وزارة الصحة
Ministry of Health

Saudi Childbirth Initiative (SCI)

Mother Baby-Family Friendly Maternity Care Facility (MBFMF) Initiative

Guidebook

مبادرة منشأة رعاية الأمومة صديقة الأم والطفل و الأسرة

كتاب ارشادي

Ministry of Health
January 2023


بسم الله الرحمن الرحيم

Preface

The Saudi Childbirth Initiative (SCI) MotherBaby-Family Friendly Maternity Care Facility (MBFMF) initiative was developed in 2018 as a proposal by Dr. Fatma Alshangiti, the Leader of Obstetrics and Gynecology Services in the MOH as part of the Hayat Initiative Project in order to decrease maternal morbidity and mortality in the Ministry of Health (MOH), Saudi Arabia, with the goal of providing evidence-based, Mother-and-Baby-Friendly maternity care and reducing the rate of interventions during childbirth. This was submitted to the Ministry of Health for preliminary approval. The first MBFMF initiative was implemented in pilot hospitals in 2018 under the direction of Dr. Tareef Alaama, Deputy Minister for Curative Services, and with the support of Dr. Mohammed Khalid Alabdulaali, Assistant Deputy Minister for Hospital Services.

In 2019, after one year of implementing the MBFMF initiative and reviewing all of the feedback and implementation challenges in the piloted hospitals, this confirmed the need for a self-assessment tool to guide healthcare professionals through the implementation process. Another obstacle emerged to complete the initiative's implementation phase in 2020 was COVID-19. Despite the fact that the self-assessment tool was developed at this time.

In June, 2021, we restarted the process to get approval from all related departments in the MOH to publish the updated version of the initiative guidebook. Therefore, Dr. Tareef Alaama, formed a taskforce in 2022 to review the MBFMF initiative guidebook with a membership of consultants from MOH to provide the final approval for the updated version.

We would encourage stakeholders and leaders in Saudi Arabia to use this guidebook as part of local quality improvement and to take the initiative to move maternity care forward. This MBFMF initiative guidebook should be reviewed every 5 years or fewer when needed after audit from the time of implementation of this initiative. All feedback is welcomed via our emails.

Authors
Dr. Fatma Alshangiti, MBBS, FRCSC
Consultant Obstetrics and Gynaecology, Consultant Female Pelvic Reconstructive and Minimal Invasive Gynaecologic Surgeries, Riyadh, Saudi Arabia.
falshangiti@gmail.com

Dr. Roa Altaweli, PhD, RM
Consultant Midwife, Director of Midwifery Department, General Department of Nursing and Midwifery Affairs, Ministry of Health, Riyadh, Saudi Arabia.
roa.altaweli@gmail.com

Acknowledgements

We would like to acknowledge and thanks many departments and individuals who have reviewed and provided constructive feedback to the Saudi Childbirth Initiative (SCI) MotherBaby-Family Friendly Maternity Care Facility (MBFMF) Initiative Guidebook.

Committee Members		
Name	Title and Affiliation	Membership
Dr. Ali Magboul Al-Arabi Al-Ghamdi	Family and Community Medicine Consultant, Deputy Minister for Therapeutic Services Advisor, MOH	Chairperson
Dr. Mohammed Faraj Alsefri	Dentist, Assistant General Director for project's and excellence program's, General Department of Hospital Affairs, MOH	Vice-Chairperson
Dr. Agariad Abdullah Aldoosari	Family Medicine Consultant, Director of Women Health Program, MOH	Member
Ms. Albandri Abdul Rahman Abonayan	Nutritionist, Breastfeeding promotion program Supervisor, General Nutrition Administration, MOH	Member
Dr. Roa Altaweli	Consultant Midwife, Director of Midwifery Department, General Department of Nursing and Midwifery Affairs, MOH	Member
Dr. Malak Abdullah Alghadier	Family Medicine Consultant, Director of Child Health Program General Department of Health Programs and Chronic Diseases, MOH	Member
Dr. Mona Sameer Ibrahim	Consultant Obstetrics and Gynecology, Breastfeeding Promotion Program Assistant Supervisor, Head of Obstetrics and Gynecology Department in Durma hospital, MOH	Member
Dr. Naemah Mohammed Alshenqiti	Consultant Obstetrics and Gynecology, Leader of Obstetrics and Gynecology Specialty, MOH	Member
Dr. Yahya Abdulrahman Elnadi	MD in Obstetrics and Gynecology, Program Manager of Obstetrics and Gynecology, General Department for Hospital Affairs, MOH	Member

Reviewer	Title and Affiliation
Dr. Ahmad Fuad Gashgari	Consultant Neuroradiologist, General Director of the General Administration of Hospital Affairs, MOH
Dr. Abdullatif Saad Alokifi	Assistant of Director General for GD of Hospital Affairs, MOH

Departments
General Department of Nursing and Midwifery Affairs
General Department of Quality and Patient Safety
General Department of Home Health Care
General Department of Patient Experience Center
General Department of Nutrition
General Department of Engineering Services
General Department of Legal Affairs

Abbreviations

ALSO: Advanced Life Support in Obstetrics
AROM: Artificial Rupture of Membrane
BLS: Basic Life Support
BLSO: Basic Life Support in Obstetrics
HDU: High Dependency Unit
ICU: Intensive Care Unit
ISBAR: Identify, Situation, Background, Assessment, Recommendation
KPI: Key Performance Indicators
MCHPs: Mother and Child Health Passports
MOH: Ministry of Health
NICU: Neonatal Intensive Care Unit
NRP: Neonatal Resuscitation Program
OBERT: Obstetric Emergency Training Course
PROM: Premature Rupture of Membrane
PTP: Perinatal Training Programme
ROM: Rupture of Membrane
SCBU: Special Care Baby Unit
SCI: Saudi Childbirth Initiative
SROM: Spontaneous Rupture of Membrane
WHO: World Health Organisation

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Introduction

Global efforts have focused on strategies to reduce maternal mortality addressing the direct causes of pregnancy-related deaths, promotion of facility births, increased skilled birth attendance, and assurance of universal access to basic maternal health care.

Worldwide, an estimated 295,000 maternal deaths occurred in 2017, a 38 % reduction from 1990 (WHO, 2019). Nonetheless, maternal morbidity and mortality have not declined as rapidly as hoped, with most countries not reaching Millennium Development Goals (MDGs) targets either because of too little, too late (TLTL), or too much, too soon (TMTS) (Miller et al, 2016). TLTL refers to care with inadequate resources, below evidence-based standards, or care withheld or unavailable until too late to help. TMTS refers to the routine over-medicalization of normal pregnancy and birth. Therefore, a global approach to quality and equitable maternal health, supporting the implementation of respectful, evidence-based care for all, is urgently needed (Morton and Simkin, 2019; Miller et al, 2016).

The Saudi health care system is reforming the maternity care services to counteract the costly impact of the drastic increase in the rate of caesarean section and undue medical/obstetric interventions on the health care system. The MOH (2018a) has introduced the Mother-and-Baby-Friendly Hospital Initiative in January, 2018 which is aimed at providing evidence-based, Mother-and-Baby-Friendly maternity care and reducing the rate of interventions during childbirth. The MOH has published five important documents that are related to this initiative: Guidebook for Midwives (MOH, 2019a), Patient's Bill of Rights and Responsibilities Document (Women's Health) (MOH, 2019b), the Mother Health Passport (MOH, 2020a), Child Health Passport (MOH, 2020b) and Companion's Policy in the Obstetrics and Gynaecology Departments (MOH, 2021a). In addition, recently the MOH has published three vital standards for midwifery units, Saudi Midwifery Clinics Standards (MOH, 2021b), Saudi Birth Centre Standards (MOH, 2021c), and Saudi Home Birth Standards (MOH, 2021d).

This document presents the 10 steps of the Saudi initiative to achieve safe and respectful Mother Baby–Family Maternity Care. This was inspired and adapted by the Saudi MOH initiative, the 10 steps of the mother-friendly hospital initiative (CIMS, 2015), and the 12 steps of the International Childbirth Initiative (ICI) (Lalonde et al, 2018).

The Saudi maternal health initiative is founded on scientific evidence and focuses on the mother, child, and family. It focuses primarily on prevention and wellness as an alternative to the current practice of obstetric medicine. This initiative was introduced to guide health facilities in improving childbirth outcomes with evidence-based care.

Saudi Ministry of Health MotherBaby-Family Maternity Care Philosophical Foundation

MotherBaby-Family Maternity Care is defined according to the following principles:

1. Collaboration between the primary health care services and hospital facilities to integrate as one unit-team work with a multidisciplinary approach for all health aspects including communication, collaboration, consultation, referral to ensure optimal care for the MotherBaby- Family Unit.
2. Birth is a normal physiological process that does not require all the current medical interventions for active management in labour, especially in low-risk pregnancies.
3. Providing care that supports a positive birth experience and respects the interconnectedness of the MotherBaby-Family Unit during pre-conception, pregnancy, birth, and postnatal period for two years. This is especially important considering the tremendous impact that MotherBaby experiences will have on multiple facets throughout their life spans.
4. Policy, education, and practice should reflect current, evidence-based knowledge that avoids harmful procedures and is beneficial in supporting and protecting normal physiological pregnancy, labour, birth, postpartum and neonatal period.
5. Using evidence-based approaches for maternity health services based on midwifery and family-centred philosophies of care.
6. Maternity care practice should be based solely on the needs of the MotherBaby-Family, not on the needs of the caregiver or healthcare provider.
7. Promoting natural breastfeeding which is the most scientifically favourable nourishment for newborns and infants.

Saudi Ministry of Health Principles for Safe and Respectful MotherBaby– Family Maternity Care Facilities:

Safe and respectful maternity care for the MotherBaby-Family unit is to ensure that all women feel safe physically and psychologically in order to achieve a positive birth experience. It includes minimizing the risks of error and harm by following evidence-based practices and avoiding the overuse of routine medical interventions. It is our mission to ensure every MotherBaby-Family unit has access to evidence-based care and that this integral unit is treated with dignity and compassion.

Safe and respectful MotherBaby-Family Maternity Care is measurable and for each of the 10 steps, there is an associated checklist to ensure these guidelines are being established by health facilities such as but not limited to, primary health care, hospitals and health care professionals.

The following principles are the Ministry of Health's 10 Steps to reflect the merging of the visions and Safe and Respectful MotherBaby– Family Maternity Care in Saudi Arabia.

1. Provide Free or Affordable Care Continuum with Cost Transparency

The Saudi health care system provides MotherBaby- Family care through integrating the primary health care services and the hospitals/clusters with all relevant health care educators, providers, and institutions. This is achieved through education, communication, prevention, collaboration, consultation, and—that is essential to ensuring optimal care for women and babies, especially those with obstetric-neonatal risk or when obstetric-neonatal complications occur. Implementation of the following points and auditing them is mandatory to reduce the rates of maternal and newborn mortality and morbidity.

1.1 MotherBaby-Family as an Integral Unit: The MotherBaby-Family refers to an integral unit during pre-conception, pregnancy, birth, and infancy influencing the health of one another. Within this triad, the MotherBaby dyad remains recognized as one unit, as the care of one significantly impacts the other.

1.2 Advocating rights and access to care: Ensure that every MotherBaby regardless of their social/educational status, race, background, citizenship, age, and health status, has the right to access well-equipped and well-staffed health services which provide quality of care from skilled medical professionals. Additionally, ensure awareness of available community services and their right to free or fairly-priced materials which they may access for the needs and care of the MotherBaby.

1.3 Implementation of the MOH Mother and Child Health Passports (MCHPs): Mandatory adherence to the strict documentation of antenatal, postpartum, and neonatal and infant care (until the infant is 2 years of age). This is inclusive of screening, vaccination, investigations, education, supplements, management with a referral for necessary treatment as outlined by the MOH MCHPs or any other government document in alignment with MCHPs.

1.4 Promote preventative care: Establish preventative care and advocate for wellness in order to prevent illness or complications. Also, ensure there are established community support via primary care physicians and frontline health providers for consultations and prompt transfer of care to appropriate institutions and specialists when necessary.

1.4.1 Education and public health measures to prevent illness and complications of the MotherBaby.

1.4.2 Provide education with subsequent access to methods of disease prevention and treatment for MotherBaby, including but not limited to, nutrition, exercise, iron deficiency anaemia, hemoglobinopathy, thyroid problems, obesity, diabetes, hypertension, infectious diseases, toxoplasmosis, breastfeeding, and immunization.

1.4.3 Educate women regarding their sexuality, reproductive rights, and family planning options. Additionally, ensure resources are available to support family planning and youth-centred services.

1.4.4 Provide support to the entire MotherBaby- Family Unit by providing culturally competent prenatal education based on evidence and antepartum, intrapartum, postpartum, and newborn care. Prenatal education for the MotherBaby- Family unit should include not only the physical wellbeing of the MotherBaby but also the emotional and mental health with regards to the family unit and community. This should be inclusive of women who experience perinatal loss.

1.4.5 Discharge preparation and planning should be inclusive of adequate education to the MotherBaby- Family Unit regarding postnatal and neonatal care (i.e. appropriate immunizations, scheduled follow-up care, understanding of maternal and neonatal danger signs, and access to emergency care).

1.5 Protecting the Rights of MotherBaby– Family Unit: Primary health care providers and health institutions should understand and honour the impact the MotherBaby- Family Unit has on the overall wellbeing of one another. This is specifically essential during pre-conception, pregnancy, birth, and infancy. Therefore, it is the duty of the health care providers and institutions to strive for informed decision-making with the mother being the final decision-maker.

2. Provide Emergency Care and Transport

Ensure staff is well trained in prompt recognition of high-risk, potentially dangerous conditions and complications. Medical staff should demonstrate competent response with regards to emergency treatment and stabilization for potential complications. Health care providers and health facilities should have a network available for appropriate consultations and reliable transportation for an emergency referral. Additionally, health institutions should ensure an effective referral system for follow-up cases to avoid errors or lost cases in the system.

3. Provide Continuous Support

3.1 Support during childbirth: Health facilities should offer unrestricted access to the following:

3.1.1 Birth companions of the mother choice, including but not limiting to, male and female family members, friends, and a professional Doula (the latter of which provides continuous emotional and physical support professionally).

3.1.2 Midwifery care

4. Respect, Dignity, and Informed Choices

4.1 Respect and dignity: Every MotherBaby- Family unit deserves to be treated with respect and dignity. Every woman must be treated in a way that protects their right to confidentiality, privacy, and support from people of their choosing. Every woman has the right to be free from disrespect such as physical, verbal, or emotional abuse by a care provider or other medical personnel.

4.2 Informed choices: Every health care provider should fully include the MotherBaby-Family unit in decision making regarding their care. This necessitates ensuring the MotherBaby- Family unit understands the risk and benefits of every decision and protects their right to informed consent and refusal.

4.3 Interaction with the newborn: Strongly encourage and support the family to interact, care for, and breastfeed their newborns. This is inclusive of sick or premature infants with congenital abnormalities to the extent which is compatible with their conditions.

4.4 Compassionate and culturally competent care: It is incumbent upon medical staff to understand the impact of their words, attitude, and demeanour on the MotherBaby- Family experience and mother's hormones. Therefore, to ensure a supportive birth environment is met, health care providers should be compassionate and encouraging throughout the process. Medical staff is also responsible for providing religious and culturally competent care (within the cultural constraints of Saudi Arabia).

5. Provide Pain Relief Measures and Supportive Birthing Environment

5.1 Provide unmedicated pain-coping mechanisms: In order to facilitate normal physiological birthing. Every woman should be educated on the importance of drug-free pain relief methods in order to facilitate normal physiological birth. This includes educating the woman and her companions on effective pain-coping mechanisms (i.e. breathing, touch, holding, massage, relaxation techniques, and labouring in water- when available). See Ministry of Health (2021) Companion's Policy in the Obstetrics and Gynaecology Department.

5.2 Informed consent and refusal: In order to effectively provide informed consent and refusal, the health care provider is responsible for explaining the risks and benefits of pharmacological pain relief methods when requested.

5.3 Well-trained staff: Ensure hospital staff are trained to provide pain-coping mechanisms. Medical staff should interact responsibly and respectfully as outlined in 4.1-4.3.

5.4 Supportive birthing environment: In light of evidence-based care, upright positions and movements during childbirth are proven to be beneficial to the progress of

labour and the birthing mother's comfort. Therefore, every woman should be supported in the upright position of her choice to facilitate evidence-based practices. This necessitates that the current practice of lithotomy (flat on back with legs elevated) should be absolved (unless it is specifically required to correct a complication). To facilitate upright movements, the following are required:

5.4.1 Comfortable, clean, adequate bedding, regular water supply, and calming birth environments.

5.4.2 Tools for facilitating such positions, such as birthing balls, chairs and stools, floor mattresses or pads, and wall ladders and ropes, are visible and easily accessible in labour and birthing spaces

5.4.2.1 However, it is important to note with regards to facilities that are not currently equipped with the aforementioned provisions, it still is incumbent upon these health institutions to improvise with low-technology tools and human support in order to afford every woman with her right to upright positions. This includes assisting the mother to assume positions of her choice including squatting, sitting, etc.

5.4.3 Comfortable room temperature with equipped bathroom with shower.

5.4.4 The health institution should respect the physical structure of the space which is required for accommodating companions, newborns, and tools in the labour ward and postpartum.

6. Provide and Promote Specific Evidence-based Practices and Avoid Harmful Practices

6.1 Provide evidence-based practices proven to be beneficial in supporting the normal physiology of labour, birth, postpartum and neonatal periods. These include, but are not limited to:

6.1.1 Refrain from applying time limits to labour and respect the normal physiological process. Health care providers should patiently observe as the mother progresses through normal physiological labour.

6.1.2. Ideally, do not admit mothers into the labour room until they are in active labour. However, women in early labour should still have access to supportive care via outpatient communication or presence in the normal ward. In all phases of labour, mothers should have space and freedom to mobilize, provisions of food and drink, access to comfort measures including partners of their choice (family, friends, or doulas), and supportive care to optimize the health of MotherBaby.

6.1.3 Support all upright birth positions as noted in section 5.4.

6.1.4 All facilities shall maintain maternal privacy to the highest extent possible, ideally providing individual labour and birth rooms, private bathrooms, and showers. However, at the very least hospitals should ensure privacy walls or curtains to visually separate one patient from another.

6.1.5 All staff should be adequately trained in turning breech foetuses to cephalic lie to ultimately conduct vaginal birth. However, trained staff must also be

competent in conducting vaginal breech deliveries and avoiding caesarean section whenever possible.

6.1.6 As per up-to-date evidence-based practices, all mothers and neonates should be afforded immediate and sustained skin-to-skin contact for warmth, bonding, and early initiation of breastfeeding. There should be no interruption therein unless there is a severe medical complication. To this effect, all routine newborn procedures can be completed in the mother's arms or delayed until at least one hour after birth in order to ensure the MotherBaby are not separated.

6.1.7 Medical providers should refrain from immediate cord clamping as it results in iatrogenic anaemia of the neonate. Neonates should be provided and optimal timing of cord clamping for a minimum of one minute when the neonate is born by caesarean section and a full three minutes at the minimum if the neonate is born vaginally. Medical providers should honour the family's wishes for even further delayed cord clamping when requested. As supported by current evidence, there is no harm in delaying cord clamping until after the birth of the placenta.

6.1.8 Ensure essential newborn care is provided including appropriate medical support for premature or ill infants. Mothers should be allowed to engage in skin-to-skin care, and breastfeed their infant (or provide other human milk for the neonate if breastfeeding is not possible due to complications).

6.1.9 The following interventions which should be limited are in coordination with international standards as per the recommendations from The Mother-Friendly Childbirth Initiative (2015) and the WHO recommendations for non-clinical interventions to reduce caesarean sections.

