Yashoda Operational Guidelines 2010

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Foreword

Dear Colleagues

I congratulate all the colleagues from the four states for implementing Yashoda intervention. While staring the process was a great challenge, it is now evolving as a comprehensive maternal and newborn care intervention within the larger hospital process. We, in the last 18 months have learnt a great deal about the potential of the intervention.

In this period Yashodas have assisted approximately over 400,000 mothers and newborn in the four states, enabling Yashodas to gain experience and NIPI to learn and streamline some of the processes. Of the planned 1584 Yashodas to serve in about 100 District hospitals and 40 selected CHC from the four states, about 1200 are in place. 60 % of these have received 2 or 3 day orientation and one day refresher training and the rest are in progress.

The operational guideline is a synthesis of the learning in establishing Yashoda intervention in the initial phase and regular feedback from the states. The NIPI Secretariat has taken the liberty to put the processes together to facilitate the expansion of the interventions. Since all the four states are in a scaling up mode I hope these guidelines will help them get a systematic overview of the steps in establishing the interventions. These guidelines are aimed at providing a framework and are not prescriptive. This is work in progress and a process for learning together.

The States as always will be driving the process and will decide if certain modifications are required to bring value addition that meet the state specific need. This work will be translated in Hindi and Oriya to make it user friendly.

We also suggest that the state should consider the Yashoda process to be institutionalised at the state level by making it part of the state ASHA coordination cell.

We look forward to getting feedback on these guidelines, from the field staff as well as from the managers, as it is a joint learning process.

I wish you success in taking this intervention forward and bringing value addition to JSY and MGD 4 in a concrete manner.

Prasanna Kumar Hota

Director, NIPI Secretariat

Yashoda

I am part of Yashoda process, and a new member of the maternity ward team. I have several responsibilities:

I welcome the pregnant woman heartily and make sure that she relaxes, and reassure that she is in a safe place and among people, who care for her.

I help her to get registered as JSY beneficiary.

I get information on her status from accompanying ASHA/family member/ANC card and inform the nurse if she needs extra care.

I provide moral support to her in the labour room.

I observe the nurse and learn to weigh the newborn, wrap her well and support mother to initiate breastfeeding.

I ensure the cleanliness including toilets and functionality of the post natal ward during my shift.

I counsel the mother on basic hygiene practices to avoid infection for the newborn.

I ensure that the baby's bed is clean; no one is sitting or eating near the bed and not crowding around the bed.

I support the mother by showing her the correct positioning for breastfeeding.

I educate her on the importance of exclusive breastfeeding, keeping the baby warm, and seeking help of a nurse when the baby is sick.

I also ensure that BCG and polio dose is given before the baby leaves the hospital. Inform the mother about the immunization schedule, when and where she can get it done in her village.

I inform her on birth spacing options and where she can get the services when she goes home.

I maintain records of all the vital information on the baby and the mother.

I ensure that each mother leaves the facility as a satisfied person, with more understanding on basic newborn care and happy about the cleanliness and support in the hospital.

No work is too small or too big for me as long as it can help the mother and newborn.
I am proud of the fact that I can empower each mother with information that can build her confidence to take care of her baby.

1 Summary

Since the inception of NRHM in 2005, the overall health budget has gone up almost 300% while the JSY programme allocation itself, aiming at safe motherhood through promoting institutional delivery has increased almost 20 fold. However during this period the investment on newborn care per say has been minimal or subsumed under maternal care. Various surveys including NFHS III and the series of surveys by UNFPA of JSY reality in the focus States have brought out the urgent need for better counseling and care coordination in the crowded health facilities for both mother and newborn cohort, to achieve goals of MDG4 and 5.

Yashoda process introduced under NIPI since 2008 is one such specific pilot effort as a quick response by the State Health Societies of MP, Bihar, Orissa and Rajasthan for addressing quality of newborn and related maternal care starting with maternity wards of the district hospitals with high delivery load. Since inception, this effort has supported over 400 000 mothers in the 12 District hospitals from the 4 states for quality care for the newborn through counseling, support and care coordination.

The non clinical support and counseling by Yashodas focuses on motivating mothers to weigh and immunize the newborn, initiate exclusive and immediate breast feeding, spacing of child birth and information on post natal care services access., The purpose is to add value to the JSY investments at a nominal addition of 7-10 %. The experience so far has shown that a dedicated support at the facility level can significantly contribute to the quality of care and achieving the optimum advantage of delivering in a facility. Though the initial results are encouraging, this intervention needs nurturing in order to get sustained results over a period of 5-7 years.

