MCLD 5 | The provider correctly manages puerperal fever. |

Area 3: Postnatal (inpatient) care for the mother and newborn (PNC)

- PNC 1** The provider conducts a routine physical examination of the woman.
- PNC 2** The provider educates and counsels the mother about proper care during the puerperium.
- PNC 3** The provider properly assesses and manages the condition of the neonate.
- PNC 4** The provider counsels the mother on baby care.
- PNC 5** All low birth weight (LBW) and premature babies are recorded and followed up according to their condition.

Area 4: Postpartum family planning/ PPIUCD counseling and insertion skills (PPFP)

- PPFP 1** The provider uses recommended general counseling skills.
- PPFP 2** The provider properly conducts postpartum IUCD insertion.
- PPFP 3** The provider carry out relevant tasks during follow-up visit.
- PPFP 4** The provider records relevant information about the services provided.

Appendix B: Example of a standard and its verification criteria

Standard	Verification criteria	Assessment scores of successive assessments					Comments
Performance Standards	Verification Criteria	Baseline Date	1st Internal Assessment Date	2nd Internal Assessment Date	3rd Internal Assessment Date	Endline Assessment Date	
		Y/N/ NA	Y/N/ NA	Y/N/ NA	Y/N/ NA	Y/N/ NA	
Performance Standard: Identifies complications and prioritize care	<ul style="list-style-type: none"> Severe headache Blurred vision <p>2.2 Assesses for premature labour (Gestational age 24–34 weeks) and gives corticosteroids (Injection Betamethasone 12 mg IM 2 doses 24 hours apart OR Injection Dexamethasone 6 mg IM 4 doses 12 hours apart). These need to be present in the labour room for at least one such labour at any given time.</p>	SCORE					
	NLD 3 The provider ensures respectful and supportive care for the women coming for delivery	<p>The provider ensures respectful and supportive care for the women coming for delivery:</p> <p>3.1 Treats woman and her companions cordially and respectfully, ensures privacy and confidentiality for the woman throughout her stay</p> <p>3.2 Encourages the presence of a birth companion throughout the duration of her stay in the facility</p> <p>3.3 Explains the above mentioned danger signs and the important care activities to the woman and companion</p>	SCORE				
NLD 4 The provider properly reviews and fills out the clinical history of the woman in labour		<p>The provider properly reviews and fills out the clinical history of the woman in labour</p> <p>4.1 Checks last menstrual period (LMP) and expected date of delivery (EDD)</p> <p>4.2 Records the woman's obstetric history (parity, gravid status, h/o live births, still births, CS, abortions etc.), medical history (TB, heart diseases, Diabetes, Hepatitis B, STD etc.) and surgical history</p>					

Appendix C: List of essential resources

SN	Items	SN	Items
1	Checklists	14	Sterile scissors
2	Magnesium sulfate (at least 20 vials)	15	Sterile pads
3	Antibiotics for mother	16	Towels for receiving newborns
4	Antibiotics for baby	17	Syringes
5	Oxytocin (5/10 IU/ml)	18	IV Sets
6	Vitamin K (1mg/ml or 1mg/0.5 ml)	19	Ambu bag for babies with both pre & term mask (size 0,1)
7	IV fluids	20	Blood pressure apparatus
8	Antiretroviral	21	Stethoscope
9	Soap & running water	22	Thermometer
10	Sterile gloves	23	Mucus extractor
11	Uristick	24	Suction device
12	Partograph	25	Functional radiant warmer
13	Cord clamps	26	Protocols posters displayed

Appendix D: Monthly reporting format for improving quality of intrapartum and postpartum care

Facility:

City:

State:

Provider name (If applicable):

Month and year:

S.No	Data element	Numbers in the reporting month	
A	Obstetric services		
A1	Total number of normal deliveries in the facility		
A2	Total number of assisted deliveries in the facility (vacuum/forceps)		
A3	Total number of cesarean deliveries in the facility		
A4	Number of live births in the facility		
A5	Number of stillbirths in the facility		
A6	Number of intrauterine deaths in the facility		
A7	Number of maternal deaths in facility in the month		
A8	Number of newborn deaths in facility in the reported month		
B	Complicated deliveries	Managed at facility	Referred to higher center
B1	Mothers with postpartum hemorrhage		
B2	Mothers with sepsis		
B3	Mothers with pre-eclampsia		
B4	Mothers with eclampsia		
B5	Mothers with obstructed labor		
B6	Newborn with asphyxia		

S.No	Data element	Numbers in the reporting month
B7	Number of newborns with sepsis	
B8	Number of newborns who were premature births	
C	Practices	
C1	Number of deliveries where partographs were used for monitoring	
C2	Number of deliveries where mother's blood pressure was recorded at admission	
C3	Number of deliveries where mother's temperature was recorded at admission	
C4	Number of deliveries where oxytocin was given as uterotonic for active management of third stage of labor	
C5	Number of deliveries where misoprostol was given as uterotonic for active management of third stage of labor	
C6	Number of deliveries where baby was dried using clean dry towels immediately after birth	
C7	Number of deliveries where baby was breastfed within 1 hour of delivery	
C8	Number of deliveries where mother's temperature was recorded at discharge	
C9	Number of deliveries where baby's birth weight was recorded after birth	
C10	Number of deliveries where Safe Childbirth Checklist was used	
C11	Number of deliveries where baby's temperature was recorded at discharge	
C12	Number of mothers who adopted a postpartum family planning method	
C12.1	PPIUCD (postpartum intrauterine contraceptive device)	
C12.2	LAM (lactational amenorrhea method)	
C12.3	Postpartum sterilization	
C12.4	Condoms	
C12.5	Male sterilization	
C12.6	Others (specify)	

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