6.1.9.1 Induction rate of 10% or less

6.1.9.2 Episiotomy rate of 10% or less in all health facilities

6.1.9.3 Primary caesarean rate of 15% or less in all health facilities and 25% to 30% (as a maximum) in tertiary care (high-risk) hospitals for a repeat caesarean.

6.1.9.4 VBAC (vaginal birth after one or two caesareans) rate of 60% or more with a goal of 75% or more.

6.1.10 Ensure there are visible posters and distributed brochures showing or educating women about their right to eat, drink, walk, and move during labour. Specifically, illustrating upright and other physiologic birth positions that include the woman being supported by a companion.

6.2 The following procedures are harmful and should never be applied as a matter of routine to every MotherBaby. These procedures should only be considered when there is a complication warranting their use whereby their benefits outweigh risks (and ideally the mother has been informed and consented to their use). These recommendations are in coordination with international standards from The International Childbirth Initiative: 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care (2018):

6.2.1 Enema

6.2.2 Artificial rupture of membranes

6.2.3 Episiotomy

6.2.4 Frequent or repetitive vaginal exams

6.2.5 Withholding food and water

6.2.6 Keeping the mother in bed or immobilized

6.2.7 Supine or lithotomy position

6.2.8 Numerous caregivers constantly going in and out

6.2.9 Caregiver-directed pushing

6.2.10 Fundal pressure (Kristeller)

6.2.11 Immediate cord clamping

6.2.12 Separation of mother and baby

6.3 Practices that can be harmful for low-risk women, yet helpful or essential in emergencies or certain high-risk cases, and thus should only be used when medically indicated:

6.3.1 Medical induction or augmentation of labour

6.3.2 Intravenous fluids (IV)

6.3.3 Continuous electronic foetal monitoring

6.3.4 Insertion of a bladder catheter

6.3.5 Manual exploration of the uterus

6.3.6 Suctioning of the newborn

6.3.7 Forceps and vacuum extraction

6.3.8 Caesarean section

6.4 Ensure that health practices following Evidence-Based Care with national and international standards.

6.4.1 Monitor staff competencies regarding evidence-based practices.

7. Provide and Support Midwifery Model of Care

This focuses specifically on strengthening the central role and function of the professional midwife in the provision of quality care during pregnancy, childbirth, other reproductive and sexual health services. We aim that all low-risk births will be attended by midwives practicing in the low intervention midwifery model of care.

a. Implementation of MOH Standard of Care: The Health Institution has the targeted midwives' numbers (for each birth you need 30 Midwives-Calculate the annual number of birth and divide by 30). Keeping in mind the midwives will be distributed to cover clinics (Primary Health Care, Birth Center, Hospitals, and etc), Antenatal, Labour and Birth, Postnatal Wards and Operating Room, etc.

b. Autonomy: The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care, and advice during pregnancy, labour, and the postpartum period, to conduct births on the midwife's responsibility, and to provide care for the new-born and the infant.

c. Scope: This care includes preventative measures, the promotion of normal physiological birth, and the detection of complications in mother and child. Midwives access the medical care or other appropriate assistance required to carry out emergency measures. The midwife has an important task in health counselling and education, not only for the woman but also within the family and the community. This work should involve antenatal education, preparation for parenthood, and may extend to women's health, sexual or reproductive health, and childcare.

d. Setting: A midwife may practice in any setting including the home, community, hospitals, clinics, or health units (as supported within the constraints of Saudi Arabia).

e. Implementation of the MOH Guidebook for Midwives (MOH, 2019) including scope of practice, competencies, privileges, code of ethics, and job descriptions.

8. Have Competent, Supportive, and Motivated Human Resources

All health facilities should have appropriate policies and measures in place in order to ensure staff is enabled to carry out evidence-based practices. Additionally, staff has the right to a safe, secure, and positive work environment where they are encouraged to follow up-to-date practices. The policies should incorporate an exclusion approach that ensures the maintenance and progression of committed, experienced, and skilled maternal healthcare providers (especially midwives, nurses and physicians) in all units and facilities where births take place. They should be protected from being transferred to other departments. Human resource should have the policy to support the following concepts:

8.1 Access to care: The Health Institution and human resource department ensure that there is an adequate staff to provide the standards of care. Every MotherBaby should have access to at least one skilled birth attendant and support staff for routine care and management of complications.

8.2 Competency: The medical birth attendants should be adequately trained to fully support the MotherBaby through labour, childbirth, and the early postnatal period.

8.3 Leadership: It is the responsibility of the health facility to have competent managerial and clinical leaders who are responsible for implementing policies and promoting a positive work environment to support staff conduct evidence-based practices.

8.4 Assessment Tools: Health facilities are required to have assessment tools in place to measure staff satisfaction, productivity, medical workload, and burnout.

9. Promote Breastfeeding and Skin-to-Skin Contact

Every health facility should strive to achieve WHO-UNICEF: Steps of the Revised Baby-Friendly Hospital Initiative (2018): Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services including Primary Health Care. This step is currently carried out and accredited by the Ministry of Health/ with a future accreditation plan to be by the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI).

9.1 Compliance: Comply with the Ministry of Health: Code of Marketing of Breast-Milk Substitutes and relevant World Health Assembly Resolutions.

9.2 Health Institution Responsibilities:

9.2.1 Ensure a written infant feeding policy is in place which is routinely communicated to staff and parents.
9.2.2 Establish and maintain ongoing monitoring and data-management systems.
9.2.3 Ensure that staff has sufficient knowledge, competence, and skills to support breastfeeding.
9.2.4 Discuss the importance of the management of breastfeeding with pregnant women and their families.
9.2.5 Facilitate immediate and uninterrupted skin-to-skin contact and support to initiate breastfeeding as soon as possible after birth.
9.2.6 Support mothers to initiate and maintain breastfeeding and manage common difficulties.
9.2.7 Do not provide breastfed newborns with any food or fluids other than breastmilk unless medically indicated.
9.2.8 Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.
9.2.9 Support mothers to recognize and respond to their infants' cues for feeding.
9.2.10 Counsel mothers on the use and risks of feeding bottles, teats, and pacifiers.
9.2.11 Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

9.3 Baby-Friendly Health Institution Certification of Intent The Health Institution applies for a Certificate of Intent to Become Baby-Friendly or has been awarded designation as a Baby-Friendly facility.

10. Provide Accurate and Descriptive Key Performance Indicators (KPIs) and Statistical Information

The Key Performance Indicators (KPIs) and Statistical Information will be provided to the Ministry of Health by the health facility such as cluster/hospital, primary care, birth centre etc. regarding their performance, about its practices and procedures for maternal and neonatal care, including measures of interventions and outcomes.

The facilities should provide accurate descriptive and statistical information to the public about their practices and procedures for MotherBaby- Family maternity care.

Each medical caregiver is responsible for the quality of care she or he provides. Each health facility is responsible for periodic review and evaluation according to the current scientific evidence, of the effectiveness, risks, and rates of its medical procedures for mothers and babies. The KPIs and Statistical Information template are available in Appendix 6 of this document, as a guide not limited to what is mentioned. You can adapt and change it according to your health institution's scope of service.

Saudi MotherBaby- Family Friendly Maternity Care Facility (MBFMF) Initiative Accreditation

To obtain accreditation the MotherBaby-Family Friendly Maternity Care Facility Self-Assessment Tool needs to be completed. This Self-Appraisal Tool has been developed to assess the current practices of Health Institution in coordination with Primary Health Care services and maternity facilities with respect to the 10 Steps to Successful MotherBaby-Family Friendly Maternity Care which is currently in place. These steps will be carried out and accredited/certified by the MOH with a future accreditation plan to be by the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI).

To Achieve MotherBaby-Family Friendly Maternity Care

- The minimum target for essential national requirements for patient safety is 85%
- The minimum target for **step 1** as follows:
    - The minimum target for **MotherBaby-Family as an Integral Unit** adoption by the Health Institution is 90%
    - The minimum target for **MotherBaby-Family as an Integral Unit** by MotherBaby-Family Unit is 70%
    - The minimum target for **continuity of care** is 80%
    - The minimum target for **education and public health awareness** for their clients is 70%
    - The minimum target for **staff training and education** is 80%
- The minimum target for **emergency care and transport** (**step 2)** is 90%
- The minimum target for **continuous support** (**step 3)** for their client is 90%
- The minimum target for **respect, dignity and informed choices (step 4)** is 90%
- The minimum target for **pain management and supportive birth environment (step 5)** is 80%
- The minimum target for **evidence-based practices (step 6)** is 90%
- The minimum target for **midwifery model of care (step 7)** is 90%
- The minimum target for **supportive human resource policy (step 8)** is 90%
- The minimum target for **breastfeeding (step 9)** is to get accredited as a Baby-Friendly Health Institution
- The minimum target for **KPI and statistic (step 10)** is 70% with a target of 90% over 3-5 year.

Percentage of minimum target is calculated according to the Yes responses for each step requirements. Therefore, No responses are considered points for improvement.

Self-Assessment Tool

Background

This self-assessment tool document presents the questions for the 10 steps of the Kingdom of Saudi Arabia model to achieve a safe and respectful MotherBaby–Family Maternity Care. This model is adopted from the 10 steps of mother-friendly hospital initiative (CIMS, 2015) and 12 steps of the International Childbirth Initiative (ICI, 2018). The model is based on scientific evidence and focuses on the mother, child and family, and on prevention and wellness as an alternative to the current practice. It is introduced to ensure improved birth outcomes and evidence-based, MotherBaby-Family Maternity Care.

The 10 steps MotherBaby-Family Maternity Care emphasize:

1. Collaboration between the Primary Health Care services and Health facilities to integrate as one unit-team working with a multidisciplinary approach for all health aspects including communication, collaboration, consultation, referral to ensure optimal care for the MotherBaby-Family Unit.
2. The MotherBaby-Family Unit refers to an integral unit during pre-conception, pregnancy, birth, and infancy influencing the health of one another.
3. The MotherBaby–Family Care model, with the integration of a midwifery scope of practice, is a strong foundation on which safe and respectful maternity care resides.

In order to achieve certification as a MotherBaby-Family Health Institution, the current practices of the 10 Steps to Successful Mother-Baby-Family Friendly Maternity Care needs to be appraised. The accreditation can be granted to the Health Institution that provides a complete healthcare coverage and follow-up of MotherBaby-Family journey from pregnancy until birth and postnatal period.
The process completing the requirement for the 10 steps of MotherBaby-Family Maternity Care might take from 3 to 5 years.

Self-Appraisal Questionnaire Health Institution Datasheet

1. General Information on the Health Institution and Staff:

Health Institution Name and Address:	
Name and Job Title of Health Institution Director or Administrator:	
Telephone number with extension:	
E-mail address of Health Institution Director or Administrator	
Name and Job Title of the organizer of MotherBaby-Family Friendly Health Institution Program:	
Telephone number with extension:	
E-mail address of the organizer of MotherBaby-Family Friendly Health Institution Program:	

1.1. The Health Institution is: [select all that apply]

- ☐ A Government Maternity Hospital
- ☐ A Government General Hospital
- ☐ A Private Maternity Hospital
- ☐ A Private General Hospital
- ☐ A Birth Centre
- ☐ A Teaching Hospital
- ☐ A Tertiary Hospital
- ☐ Other (specify:) _____

1.2. If you selected [Private Hospital], please select all which are applicable from the following:

- ☐ Our Health Institution has an agreement with a Polyclinics for referral of pregnant women who are at 36+ weeks gestation.
- ☐ Our Health Institution has an agreement with another Hospital or Polyclinics for referral of pregnant women regardless of gestation period.
- ☐ Our Health Institution has Primary Care Physicians caring for women until 36+ weeks of gestation before they are referred to an Obstetrician.
- ☐ Our Health Institution has Obstetricians exclusively caring for pregnant women during their entire pregnancy.
- ☐ Our Health Institution has no any agreement with a Polyclinics for referral of pregnant women.

Total number of Primary Health Care Facilities related to the Hospital: _____

1.3. Total number of Health Institution beds: _____

1.3.1. Number of antenatal beds: _____

1.3.2. Number of induction beds: _____

1.3.3. High Dependency Unit (HDU) beds: _____

1.3.4. Total Number of labour and birth beds: _____
1.3.4.1. Total number of labour beds: _____
1.3.4.2. Total number of birth beds: _____
1.3.4.3. Total number of single rooms with private bathrooms_____
1.3.4.4. If there are no single rooms with private bathrooms available in the Health Institution please describe & why:_____
1.3.5. Total number of postnatal beds: _____
1.3.5.1. Total number of postnatal rooms: _____
1.3.6. Number of High-risk beds: _____
1.3.7. Number of incubators: _____
1.3.8. Number of nursery beds: _____

1.4. Total number of Health Institution staff: _____
1.4.1. Total number of Physicians _____
1.4.1.1. Obstetrics and Gynaecology Consultants _____
1.4.1.2. Obstetrics and Gynaecology Senior Registrars _____
1.4.1.3. Obstetrics and Gynaecology Registrars _____
1.4.1.4. Obstetrics and Gynaecology Residents_____
1.4.1.5. Neonatologist Consultants _____
1.4.1.6. Anaesthetists Consultants _____
1.4.2. Total number of Lactation Consultants _____
1.4.3. Total number of Midwives _____
1.4.4. Total number of Nurses _____
1.4.5. Total number of Maternity Care Assistants _____
1.4.6. Total number of Nursing/Health Care Assistants _____
1.4.7. Others (Specify)_____

1.5. Medical Records and Coding

1.5.1. Select all that apply with regards to the Health Institution's medical records system:

□ Paper-based medical record

□ Electronic medical record

□ Both paper-based and electronic medical records

1.5.2. The Health Institution has unified electronic health system connected to its Primary Health Care

□ Yes □ No

1.5.3. The Health Institution has unified electronic health system connected to national unified medical records

□ Yes □ No

1.5.4. The Health Institution has medical coding system in place

□ No

□ Yes: Specify the name _____

1.5.5. The Health Institution has an electronic health application/website for health professionals

□ Yes □ No

1.5.6. The Health Institution has an electronic health application/website for clients/patients

□ Yes □ No

1.5.6.1. The clients/patients can access the following through the application/website

□ Medications
□ Appointments
□ Lab Work Results
□ Medical Reports
□ Surgical Reports
□ Radiological Images and Reports
□ Discharge Summary
□ Education resources
□ Others, (Specify) _____

1.5.6.2. The clients/patients can print all the above through the application/website

□ Yes □ No

1.6. Communication and Feedback

1.6.1. The Health Institution has a hotline for clients/patients

□ Yes □ No

1.6.2. The Health Institution has a social media accounts for clients/patients

□ Yes □ No

1.6.3. The Health Institution has data available on the social media accounts for clients/patients interaction

□ No

□ Yes, please provide the data from last year _____

1.6.4. The Health Institution has a third party for evaluating clients/patients satisfaction

□ No

□ Yes, <u>please attach the report and action taken</u>

1.7. Function

1.7.1. Hour of operation of the Health Institution

□ 8
□ 12
□ 16
□ 24

1.7.2. Model of care of the Health Institution: [select all that apply]

- ☐ Midwifery-led care
- ☐ Obstetric-led care
- ☐ General practitioner-led care
- ☐ Shared care
- ☐ Women-centered care
- ☐ Family-centered care

1.7.3. The Health Institution ensures continuity of maternal care i.e a known healthcare provider support a woman throughout the antenatal, intrapartum and postnatal continuum

☐ Yes ☐ No

1.7.4. The Health Institution holds some clinics virtually

- ☐ No
- ☐ Yes: [select all that apply]
  - ☐ Midwife clinic
  - ☐ Women's health clinic
  - ☐ Other……..

If yes please describe the specifics on when _____

If yes please specify the services given virtually

- ☐ Premarital screening
- ☐ Preconception care
- ☐ Antenatal care
- ☐ Postnatal care
- ☐ Breastfeeding counselling
- ☐ Neonatal care
- ☐ Well baby
- ☐ Family Planning
- ☐ Sexual and reproductive health
- ☐ Education
- ☐ Women's health issues screening
- ☐ Cancer screening
- ☐ Peri and Postmenopausal
- ☐ Other……..

1.8. Safety of MotherBaby-Family

1.8.1. The Health Institution has an infant abduction/exchange prevention electronic system

□ No

□ Yes, please attach the report and action taken

1.8.2. The Health Institution has an infant abduction/exchange prevention policy and procedure

□ Yes □ No

1.8.3. The Health Institution has pink code policy and procedure

□ Yes □ No

1.8.4. The Health Institution has onsite blood bank

□ Yes

□ No If no answer the following questions

1.8.4.1. The Health Institution has blood unit available upon request

□ Yes □ No

1.8.4.2. The Health Institution has agreement with a local central blood bank

□ Yes □ No

2. Information on Antenatal Services:

Health Institution Name and Address:	
Telephone number with extension:	
E-mail address of the Head of Obstetric Ultrasound Unit:	
Name and Job Title of the Director of the Obstetric or the Antenatal Services/Clinic:	
Telephone number with extension:	
E-mail address of Director of Obstetrics or the Antenatal Services/Clinic:	

2.1. Select all that apply with regards to the Health Institution's antenatal services:

- ☐ Antenatal care for low and high-risk pregnancy (regardless of gestational age)
- ☐ Antenatal care for referred low-risk pregnancy from 35-36 weeks and high-risk pregnancy
- ☐ Antenatal care for high risk pregnancy only
- ☐ Antenatal pelvic and maternal health physiotherapy

2.2. The Health Institution holds antenatal clinics at other sites outside the hospital

- ☐ No
- ☐ Yes: Please describe the specifics on when and where they are held

_____
_____

2.3. Indicate the percentage of mothers giving birth at the Health Institution who attend the Health Institution's antenatal clinic _____%

2.4. Indicate the percentage of mothers who arrive for birth without antenatal care_____%

- ☐ Don't have this statistic

2.5. Indicate the number of beds which are designated for high-risk pregnancy cases

_____

2.6. The Health Institution has an Obstetric Ultrasound Unit

- ☐ No
- ☐ Yes if yes, please describe the Obstetric Ultrasound Unit

---

2.6.1. Total number of all Obstetric Ultrasound Unit Staff _____

- 2.6.1.1. Total number of Feto-maternal Medicine Consultants _____
- 2.6.1.2. Total number of Obstetrics and Gynaecology Consultants_____
- 2.6.1.3. Total number of Radiology Consultants _____
- 2.6.1.4. Total number of Obstetrics and Gynaecology Specialists _____
- 2.6.1.5. Total number of Ultrasound Technicians _____
- 2.6.1.6. Others (Specify) _____

2.6.2. Total number of Ultrasound machine _____

2.6.3. Total number of beds____

3. Information on Maternity Services (Labour and Birth Ward):

Name and Job Title of the Director of Maternity Services:	
Telephone number with extension:	
E-mail address of the Director of Maternity Services:	
Name and Job Title of the Head of Midwifery Services:	
Telephone number with extension:	
E-mail address of the Head of Midwifery Services:	

3.1. Labour and Birth Ward Organization

3.1.1. The Health Institution has: [select all that apply]

- ☐ Single (Private) Labour Room is separated from Birth Room
- ☐ Shared Labour Room is separated from Birth Room
- ☐ Single (Private) Labour and Birth Room are together
- ☐ Shared Labour and Birth Room are together
- ☐ Single (Private) Labour and Birth and 4th stage Labour Room are together
- ☐ Shared Labour and Birth and 4th stage Labour Room are together
- ☐ Single (Private) 4th stage labour room is separated from Birth Room
- ☐ Shared 4th stage labour room is separated from Birth Room