It is strongly recommended that scaling up of the intervention should be limited to the District hospitals and CHCs that are FRUs and have high delivery load. Approximately 5-7 years must be the learning cycle to get the intervention functional to the expected standards and get solid evidences to demonstrate the value addition that it brings to JSY. Prior to that, expanding to cover the CHCs and PHC with low delivery load will unduly burden the existing system,. Though all the mothers would benefit from counseling, those facilities with low delivery load may find methods to train the nurse /even ASHA who brings the mothers to counsel during their stay at the facility.

1.1 Learning from the NIPI States and rationale for revised guidelines

The experience of implementing the intervention has resulted in several critical lessons in managing and scaling up a pilot. The management structure of the intervention was visualized as a simple one that would put minimum burden on the existing system but would draw heavily on their experience and expertise to embed the intervention within the hospital system subsequently. Since there is no similar experience within the hospital system in the NIPI States, a set of operational guidelines were prepared and shared with the state teams for suggestions in 2008.The guidelines are revisited due to the following:

- The State Health societies and the state NIPI program teams have pointed out a few ambiguities in the Yashoda selection criteria, which allow interpretations resulting in delay/non standardization (Example: calculation of required number of Yashodas, mode of engagement, incentive payment etc). Clarifications were provided on specific aspects periodically. (e.g: Decision in the 7th JSC, regarding basis of calculation of Yashoda requirement based on total delivery in one year in the facility and not on the number of available beds).

- By the last quarter of 2008, the state of Rajasthan and Orissa began scaling up of the intervention to cover more than the original 3 Districts Hospitals, including select CHCs (in Rajasthan), while Government of Bihar scaled up to cover the entire state from the start. MP has decided to include one additional district hospital and 7 CHCs from the existing focus districts. The original guidelines did not cover several of the aspects relevant for scaling up of the intervention.

- A process documentation of Yashoda intervention conducted in MP, Rajasthan and Orissa in September 2009 indicated a positive acceptance of the intervention by the district and hospital administration but highlighted a number of management gaps.

- A capacity building training conducted by the Indian Institute of Management (IIM) Ahmedabad in December 2009, for the State health system functionaries and NIPI State program team from the three states highlighted the need for improved management of the Yashoda intervention for scaling up and sustainability

This revised guideline is a result of continued dialogue at the state level and handholding at the district level. This is expected to help the program managers to improve their performance.

1.2 Key issues highlighted in the revised guidelines include:

1.2.1 Yashoda is part of a process and does not denote a person

The objective of the process is to enhance a joint ownership for care coordination at the facility with 'Yashoda' as part of the larger system, where the pregnant women feels welcome as she enters the facility and leaves with a feeling of being cared for and looked after with her newborn baby. The value addition that the Yashoda process brings is the demand generation of services for care for newborn and improved accountability at the facility level. While Yashoda fills a critical gap for counseling the mother on newborn care and coordinate services within the maternity ward, Yashoda is NOT a substitute for the nurses. Her success depends a lot on the support, ownership and leadership given by the hospital team including the matron, nurses, hospital manager and hospital administrators.

The hospital committee will ensure that the Yashodas and the Child Health Supervisors (CHS) are treated as team members of the maternity ward and supported in their daily effort.

1.2.2 Ownership and decision making mechanism

The RKS has the overall managerial responsibility for all decisions related to the intervention. However, a committee within the hospital need to be formed to have a formal decision making process to manage the intervention efficiently. This committee will also ensure that the Yashodas and the Child Health Supervisors (CHS) are treated as team members of the maternity ward and supported in their daily efforts. (see details under 4.2 Establishment of decision making mechanism within the hospital.)

1.2.3 Yashoda engagement

- The total **annual delivery averaged out to a daily/monthly load will be the basis for calculation** of Yashoda requirement. This may be different from the situation at Block Hospital where a separate approach has been suggested.

- Yashoda should be clearly informed of the temporary and voluntary nature of the engagement without any ambiguity

- **Each Yashoda will get an incentive of around Rupees 3000 - 3500** for 23-24 shifts of work in a month. This could be lower in a Block hospital with partial delivery load.