3.1.2. The Health Institution has: [select all that apply]

- ☐ One common area for labour/birth and 4th stage of labour
- ☐ Specific beds for high-risk birth
- ☐ Specific beds for low-risk birth
- ☐ Specific Ward for high-risk birth
- ☐ Specific Ward for low-risk birth
- ☐ High Dependency Unit (HDU)

3.1.3. Specify the number of rooms for the following:

3.1.3.1. Total number of labour rooms: _____

3.1.3.2. Total number of birth rooms: _____

3.1.3.3. Total number of labour and birth rooms: _____

3.1.3.4. Total number of 4th stage of labour rooms: _____

3.1.3.5. Total number of High Dependency Unit (HDU) rooms: _____

3.2. Labour and Birth Ward Equipment

3.2.1. The Health Institution has Foetal Monitoring System: [select all that apply]

3.2.1.1. Central Monitoring Unit

- ☐ No
- ☐ Yes: Please specify the Number _____

3.2.1.2. Internal Cardiotocography (CTG) Machine such as using Foetal Scalp Electrode (FSE)

□ No

□ Yes

3.2.1.3. External Cardiotocography (CTG) Machine

□ No

□ Yes: Please specify the Number _____

3.2.1.4. Wireless External Cardiotocography (CTG) Machine

□ No

□ Yes: Please specify the Number _____

3.2.1.5. Electronic Doppler (Sonicaid)

□ No

□ Yes: Please specify the Number _____

3.2.1.6. Electronic Waterproof Doppler (Sonicaid)

□ No

□ Yes: Please specify the Number _____

3.2.1.7. Pinard Stethoscope

□ No

□ Yes: Please specify the Number _____

3.2.2. The Health Institution has an Ultrasound machine in the labour and birth ward

□ No

□ Yes: Please specify the Number _____

3.2.3. The Health Institution has an newborn incubator in the labour and birth ward

□ No

□ Yes: Please specify the Number _____

3.2.4. The Health Institution has an newborn resuscitator in the labour and birth ward

□ No

□ Yes: Please specify the Number _____

3.2.5. The Health Institution has an newborn cots in the labour and birth ward

□ No

□ Yes: Please specify the Number _____

4. Information on Postpartum/Postnatal Services:

4.1. Average daily number of births: _____

4.2. Average daily number of full-term babies in the postnatal unit(s) (Rooming-in): _____

4.3. The facility has unit (s) for newborn that need special care (LBW, premature, ill, etc.)

□ No

□ Yes: please answer the following:

4.3.1. Name of unit: _____

4.3.2. Level of unit: _____

4.3.3. Average daily census: _____

4.3.4. Name of Director(s) of the unit:_____

4.3.5. Name of additional unit: _____

4.3.6. Level of unit: _____

4.3.7. Average daily census: _____

4.3.8. Name of Director(s) of this unit:_____

4.4. There are areas in the maternity wards which are designated as well-baby observation areas

□ No

□ Yes: please answer the following:

4.4.1. Name of unit: _____

4.4.2. Level of unit: _____

4.4.3. Average daily census of each area: _____

4.4.4. Name of Head/Director(s) of these areas: _____

4.5. Select all that apply with regards to the Health Institution's Postpartum/Postnatal Services:

□ Our Health Institution has a maternal postnatal care follow-up system up to 6-8 weeks in the hospital/Primary Health Care

□ Our Health Institution has maternal phone call assessments in place

□ Our Health Institution has home care visit arrangements for high-risk cases

□ Our Health Institution has postnatal screening tools for all health-related issues completed in the first weeks

□ Our Health Institution has postnatal pelvic and maternal health physiotherapy

□ Our Health Institution provides the mother with a list of helplines for all postnatal issues related to her and/or her baby (If you selected this option, please attach the list of helplines provided to mothers).

□ Before discharge, our Health Institution provides the mother with educational materials to help her during the postpartum period (If you selected this option, please attach the educational materials provided to mothers).

□ Our Health Institution has a neonatal screening program to ensure everything is completed for the neonate during the first 28 days and for the infant until 2 years old.

□ Our Health Institution has maternal, neonatal and infant vaccination implementation follow-up.

□ Our Health Institution has phone calls and/or manual forms and questionnaires to assess the needs of the mother during pregnancy until 6 weeks postpartum. (If you selected this option, please attach the policy and pathway for postpartum care delineating the relationship between hospital, social services, home care, patient experience, quality departments, etc., and Primary Health Care as one system.)

5. Availability of responsible staff for breastfeeding/infant feeding:

5.1. The following staff has direct responsibility for assisting women with breastfeeding (BF), feeding breast-milk substitutes (BMS), or providing counselling on Human Immunodeficiency Virus (HIV) and infant feeding. Please select the counselling responsibilities which are attributed to the health care professional:

☐ No

☐ Yes: [*select all that apply]*

5.1.1. Nurses counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.2. Neonatologists/Paediatricians counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.3. Midwives counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.4. Obstetricians counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.5. Special Care Baby Unit (SCBU) nurses counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.6. Neonatal Intensive Unit (NICU) nurses counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.7. Infant feeding counsellors counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.8. Dieticians counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.9. Lay/peer counsellors counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.10. Nutritionists counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.11. Lactation Consultants counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.12. General Physicians counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

5.1.13. Other staff counsel women on the following:
☐ BF ☐ BMS ☐ HIV ☐ Does not counsel women

Specify “other” staff: _____

5.2. There are breastfeeding and/or HIV and infant feeding committee(s) in the health institute

☐ No

☐ Yes: describe the committee(s)

_____

_____

5.3. There is Baby-Friendly Hospital Initiative (BFHI) coordinators at the health institution?

☐ No

☐ Yes: provide their name(s), phone number, and email addresses

_____

_____

_____

6. Statistics on births, infant feeding and HIV/AIDS

6.1. Total births in the last year: _____

6.1.1. Of which were:

_____% by C-section without general anaesthesia (with epidural or spinal)

_____% by C-section with general anaesthesia

_____% infants admitted to the SCBU/NICU or similar units

6.2. Total number of babies discharged from the Health Institution last year: _____

6.2.1. Of which were (the total percentages listed should equal 100%):

_____% exclusively breastfed (or fed human milk) from birth to discharge

_____% received at least one feed other than breast milk (formula, water or other fluids) in the hospital due to a documented medical reason (i.e. if a mother knew she was HIV positive and made an informed decision for replacement feeding, this can be considered a medical reason)

_____% received at least one feed other than breast milk without any documented medical reason.

6.3. _____% pregnant women who received testing and counselling for HIV

6.4. _____% mothers who were known to be HIV-positive at the time of babies' births

Data sources: Please describe sources for the above data:

_____

_____

7. Information on Primary Health Care (PHC)

7.1. The Health Institution is associated with PHC Services

- □ No
- □ Yes: If yes answer the following questions

7.1.1. Total number of PHC Facilities_____

7.1.2. Total number of PHC Facilities providing maternity care_____

7.1.3. Select all that apply with regards to the PHC medical records system:

- □ Paper-based medical record
- □ Electronic medical record
- □ Both paper-based and electronic medical record

7.1.4. The PHC use an electronic MOH Mother and Child Health Passports (MCHPs) or other government document in alignment with MCHPs (i.e. designed to track the patient's medical history, monitor health condition, conduct the necessary diagnostics and test, and document all within the system to be used by respective health centres as the prime reference for mother and child healthcare).

□ No □ Yes

7.1.5. The PHC Facilities has an Obstetric Ultrasound Machines

- □ No
- □ Yes: If yes please answer the following

7.1.5.1. Total number of staff conducting Obstetric Ultrasounds

7.1.5.2. Total number of Ultrasound Machines _____

Step 1: Provide Free or Affordable Care Continuum with Cost Transparency

The Saudi health care system provides MotherBaby-Family Maternity Care through teamwork integrating the Primary Health Care (PHC) services and the hospitals/clusters with all relevant health care educators, providers, and institutions—including education, communication, prevention, collaboration, consultation, and referral—which is essential for ensuring optimal care for women and babies, especially those with obstetric-neonatal risk or when obstetric-neonatal complications occur.

This section is divided into two sections. Part (1A) is to be completed by the Primary Health Care/Polyclinics (whether they be contracted or in-house and part (1B) is to be completed by the Health Institution.

Part 1A: Primary Health Care's Role in Providing a Care Continuum

1A.1. MotherBaby-Family as an Integral Unit:

The MotherBaby-Family refers to an integral unit during pre-conception, pregnancy, birth and infancy influencing the health of one another. Within this triad, the MotherBaby dyad remains recognized as one unit, as the care of one significantly impacts the other.

1A.1.1. The Primary Health Care should recognize that an integral MotherBaby–Family Unit during pre-conception, pregnancy, birth, and postpartum period influencing the health of one another.

☐ I understand and acknowledge this

☐ I do not understand or acknowledge this

1A.1.2. Please confirm the Primary Health Care integrates the MotherBaby-Family Unit during counselling

☐ Yes ☐ No

1A.1.3. Please confirm that the Primary Health Care integrates the MotherBaby-Family unit during a referral

☐ Yes ☐ No

1A.1.4. Please confirm the Primary Health Care integrates MotherBaby-Family Unit during family planning

☐ Yes ☐ No

1A.1.5. Please confirm the Primary Health Care integrates MotherBaby-Family unit during an emergency

☐ Yes ☐ No

1A.1.6. Please confirm as the Primary Health Care have a policy and procedure to integrate MotherBaby-Family Unit during all of the above

☐ Yes ☐ No

1A.2. Advocating rights and access to care:

1A.2.1. The Primary Health Care ensure that every MotherBaby-Family regardless of their social/educational status, race, background, citizenship, age, and health status, has the right to access well-equipped health services

- □ No
- □ Yes: [select all services that apply]
  - □ Healthcare for integrating MotherBaby-Family Unit
  - □ Family Medicine
  - □ Healthcare Promotion, Screening and Prevention Services
  - □ Communicable Disease Management
  - □ Non-Communicable Diseases including Chronic Diseases
  - □ Vaccination and Immunization
  - □ Pharmacy on-site
  - □ Access to basic diagnostic services

1A.2.2. The Primary Health Care ensure that every MotherBaby-Family regardless of their social/educational status, race, background, citizenship, age, and health status, has the right to access to well-staffed health services

- □ No
- □ Yes: [select all that apply]
  - □ Led by a Consultant/Specialist in:
    - □ Family Medicine
    - □ Paediatrics
    - □ Obstetrics
    - □ Midwifery

1A.2.2.1. The Primary Health Care is staffed by multidisciplinary team based on the scope and services provided

- □ No
- □ Yes: Please describe the scope and services provided

_____

1A.3. In the Primary Health Care there are visible posters displaying the available community services and their right to free or fairly-priced materials which they may access for the needs and care of the MotherBaby-Family and brochures distributed to increase the awareness

□ Yes □ No

1A.3.1. The Primary Health Care has a social media accounts for clients/patients about the available community services and their right to free or fairly-priced materials which they may access for the needs and care of the MotherBaby-Family

□ Yes □ No

1A.4. Implementation of Ministry of Health (MOH) Standards:

1A.4.1. The Primary Health Care implemented and applied the MOH Mother and Child Health Passports (MCHPs) Guidelines or any other government document in alignment with MCHPs (i.e. designed to track the patient's medical history, monitor health condition, conduct the necessary diagnostics and test, and document all within the system to be used by respective health centres as the prime reference for mother and child healthcare)

- □ No
- □ Yes: indicate the percentage of mothers has it been applied _____%

1A.4.1.1. It has been applied for the mother during postpartum visits

- □ No
- □ Yes: indicate the percentage of mothers has it been applied_____%

1A.4.1.2. It has been applied by the hospital during the postpartum period for high-risk mothers

- □ No
- □ Yes: indicate the percentage of high-risk mothers has it been applied _____%

1A.4.1.3. It has been applied for the infant during the postnatal period

- □ No
- □ Yes: indicate the percentage of infant has it been applied _____%

1A.4.1.4. It has been applied for high-risk infants during the postnatal period

- □ No
- □ Yes: to what percentage of high-risk infant has it been applied _____%

1A.4.2. There is a women's health clinic run by physicians available at the Primary Health Care

- □ No
- □ Yes: Clinics per week _____
  Clients per week _____%

1A.4.2.1. If you selected yes to the previous section: Please indicate the scope of the women health clinic: [select all that apply]

- □ Premarital screening
- □ Preconception care
- □ Antenatal care
- □ Postnatal care
- □ Breastfeeding counselling
- □ Neonatal care
- □ Well baby
- □ Family Planning
- □ Sexual and reproductive health
- □ Education
- □ Women's health issues screening
- □ Cancer screening
- □ Peri and Postmenopausal
- □ Other……..

1A.4.3. There is a midwife clinic available at the Primary Health Care

- ☐ No
- ☐ Yes: Clinics per week _____
  Clients per week _____

1A.2.3.1. If you selected yes to the previous section: Please indicate the scope of the midwife clinic: [select all that apply]

- ☐ Premarital screening
- ☐ Preconception care
- ☐ Antenatal care
- ☐ Postnatal care
- ☐ Breastfeeding counselling
- ☐ Neonatal care
- ☐ Well baby
- ☐ Family Planning
- ☐ Sexual and reproductive health
- ☐ Education
- ☐ Women's health issues screening
- ☐ Cancer screening
- ☐ Peri and Postmenopausal
- ☐ Other……..

1A.4.4. There is a pelvic and maternal health physiotherapy clinic available at the Primary Health Care

- ☐ No
- ☐ Yes: Clinics per week _____
  Clients per week _____

1A.4.5. There is a pelvic and maternal health physiotherapy classes available at the Primary Health Care

- ☐ No
- ☐ Yes: Antenatal classes per week _____
  Clients per week _____
  Postnatal classes per week _____
  Clients per week _____

1A.4.6. There is a Point-of-Care Testing (POCT) available at the Primary Health Care

- ☐ No
- ☐ Yes: specify name of the tests:

1A.5. MotherBaby-Family Education

1A.5.1. There is education and public health measures to prevent illness and complications of the MotherBaby at the Primary Health Care facilities

- ☐ No
- ☐ Yes, please attach the report of the program and percentage of the achievements and topics covered.

1A.5.2. The Primary Health Care institution has prenatal, birth and postnatal education classes with supporting materials

□ Yes □ No

1A.5.3. The Primary Health Care Institution provides all mothers with a current list for independent educational material or other support services (i.e. educational services, prenatal, postpartum/post-discharge follow-up and breastfeeding support services, childbirth educators, physicians, and other primary care providers, mental health providers, independent breastfeeding care providers, social service providers, and other therapists and healthcare providers)

□ No

□ Yes, please attach the associated lists

1A.6. Transfer of Care

1A.6.1. The Health Institution has written policies for collaboration and care transfers available between Primary Health Care and other hospitals

□ Yes □ No

1A.6.2. The Health Institution has a good referral system with a system to follow-up on cases which were referred between Primary Health Care and Hospital

□ Yes □ No

1A.6.2.1. The Health Institution has a system to ensure recommendations on referred cases are shared between Primary Health Care and Hospital

□ Yes □ No

1A.6.2.2. The Health Institution conducts surveys and/or interviews to establish if the referral system and follow up system is working between Hospital and Primary Health Care

□ Yes □ No

1A.6.2.3. The Health Institution conducts surveys and/or interviews to establish the MotherBaby-Family experience with the referral system

□ Yes □ No

1A.7. Postpartum/postnatal Follow-up

1A.7.1. There is postpartum/postnatal care programs for high-risk mothers and neonates between the Primary Health Care and Health Institution

□ Yes □ No

1A.7.2. There are measurements in place to evaluate the MotherBaby-Family experience through pregnancy and 6 weeks' postpartum care

□ No

□ Yes: attach a report indicating the number of experiences recorded in comparison to annual ratio of pregnant mother's treated in the institution

1A.8. Competency Assessment Tools

1A.8.1. Health Institution ensures availability of competent and motivated skilled healthcare professionals

□ Yes □ No

1A.8.2. The Health Institution ensures the provision of efficient and effective care

□ Yes □ No

1A.8.3. The Health Care Institution conducts training and implements competency assessment tools/drills for Primary Health Care providers to demonstrate their knowledge, implementation of the policy/procedures, and adherence to it

□ No

□ Yes: specify the frequency of the training and topics covered

_____

_____

1A.9. The Primary Health Care can provides emergency care and transport (See step 2, answer applicable questions)

□ Yes □ No

1A.10. The Primary Health Care provide continuous maternity care support and midwifery-led care model (See step 3 and 7, answer applicable questions)

1A.11. The Primary Health Care provide every MotherBaby-Family Unit a respected maternity care with informed choice (See step 4, answer applicable questions)

□ Yes □ No

1A.12. The Primary Health Care provide supportive human resources policy (See step 8, answer applicable questions).

□ Yes □ No

1A.13. The Primary Health Care is an accredited as Baby Friendly facility (See step 9)

□ Yes □ No

1A.14. The Primary Health Care has accurate and descriptive Key Performance Indictors (KPIs) and statistical information related to MotherBaby-Family Friendly Maternity Care Facility (See step 10)

□ Yes □ No

Part 1B: The Health Care Institution's Role in Providing a Care Continuum

1B.1 MotherBaby-Family as an Integral Unit:

1B.1.1. The Health Institution should recognize that an integral MotherBaby–Family Unit during pre-conception, pregnancy, birth, and postpartum period influencing the health of one another

☐ I understand and acknowledge this

☐ I do not understand or acknowledge this

1B.1.2. Please confirm that the Health Institution integrates the MotherBaby-Family Unit during counselling

☐ Yes ☐ No

1B.1.3. Please confirm that the Health Institution integrates the MotherBaby-Family Unit during a referral

☐ Yes ☐ No

1B.1.4. Please confirm the Health Institution integrates MotherBaby-Family Unit during family planning

☐ Yes ☐ No

1B.1.5. Please confirm the Health Institution integrates MotherBaby-Family Unit during an emergency

☐ Yes ☐ No

1B.1.6. Please confirm as the Health Institution have a policy and procedure to integrate MotherBaby-Family Unit during all of the above

☐ Yes ☐ No

1B.2. Advocating rights and access to care:

1B.2.1. The Health Institution ensure that every MotherBaby-Family regardless of their social/educational status, race, background, citizenship, age, and health status, has the right to access well-equipped health services

☐ Yes ☐ No

1B.2.2. The Health Institution ensure that every MotherBaby-Family regardless of their social/educational status, race, background, citizenship, age, and health status, has the right to access to well-staffed health services

☐ Yes ☐ No

1B.2.2.1. The Health Institution is staffed by multidisciplinary team

☐ Yes ☐ No

1B.3. In the Health Institution, there are visible posters displaying the available community services and their right to free or fairly-priced materials which they may access for the needs and care of the MotherBaby-Family and brochures distributed to increase the awareness:

□ Yes □ No

1B.3.1. The Health Institution has a social media accounts for clients/patients about the available community services and their right to free or fairly-priced materials which they may access for the needs and care of the MotherBaby-Family

□ Yes □ No

1B.4. Implementation of Ministry of Health (MOH) Standards

1B.4.1. Has the Health Institution implemented and applied the principle and guidelines of the MOH Mother and Child Health Passports (MCHPs) or any other government document in alignment with MCHPs (i.e. designed to track the patient's medical history, monitor health condition, conduct the necessary diagnostics and test, and document all within the system to be used by respective health centres as the prime reference for mother and child healthcare)

□ No

□ Yes: indicate the percentage of mothers has it been applied _____%

1B.4.1.1. It has been applied by the Health Institution during pregnancy

□ No

□ Yes: indicate the percentage of mothers has it been applied _____%

1B.4.1.2. It has been applied by the Health Institution for the mother during postnatal visits

□ No

□ Yes: indicate the percentage of mothers has it been applied _____%

1B.4.1.3. It has been applied by the Health Institution during the postnatal period for high-risk mothers

□ No

□ Yes: indicate the percentage of high-risk mothers has it been applied _____%

1B.4.1.4. It has been applied by the Health Institution for the infant during the postnatal period

□ No

□ Yes: indicate the percentage of infant has it been applied _____%

1B.4.1.5. It has been applied by the Health Institution for high-risk infants during the postnatal period

□ No

□ Yes: indicate the percentage of high-risk infant has it been applied _____%

1B.4.2. There is a women's health clinic run by physicians available at the Health Institution

□ No

□ Yes: Clinics per week _____%

1B.4.2.1. If you selected yes to the previous section: Please indicate the scope of the women's health clinic: [select all that apply]

- □ Premarital screening
- □ Preconception care
- □ Antenatal care
- □ Postnatal care
- □ Breastfeeding counselling
- □ Neonatal care
- □ Well baby
- □ Family Planning
- □ Sexual and reproductive health
- □ Education
- □ Women's health issues screening
- □ Cancer screening
- □ Peri and Postmenopausal
- □ Other……..

1B.4.3. There is a midwife clinic available at the Health Institution

- □ No
- □ Yes: Clinics per week _____

  Clients per week _____%

1B.4.3.1. If you selected yes to the previous section: Please indicate the scope of the midwife clinic: [select all that apply]

- □ Premarital screening
- □ Preconception care services
- □ Antenatal care
- □ Postnatal care
- □ Breastfeeding counselling
- □ Neonatal care
- □ Well baby
- □ Women's health
- □ Family Planning
- □ Sexual and reproductive health
- □ Education
- □ Other……..

1B.4.4. Women have access to professional midwifery care during

1B.4.4.1. Pregnancy

□ Yes □ No

1B.4.4.2. Labour

- □ No
- □ Yes: Please specify ratio
  - □ 1:1
  - □ 1:2
  - □ 1:3
  - □ 1:4
  - □ Other: Specify _____

1B.4.4.3. Birth

- □ No
- □ Yes: Please specify ratio
  - □ 1:1
  - □ 1:2
  - □ 1:3
  - □ 1:4
  - □ Other: Specify _____

1B.4.4.4. Postpartum period

- □ No
- □ Yes: Please specify ratio
  - □ 1:1
  - □ 1:2
  - □ 1:3
  - □ 1:4
- □ Other: Specify _____

1B.4.5. The Health Institution has a well-organized, all-inclusive, and synergetic approach to prenatal, birth, and postpartum services

□ Yes □ No

1B.5. MotherBaby-Family Education

1B.5.1. There is education and public health measures in place to prevent illness and complications of the MotherBaby-Family Care Unit

- □ No
- □ Yes, please attach the report of the program and percentage of the achievements and topics covered.

1B.5.2. The Health Institution has prenatal and postnatal birth education classes with supporting materials

□ Yes □ No

1B.5.3. The Health Institution provides all mothers with a current list for independent educational material or other support services (i.e. educational services, prenatal, postpartum/post-discharge follow-up and breastfeeding support services, childbirth educators, physicians, and other primary care providers, mental health providers, independent breastfeeding care providers, social service providers, and other therapists and healthcare providers)

- □ No
- □ Yes: attach the associated lists

1B.5.4. The Health Institution has post-birth warning signs educational programs for mothers

□ Yes □ No

1B.5.5. The Health Institution has a collaborative program with universities and schools to increase awareness and public education about the running prevention programs, including but not limited to antenatal care, nutrition, exercise, iron deficiency anaemia, Hemoglobinopathy, thyroid problems, obesity, diabetes, hypertension, infectious diseases, toxoplasmosis, breastfeeding, and immunization

□ No

□ Yes: If yes answer the following questions

1B.5.5.1. Indicate the number of universities the program covered

_____

1B.5.5.2. Name the universities that were involved in the aforementioned program:

_____

_____

1B.5.5.3. Indicate the number of women which were educated during the course of the program _____

1B.5.5.4. Topics covered during the program

_____

_____

1B.5.5.5. Indicate the number of events conducted per year and explain

_____

1B.5.5.6. Indicate the number of volunteers who participated in the increasing public awareness about MotherBaby-Family Friendly Maternity Care

---

1B.5.5.7. Indicate the number of volunteers who participated in the increasing public awareness and education about running prevention program, including but not limited to antenatal care nutrition, exercise, iron deficiency anaemia, Hemoglobinopathy, thyroid problems, obesity, diabetes, hypertension, infectious diseases, toxoplasmosis, breastfeeding, and immunizatio

1B.6. Transfer of Care

Ensure there is established community support via primary care physicians and frontline health providers for consultations and prompt transfer of care to appropriate institutions and specialists when necessary. Additionally, Health Institutions should ensure an effective referral system for follow-up cases to avoid errors or lost cases in the system.

1B.6.1. The Health Institution has a up-to-date all-inclusive list of collaborative professionals who agreed to support/consult with the pregnant women or mother of that service

□ Yes □ No

1B.6.2. The Health Institution has written policies for collaboration and care transfers available between Primary Health Care and other Hospitals

□ Yes □ No

1B.6.3. The Health Institution has a good referral system with a system to follow-up on cases which were referred between Primary Health Care and Hospitals

□ Yes □ No

1B.6.4. The Health Institution has a system to ensure recommendations on referred cases are shared between Primary Health Care and Hospitals

□ Yes □ No

1B.6.5. The Health Institution conducts surveys and/or interviews to establish if the referral system and follow-up system is working between facilities, Primary Health Care Institutions, or Community Health Providers

□ Yes □ No

1B.6.6. The Health Institution conducts surveys and/or interviews to establish the MotherBaby-Family experience with the Health Institution referral system

□ Yes □ No

1B.6.7. The Health Institution provides home care services

□ No

□ Yes: Select all that apply with regards to the home care services:

- □ Nursing Care
- □ Antenatal care
- □ Postnatal care
- □ Breastfeeding care
- □ Neonatal care
- □ Others:_____

1B.7. Postpartum Follow-up

1B.7.1. There is postpartum care programs for low-risk mothers and neonates between the Primary Health Care and Health Institution

□ Yes □ No

1B.7.2. There is postpartum care programs for high-risk mothers and neonates between the Primary Health Care and Health Institution

□ Yes □ No

1B.7.3. There are measurements in place to evaluate the MotherBaby Family experience through pregnancy, labour and 6 weeks postnatal care

□ No

□ Yes: attach the report indicating the number of experiences recorded in comparison to the annual birth rate at your Institution or Cluster

1B.8. Competency Assessment Tools

1B.8.1. Health Institution ensures availability of competent and motivated skilled healthcare professionals

□ Yes □ No

1B.8.2. The Health Institution ensures the provision of efficient and effective care

□ Yes □ No

1B.8.3. The Health Institution conducts training and implements competency assessment tools/drills for their maternity staff to demonstrate their knowledge, implementation of the policy/procedures, and adherence to it

□ No

□ Yes: specify the frequency of the training and topics covered

_____

_____

1B.9. Accountability

1B.9.1. The Health Institution provides informational posters and/or signs on how patients/families can report non-adherence to the policies and/or requests for bribes

□ Yes □ No

1B.9.2. Private Sector/ Business Centre in a Health Institution

If your Health Institution take payment for the services provided please answer the following:

1B.9.2.1. Families are informed about the charges which can be anticipated if any, and how they might plan to pay for services

□ Yes □ No

1B.9.2.2. Surveys and interview responses from women indicate that the fees paid met advertised rates without extra fees or Payment-in-kind (PIK)

□ Yes □ No

1B.9.2.3. The Health Institution does not have cases in which women, newborns, or infants are refused care or detained aftercare due to the inability to pay

□ That is correct, we do not have cases of the aforementioned

□ That is incorrect, we do have cases of the aforementioned

Step 2: Provide Emergency Care and Transport

Health institutions are expected to provide access to skilled emergency treatment for life-threatening complications. They also need to ensure that staff are trained in timely recognition of potentially dangerous conditions and complications and in providing effective treatment or stabilization and have established links for consultation and an accessible and reliable system of transport. Additionally, Health Institutions should ensure an effective referral system for follow-up cases to avoid errors or lost cases in the system.

2.1. Competencies and Assessment Tools

2.1.1. Indicate the level of the health institution (see Appendix 1)

- ☐ Accredited birth centre
- ☐ Level 1 (basic care hospital)
- ☐ Level 2 (specialty care hospital)
- ☐ Level 3 (subspecialty care hospital)
- ☐ Level 4 (regional hospital)

2.1.2. The Health Institution has a Rapid Response Team (RRT) for the obstetrics and gynaecology crisis

☐ Yes ☐ No

2.1.3. The Health Institution has a Rapid Response Team (RRT) policy and procedures

- ☐ No
- ☐ Yes: attach the policies and procedures

2.1.4. The Health Institution has education and training programs in RRT in obstetrics and gynaecology crisis

- ☐ No
- ☐ Yes: please attach the programs and answer the following:

  Number of drills conducted per year _____

  Number of attendees: _____

  Provide the list of attendees if available

2.1.5. The Health Institution has competency assessment tools for the RRT in obstetrics and gynaecology crisis

- ☐ No
- ☐ Yes: attach the assessment tools and answer the following

Number of staff members which were assessed_____

Number of times the assessment tools are used annually_____

2.1.6. The Health Institution has a Maternal Early Warning Signs (MEWS) policy and procedures

- ☐ No
- ☐ Yes: attach the policies and procedures

2.1.7. The Health Institution has MEWS system, educational, and training programs

□ Yes □ No

2.1.8. The Health Institution has competency assessment tools for the MEWS system

□ No

□ Yes: attach the assessment tools and answer the following:

Number of staff members which were assessed _____

Number of times the assessment tools are used annually_____

2.1.9. The Health Institution has a post-birth warning signs policy and procedures

□ No

□ Yes: attach the policies and procedures

2.1.10. The Health Institution has post-birth warning signs systems, educational, and training programs

□ Yes □ No

2.2. Triaging System

2.2.1. The Health Institution has a triaging system in the emergency room for all obstetric and gynaecological cases

□ Yes □ No

2.2.2. Indicate whether the Health Institution has a general triaging system or specific for obstetrics and gynaecologic cases

□ We have a general triage

□ We have a specific triage for obstetrics and gynaecology cases

2.2.3. The Health Institution audits the triaging cases in the emergency room to decrease the non-emergency cases and increases the effectiveness of the emergency department visits

□ Yes □ No

2.2.4. Health Institution ensures availability of competent and motivated skilled healthcare professionals

□ Yes □ No

2.2.5. The Health Institution conducts training and implements competency assessment tools/drills for their maternity staff to demonstrate their knowledge, implementation of the policy/procedures, and adherence to it

□ No

□ Yes: specify the frequency of the training and topics covered

_____

_____

2.3. Transportation Services

2.3.1. The ambulances are equipped for maternal transport in obstetric emergencies

□ Yes □ No

2.3.2. The ambulances are equipped for maternal transport in newborn/neonatal emergencies

□ Yes □ No

2.3.3. The paramedical services staffed for maternal and newborn/infant transfer are well trained personnel

□ Yes □ No

2.3.4. The Health Institution conducts training and implements competency assessment tools/drills for their paramedical staff to demonstrate their knowledge, implementation of the policy/procedures, and adherence to it

□ No

□ Yes: specify the frequency of the training and topics covered

_____

_____

2.3.5. The Health Institution audits paramedical staff performance during emergency cases to ensures the provision of efficient and effective care

□ Yes □ No

2.3.6. Surveys and interviews from women questionnaires for cases of referral from home, clinic, birthing centre, etc. to a medical facility, indicate all referrals and those referring are welcomed at the facility, treated with respect, and without blame during emergency care and transport

□ Yes

□ No, the questionnaires do not indicate this

□ No, this service is not available

2.3.6.1. Confirm that as a Health Institution integrate the MotherBaby-Family Unit during the evaluation survey of emergency care and transport services

□ Yes □ No

2.4. Emergency Resources and Procedures

Every Health Institutions should have all emergency treatment drugs, devices, and equipment, including Magnesium Sulphate, uterotonics, balloon tamponade kits, LifeWrap NASGs (at the peripheral areas), resuscitation equipment, oxygen tanks, and transport incubators for sick newborns.

2.4.1. All staff in the obstetrics and gynaecology department are aware these resources are in place

□ Yes □ No

2.4.2. These resources are visible to observers in the obstetrics and gynaecology department

□ Yes □ No

2.4.3. There is ongoing training for staff with regards emergency care and referral in obstetrics and gynaecology department

□ Yes □ No

2.4.4. The staff in the neonatology/paediatric department are aware these resources are in place

□ Yes □ No

2.4.5. These resources are visible to observers in the neonatology/paediatric department

□ Yes □ No

2.4.6. There is ongoing training for staff with regards emergency care and referral in neonatology/paediatric department

□ Yes □ No

2.4.7. There are written policies and guidelines for transport and information on transfer for referrals in place

□ Yes □ No

2.4.8. There are checklist for emergency resources availability, validity, and maintenance

□ No

□ Yes: specify the frequency of checking the list

Availability _____

Validity_____

Maintenance _____

2.5. Ongoing Documentation and Certification

Documented evidence of ongoing education and practice for all emergency procedures which are then accessible to be shown to assessors (i.e. the topic title of the drills/frequency of the drill/numbers attended the drills/competency assessment tool for the staff).

2.5.1. There is documented evidence of the aforementioned in the obstetrics and gynaecology department

□ No

□ Yes: specify the number of Physicians, Midwives and Nurses which were certified

Physicians _____ Midwives_____ Nurses_____

2.5.2. There is documented evidence of the aforementioned in the neonatology and paediatric department

□ No

□ Yes: specify the number of Physicians and Nurses which were certified

Physicians _____ Nurses_____

2.5.3. All staffed physicians in the obstetrics and gynaecology department have at least a valid certificate of one of the emergency courses on a yearly basis as

2.5.3.1. Advanced Life Support in Obstetrics (ALSO)

□ No

□ Yes: specify the number of Physicians which were certified

Consultants _____ Senior Registrars_____ Registrars_____ Residents____

2.5.3.2. Obstetric Emergency Training Course (OBERT)

□ No

□ Yes: specify the number of Physicians which were certified

Consultants _____ Senior Registrars_____ Registrars_____ Residents____

2.5.3.3. The Neonatal Resuscitation Program (NRP)

□ No

□ Yes: specify the number of Physicians which were certified

Consultants _____ Senior Registrars_____ Registrars_____ Residents____

2.5.3.4. K2 Foetal Monitoring

□ No

□ Yes: specify the number of Physicians which were certified

Consultants _____ Senior Registrars_____ Registrars_____ Residents____

2.5.3.5. Other courses such as breastfeeding, Specify the name_____

□ No

□ Yes: specify the number of Physicians which were certified

Consultants _____ Senior Registrars_____ Registrars_____ Residents____

2.5.4. All staff nurses/ midwives in the obstetrics and gynaecology department have at least one valid certificate of one of the emergency courses on a yearly basis as

2.5.4.1. Basic Life Support in Obstetrics (BLSO)

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants _____

2.5.4.2. Advanced Life Support in Obstetrics (ALSO)

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants _____

2.5.4.3. Obstetric Emergency Training Course (OBERT)

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants _____

2.5.4.4. The Neonatal Resuscitation Program (NRP)

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants _____

2.5.4.5. Medical Obstetric Emergencies and Trauma (MOET)

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants ____

2.5.4.6. K2 Foetal Monitoring

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants _____

2.5.4.7. Other courses such as breastfeeding, specify the name _____

□ No

□ Yes: specify the number of Midwives, Obstetric Nurses and Maternity Care Assistants which were certified

Midwives _____ Obstetric Nurses _____ Maternity Care Assistants _____

2.5.5. All staff in the neonatology and paediatric department have a valid certificate of

2.5.5.1. The Neonatal Resuscitation Program (NRP)

□ No

□ Yes: specify the number of Physicians and Nurses which were certified

Physicians _____ Nurses_____

2.5.5.2. K2 Foetal Monitoring

□ No

□ Yes: specify the number of Physicians and Nurses which were certified

Physicians _____ Nurses_____

2.5.5.3. Other courses such as breastfeeding, Specify the name_____

□ No

□ Yes: specify the number of Physicians and nurses which were certified

Physicians _____ Nurses_____

2.5.6. All staff physician, midwives and nurses in the Primary Health Care have at least one valid certificate of one of the emergency courses on a yearly basis as

2.5.6.1. Basic Life Support in Obstetrics (BLSO)

□ No

□ Yes: specify the number of Physicians, Midwives, and Nurses which were certified

Physicians _____ Midwives _____ Nurses _____

2.5.6.2. Advanced Life Support in Obstetrics (ALSO)

□ No

□ Yes: specify the number of Physicians, Midwives, and Nurses which were certified

Physicians _____ Midwives _____ Nurses _____

2.5.6.3. The Neonatal Resuscitation Program (NRP)

□ No

□ Yes: specify the number of Physicians, Midwives, and Nurses which were certified

Physicians _____ Midwives _____ Nurses _____

2.5.6.4. Other courses such as breastfeeding, Specify the name _____

□ No

□ Yes: specify the number of Physicians, Midwives and Nurses which were certified

Physicians _____ Midwives _____ Nurses _____

2.5.7. All paramedics staffed for maternal and newborn/infant transfer have at least one valid certificate of one of the emergency courses on a yearly basis as

2.5.7.1. Basic Life Support (BLS)

□ No

□ Yes: specify the number of Paramedics which were certified

Paramedics _____

2.5.7.2. Basic Life Support in Obstetrics (BLSO)

□ No

□ Yes: specify the number of Paramedics which were certified

Paramedics _____

2.5.7.3. The Neonatal Resuscitation Program (NRP)

□ No

□ Yes: specify the number of paramedics which were certified

Paramedics _____

2.5.7.4. Other courses such as breastfeeding, Specify the name_____

□ No

□ Yes: specify the number of Paramedics which were certified

Paramedics _____

2.5.8. Is a plan for the aforementioned courses to be accomplished by the staff

□ Yes □ No

2.5.9. Evaluation and auditing of all the above points with documented reports of implementation and follow-up of recommendations are completed every 4 months

□ Yes □ No

Step 3: Provide Continuous Support

Health facilities should offer unrestricted access to the following:

- Birth companions of the mother choice, including but not limiting to, male and female family members, friends, and a professional Doula (the latter of which provides continuous emotional and physical support in a professional manner.
- Midwifery care

Additionally, the Health Institution should respect the physical structure of the space which is required for accommodating companions, newborns, and tools in the labour ward and postpartum. See Ministry of Health Companion's Policy in the Obstetrics and Gynaecology Department.