- In order to improve performance efficiency, **Yashoda will be given every fourth day off after completion of night duty.**

- **The non clinical support and counseling role of Yashoda** must be communicated clearly and continuously to all the hospital staff and district team including the fact that Yashoda is **NOT** a substitute for the nurses.

The districts must build their in-house capacity by developing the ANMTCs to meet the continuous learning and on the jobs skills building requirements Yashodas.

1.2.4 Supervision

- At the district facilities appointment of the Child Health Supervisor/ Deputy Child Health Supervisor must precede the engagement of Yashoda At the block level effort must be to identify a supervisor from among the available staff prior to the engagement of Yashodas to make the intervention function efficiently.

- A formal linkage must be established for liaising of the child health supervisor and deputy supervisors with the hospital manager/ and hospital administrators and the District Project Management Unit/Block Project Management Unit (DPMU/BPMU).

1.2.5 Capacity building

- The capacity building is not a one time effort. While formal trainings are provided, the districts must build their in-house capacity by developing the ANMTCs to meet the continuous learning needs and on the jobs skills building requirements of Yashodas.

1.2.6 Monitoring

- **Yashoda daily reporting registers must be monitored** regularly by the supervisors for quality.

- **Formal assessment mechanism must be established** for monitoring Yashoda performance on an ongoing basis along with feedback mechanism.

- Managers must ensure that a **community monitoring process is established as part of social auditing** of the intervention.

- The NIPI State program Unit has a large responsibility to ensure supporting systems are in place for the district teams to monitor the intervention appropriately.

2 Rationale and Evidence

2.1 Why Yashoda intervention – Evidences and Rationale:

The sudden influx of beneficiaries in public health institutions due to JSY has added to the challenge to provide quality maternal and neonate health care. However, it provides a window of opportunities to improve the RCH services at the facilities.

Women have complex needs during childbirth. The In addition to the modern obstetrical care, women need consistent, continuous reassurance, comfort, encouragement and respect. They and their newborn need individualized care and more so when a poor rural women chooses to deliver in an alien environment like a district or block facility.

Women have complex needs during childbirth. In addition to the modern obstetrical care, women need consistent, continuous reassurance, comfort, encouragement and respect.

The scientific evidence for emotional support and hand holding during delivery and immediate post natal care comes from the United States, Drs. John Kennel and Marshall Klaus while investigating ways to enhance maternal-infant bonding in the late seventies , they found , that introducing a 'doula' (a mother's companion) into the labor room not only improved the bond between mother and infant, but also seemed to decrease the incidence of complications. (Kennel, JH et all) Since their original studies, published in 1980 and 1986, numerous scientific trials have been conducted in many countries comparing usual care with usual care plus a 'doula'.

Analysis of the numerous scientific trials of labor support led the Cochrane Collaboration's Pregnancy and Childbirth Group to state: "Given the clear benefits and no known risks associated with intra partum support, every effort should be made to ensure that all labouring women receive support, not only from those close to them but also from specially trained caregivers. This support should include continuous presence, the provision of hands-on comfort, and encouragement." (McGrath,SK et all)

Tamil Nadu has successfully demonstrated the need and usefulness of a women who 'holds hands' and provides the much needed emotional support besides helping the women to navigate through the complex processes in the hospitals. The more recent example of 'Breast feeding counselor' in Madhya Pradesh provides a further example of improving the quality of care for the women coming in for institutional deliveries.

Surveys on JSY show that many of the women stay in the institution for less than 24 hours after delivery, regardless of a normal delivery or a difficult delivery. Concurrent assessment of Janani Suraksha Yojana (JSY) scheme in selected states of India, 2008 sponsored by UNFPA raised several issues about its benefits and processes for the women. These include: the duration of stay at the facility, the quality of services, the facilities available at the hospital, the safety of mother & child, and the availability of counselling on follow up visit, breastfeeding, immunization, family planning, newborn care and diarrhoea management, etc.

Many of the conditions responsible for the mother and/or neonate's death are recognizable in the first 48-72 hours after delivery. Therefore the Government of India norms require that mothers stay in the hospital with the newborn for 48 hours after delivery.

The first 24-48 hours after delivery offer a golden opportunity for integrating neonatal care with postpartum care. Many of the conditions responsible for the mother and/or neonate's death are recognizable in the first 48-72 hours after delivery. Therefore the government of India norms require that mothers stay in the hospital with the newborn for 48 hours after delivery.