3.3. Policies and Procedures

3.3.1. The Ministry of Health Companion's Policy in the obstetrics and gynaecology department is implemented
□ Yes □ No

3.3.2. There are written policies stating that all mothers may have access to continuous support from the person of her choice? (i.e. doula or family member)
□ Yes □ No

3.3.3. There are written policies stating that all mothers may have access to one-to-one midwifery continuous support
□ Yes □ No

3.2. Access to Support Personnel

3.2.1. Pregnant women have access to professional midwifery care at the health institution
□ Yes □ No

3.2.2. Pregnant women have access to the companion(s) of their choice during labour, birth, and the postpartum period
□ Yes □ No

3.2.3. Every labouring and birthing woman receives support from companion to strengthens her capability during childbirth
□ Yes □ No

3.2.4. The Health Institution allow any companion in the labour and birth room?
□ Not allowed
□ Always allowed
□ Not allowed but with exceptions (i.e in special cases as healthcare providers decide)
□ Up to healthcare provider (No policy)

3.2.4.1. if companion are allowed, who decides the identity of the companion?
□ Women
□ Healthcare providers
□ Women and healthcare providers

3.2.4.2. What is the number allowed? _____

3.2.5. The Health Institution allow any companion in the postpartum/postnatal room?

- Not allowed
- Always allowed
- Not allowed but with exceptions (i.e in special cases as healthcare providers decide)
- Up to Healthcare provider (No policy)

3.2.6. The Health Institution allows the husband to accompany women?

Yes No

3.2.7. The Health Institution allows companions to accompany women having elective caesarean section?

Yes No

3.2.8. The Health Institution allows companions to accompany women having emergency caesarean section?

Yes No

3.2.9. Provisions are made for the comfort and convenience of birth companions

Yes No

3.2.10. The Health Institution ensures continuous access to family and community support

Yes No

3.2.11. The Health Institution enhances the quality of the physical environment and resources

Yes No

3.2.12. Women and families state in interviews and/or questionnaires that companion was encouraged and supported

Yes No

3.2.13. Women and families state in interviews and/or questionnaires that space was made for their chosen companions

Yes No

3.3. Education

3.3.1. The Health Institution has antenatal education and training programs for pregnant women about continuous emotional and physical support during pregnancy, birth and postpartum

Yes No

3.3.2. The Health Institution has antenatal education and training programs for companions

Yes No

3.3.3. There are visible posters and distributed brochures showing or educating companion about their right and rules during childbirth and postpartum care.

Yes No

Step 4: Respect, Dignity and Informed Choices

Every MotherBaby- Family Unit deserves to be treated with respect and dignity. It is essential that every woman is treated in a way which protects their right to confidentiality, privacy, and support from people of their own choosing. Every woman has the right to be free from disrespect such as physical, verbal, or emotional abuse by a care provider or other medical personnel.

Additionally, every health care provider should fully include the MotherBaby- Family Unit in decision making regarding their care. This necessitates ensuring the MotherBaby- Family Unit understands the risk and benefits of every decision and protects their right to informed consent and refusal.

It is incumbent upon health providers to strongly encourage and support the family to interact, care for, and breastfeed their newborns. This is inclusive of sick or premature infants with congenital abnormalities to the extent which is compatible with their conditions.

Medical staff should understand the impact of their words, attitude, and demeanour on the MotherBaby-Family experience and mother's hormones. In order to ensure a supportive birth environment is met, healthcare providers should be compassionate and encouraging throughout the process. Medical staff are also responsible for providing religious and culturally competent care (within the cultural constraints of Saudi Arabia).

4.1. Respect and Dignity

4.1.1. Please acknowledge that under no circumstances is physical, verbal, sexual, or emotional abuse, discrimination, neglect, detainment, extortion or denial of services of women, their newborns and their families ever allowed.

☐ Yes ☐ No

4.1.2. Please select from the following with regards to what has been the treatment of the MotherBaby-Family Unit:

4.1.2.1. The MotherBaby-Family Unit is free from harm and mistreatment

☐ Yes ☐ No

4.1.2.2. The Health Institution maintains the privacy and confidentiality of the MotherBaby-Family Unit

☐ Yes ☐ No

4.1.2.3. The Health Institution preserves the women's dignity

☐ Yes ☐ No

4.1.2.4. Every woman has access to private birth room with walls

☐ Yes ☐ No

4.1.2.5. Every woman has access to a shared birth room with curtains or partitions

☐ Yes ☐ No

4.1.2.6. Every woman has the right to confidentiality and privacy during examinations such as vaginal examination

☐ Yes ☐ No

4.1.2.7. The Health Institution provides equitable maternity care

☐ Yes ☐ No

4.2. Informed Consent

4.2.1. The Health Institution provides prospective provision of information in order to seek informed consent

☐ Yes ☐ No

4.2.2. The Health Institution engages the MotherBaby-Family Unit with effective communication

☐ Yes ☐ No

4.2.3. The Health Institution respects women's choices that strengthen their capabilities to give birth

□ Yes □ No

4.2.4. All women are able to make informed choices in the services they receive and the reasons for interventions or outcomes are clearly explained

□ Yes □ No

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

□ Yes □ No

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

□ Yes □ No

4.2.7. In the Health Institution there are visible posters displaying the universal rights of childbearing women and brochures distributed to increase the awareness

□ Yes □ No

4.3. Cultural Competency and Feedback

4.3.1. In the Health Institution a grievance process is defined and available to mothers and their families

□ Yes □ No

4.3.2. Feedback mechanisms are provided for addressing complaints (such as a complaints boxes)

□ Yes □ No

4.3.3. The Health Institution regularly contacts the MotherBaby-Family Unit to comprehensively evaluate the cultural competence of the care delivered

□ Yes □ No

4.3.3.1. The Health Institution adjusts (i.e., enhances) care to all relevant populations in the region based on the evaluations collected

☐ Yes ☐ No

4.3.4. The Health Institution has cultural competency education and training programs for staff

☐ Yes ☐ No

4.3.5. Staff continues to acquire, apply and/or produce resources or services to better meet the beliefs, values, language, and customs of the mothers in the Health Institution

□ Yes □ No

4.3.6. Practices are modified to the beliefs, values, and customs of the mothers at the Health Institution

□ Yes □ No

4.4. Interaction with the newborn

4.4.1. The Health Institution has a written policy to support the family to interact, care for, and breastfeed their newborns.

□ Yes □ No

4.4.2. The Health Institution has a written policy to support the family to interact, care for, and breastfeed their sick or premature infants or infants with congenital abnormalities to the extent which is compatible with their conditions.

□ Yes □ No

4.4.3. The Health Institution has a family centred-care programme for sick newborn

□ Yes □ No

4.4.4. MotherBaby-Family Unit is empowered, encouraged and supported in caring for their baby while in the hospital

□ Yes □ No

4.4.5. MotherBaby-Family Unit is empowered, encouraged and supported in caring for their baby while at home after discharge

□ Yes □ No

4.4.6. The Health Institution offers family centred-care programme training programmes for staff

□ No

□ Yes, please attach the training programmes materials and all related policy and procedure

4.4.7. The Health Institution offers brochures about family centred-care programme

□ No

□ Yes, please attach the brochures

4.5. Compliance

4.5.1. After evaluating women's questionnaires and/or interviews, they show compliance with all the steps 4

□ No

□ Yes: attach the evaluation report such as orientation booklet, training programmes for staff and any related brochures for MotherBaby Family Unit.

Step 5: Provide Pain Relief Measures and a Supportive Birth Environment

Every woman should be educated on the importance of drug-free pain relief methods in order to facilitate normal physiological birth. This includes educating the woman and her companions on effective pain-coping mechanisms (i.e. breathing, touch, holding, massage, relaxation techniques, and labouring in water- when available). All hospital staff should be trained to provide pain-coping mechanisms.

Additionally, in order to effectively provide informed consent and refusal, the health care provider is responsible for explaining the risks and benefits of pharmacological pain relief methods when requested.

With regards to providing a supportive birth environment, in light of evidence-based care, upright positions and movements during childbirth are proven to be beneficial to the progress of labour and the birthing mother's comfort. Therefore, every woman should be supported in the upright position of her choice to facilitate evidence-based practices. This necessitates that the current practice of lithotomy (flat on back with legs elevated) should be absolved (unless it is specifically required to correct a complication). In order to facilitate upright movements, the following are required:

- Comfortable, clean, adequate bedding, regular water supply, and calming birth environments
- Tools for facilitating such positions, such as birthing balls, chairs and stools, floor mattresses or pads, and wall ladders and ropes, are visible and easily accessible in labour and birthing spaces
- However, it is important to note with regards to facilities that are not currently equipped with the aforementioned provisions, it still is incumbent upon these Health Institutions to improvise with low-technology tools and human support in order to afford every woman with her right to upright positions. This includes assisting the mother to assume positions of her choice including squatting, sitting, etc.
- Comfortable room temperature with equipped bathroom with shower
- The Health Institution should respect the physical structure of the space which is required for accommodating companions, newborns, and tools in the labor ward and postpartum.

5.1. Pain Relief Competencies, Policies and Procedures

5.1.1. The Health Institution educates the woman and her companions on effective drug-free pain-coping mechanisms in order to facilitate normal physiological birth during

5.1.1.1. Antenatal classes

□ Yes □ No

5.1.1.2. Upon admission

□ Yes □ No

5.1.2. The Health Institution offers brochures about effective drug-free pain-coping mechanisms in order to facilitate normal physiological birth

□ No

□ Yes, please attach the brochure(s)

5.1.3. All staff attends a minimum of one annual in-house education on labour support skills, comfort measures, and nonpharmacologic pain relief

□ Yes □ No

5.1.4. The Health Institution has a policy banning routine use of analgesic or anaesthetic drugs

□ Yes □ No

5.1.5. The Health Institution offers informed consent for all pharmacologic and/or alternative remedies (including the risks of the drugs or substances to the labour, the mother, her baby, breastfeeding and other perinatal outcomes)

□ No

□ Yes, please attach the brochure(s) outlining the informed consent

5.1.6. The Health Institution has discontinued the use of Pethidine drug for pain relief in labour

□ Yes □ No

5.1.7. There are written protocols, which are available to accessors, on comfort measures, non-pharmacological methods of pain relief, and the need for increased monitoring of the MotherBaby-Family Unit if pharmacological pain relief is used

□ Yes □ No

5.1.8. In interviews and/or surveys, staff confirms their knowledge of these protocols and report being trained in all methods of comfort measures and pain relief (this has to be completed twice a year with a competency assessment for physicians, midwives, and nurses)

□ No

□ Yes: attach the report(s) indicating the above

5.1.9. Survey /questionnaires are in place to determine whether comfort measures and natural pain relief are being offered and appropriate monitoring is being done for at least fifty (50%) of the annual births

□ Yes □ No

5.1.10. The quality care department randomly assesses and documents the Health Institution for compliance on the written policies in place to provide non-pharmacological pain relief

□ Yes □ No

5.1.11. New mother's questionnaires and interviews regarding the availability of non-pharmacological pain relief measures are being completed for at least fifty percent (50%) of the annual primigravida births

□ Yes □ No

5.1.12. Please confirm that as a Health Institution you integrate MotherBaby-Family Unit during the evaluation survey for pain relief measure

□ Yes □ No

5.2. Supportive Birthing Environment

5.2.1. Staff are competent in upright/ambulatory labour support and birthing positions

□ Yes □ No

5.2.2. Answer the following with regards to the services provided in the labour and birth room:

5.2.2.1. Every labour and birthing room has a minimum clear floor area 31 square meters (see Appendix 2)

□ Yes □ No

5.2.3. Every labour and birthing room has comfortable, clean, adequate bedding, and calming birth environments

□ Yes □ No

5.2.4. Every labour and birthing room has regular water supply

□ Yes □ No

5.2.5. Every labour and birthing room has access to snacks and food supply

□ Yes □ No

5.2.6. Every labour and birthing room has comfortable room temperature

□ Yes □ No

5.2.7. Every labouring and birthing woman has access to a bathroom with a shower

□ They have access to a shared shower

□ Yes, they have access to a private shower

□ No, they do not have access to a shower

5.2.8. Every labouring and birthing woman has access to birth tub for hydrotherapy or water birth

□ Yes □ No

5.3. Freedom of Movement

5.3.1. The women's movements and positions are restricted during labour at the Health Institution

□ Yes □ No

5.3.2. All labouring and birthing women are offered the ability to walk, stand, and move around and to assume the position of her choice/comfort unless medically contraindicated, during

5.3.2.1. The first stage of labour

□ Yes □ No

5.3.2.2. The second and third stages of labour

□ Yes □ No

5.3.3. The Health Institution has equipment that encourage upright and other birthing positions readily accessible to all labouring women 24 hours a day

- No
- Yes: indicate the birthing tools at your facility [select all that apply]
  - Birthing stools
  - Birthing beds
  - Birth balls
  - Rocking or comfortable chairs
  - Showers
  - Squatting bars
  - Warm water tubs
  - Celling Rope
  - Other (specify:) _____

5.3.4. If the Health Institution does not have birthing tools, there are methods in place to assist the labouring women in upright movements 24 hours a day

- No
- Yes: Please indicate which methods are used

_____
_____
_____

Step 6: Provide and Promote Specific Evidence-based Practices and Avoid Harmful Practices

In coordination with international standards it has been proven to be beneficial in supporting the normal physiology of labour, birth, and the postpartum and neonatal periods and avoid harmful practices for needed multidisciplinary policies and procedure (see Appendix 3), equipment, supplies and medications for OBGYN services (see Appendix 4), these can be used as a guide.

The Health Institutions should be targeting the following standards in their practices:

- Induction rate of less than 10%
- Episiotomy rate of less than 10%
- Primary caesarean rate of less than 15%
- Total caesarean section rate of less than 25% in all facilities except level 3 facilities and above (less than 30%)
- VBAC (vaginal birth after one or two caesareans and more) rate of 60% or more with a goal of 75% or more

6.1. Elimination of Routine Procedures

6.1.1. The Health Institution eradicated policies and protocols requiring routine use of the following during labour and birth:

6.1.1.1. Enemas
☐ Yes ☐ No

6.1.1.2. Perineal shaving
☐ Yes ☐ No

6.1.1.3. Withholding nourishment
☐ Yes ☐ No

6.1.1.4. Early rupture of membranes
☐ Yes ☐ No

6.1.1.5. Continuous electronic foetal monitoring using CTG for low-risk pregnancy
☐ Yes ☐ No

6.1.1.6. Mandating that mother should be in bed or immobilized
☐ Yes ☐ No

6.1.1.7. Supine and lithotomy position
☐ Yes ☐ No

6.1.1.8. Fundal pressure (Kristeller)
☐ Yes ☐ No

6.1.1.9. Episiotomy for all primigravida
☐ Yes ☐ No

6.1.1.10. Liberal use of episiotomy
☐ Yes ☐ No

6.1.1.11. Urinary bladder catheterization without any indication
☐ Yes ☐ No

6.1.1.12. Immediate cord clamping
☐ Yes ☐ No

6.1.1.13. Caregiver directed pushing (Valsalva's manoeuvre)
☐ Yes ☐ No

6.1.1.14. Separation of the mother and baby
☐ Yes ☐ No

6.2. Informed Consent and Education

6.2.1. There are visible posters and distributed brochure showing or educating women about their right to eat, drink, walk, and move during labour. Specifically, illustrating upright and other physiologic birth positions that include the woman being supported by a companion

□ No

□ Yes, please attach the brochures

6.2.2. The Health Institution obtains precise informed consent for each and every (all) obstetric practices and procedures, including instrument delivery (forceps and vacuum extraction)

□ Yes □ No

6.2.3. There are surveys and/or interviews of women in place which indicate their satisfaction of the medical care providers to respect their wishes with regards to delayed cord clamping, immediate and prolonged skin-to-skin care and rooming-in

□ No

□ Yes: attach the report(s) indicating the aforementioned

6.2.4. The health institution's related department assesses, interviews and measure women's experiences indicating, the mother's full access to the Neonatal Intensive Care unit (NICU), and to providing kangaroo (skin-to-skin) care to her newborn

□ Yes □ No

6.3. Staff Competencies Regarding Evidence-Based Practices

6.3.1. The Health Institution provides obstetric staff training in normal birth without using medical interventions

□ Yes □ No

6.3.2. All obstetricians and midwives are trained and competent in conducting normal birth without using medical interventions

□ Yes □ No

6.3.3. The Health Institution provides obstetric staff training in electronic foetal monitoring (EFM)

□ Yes □ No

6.3.4. All obstetric staff trained and competent in interpretation of electronic foetal heart monitoring (EFM)

□ Yes □ No

6.3.5. The Health Institution provides obstetricians and midwives training in perineal trauma and repair

□ Yes □ No

6.3.6. All obstetricians and midwives are trained and competent in prevention of perineal trauma

□ Yes □ No

6.3.7. All staff are trained that they should refrain from immediate cord clamping as it results in iatrogenic anaemia of the neonate and that according to the WHO there is no harm in delaying cord clamping until after the birth of the placenta

□ Yes □ No

6.3.8. The Health Institution provides obstetricians training in External Cephalic Version (ECV) and breech birth

□ Yes □ No

6.3.9. All obstetricians and midwives trained and competent in conducting vaginal breech births to avoid caesarean section wherever possible
□ Yes □ No

6.3.10. All appropriate medical staff are trained to provide all routine newborn procedures while rooming-in for low-risk neonates and mothers
□ Yes □ No

6.4. Health Practices in Accordance with Evidence-Based Care and International Standards

6.4.1. The Health Institution rates of practice for the following procedures are within acceptable international ranges (attach your statistics of all key performance indicators)

6.4.1.1. Induction rate of less than 10%
□ Yes □ No

6.4.1.2. Episiotomy rate of less than 10%
□ Yes □ No

6.4.1.3. Primary caesarean rate of less than 15%
□ Yes □ No

6.4.1.4. Total caesarean section rate of less than 25%
□ Yes □ No

6.4.1.5. Total caesarean section rate of less than 30% in level 3 hospitals and above
□ Yes □ No □ Not applicable

6.4.1.6. VBAC (vaginal birth after one) rate of 60% or more with a goal of 75% or more
□ Yes □ No

6.4.1.7. VBAC (vaginal birth after two caesareans) rate of 60% or more with a goal of 75% or more
□ Yes □ No

6.4.2. The aforementioned statistics or key performance indicators are available to accessors
□ Yes □ No

6.4.3. The Health Institution has applied a plan to decrease the rates of the practice for the following medical procedures:

6.4.3.1. Intravenous Fluids (IV)
□ Yes □ No

6.4.3.2. Medical induction or augmentation of labour
□ Yes □ No

6.4.3.3. Augmentation of labour
□ Yes □ No

6.4.3.4. Continuous Electronic foetal monitoring (EFM)
□ Yes □ No

6.4.3.5. Instrumental vaginal delivery
□ Yes □ No

6.4.3.6. Episiotomy
□ Yes □ No

6.4.3.7. Manual exploration of the uterus
□ Yes □ No

6.4.3.8. Primary Caesarean section

□ Yes □ No

6.4.3.9. Caesarean section for Breech presentation

□ Yes □ No

6.4.3.10. Total Caesarean section rate

□ Yes □ No

6.4.3.11. Suctioning of the newborn

□ Yes □ No

6.4.4. The Health Institution has applied a plan to increase the VBAC rate after one caesarean section

□ Yes □ No

6.4.5. The Health Institution implemented a plan to increase the VBAC rate after two caesarean sections

□ Yes □ No

6.4.6. The Health Institution has policies and procedures to prevent the incidence of primary caesarean sections

□ Yes □ No

6.4.7. Measures are in place to ensure the neonate receives a minimum of 3 minutes of delayed cord clamping if born vaginally

□ Yes □ No

6.4.8. Measures are in place to ensure the neonate receives a minimum of 1 minute of delayed cord clamping if born via caesarean

□ Yes □ No

6.4.9. All mothers are provided with a minimum of 1 hour of uninterrupted skin-to-skin contact after birth unless there is a severe complication indication otherwise

6.4.9.1. All mothers are provided with the aforementioned after a vaginal birth

□ Yes □ No

6.4.9.2. All mothers are provided with the aforementioned after a caesarean birth

□ Yes □ No

Step 7: Provide and Support the Midwifery Model of Care

This focuses specifically on strengthening the central role and function of the professional midwife in the provision of quality care during pregnancy, childbirth, other reproductive and sexual health services. For safe midwifery staffing refer to Safe Staffing: Nurse/Midwife to Patient Ratios Guidelines for Regulatory Decision Making within the Kingdom of Saudi Arabia (2021).

7.1. Implementation of MOH Standard of Care

7.1.1. The Health Institution has the targeted midwives' numbers (for each birth you need 30 midwives-Calculate the annual number of birth and divide by 30). Keeping in mind the midwives will be distributed to cover clinics (Primary Health Care and hospitals), Antenatal, Labour and Birth, Postnatal Wards and Operating Room, etc. *Note the international ratio of midwife to birth is 1:29.5*

☐ Yes ☐ No

7.1.1.1. Specify the total number of midwives distributed in the Health Institution is as follow:

7.1.1.1.1. Antenatal ward_____
7.1.1.1.2. Postnatal ward _____
7.1.1.1.3. Labour and Birth ward _____
7.1.1.1.4. Out Patient Department (OPD) _____
7.1.1.1.5. Operating Room (OR) related to Obstetric cases _____
7.1.1.1.6. Education (such as breastfeeding, antenatal)_____
7.1.1.1.7. Well baby nursery _____
7.1.1.1.8. Primary Health Care (PHC) _____
7.1.1.1.9. Home/community midwifery care _____

7.1.1.2. Specify the total number of Obstetric Nurses distributed in the Health Institution_____

7.1.1.3. Specify the total number of and Maternity Care Assistants distributed in the Health Institution_____

7.1.1.4. The Health Institution is working on providing the standard of midwifery care?

☐ Yes ☐ No

7.1.1.5. The Health Institution provides a successful scaling up of the number and quality of practicing midwives

☐ Yes ☐ No

7.1.2. The Health Institution provides a midwifery model of care which supports women throughout the antenatal, intrapartum and postnatal period, to facilitate a healthy pregnancy, childbirth, and healthy parenting practices

☐ Yes ☐ No

7.1.3. The Health Institution shifts the roles and responsibilities of midwives as well as other health-care professionals who have previously been responsible (i.e. between antenatal and postnatal care)

☐ Yes ☐ No

7.1.4. The Health Institution provides continuous care through a midwifery-led care model integrating MotherBaby-Family Unit (i.e involves a midwife as the main care provider, that the midwife is the lead health-care professional, responsible for the planning, organisation and delivery of care given to a woman from the initial booking of antenatal visits through to care during the postnatal period).

☐ Yes ☐ No

7.1.5. The Health Institution is working on providing the midwifery-led care

☐ Yes ☐ No

7.2. Midwifery-led care Competencies

7.2.1. The Health Institution has implemented the MOH guidebook for midwives

☐ Yes ☐ No

7.2.2. The Health Institution has a recurring training programmes and education assessment for Midwives and Obstetric Nurses and Maternity Care Assistants that can be provided when necessary

☐ Yes ☐ No

7.2.3. The Health Institution has a recurring midwifery competency assessment covering the entire scope and service of the midwives that can be provided when necessary

☐ Yes ☐ No

7.2.3.1. The Health Institution provides Midwives and Obstetric Nurses and Maternity Care Assistants training in normal birth without using medical interventions

☐ Yes ☐ No

7.2.3.2. All midwives are trained and competent in conducting normal birth without using medical interventions

☐ Yes ☐ No

7.2.3.3. The Health Institution provides Midwives and Obstetric Nurses and Maternity Care Assistants training in electronic foetal heart monitoring (EFM)

☐ Yes ☐ No

7.2.3.4. All midwives trained and competent in interpretation of electronic foetal heart monitoring (EFM)

☐ Yes ☐ No

7.2.3.5. The Health Institution provides Midwives training in perineal trauma and repair

☐ Yes ☐ No

7.2.3.6. All Midwives and Obstetric Nurses and Maternity Care Assistants are trained and competent in prevention of perineal trauma

☐ Yes ☐ No

7.2.4. The Health Institution has a recurring competency assessment for Obstetric Nurses covering the entire scope and service that can be provided when necessary

□ Yes □ No

7.2.5. The Health Institution has a recurring competency assessment for Maternity Care Assistants covering the entire scope and service that can be provided when necessary

□ Yes □ No □ Not applicable

7.2.6. The Health Institution provides burnout and workload assessment tools for a midwifery-led care model

7.2.6.1. The aforementioned is provided to Midwives

□ Yes □ No

7.2.6.2. The aforementioned is provided to Obstetric Nurses

□ Yes □ No

7.2.6.3. The aforementioned is provided to Maternity Care Assistant

□ Yes □ No □ Not applicable

7.2.7. The Health Institution reviews the privileges of the midwives and updates them annually according to their individual performance and competency assessments

□ Yes □ No

7.3. MotherBaby-Family Education

7.3.1. The Health Institution provides all parents with education about the Midwifery-led care model

□ Yes □ No

7.3.2. The Health Institution offers brochures about Midwifery-led care model

□ No

□ Yes, please attach the brochure(s)

7.3.3. The Health Institution provides questionnaires and interviews regarding the availability of Midwifery-led care

□ No

□ Yes: please attach a copy of the feedback

7.3.4. The Health Institution provides questionnaires and interviews regarding the MotherBaby-Family experience with Midwifery-led care model

□ No

□ Yes: please attach a copy of the results

Step 8: Have Supportive Human Resources Policy

All Health Institutions (Clusters, Hospitals, Birth centers, Primary Health Care, etc.) should have appropriate policies and measures in place in order to ensure staff is enabled to carry out evidence-based practices. Additionally, staff has the right to a safe, secure, and positive work environment where they are encouraged to follow up-to-date practices. The policies should incorporate an exclusion approach that ensures the maintenance and progression of committed, experienced, and skilled maternal healthcare providers (especially midwives, nurses, maternity care assistants and physicians) in all units and facilities where births take place. These professionals should be protected from being transferred to other departments.

8.1. Policies and Procedures

8.1.1. The human resource department and ensures the Health Institution is adequately staffed to provide the standards of care (see 7.a and Appendix 5)

☐ Yes ☐ No

8.1.2. The Health Institution has a supportive human resource policy for recruitment and retention of all employees

☐ Yes ☐ No

8.1.3. The Health Institution has a supportive human resource policy to ensure that employees are safe, secure, and encouraged and enabled to provide quality care in a respectful and positive work environment

☐ Yes ☐ No

8.1.4. The Health Institution and human resource department ensures employees are well-trained and provide regular trainings to update practices in order to get promoted

☐ Yes ☐ No

8.1.5. The Health Institution has a human resource policy to measure staff productivity that is matching with the workload

☐ Yes ☐ No

8.1.6. The Health Institution provides satisfaction assessment tools for all employees

☐ Yes ☐ No

8.1.7. The human resource department ensures staff have a valid accreditation with SCFHS and are legal in their practice, profession, knowledge and competence

☐ Yes ☐ No

8.1.8. The human resource department ensures staff have a valid malpractice insurance

☐ Yes ☐ No

8.1.9. The Health Institution provides burnout and workload assessment tools for all employees

☐ Yes ☐ No

8.2. Accountability

8.2.1. The Health Institution regularly interviews employees regarding their work environment and strives to implement the comments provided to ensure a positive environment

□ Yes □ No

8.2.2. Surveys and/or interviews with staff demonstrate an understanding of the policies and confirm that it addresses all the aforementioned issues (8.2.1)

□ Yes □ No

8.2.3. Surveys and/or interviews are prepared by the quality assurance department to check, evaluate, and measure the performance of the human resources responsibility as illustrated above

□ Yes □ No

8.3. Leadership

8.3.1. The Health Institution have competent managerial and clinical leaders who are responsible for implementing policies and promoting a positive work environment to support staff conduct evidence-based practices.

□ Yes □ No

Step 9: Promote Breastfeeding and Skin-to-Skin Contact

Every Health Institution should strive to achieve WHO-UNICEF: Steps of the Revised Baby-Friendly Hospital Initiative (2018): Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services including Primary Health Care. This step is currently carried out and accredited by the Ministry of Health.

9.1. Policies and Procedures

9.1.1. The Health Institution complies fully with the *International Code of Marketing of Breast-milk Substitutes* and relevant World Health Assembly resolutions

☐ Yes ☐ No

9.1.2. The Health Institution complies fully with the *Breast-milk substitutes Marketing Saudi Board Executive Regulation*

☐ Yes ☐ No

9.1.3. The Health Institution has written infant feeding policies that are routinely communicated to staff and parents

☐ Yes ☐ No

9.1.4. The Health Institution has established ongoing monitoring and data-management systems

☐ Yes ☐ No

9.1.5. The Health Institution ensures staff have sufficient knowledge, competence and skills to support breastfeeding

☐ Yes ☐ No

9.1.6. All staff and related collaborative professionals are trained in co-care of the mother-baby

☐ Yes ☐ No

9.1.7. The Health Institution has a written policy that keeps mothers and babies together from birth until discharge, 24-hours a day (unless there are specific [i.e., life-threatening] situations when co-care would compromise the safety of the mother or child)

☐ Yes ☐ No

9.2. Implementation

9.2.1. All staff are encouraging skin-to-skin contact immediately after birth in the labour and birth room

☐ No

☐ Yes : indicate how long (in minutes)

_____

9.2.2. All staff are encouraging skin-to-skin contact immediately after birth in the operating room

☐ No

☐ Yes : please indicate how long (in minutes)

9.2.3. The Health Institution ensures mothers are kept together with their newborns to establish breastfeeding as soon as possible

☐ Yes ☐ No

9.2.4. The Health Institution acquires informed consent from the mother for all non-emergency separation(s) of her and her baby

☐ Yes ☐ No

9.2.4.1. Informed consent is obtained for anyone other than the mother feeding her baby

☐ Yes ☐ No

9.2.4.2. Informed consent is attained for anything except mother's milk for feeding her baby

☐ Yes ☐ No

9.2.4.3. Informed consent is attained for any other apparatus for infant feeding other than the mother's breast

☐ Yes ☐ No

9.2.5. The Health Institution provides combined care and sufficient space for the MotherBaby-Family Unit in beds large enough for both with bassinets at hand (when available)

☐ Yes ☐ No

9.2.6. The Health Institution has measures in place to ensure there are no pharmaceutical posters advertising infant formula are displayed and no infant formula is provided as a parting gift

☐ Yes ☐ No

9.2.7. There are culturally appropriate and heavily graphic posters in Arabic languages depicting skin-to-skin contact and breastfeeding, along with explanations of their benefits, are prominently placed

☐ Yes ☐ No

9.3. Baby-Friendly Hospital Certification of intent

9.3.1. The Health Institution applied for a Certificate of Intent to Become Baby-Friendly or has been awarded designation as a Baby-Friendly facility from Baby-Friendly USA (formerly the US Committee for UNICEF)

9.3.1.1. The hospital has applied for a Certificate of Intent or has already been awarded the aforementioned designation

☐ Yes: indicate whether the certification is valid currently and attach a copy of valid certificates, If you answered yes, do not complete questions in section 9.4

☐ No: If you answered no, complete questions in section 9.4

9.3.1.2. The associated Primary Health Care attached to the hospital has applied for a Certificate of Intent or has already been awarded the aforementioned designation

☐ Yes: indicate whether the certification is valid currently and attach a copy of valid certificates, If you answered yes, do not complete questions in section 9.4

☐ No: If you answered no, complete questions in section 9.4

9.4. Baby-Friendly Hospital Certification 10 Steps

9.4.1. The Health Institution has written breastfeeding/infant feeding policies that is routinely communicated to all healthcare staff

9.4.1.1. The Health Institution has a written breastfeeding/infant feeding policy that addresses all 10 Steps to Successful Breastfeeding in maternity services and support for HIV-positive mothers

□ Yes □ No

9.4.1.2. The policy protects breastfeeding by prohibiting all promotion of breastmilk substitutes, feeding bottles, and teats

□ Yes □ No

9.4.1.3. The policy prohibits the distribution of gift packs with commercial samples and supplies or promotional materials for these products to pregnant women and mothers

□ Yes □ No

9.4.1.4. There is a breastfeeding/infant feeding policy available so all staff who take care of mothers and babies can refer to it

□ Yes □ No

9.4.1.5. A summary of the breastfeeding/infant feeding policy is posted and displayed in all areas of the health facility which serve mothers, infants, and/or children. These posters should include issues related to the 10 Steps of The International Code of Marketing of Breast-milk Substitutes, subsequent WHA resolutions, support for HIV-positive mothers

□ Yes □ No

9.4.1.6. There is a summary of the policy posted in language(s) and written with wording most commonly understood by mothers and staff

□ Yes □ No

9.4.1.7. There is a mechanism for evaluating the effectiveness of the policy

□ Yes □ No

9.4.1.8. All policies or protocols are related to breastfeeding and infant feeding in line with current evidence-based standards

□ Yes □ No

9.4.2. Train all health care staff in skills necessary to implement the policy

9.4.2.1. All staff members caring for pregnant women, mothers, and infants are oriented to the breastfeeding/infant feeding policy of the Health Institution when they start working

□ Yes □ No

9.4.2.2. All staff members who care for pregnant women, mothers, and babies are aware of the importance of breastfeeding and acquainted with the facility's policy and services to protect, promote, and support breastfeeding

□ Yes □ No

9.4.2.3. Staff members caring for pregnant women, mothers, and infants (or all staff members if they are often rotated into positions with these responsibilities) receive training on breastfeeding, promotion, and support within 6 months of commencing work, unless they have received sufficient training elsewhere

□ Yes □ No

9.4.2.4. Staff training covers all the Ten Steps to Successful Breastfeeding and The International Code of Marketing of Breast-milk Substitutes

□ Yes □ No

9.4.2.5. The training for clinical staff is at least 20 hours in total, including a minimum of 3 hours supervised clinical experience

□ Yes □ No

9.4.2.6. Training for non-clinical staff is sufficient, given their roles, to provide them with the skills and knowledge needed to support mothers in successfully feeding their infants

□ Yes □ No

9.4.2.7. Clinical staff members who care for pregnant women, mothers, and infants able to answer simple questions on breastfeeding promotion and support and care for non-breastfeeding mothers

□ Yes □ No

9.4.2.8. Non-clinical staff such as care attendants, social workers, clerical, housekeeping, and catering staff are able to answer simple questions about breastfeeding and how to provide support for mothers on feeding their babies

□ Yes □ No

9.4.2.9. Healthcare facilities have arranged for specialized training in lactation management for specific staff members

□ Yes □ No

9.4.3. Inform all pregnant women about the benefits and management of breastfeeding

9.4.3.1. The hospital includes an antenatal clinic, satellite antenatal clinic(s), or in-patient antenatal wards

□ No

□ Yes: indicate whether pregnant women who receive antenatal services are informed about the importance and management of breastfeeding

9.4.3.2. Antenatal records indicate whether breastfeeding has been discussed with pregnant women

□ Yes □ No

9.4.3.3. Antenatal education, including both which are provided orally and in written format, cover key topics related to the importance and management of breastfeeding

□ Yes □ No

9.4.3.4. Pregnant women are protected from oral, written promotion, or group instruction of artificial feeding

□ Yes □ No

9.4.3.5. Pregnant women who receive antenatal services are able to describe the risks of giving supplements while breastfeeding during the first six months

□ Yes □ No

9.4.3.6. Pregnant women who receive antenatal services are able to describe the importance of early skin-to-skin contact between the MotherBaby and rooming in

□ Yes □ No

9.4.3.7. A mother's antenatal records are available at the time of delivery

□ Yes □ No

9.4.4. Help mothers initiate breastfeeding within a half hour of birth

9.4.4.1. Babies who have been delivered vaginally or by caesarean section without general anaesthesia are placed in skin-to-skin contact with their mothers immediately after birth and are their mothers encouraged to continue this contact for an hour or more

□ Yes □ No

9.4.4.2. Babies who have been delivered by caesarean section with general anaesthesia are placed in skin-to-skin contact with their mothers as soon as the mother is responsive and alert, and the same procedure is followed

□ Yes □ No

9.4.4.3. All mothers are helped during this time to recognize signs that their babies are ready to breastfeed and offered help if needed

□ Yes □ No

9.4.4.4. Mothers with babies in special care are encouraged to hold their babies with skin-to-skin contact unless there is a justifiable reason not to do so

□ Yes □ No

9.4.5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infant

9.4.5.1. Staff offers all breastfeeding mothers further assistance with breastfeeding their babies within 6 hours of birth.

□ Yes □ No

9.4.5.2. Staff is able to describe the types of information and demonstrate the skills to provide to both mothers who are breastfeeding and those who are not to assist them in successfully feeding their babies

□ Yes □ No

9.4.5.3. Staff members or counsellors who have specialized training in breastfeeding and lactation management are available full-time to advise mothers during their stay in healthcare facilities and in preparation for discharge

□ Yes □ No

9.4.5.4. Staff offers advice on other feeding options and breast care to mothers with babies in special care who have decided not to breastfeed

□ Yes □ No

9.4.5.5. Breastfeeding mothers are able to demonstrate how to correctly position and attach their babies for breastfeeding

□ Yes □ No

9.4.5.6. Breastfeeding mothers are shown how to hand express their milk or given information on expression and advised of where they can get help, should they need it

□ Yes □ No

9.4.5.7. Mothers who have never breastfed or who have previously encountered problems with breastfeeding receive special attention and support from the staff of the healthcare facility, both in the antenatal and postpartum period

□ Yes □ No

9.4.5.8. Mothers who have decided not to breastfeed shown individually how to prepare and give their babies feeds and asked to prepare feeds themselves, after being shown how

□ Yes □ No

9.4.5.9. Mothers with babies in special care who are planning to breastfeed are helped within 6 hours of birth to establish and maintain lactation by frequent expression of milk and told how often they should do so

□ Yes □ No

9.4.6. Given newborn infants no food or drink other than breast milk, unless medically indicated

9.4.6.1. Hospital data indicates that at least 75% of the full-term babies are discharged in the last year have been exclusively breastfed (or exclusively fed expressed breast milk) from birth to discharge, or if not that they were acceptable medical reasons

□ Yes □ No

9.4.6.2. Babies breastfed, receiving no food or drink other than breast milk, unless there were acceptable medical reasons or fully informed choices

□ Yes □ No

9.4.6.3. The health facility takes care not to display or distribute any materials that recommend feeding breast-milk substitutes, scheduled feeds, or other inappropriate practices

□ Yes □ No

9.4.6.4. Mothers who have decided not to breastfeed report that the staff discussed with them the various feeding options and helped them to decide what was suitable in their situations

□ Yes □ No

9.4.6.5. The facility has adequate space and the necessary equipment and supplies for giving demonstrations of how to prepare formula and other feeding options away from breastfeeding mothers

□ Yes □ No

9.4.6.6. All clinical protocols or standards related to breastfeeding and infant feeding are in line with BFHI standards and evidence-based guidelines

□ Yes □ No

9.4.7. Practice rooming-in -allow mothers and infants to remain together- 24 hours a day

9.4.7.1. The MotherBaby stay together and/or start rooming-in immediately after birth

□ Yes □ No

9.4.7.2. Mothers who have had caesarean sections or other procedures with general anaesthesia stay together with their babies and/or start rooming in as soon as they are able to respond to the babies' needs

□ Yes □ No

9.4.7.3. Mothers and infants remain together (rooming-in or bedding-in) 24 hours a day, unless separation is fully justified

□ Yes □ No

9.4.8. Encourage breastfeeding on demand

9.4.8.1. Breastfeeding mothers are taught how to recognize the cues that indicate when their babies are hungry

□ Yes □ No

9.4.8.2. Breastfeeding mothers are encouraged to feed their babies as often and for as long as the babies needs

□ Yes □ No

9.4.8.3. Breastfeeding mothers are advised that if their breasts become overfull, they should try to breastfeed

□ Yes □ No

9.4.9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants

9.4.9.1. Breastfeeding babies are being cared for without any bottle feeds

□ Yes □ No

9.4.9.2. Mothers have been given information by the staff about the risks associated with feeding milk or other liquids with bottles and teats

□ Yes □ No

9.4.9.3. Breastfeeding babies are being cared for without using pacifiers

□ Yes □ No

9.4.10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital and clinic

9.4.10.1. Staff discusses plans with mothers who are close to discharge for how they will feed their babies after the family returns home

□ Yes □ No

9.4.10.2. The hospital has a system of follow-up support for mothers after they are discharged, such as: early postnatal, lactation clinic check-ups, home visits, or telephone calls

□ Yes □ No

9.4.10.3. The Health Institution fosters the establishment of and/or coordinates with mother support groups and other community services that provide support to mothers on feeding their babies

□ Yes □ No

9.4.10.4. Mothers are referred for help with feeding to the facility's system of follow-up support groups, peer counsellors, and other community health services such as Primary Health Care for MCH centres, if these are available

□ Yes □ No

9.4.10.5. Printed material is made available to mothers before discharge, if appropriate and feasible, on where to get follow-up support

□ Yes □ No

9.4.10.6. Mothers are encouraged to see a health care worker or skilled breastfeeding support person in the community soon after discharge (preferably 2-4 days after birth and again in the second week) who can assess how they are doing in feeding their babies and give any support needed

□ Yes □ No

9.4.10.7. The facility allows breastfeeding/infant feeding counselling by trained mother-support group counsellors in its maternity services

□ Yes □ No

Step 10: Provide Accurate and Descriptive Statistical Information and Key Performance Indicators (KPIs)

The Health Institutions (Cluster, Hospital, Birth Centre, Primary Health Care, etc.) should provide the Key Performance Indicators (KPIs) and Statistical Information to the health regulatory body regarding their performance, about its practices and procedures for maternal and neonatal care, including measures of interventions and outcomes.