Can a person from within facility be found to make the pregnant women feel welcome, to make her feel comfortable after delivery, initiate exclusive and immediate breast feeding, counsel the mother on basic newborn care, and to motivate the mother to stay at the facility for a longer duration? The hospitals, with increasing volumes of deliveries per day, have not been able to use this opportunity fully due to a shortage of nurses and a poorly managed logistics system. While there are prescribed standards regarding the availability of number of qualified nurses by the Medical Council of India, in the Medical Colleges, and penalties for non compliance no such standards are available for the maternity ward in a District hospital, which are cronically understaffed. The Indian Public Health Standards are not tied to penalties. While these long-term HR processes are still debated, the Yashoda process provides a quick response to help the hospital system to cope with the increasing demand for quality care for the newborn by having dedicated team to take on non clinical tasks and free up the time of the nurses to focus on curative tasks.

If and when the availability of extra posts of ANMs come up, the Yashoda process will get even more strengthened. The additional trained ANMs can even operate as Deputy Child Health Supervisors. In an average Dist. Hospital with 25 deliveries per day, the number of supporting persons in a Yashoda process will be around 16/17. One cannot visualize so many ANM/Nurse posts being created by States overnight; and even if these are created, finding qualified staff and higher budget for them will take time.

Why Yashoda, and why not ASHA? It has been observed that in almost 30-40

% of cases, ASHAs do not accompany the pregnant women to the hospital. Even those who accompany do have other responsibilities under NRHM and cannot be away from the community for over 24 hours. If we assume that ASHAs accompany pregnant women to a District hospital where 20-30 deliveries take place a day, in the course of two days, there will be 40-60 ASHAs at the hospital. There is no arrangement for their stay, food, or security. These additional people in an already stretched infrastructure could create chaos. **Also, it will be difficult for the RCH nurses, doctors etc in a district hospital to relate to 1000 strong ASHA force in a district; while their ability to organize support and counselling through Yashodas who are to become regular features of the maternity ward over a period of time will be considerably smoother. Accountability can be organized much better.**

Yashoda is not a substitute for the nursing staff or paramedical staff available at the facility.

The NIPI focus states have engaged 'Yashoda' /'Mamta' for facilitating the initial care that the newborn and the mother require during their stay at the facility, thereby addressing the above gaps to some extent.

3 Role of Yashoda

As a support worker for improving quality of care, Yashodas also have the responsibility to facilitate safety, security, dignity and privacy of the mother and special and dedicated attention to the newborn.

Yashodas have a range of responsibilities; Ensuring cleanliness and functionality of the ward, be a friend to the mother, to counsel the mother on nutrition for self and newborn, immunization and family planning choice etc. **Since Yashodas, will be on duty 24 hours they will provide a closer watch over the mother and the newborn, and alert the nurse or the doctor immediately for any difficulty faced by the newborn or the mother.** As a support worker for improving quality of care, Yashodas also have the responsibility to facilitate safety, security, dignity and privacy of the mother and special and dedicated attention to the newborn. **Since each healthy mother and newborn leaving the hospital will be an ambassador for spreading the message of improved care at the institution, Yashoda's role in building confidence of the mother becomes crucial.**

3.1 A congenial environment

Yashoda makes the mother feel welcome and makes her stay comfortable by being friendly and cordial. She will function as an interface between the hospital staff, the mother and her family. She will link with the ASHA accompanying the pregnant woman and gather basic information on completion of ANC check up, any problem etc, and inform the nursing staff for necessary action. She will assist the nurses in bed making and avoid crowding in the ward.

3.2 Newborn and mother care

Yashoda will make arrangement to ensure cleanliness of the area, prepare the bed for the mother and baby, manage the food and other ancillary requirements of the mother and baby, and keep the paper work ready.

3.3 Assist in pre and post delivery care

Yashodas function as an emotional support to the pregnant woman in the labour room; subsequently assist the nurse in receiving the newborn, cord care, putting identification tags, taking the weight of the newborn, cleaning and draping the newborn in adequate sheet and blankets as per the weather. She will assist the mother to initiate immediate and exclusive breastfeeding and ensure all Zero-dose immunization from the institution.