The Health Institutions should provide accurate descriptive and statistical information to the public about their practices and procedures for MotherBaby-Family Maternity Care.

Each medical caregiver is responsible for the quality of care she or he provides. Each hospital or birth centre is responsible for periodic review and evaluation according to the current scientific evidence, of the effectiveness, risks and the rates of its medical procedures for mother and babies. The KPIs and Statistical Information template are available in Appendix 6 of this document, as a guide not limited to what mentioned. You can adapt and change it according to your Health Institution scope of service.

10.1. Publication and Availability of Data

10.1.1. The Health Institution have an electronic website

☐ Yes ☐ No

10.1.2. The Health Institution publishes annual information to the public about the practices and procedures for birth care, together with all interventions and outcomes listed in this document, in a manner that is readily comprehensible to the general public (check international birth registration data available to public)

☐ Yes ☐ No

10.1.3. The information and statistical data is presented in at least one of the following forms: (a) brochure that is provided to all interested individuals and clients at entry into care, (b) newspaper article; (c) signposted in the facility; (d) free audio or videotape, (f) website, etc.

☐ No

☐ Yes: please specify which format(s)

_____

_____

10.1.4. This information has clear language and is available to all clients in the region (e.g., low or multiliteracy clients, etc.)

☐ Yes ☐ No

10.1.5. The obstetrics and gynaecology department have a continuous quality improvement programs which includes the collection of related statistics

☐ Yes ☐ No

10.1.6. The obstetrics and gynaecology department has a continuous quality improvement programs which include the collection of data about clinical measurable KPIs

☐ Yes ☐ No

10.1.7. The obstetrics and gynaecology department uses the resulting quality improvement data to:

10.1.7.1. Measure performance

□ Yes □ No

10.1.7.2. Identify opportunities for improvement including health improvement

□ Yes □ No

10.1.7.3. Measure the effectiveness of improvement interventions

□ Yes □ No

10.1.7.4. Benchmark against best practices and professional practice guidelines

□ Yes □ No

10.1.8. The obstetrics and gynaecology department with quality department investigate all cases of maternal mortality and morbidity at reproductive age on a monthly base

□ Yes □ No

10.1.8.1. The Health Institution conducts an intense analysis of cases of maternal mortality and morbidity

□ Yes □ No

10.1.8.2. Whenever applicable, the Health Institution makes intervention(s) to prevent or minimize recurrence

□ Yes □ No

10.1.9. The Health Institution conducts perinatal mortality and morbidity analysis on a monthly basis with the related departments

□ Yes □ No

10.1.10. The Health Institution conducts risk management for obstetric practices every 3-4 months

□ Yes □ No

10.1.11. Whenever applicable, the Health Institution follows the implementation of the recommendation(s) resulting from risk management meetings in order to prevent or minimize recurrence

□ Yes □ No

10.1.12. The Health Institution implements the statistic collection and KPIs (see Appendix 6).

□ Yes □ No

10.1.13. The Health Institution conduct annual meetings with all related department to discuss the KPIs and Statistical Information and compare with previous year for future planning and improvement.

□ Yes □ No

Appendix 1: Maternity Unit / Hospital Levels

	Minimum care provider available	Anesthesia	OBGYN	MFM	Blood bank	Ultrasound service	ICU	Medical Specialist	Surgical Specialist	Laboratory
Levels I (Basic)	Obstetric Provider to perform emergency CS	Available all the time	Specialist available 24 hours / consultant accessible when needed	Accessible for consult by phone	Accessible	Accessible by referral	No	No	No	Accessible
Levels II (Specialty)	Obstetric Provider to perform emergency and elective CS	Available all the time	Available all the time	Accessible for consult by phone / part time	Accessible	Onsite	HDU	Internist	General surgeon accessible	Onsite
Levels III (Subspecialty)	Obstetric Provider to perform emergency and elective CS	Obstetric Anesthesia available	Available all the time	Onsite for consult	Onsite	Onsite	Available	Medical subspecialties accessible	Subspecialties accessible	Onsite
Levels IV (Regional)	Obstetric Provider to perform emergency and elective CS	Obstetric Anesthesia available	Available all the time	Onsite for 24 hours	Onsite	Onsite	Available with subspecialties	Medical subspecialties onsite	Surgical subspecialties Onsite	Onsite

Appendix 2: Structure of Labour and Birth Department/Ward

- Labour and birth rooms shall have a minimum clear floor area of 325 square feet (31 square meters) with a minimum wall width at the head of the bed of 13 feet (3.96 meters) includes (3 square meters) store within the room. This clear floor area includes an infant stabilization and resuscitation space with a minimum clear floor area of at least 40 square feet (3.7 square meters).
- Where renovation work is undertaken and it is not possible to meet the above minimum square footage standards, existing labour and birth rooms shall be permitted to have a minimum clear floor area of 240 square feet (22.3 square meters).
- Labour and birth rooms shall have a minimum of the following:
  - feet (1.52 meters) from the foot of the bed to a wall or fixed obstruction
  - 5 feet (1.52 meters) on the transfer side of the bed to a wall or fixed obstruction 4 feet (1.22 meters) on the non-transfer side of the bed to a wall or fixed obstruction

Clearance: the required minimum distance between a specified object (e.g the patient bed or exam table) and any fixed or immovable element of the environment. Note: Movable equipment and furniture that do not interfere with functions or could be easily moved out of the way are not used to calculate minimum clearance.

Clear dimension: An unobstructed room dimension exclusive of built-in casework and equipment and available for function use.

Clear floor area:
The floor area of a defined space that is available for function use excluding toilet rooms, closets, lockers, wardrobes, alcoves, vestibules, anterooms, and auxiliary work area. Note: Door swings and floor space below sinks, counters, cabinets, modular units or other wall hung equipment that is mounted to provide usable floor space count toward “clear floor area”.

Space taken up by minor fixed encroachments that do not interfere with room functions can be included in calculating clear floor area.

Appendix 3: Multidisciplinary Policies and Procedures

Multidisciplinary policies and procedure should be available to guide the care of women in labour and postnatal including the following, but are not limited to:

A. Obstetrics, Midwifery and Nursing Practices

- Management of women in normal labour and birth, including immediate postpartum care and criteria for discharge from labour and delivery room.
- Management of ante-partum and post-partum haemorrhage
- Augmentation of labour and the use of oxytocin
- Induction of labour
- Prevention of primary Caesarean section
- Caesarean section repeated caesarean section, and emergency hysterectomy.
- The use of foetal heart rate monitoring (CTG, Doppler) during labour and birth
- Ultrasound
- Management of non-reassuring foetal heart rate
- Labour and birth pain management (pharmacological including regional analgesia and non-pharmacological)-Meperidine (Pethidine) should NOT be used for labour and birth pain
- Use of Portogram for woman in labour
- Midwifery-led model of care
- General Nursing care
- Management of hypertensive disorders of pregnancy
- Management of the diabetic patient in labour and postpartum
- Management of Venous Thromboembolism (VTE) risk assessment and prophylaxis in pregnancy and postpartum
- Management of septicaemia in pregnancy
- Suppression of pre-term labour
- Management of multiple births
- Instrumental vaginal delivery
- Management of rupture of membranes (PROM, Preterm Prelabour ROM, SROM)
- Management of un-booked mothers
- Infection control measures in labour, birth and postpartum
- Management of perineal trauma (episiotomy, first, second-, third- and fourth-degree perineal tears)
- Postpartum care
- Newborn assessment, care, resuscitation, and transport
- Newborn identification including prevention of newborn and infant abduction and exchange.
- Birth summary
- Lactation and Breastfeeding
- Discharge plan
- Transfer of care and criterion
- Vaccination before, during and after pregnancy which includes but is not limited to the updated recommendations of the following list of vaccines:
    - Flu vaccine
    - Tdap vaccine
    - Human papillomavirus HPV vaccine
    - Measles, mumps, and rubella (MMR) vaccine
    - Varicella (chicken pox) vaccine

B. Emergency

- Emergency Obstetrics Care (EmOC)
- Triage to prioritize emergency patients, pathways, and guidelines.
- Early detection, management, and transfer of respiratory illness for OBGYN women
- Blood transfusion
- Massive blood transfusion
- Clinical triggers-Maternal Early Warning Signs (MEWS)
- Post-Birth Warning Signs
- Prevention of newborn and infant kidnapping and exchange
- Pink Code
- The rights and responsibility for patients in the OBGYN emergency department, including patients under observation, patients waiting for admission, patients waiting for admission with no beds available (boarding patients) and patients waiting for transfer to another organization
- OBGYN Team STAT
- Emergency care and transport for mother and neonate
- Born before arrival
- Transfer of patient care detailing responsibility at times of shifts, handovers, referral, admission and etc.
- Suspected or confirmed OBGYN women with clinical pathway
- Suspected or confirmed MERS-COV and COVID-19 patients

D. General:

- For medical consultations including but not limited to: the level of consultation including immediate (life, limb, or function threatening), ways of communications, timelines of phone response and physical presence to different types of consultations
- Communication using appropriate communication model for example ISBAR
- Communication channel between staff and with the designated regional drug and poison information Centre.
- OPD Short Stay Unit including but not limited to admission and discharge criteria.
- Staff trainings and competency assessment
- Morbidity and mortality reviews

N.B. the above lists of policies and procedure should be read in conjunction with listed polices and procedure in the main document and self-assessment form.

Appendix 4: Equipment, Supplies and Medications for OBGYN services

Emergency Room:
• CTG- ECG –X-ray machines, Ultrasounds machines- OBGYN Beds • Log book/sheet for checking the available/needed supplies • Fully equipped ambulatory emergency bags for (birth, pre-eclampsia and eclampsia, postpartum haemorrhage, etc). with log sheet for daily checking • Fully equipped crash cart • Normal birth and Caesarean birth Trays • Suturing kit • Plastic sheeting • Vaginal speculum • Sponge forceps • Needle holder • Stitch scissors • Forceps – Dissecting toothed and non-toothed
The labour and birth rooms
• Birth bed suitable for all labour position, but avoid candy cane stirrups • Ceiling light • Portable examination lights • Baby weighing scale • Adult weighing scale • Pulse-oximeters • Laryngoscope • Ophthalmoscope • Sphygmomanometer • Stethoscope • Pinard stethoscope • Foetal heart Doppler • Thermometer • CTG • Breast pumps (manual and electrical) • On-site portable Ultrasounds machines • ECG machine and sensor • Sterilized normal birth sets (including but not limited to sheets, neonates bulb suction, cord clamp, gauze). • Postpartum haemorrhage trays • Balloon Tamponade for Postpartum haemorrhage • Normal vaginal birth trays (2 cord clamps, kidney dish, cord cutter, blunt-ended scissors, medium • Perineal and vaginal repairs trays (2 Artery forceps, curved and straight medium length scissors, tissue forceps, needle holder). • Dressing kit • Urinary catheter kit • Caesarean section tray • Adult and neonatal resuscitation equipment and medication

- Sterilized instrument packaged separately with the quantity matching the expected number of birth. The instrument per package are:
    - 1 Needle holder size 16-18 cm
    - 1 Needle holder size 20-22 cm
    - 1 Curved medium length scissor size 16-18 cm
    - 1 Straight medium length scissor 16-18 cm
    - 1 Curved medium length scissor size 20-22 cm
    - 1 Straight medium length scissor 20-22 cm
    - 2 Artery forceps (either small, medium or large)
    - 2 Sims vaginal speculums (either small, medium or large)
    - 2 Vaginal speculums (either small, medium or large)
    - 1 Cord clamp
    - 1 Sponge forceps
    - 1 Toothed cervical forceps
    - Obstetrics forceps for breech
    - Ambu-bags
    - Blades (reusable or disposable)
- Toothed Stitch scissors
- Absorbable Suture for perineal trauma
    - For skin: Coated Vicryl Rapide (polyglactin 910/ 3-0/ 75 cm/ 26 mm/3/8/ reverse cutting
    - For 1st degree tears: Coated Vicryl Rapide (polyglactin 910), 2/0, 75cm on a swaged (eyeless) round bodied 26 mm ½ circle needle with taper cut or reverse cutting
    - For 2nd degree tears: Coated Vicryl Rapide (polyglactin 910), 2/0, 90 cm on a swaged (eyeless) round bodied 36 mm ½ circle needle with tapered point or taper cut
    - For 3rd and 4th degree tears: PDS 2-0/ 70cm/26 mm/SH
    - For 3rd and 4th degree tears: Vicryl plus 2-0/ 70 cm/22 mm/ ½ circle
- Cervical cerclage removal set
- Entonox supplies such as mask and tube
- Functioning vacuum extractor machines and cups (reusable) and Kiwi (disposable)
- Functioning suction machine with suction tube
- Functioning suction machine with mucus extractors for neonates (for emergencies, not for routine suction)
- Regulators for Nitrous Oxide and Oxygen (Entonox) in each labour and birth room
- Sterilized low forceps set (outlet)
- Sterilized gloves, gowns, gauze, cotton balls
- Clean linen, e.g., gowns.
- Filled oxygen cylinder with cylinder carrier and key or source of oxygen
- Oxygen concentrator
- Essential and emergency equipment, consumable linen are available based in Periodic Automatic Replenishment (PAR) level
- Intravenous stands, Infusion pumps, intravenous needles and cannulas for adult and newborn
- Stretcher or trolley
- Supply cabinets in each room
- Point-of-Care (POC) testing for investigations (blood sugar, fetal blood, cord blood sampling for blood gases (arterial and venous): machines, kits, reagents, papers, any related supplies should be available all the time
- Multi-functions monitors (central monitoring CTG and patient vital signs)
- Portable incubators (with ventilator)
- Radiant warmer
- Instrument for intubation (Pipe for suction- -Oxygen mask- -Nasogastric tube
- Foley indwelling catheter size to 12-14 F

- In and out (intermittent) urinary bladder catheter
- Urine dipstick strips for all parameter specifically sugar, ketone and protein
- Clean razors
- Gauze sterile/not sterile
- Gloves sterile/not sterile
- Wound drainage system
- Disposable sterile gowns
- Disposable surgical mask
- Disposable surgical drapes
- Paper disposable tape measure

Emergency/lifesaving drugs for OBGYN cases

Include but is not limited to:

- Methotrexate Injection (50 mg/2 ml)
- Dinoprostone 3 mg pessary
- Dinoprostone 500 microgram/2.5 ml vaginal gel
- Dinoprostone 5 mg/0.5 ml injection: extraamniotic, 0.5 ml ampoule
- Methylergometrine maleate 125 microgram tablet
- Oxytocin 5 international units/0. 5 ml injection, 0.5 ml ampoule
- Misoprostol Tablet (200 microgram)
- Carbetocin 100 microgram/ml injection, 1 ml ampoule
- Methylergometrine maleate 200 microgram/ml injection, 1 ml ampoule
- Carboprost 250 microgram/ml injection, 1 ml ampoule
- Ferric carboxymaltose Injection (50 mg/ml)
- Tranexamic Acid Tablet (650 mg)
- Hydralazine tablets (25mg, 10mg)
- Hydralazine injection (20mg/ml)
- Labetalol hydrochloride Tablets (100 mg)
- Labetalol hydrochloride Injection (20ml)
- Atosiban 6.75 mg/0.9 ml injection, 0.9 ml vial
- Atosiban 3.75 mg/5 ml injection: concentrated, 5 ml vial
- Calcium gluconate monohydrate 10% (1 g/10 mL, 2.2 mmol/10 mL) injection, 10 ml ampoule
- Magnesium sulphate 1% (1 g/100 ml) injection: intravenous infusion, 100 ml bag
- Nifedipine Retard Tablet or Capsule (10, 20 mg).

Appendix 5: Obstetrics and Gynecology Physician Staffing

General rule that applicable to public, maternity and children hospitals which should cover up to 1000 births annually.

- The hospitals must have a minimum of 2 OBGYNE Consultants available at all times regardless of how small the unit capacity is. Thereafter 1 more OBGYNE Consultant for every 500-1000 births annually.
- A minimum of 2 OBGYNE Specialists per unit. Thereafter 1 more OBGYNE Specialists for every 500 births annually.
- A minimum of 4 OBGYNE Residents per unit. Thereafter 2 OBGYNE Residents for every 500 births annually.

Below is the suggested number of OBGYNE physicians required in the maternity unit based on bed number. It is mandatory to follow the above general rule considering birth numbers.

Public Hospitals			
Number of beds	Consultants	Specialists	Residents
50	2	2	4
100	2	2	4
150	2	4	5
200	2	4	7
300	3	5	9
400	3	6	10
500	4	6	10

Maternity and Children's Hospitals			
Number of beds	Consultants	Specialists	Residents
100	3	4	7
150	5	7	8
200	6 (+1 urogynecologist)	8	10
300	8 (+1 urogynecologist, +1 MFM)	11 (+1 service urogynecology),	18
400	11 (+1 urogynecologist, +1 MFM, +1 gyne-oncologist, +1 infertility)	13 (+1 services urogynecology, +1 infertility, +1 gyne-oncology, +1 MFM)	20
500	15 (+2 urogynecologist, +2 MFM, +2 gyne-oncologist, +2 infertility),	18 (+2 service urogynecology, +2 gyne-oncology, +1 MFM),	25

- Infertility (Reproductive Endocrinology and Infertility)
- MFM (Maternal Foetal Medicine)
- Urogynecologist= Pelvic Reconstructive Surgeon
- For hospital from 200 to 500 beds the subspecialities can be on site or shared coverage with other health institutions.