3.4 Counsel the mothers

Motivate the mother to stay at the facility for 48 hours as per the guidance of the doctors. During the stay at the health facility the Yashoda will counsel the mother on:

- Breastfeeding and complementary feeding and nutrition requirements for mother.
- Details about further immunization requirements, schedule, availability.
- Preparations to be made in case of illness of the baby and mother.
- Prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/ STIs).
- Family planning advice as required including spacing, contraception.
- Accessing institutional care in future, if the need would arise for the baby/child, whom to contact, etc.
- Personal hygiene

3.5 Initiate birth registration / procuring birth certificate:

Yashoda will assist in filling of the forms for registration of birth and still birth and explain the rationale for registration to the mother and family members.

As Yashoda takes over the pregnant woman from ASHA on arrival, she needs to link with the ASHA as much as possible when the mother leaves the facility with the newborn.

3.6 Provide information on the follow-up after discharge from the health facility

Provide information on the need for regular weight check ups, weight gain for the baby in the ensuing months, immunization, feeding of the baby (exclusive breast feeding till 6 months and introduction of complimentary feeding thereafter); contact points such as ANM, AWW, and other support systems in the community.

3.8 Informing family members present at the health facilities about:

- Basic care for mother and newborn after leaving the facility including rest, nutrition, basic sanitation & hygienic practices.

- Existing health services, immunization days, and other maternal child health care services, especially for post natal care (provided by ANM and ASHA, supplementary nutrition services available at the Anganwadi centres).

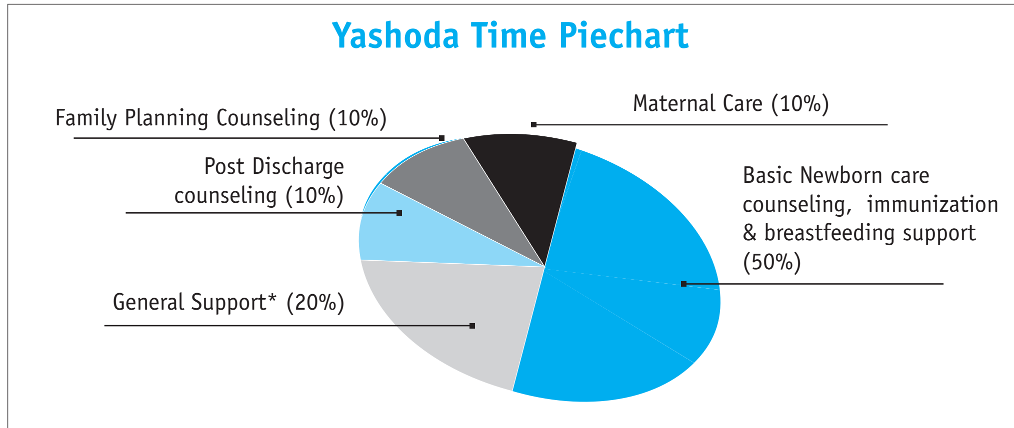
3.9 Record Maintenance

This innovation requires appropriate follow up of the services rendered to improve quality.

Monitoring effectiveness of Yashoda intervention contributing to increasing the duration of the stay of mothers, by initiation of immediate and exclusive breast feeding and zero dose immunization in addition to mothers receiving appropriate information on care for self and newborn after leaving the facility. Towards this, it is suggested that Yashoda capacity is built to maintain appropriate daily records, which are expected to facilitate the nursing staff as well as the Child Health Supervisors to take suitable measures to improve the quality of service.

3.10 Linkage with ASHA

As Yashoda takes over the pregnant woman from ASHA on arrival, she needs to link with the ASHA as much as possible when the mother leaves the facility with the newborn. She must provide information on immunization received, information that require reiteration, problem if any regarding the health of the newborn or the mother that can facilitate better counselling and care coordination to the mother by the ASHA in the community.



The pie chart is an approximate suggested time devoted by Yashoda for the various counselling activities in a day during her shift.

3.11 Managing Yashoda intervention: Role of the State program management unit (SPMU)

- Have clarity on the rationale behind Yashoda intervention under NRHM
- Have clarity on the role of Yashodas
- Ensure that all the hospital staff (nurses, doctors, hospital managers and support staff) understands the voluntary and non clinical nature of Yashoda work.
- Establish supervisory mechanism that will ensure that:
  - Yashoda provides only non clinical support in the ward
  - Non clinical role of Yashoda is posted prominently in the ward
- Inform mothers that the service is free and available round the clock.