Appendix 6: Key Performance Indicators (KPIs) and Statistical Information

MotherBaby-Family Maternity Care Statistics & Key Performance Indicators (KPIs)	
Concerned Area	No or %
CLINICS	
Un-booked Antenatal cases	
Antenatal Booked women	
LABOUR AND DELIVERY ROOM CARE	
Total number of Birth	
Total Term Vaginal Birth	
Total number of Caesarean Section	
1. Elective C/S	
2. Emergency C/S	
3. Primary C/S	
Total number of Operative Vaginal Birth	
Preterm Birth	
QUALITY OF CARE NUMBER OF PREGNANT WOMEN HAD	
1. Received 1:1 Care in Labour room	
2. Vaginal birth conducted by midwives	
3. Vaginal birth conducted by physicians	
4. Vaginal birth outside labour and birth room including emergency room	
5. Unattended Birth	
MEDICAL INTERVENTIONS DURING LABOUR	
1. Routine perineal shaving on admission in labour	
2. Receive routine enema	
3. Receive Intravenous (IV) drip	
4. Artificial Rupture of Membrane (AROM)	
5. Continuous Electronic Foetal Monitoring (EFM)	
a. Low Risk Pregnancy	
b. High Risk Pregnancy	
6. Augmentation of labour	
7. Woman in their 1st stage of labour on free mobilization and diet	
8. Bladder catheterization (in & out or Foley's Catheter)	
NEONATAL	
1. Early Umbilical cord clamping < 1 minute	
2. Delayed Umbilical cord clamping ≥ 1 minute for caesarean births	
3. Delayed Umbilical cord clamping ≥ 3 minute for vaginal births	
3. Early skin-to-skin contact between mother and newborn for one hour after Vaginal birth	
4. Early skin-to-skin contact between mother and newborn for one hour after C-section	
PAIN CONTROL & SUPPORT	
1. Presence of family member or doula support	
2. Pharmacologic pain relief	
3. Non-pharmacologic relief	

4. Epidural	
INDUCTION OF LABOUR (IOL)	
1. Total number of induced labour between 37 and 39 weeks of gestation	
2. Total number of induction of labour for post-dated pregnancy	
NUMBER OF SPONTANEOUS VERTEX VAGINAL BIRTH	
1. Primigravida (PG)	
2. P2 & above	
PERINEAL TEARS NUMBER OF VAGINAL BIRTH WITHOUT EPISIOTOMY	
1. Intact perineum	
2. Primigravida (PG) with Intact perineum	
3. P2 & above with Intact perineum	
4. PG with 1st & 2nd degree perineal tear	
5. Para 2 & above 1st & 2nd degree perineal tear	
6. PG with 3rd and 4th perineal tear	
7.Total women with 3rd and 4th perineal tear	
PERINEAL TEARS: NUMBER OF VAGINAL BIRTH WITH EPISIOTOMY	
1. Para 2 & above with 3rd and 4th perineal tear	
2. Primigravida (PG)	
3. Para 2 & above	
4. With 1st & 2nd degree perineal tear in primigravida	
5. With 1st & 2nd degree perineal tear in P2 and above	
6. With 3rd and 4th perineal tear in Primigravida	
7. With 3rd and 4th perineal tear in P2 and above	
8.Total women with 3rd and 4th perineal tear	
INSTRUMENTAL/OPERATIVE DELIVERY	
1. FORCEPS	
a. Gravida1	
b. P2 & above	
c. Intact perineum	
d. With episiotomy	
e. Failed forceps delivery	
2. VENTOUSE (VACUUM)	
a. Gravida 1	
b. P2 & above	
c. Intact perineum	
d. With episiotomy	
e. Failed ventouse delivery	
TOTAL NUMBER OF BREECH PRESENTATION Birth	
1. <37 weeks	
2. >37 weeks	
3. Successful External Cephalic Version (ECV)	
4. Failed External Cephalic Version (ECV)	
5. Assisted Vaginal Breech Birth	
6. Vaginal Breech Birth in nulliparous	

7. Vaginal Breech Birth in multiparous	
INDICATIONS FOR EPISIOTOMY	
1. Forceps delivery	
2. Ventouse delivery	
3. Vaginal Breech Birth	
4. Foetal malpresentation	
5. Previous history of perineal tear	
CAESAREAN SECTIONS (C/S): total number of	
1. Nullipara, singleton cephalic, ≥ 37 weeks, spontaneous labour	
2. Nullipara, singleton cephalic, ≥ 37 weeks	
(2a) Induced labour	
(2b) Caesarean section before labour	
3. Multipara, singleton cephalic, ≥ 37 weeks, spontaneous labour	
4. Multipara, singleton cephalic, ≥ 37 weeks	
(4a) Induced labour	
(4b) Caesarean section before labour	
5. Previous Caesarean section, singleton cephalic, ≥ 37 weeks	
(5a) Spontaneous labour	
(5b) Induced labour	
(5c) Caesarean section before labour	
6. All nulliparous breeches	
(6a) Spontaneous labour	
(6b) Induced labour	
(6c) Caesarean section before labour	
7. All multiparous breeches (including previous Caesarean section)	
(7a) Spontaneous labour	
(7b) Induced labour	
(7c) Caesarean section before labour	
8. All multiple pregnancies (including previous Caesarean section)	
(8a) Spontaneous labour	
(8b) Induced labour	
9. All abnormal lies (including previous Caesarean section, excluding breech)	
(9a) Spontaneous labour	
(9b) Induced labour	
(9c) Caesarean section before labour	
10. All singleton cephalic, <37 weeks (including previous Caesarean section)	
(10a) Spontaneous labour	
(10b) Induced labour	
(10c) Caesarean section before labour	
11. Total number of caesarean sections under general anaesthesia	
PREVIOUS ONE CAESARIAN SECTION (C/S): TOTAL NUMBER OF	
1. Successful vaginal birth after one C/S	
2. C/S after 1 C/S	

3. Refused Trial of labour after one C/S	
PREVIOUS ≥ 2 CAESARIAN SECTIONS (C/S)	
1. Vaginal Birth after ≥ 2 C/S	
2. C/S after ≥ 2 C/S	
3. Refused TOLAC (2 C/S)	
INDICATIONS FOR CAESARIAN SECTION (C/S)	
1. Previous one S/S	
2. Previous 2 C/Ss	
3. Previous 3 or more C/Ss	
4. Labour dystocia (first stage arrest) **	
5. Labour dystocia (second stage arrest)**	
6. Failed induction of labour	
7. Non-reassuring foetal heart rate tracing	
8. Foetal macrosomia**	
9. Foetal malpresentation (exclude breech)	
10. Breech foetal malpresentation	
11. Multiple gestation	
12. Funic presentation or cord prolapse	
13. Abnormal placentation (e.g. placenta previa, vasa previa, placenta accreta)	
14. Eclampsia and HELLP syndrome	
15. Mechanical obstruction to vaginal birth (e.g., large fibroid, severely displaced pelvic fracture, severe foetal hydrocephalus)	
16. Others	
CAESARIAN SECTION COMPLICATIONS	
1. Maternal blood loss >1000cc	
2. Caesarean hysterectomy	
3. Urinary bladder injury	
4. Bowel injury	
5. Vascular injury	
6. Unplanned removal of an organ during operative procedure.	
7. Length of stay (LOS) > 5 days post C/S without any complications.	
8. Post-operative wound dehiscence requiring re-suturing.	
9. Unplanned return to the Operating Room	
10. Post-operative thromboembolism.	
11. Post-operative systemic or surgical site infection.	
12. Infection treated with parenteral antibiotics which was not thought to be present pre-operatively & is related to an obstetric cause.	
13. Blood transfusion during C/S	
14. Injury of the foetus with the scalpel during C/S	
MULTIPLE PREGNANCY	
1. Twins	
2. Triplets	
3. Quadruplets	

4. Pentaplets	
MALPRESENTATION (OTHER THAN BREECH)	
1. Face	
2. Brow	
3. Transverse (Oblique)	
4. Compound	
5. Cord presentation (Vasa Praevia)	
6. Cord prolapse	
BIRTH TRAUMA	
1. Shoulder dystocia	
2 Cervical laceration	
4. Subgaleal hematoma post ventouse extraction	
5. Fractures of clavicle/humerus during delivery	
6. Cord prolapse due to severe effect on the neonatal condition	
7. Newborn injury during vaginal birth	
8. Others	
PREGNANCY COMPLICATIONS	
1. Hypertension	
a. Essential	
b. Pregnancy Induced / PET	
c. Eclampsia	
d. HELLP	
2. Diabetes Mellitus	
a. Overt	
b. Gestational	
3. Antepartum Haemorrhage	
a. Placenta previa	
b. Vasa Previa	
c. Abruptio Placenta	
d. Caesarean hysterectomy	
OTHER PREGNANCY COMPLICATIONS	
4. Premature labour	
5. Low amniotic fluid (Oligohydramnios)	
6. Ectopic pregnancy	
7. Iron Deficiency Anaemia	
8. Rh-Iso-Immunization	
9. Thrombocytopenia	
10. Epilepsy	
11. Cardiac Disease	
12. Sickle Cell	
13. Renal Disease	
14. Thalassemia disease	
15. Glucose-6-phosphate dehydrogenase (G6PD) Deficiency	
16. Sepsis	

17. Embolism	
18. Obstetric high risk patient received DVT prophylaxis	
19. Percentage of pharmacological thromboprophylaxis among unplanned c section	
20. Percentage of pharmacological thromboprophylaxis among planned c section	
21. Other……..	
COMPLICATIONS OF THE 3rd STAGE OF LABOUR	
1. Postpartum haemorrhage >1000 ml **	
2. PPH by sign & symptom (moderate/severe) **	
3. Retained placenta	
4. Uterine inversion	
5. Uterine rupture	
6. Postpartum return to operating room for management after completion of 3rd stage of labour.	
7. Other……..	
POST PARTUM COMPLICATIONS	
1. Maternal length of stay (LOS) >2 days after vaginal delivery.	
2. Unplanned Maternal postpartum re-admission to hospital within 40 days of delivery due to direct obstetric indication.	
3. Post-obstetrics perineal repair wound dehiscence, infection	
4. Vulva / perineum hematoma formation	
5. Maternal micturition problems or faecal incontinence	
6. Retained vaginal swabs or instruments in the peritoneal cavity	
7. Post-partum anaemia Hb <7gm/dL or HCT <22%	
8. Post-partum blood transfusion	
9. Patient who received 4 or more units of blood	
10. Primary postpartum haemorrhage	
11. Postpartum haemorrhage (early and late)	
12. Maternal admission to ICU	
13. Obstetrics/post-partum cases re-admission to ICU	
14. Septic shock or sepsis	
15. Embolism	
16. Cardiopulmonary arrest	
17. Fistula formation in the late post-caesarean section	
18. Other……	
OPERATING ROOM	
1. Use of prophylactic antibiotics (maternity cases)	
2. Use of prophylactic antibiotics (major gynaecology operations)	
APPOINTMENTS / FOLLOW-UP	
1. Patient attended postnatal follow up	
2. Woman completed pre-natal visit	
3. Woman received prenatal screening	
4. Woman visited the clinic in her 1st trimester	
5. No show in obstetrics clinics	
BREASTFEEDING	
1. Mothers continue breastfeeding in the postpartum period	

2. Woman who received counselling regarding breastfeeding in antenatal visit	
3. Woman participated in skin to skin bonding for one hour	
4. Woman initiates breastfeeding within 48 hours	
5. Woman received teaching for breastfeeding within 24 hours after birth	
6. Mothers given discharge instructions for breastfeeding before discharge	
7. Number of qualified breastfeeding health educators per year	
8. Numbers of woman participated in Kangaroo care	
9. Number of babies with exclusive breastfeeding for first 6 months post-partum	
TOTAL MATERNAL MORTALITY	
MATERNAL MORTALITY CAUSES	
1. Postpartum Haemorrhage	
2. Hypertension	
3. Sepsis	
4. Embolism	
5. Cardiac	
6. Hemoglobinopathy	
7. Others	
TOTAL NUMBER OF LIVE BIRTHS	
1. Low Birth Weight < 2.5 kg	
2. Macrosomia (>4 kg)	
NEONATAL ADMISSION	
1. Neonatal admission after vaginal or C/S birth	
2. Admission to NICU of baby weighing > 2.5kg without birth defects	
3. Admission to NICU of baby with ≥37 weeks gestational age without birth defects	
4. Babies in NICU that is fed by breast milk	
NEONATAL COMPLICATIONS	
1. Diagnosed with birth asphyxia	
2. Diagnosed with Neonatal Encephalopathy	
3. Diagnosed with Hypoxic Ischemic Encephalopathy (HIE)	
4. Diagnosed with Brachial plexus injury	
5. Diagnosed with Foetal Meconium Aspiration Syndrome	
6. Diagnosed with Erb's palsy	
7. Undiagnosed severe foetal anomalies in booked patient	
8. Inborn infant with clinically apparent seizures recorded prior to discharge. (Inborn infant is one born in this hospital rather than transferred from another institution)	
9. Inborn term infant admitted to NICU within 1 day of birth & with NICU stay greater than 48 hrs	
10. Subgaleal hematoma post ventouse extraction	
11. Fractures of clavicle/humerus during delivery	
12. Cord prolapse due to severe effect on the neonatal condition	
13. Newborn injury during vaginal birth	
14. Birth at ≤32 weeks of gestational age but don't require NICU	
15. Diagnosed as Intrauterine Growth Restriction (IUGR) baby during pregnancy	
16. Diagnosed as Intrauterine Growth Restriction (IUGR) baby after birth	

HIE CASES TREATED WITH HYPOTHERMIA	
1. Hypothermia treatment of HIE > 6 hours after HIE or Neonatal Encephalopathy	
2. Hypothermia treatment of HIE < 6 hours after HIE or Neonatal Encephalopathy	
STILLBIRTHS	
1. < 1kg	
2. 1 - 2.5 kg	
3. > 2.5 kg	
4. Low Apgar score <5 at 5 and 10 mins	
5. Low venous cord pH below 7	
6. Low cord pH between 7.0 and 7.24	
7. Foetal umbilical artery pH < 7.0	
EARLY NEONATAL DEATHS	
1. < 1kg	
2. 1 - 2.5kg	
3. > 2.5kg	
4. Low Apgar score <5 at 5 and 10 mins	
5.Low venous cord pH below 7	
6. Low cord pH between 7.0 and 7.24	
7. Foetal umbilical artery pH < 7.0	
PERINATAL MORTALITY RATE - Crude	
PERINATAL MORTALITY RATE- Corrected	
PERINATAL MORTALITY RATE (excluding Un-booked)	
PERCENTAGE OF PEER REVIEW OF SERIOUS ADVERSE EVENTS	
PATIENT SATISFACTION: POSITIVE BIRTH EXPERIENCE	
1. Number of positive birth experience questionnaires forms collected per month	
2. Percentage of positive birth experience (forms and phone calls)	
PATIENT SATISFACTION: POSTPARTUM CARE AFTER 6 -8 WEEKS	
1. Number of manual (forms) survey collected	
2. Number of phone calls survey collected	
3. Number & Percentage of Breastfeeding with positive patient satisfaction	
4. Number & Percentage of Postpartum Care with positive patient satisfaction	
5. Number & Percentage of women with positive satisfaction from midwife-led model of care	

Glossary/Definitions

The MotherBaby-Family:
Is an integral unit during pre-conception, pregnancy, birth and infancy influencing the health of one another. Within this triad, the MotherBaby dyad remains recognized as one unit, as the care of one significantly impacts the other.

Family:
Can be the husbands, and/or the extended family members (consisting of parents and children, along with either grandparents, grandchildren, aunts or uncles, cousins etc) in which a child in conceived, born and raised.

K2 Foetal Monitoring (Perinatal Training Programme (PTP)): an online, interactive e-learning tool covering a comprehensive array of topics in Foetal Monitoring and Maternity Crisis Management, including Competency Assessments covering all modules.

Birth Asphyxia:
Is a process of varying severity and duration rather than an endpoint, should not be applied to birth events unless specific evidence of markedly impaired intrapartum or immediate postnatal gas.

Neonatal Encephalopathy:
A heterogeneous, clinically defined syndrome characterized by disturbed neurologic function in the earliest days of life in an infant born at or beyond 35 weeks of gestation, manifested by a reduced level of consciousness or seizures, often accompanied by difficulty with initiating and maintaining respiration, and by depression of tone and reflexes.

Hypoxic-Ischaemic Encephalopathy (HIE):
Is a type of neonatal encephalopathy caused by systemic hypoxemia and/or reduced cerebral blood flow resulting from an acute peripartum or intrapartum event.

Criteria needed to implicate intrapartum hypoxia/acidosis as a possible cause of CP in term infants:

1. Apgar scores < 5 at 5 and 10 minutes
2. Foetal umbilical artery pH < 7.0 and/or base deficit ≥ 12 mmol/L
3. Neuroimaging evidence of acute brain injury consistent with hypoxia-ischemia
4. Multisystem organ failure consistent with hypoxic-ischemic injury
5. Sentinel hypoxic or ischemic event that occurs proximate to labour and delivery (e.g. severe abruption or uterine rupture))
6. Intrapartum foetal heart rate classification that is initially Category I then converts to Category III
7. Absence of other possible aetiologies
8. Developmental outcome of spastic quadriplegic or dyskinetic cerebral palsy.

Recommendations for the Safe Prevention of the Primary Caesarean Birth (first stage of labour):

- A prolonged latent phase (e.g., greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women) should not be an indication for caesarean delivery.
- Cervical dilation of 6 cm should be considered the threshold for the active phase of most women in labour. Thus, before 6 cm of dilation is achieved, standards of active phase progress should not be applied.
- Caesarean delivery for active phase arrest in the first stage of labour should be reserved for women at or beyond 6 cm of dilation with ruptured membranes who fail to progress despite 4 hours of adequate uterine activity, or at least 6 hours of oxytocin administration with inadequate uterine activity and no cervical change.
- Slow but progressive labour in the first stage of labour should not be an indication for caesarean birth. A minimum of 12 hours of oxytocin after membrane rupture before failed labour induction could be diagnosed.

The Arrest of Labour in the First Stage:

Spontaneous labour: More than or equal to 6 cm dilation with membrane rupture and one of the following:

- 4 hours or more of adequate contractions (e.g., more than 200 Montevideo units)
- 6 hours or more of inadequate contractions and no cervical change

Recommendations for the Safe Prevention of the Primary Caesarean Delivery for the 2nd stage of labour

Before diagnosing arrest of labour in the second stage, if the maternal and foetal conditions permit, allow for the following:

- At least 2 hours of pushing in multiparous women
- At least 3 hours of pushing in nulliparous women

Longer durations may be appropriate on an individualized basis (e.g., with the use of epidural analgesia or with foetal malposition) as long as progress is being documented.

Caesarean Delivery for Macrosomia:

Caesarean delivery to avoid potential birth trauma should be limited to estimated foetal weights of at least 5,000 g in women without diabetes and at least 4,500 g in women with diabetes. The prevalence of birth weight of 5,000 g or more is rare, and patients should be counselled that estimates of foetal weight, particularly late in gestation, are imprecise.

Postpartum Haemorrhage (Maternal Haemorrhage):

A cumulative blood loss of greater than or equal to 1,000 mL of blood loss accompanied by signs or symptoms of hypovolemia within 24 hours after the birth process. Signs/symptoms of hypovolemia may include tachycardia, hypotension, tachypnea, oliguria, pallor, dizziness, or altered mental status.

Maternal Early Warning Criteria:

- Systolic BP; mmHg <90 or >160
- Diastolic BP; mmHg >100
- Heart rate; beats per min <50 or >120
- Respiratory rate; <10 or >30 breaths per min
- Oxygen saturation; % <95 room air, sea level
- Oliguria; <30 mL/hr for 2 hours
- Maternal agitation, confusion, or unresponsiveness
- Patient with hypertension reporting a non-remitting headache or shortness of breath".

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