Scaling up of Yashoda Intervention

4

The scaling up of the intervention from three district hospitals to cover the entire state is a challenge for the State Program Management units (SPMU) in terms of planning and organizing and implementing the intervention without diluting quality. Institutionalizing Yashoda process at the state level requires a strategic approach. Towards that the State Program Management Units need to establish systems that will facilitate smooth transition from the pilot to scaling up stage. Simultaneously, enhancing the ownership of the community and their involvement in the Yashoda process through community social audit process would build the credibility of the intervention. The SPMU has the responsibility to provide the appropriate guidelines to make the social audit as a functional mechanism.

4.1 Planning

This is the most critical step since it provides the framework for the entire scaling up process. Planning the scaling up with the diverse stakeholders is important to get the perspectives from different dimension of the intervention. To facilitate the interaction with the stakeholders, the SPMU requires to have a systematic documentation of the lessons learned in the pilot phase. This would help the stakeholders to understand with evidence as to what worked, why and the gaps.

The outcome of the planning should be:

- Clearly articulated objectives

Detailed implementation strategy including:

- Identification of institutional mechanism and responsible nodal persons at the state, district and Block levels
- Clarity on the role of the various stakeholders engaged in Yashoda process at all levels
- Managing the Yashoda budget and finances including streamlining the Yashoda incentive payment mechanism
- Identification of nodal points at different levels for monitoring the process
- Establishing processes for capacity building
- Expected output by each quarter, expected outcome at the end of the year, and indicators of measuring , risks that could affect the implementation
- A plan for sustainability of the intervention

4.2 Preparation of an implementation strategy:

An implementation strategy that would articulate if the scaling up would be simple replication of the previous strategy; or will there be changes in the structure/systems/management processes: and if yes, which are the aspects that would be modified and how; who will be responsible. For example, if the pilot phase included only health facilities from the plain regions and the scaled up version includes mountainous regions/desert/ other hard to reach areas, the strategy needs to be modified accordingly.

- The strategy will also clearly identify how the scaling up will be implemented- Will it be in phased manner? Will it be scaled up with different levels of standards to meet the local needs (example: Facilities located in tribal/desert areas may find it difficult to get supervisors with the prescribed qualification or experience. A strategy to use a different yard stick for selection of supervisory staff may be adopted for those areas)

4.3 Institutional mechanism:

For managing the expansion to cover the entire state requires well established institutional mechanism that would be constantly assessing the intervention and providing policy and other required support. SPMU must ensure that the management structure is clearly articulated and roles and responsibilities at the various levels are communicated effectively. For example, In order to strategically link the Yashoda process to the ASHA process and institutionalize the Yashoda process, the State ASHA Coordinator could be the state node for coordinating the Yashoda intervention and re-designated as ASHA –Yashoda Coordinator.

The SPMU has the additional responsibility of ensuring that the administrative and program implementation guidelines and office orders organized and disseminated to the field without any delay and provide clarification s necessary incase of ambiguity.

In addition to the state level mechanism such as State Coordination Committee, appropriate institutional structure must be established at the district /block level and even at the facility level. For example, though CMHO is the overall supervisor and RKS is the decision making body at the facility level, both have inadequate time to get involved in the day to day management of the Yashoda intervention. Formation of a hospital committee at the district hospital will enable the Yashodas and supervisors to know their focal point within the hospital for grievance redressal and day to day operational support related to implementation.The committee could have the matron/senior nurse, District maternal and child health coordinator, hospital manager and Yashoda child health supervisor as members.

Expansion to cover the state also requires special skills for managing the budget and leveraging the resources. A specific nodal finance person at the state level may be engaged to manage the finances including, calculating the overall intervention cost, tracking expenditure, documenting the payment of incentive profile, use of untied funds and building local capacity to understand the management of the finance aspects .

4.4 Human Resource Management:

The scaling up results in induction of large number of Yashodas as well as supervisors and involvement of public health nurses, counselors, accountants, medical officers , nurses, and others from time to time for various purposes.

A human resource management policy should be in place that would articulate the various aspects of human resource management related to the intervention including selection, placement, supervision, capacity building among other things. The HR policy must also enable the district or block to analyze their capacity to implement as per standards since often the existing systems are ill prepared or inadequate in terms of manpower ad technical capacity to manage the scaled up process. HR policy should have the flexibility to explore hiring of external agency/ies that can give appropriate support for establishment of systems related to managing the processes.

To remain a catalytic process, the Yashoda intervention has to be innovative . In order to have in built self resurgence and keep Yashodas alert , it is suggested that the HR policy should consider inducting 1/5 of new Yashodas every third year by replacing from the existing pool. This method would ensure continuation of experienced staff but induction of new Yashodas periodically.

4.5 Capacity building:

The pilot phase by and large focused on orientation and induction training of the Yashodas and the supervisor cadre to a limited extent. Capacity building in a scaled up mode requires a consistent approach to cover the entire gamut of capacity building including training, mentoring, counseling, exchange visits, continuous learning opportunities etc.

It is essential to equip Yashodas with upgraded their skills and counseling abilities to provide quality care to the newborn and the mothers through orientation, induction training, refresher training and continuous learning opportunities. The capacity of the supervisors must be suitably enhanced to manage the above processes, keep Yashoda team together, document the best practices, monitor the implementation, and liaise with the hospital teams and report.

Another challenge is creating a pool of trainers. Since the intervention is expanded to cover facilities located at districts and below, a pool of district and block level trainers need to be identified, provided with Training of trainers program to meet the capacity building requirements. The SPMU capacity building planning also must address the issue of accessing innovative learning materials for Yashodas.

Enhancing understanding of the Yashoda intervention to the District hospital and Block hospital teams, District health society, DPMU and RKS is equally important. The above stakeholders must have clear understanding their own role in facilitating the quality care aspect through Yashoda process. Performance assessment is another step in capacity building of Yashodas. The SPMU must ensure that a suitably designed performance assessment system is established and conducted by the supervisors.

4.6 Monitoring and reporting:

A state level scaling up requires rigorous follow up of the implementation at every level and appropriately trained personnel at the district and block level handle the monitoring effectively. While the day today monitoring is managed by the trained managers, establishment of a state level structure (A cell) to monitor the implementation from the policy perspective is important.

As a process of continuum of care the district ASAH coordinator could have the lead responsibility to monitor the implementation at the district level, ably supported by the child health supervisor, district maternal and child health coordinator. At the Block level the Block maternal and child health coordinator could take up the responsibility to monitor the Yashoda intervention.

5 Yashoda Implementation Process

5.1 Preparatory activities

State Program Management Unit (SPMU) has a crucial role in the preparatory activities.

- **Orienting the state and district RCH /NRHM teams:** Prepare a handout with salient features of the Yashoda program and orient the State NRHM officers and the district officials (CDMO, ADMO/ Medical Superintendent, DPM, DIO, doctors, matron, nurses, Hospital Managers) on the rationale, administrative and financial arrangements, mode of engagement, and training and monitoring of Yashoda.
- **Issue appropriate administrative guidelines** for engagement, training, incentive disbursement, supervision, monitoring and reporting of Yashoda intervention. This process will be facilitated by the NIPI State Program Units.
- **Ensure transfer of funds to the districts** for the implementation based on the projected need. Ensure transfer of funds to the districts for the implementation based on the projected need.

State NRHM will issue appropriate guidelines for recruitment, engagement, training, incentive disbursement, supervision, monitoring and reporting of Yashoda intervention.

5.2 Establishment of a decision making mechanism within the hospital

State Health Society issues overall administrative guidelines regarding the intervention. However, there will be situations where interpretation of the guidelines to meet the local needs may arise. Similarly, there may be local specific emergency situation calling for immediate decision which may not be covered in the overall guidelines.(e.g: very low /very high delivery load, Yashoda grievance, disciplinary action, leave, awards and rewards, recognition etc). To avoid adhoc processes and facilitate a streamlined decision making, it is essential to have formal decision making committee established within the hospital. Suggested representation could include Hospital Manager, Matron, Child Health Supervisor and District Child Health Manager. Decisions made should be recorded and put up the CDMO/ RKS for information/approvals as appropriate. The decisions must also be communicated on time to Yashodas.

Though Yashodas, DCHS and CHS have been introduced within the system, often they are not considered as part of the maternity ward team. They also have difficulty finding their focal points within the hospital administration. The committee must ensure that all concerned understand the purpose of Yashoda intervention and role of the inducted members, need for functioning as a team and treat them with respect and give the space to discharge their functions effectively. NIPI State Program Unit must ensure that the committee is well oriented on all the above mentioned aspects.

The hospital committee must ensure that all concerned understand the purpose of Yashoda intervention, the role of the inducted members, need for functioning as a team, treat Yashodas with respect and give the space to discharge their functions effectively.

5.3. Engaging Yashodas.

a) **Placing Local News Paper Advertisement:** This will be placed by District Immunization officer (DOI) or Chief Medical Officer (CMO) /Civil Surgeon// RCH Nodal officer/DPM with permission from District health society (DHS).

b) **Suggested criterion for Selection:**

- A local woman living within the municipal limits .
- Has completed 8th grade as a minimum.
- She agrees to work as a volunteer
- She will receive performance-linked incentives.
- Her engagement as volunteer worker does not entitle her to claim the regular position in the system.
- Free from communicable diseases, subject to clearance by the Medical Officer.
- Willing to work on rotational basis including night shifts.

Decisions on the criteria are to be finalised at the district level by the DHS and / or Rogi Kalyan Samiti (RKS) of the hospital. These agencies must have a process for screening of the applications within a limited time since large numbers may apply for a few positions.

c) **Short listed candidates will be invited for interview.**

Suggested evaluation parameters for the candidates during interview

Parameters*	Marks*				
	1	2	3	4	Additional 2
Education	8th Grade	10th Grade	12th Grade	Graduate	Nurse/ANM degree/diploma
Age	50 +	45-50	35-45	25-35	-
Work experience	Never worked	Worked in non–health sector	Worked as private nurse/ assistant	Worked in hospital setting	-
Communication skills	Poor	Average	Good	Excellent	-
Distance of residence from facility					
Willingness to work in rotation and at night	-	-	-	-	-

* The district authorities may modify the parameters/weightage keeping in view the local needs.

5.4 Mode of engagement of Yashoda:

As Yashoda is a voluntary support worker, the engagement will be through Rogi Kalyan Samiti in the respective districts.

- In order to avoid any complexities related to engagement of Yashoda in future, it is suggested that legal opinion may be obtained from the competent state authority.

Any mode of engagement should ensure that the roles and responsibilities, incentives, reporting and notice period etc are stated clearly without ambiguity and the Yashoda understand the voluntary nature of their work, compensation through an incentive system and does not entitle Yashoda for any claim for an adhoc or a permanent position in the health system in future.

The calculation of the Yashoda requirement should be based on the total delivery in a year in the given facility.

Managing Yashoda engagement: The role of State Program Management Unit

- Orient the State, District and Hospital administration on the purpose and role of Yashoda.
- Ensure that all the required administrative guidelines are sent from State Health Society to the Districts prior to orientation.
- Get the districts to calculate number of Yashoda required and project a budget.
- Ensure that the required fund is disbursed by the State Health Society without any delay.
- Facilitate the districts/RKS to place the advertisement appropriately.
- Ensure that the Yashoda selection criteria provides equal opportunity to all applicants without discrimination.
- Ensure that the legal department is consulted regarding the mode of engagement of Yashodas, based on the voluntary nature of their services.
- Whatever the mode may be, ensure that there is no ambiguity regarding the voluntary and temporary nature of work and does not entitle Yashoda for full or part time work in the health system.

5.5 Determining the required number of Yashoda in a District Hospital

District Hospitals with a high delivery load are taken for implementation of Yashoda process since they have the ability to support the mentoring and monitoring of the Yashoda intervention. The calculation of the Yashoda requirement should be based on the total delivery in a year in the given facility. Observe and record if the fluctuations are more than 10-15% either way.

It is well known that the delivery status varies from month to month and some months with very high load and some with low load. During these months, the quantum of incentive generated will vary but not the number of Yashodas. The facility should calculate the optimal number of Yashodas required functioning as a core pool of workers on whom investment is made in terms of training, uniform, supervision, consumables etc.

Therefore the following is suggested:

5.5.1 The calculation of required number of Yashodas

Calculation of Yashoda requirement should be based on:

- Total number of deliveries occurring in one year in the facility.
- Arrive at per day average delivery by dividing the total number by 365.
- To provide around the clock services, Yashoda will work in 8 hourly shifts.

- The calculation of required number of Yashoda must be based on clear understanding of the required shifts of work, rest, incentive payment and other costs involved in managing the intervention.
- Currently, Yashodas are taking care of five newborn babies per shift. The new born and mother are expected to stay for about 48 hours after delivery, so each Yashoda take care of about 10 newborns in a shift. However in reality each Yashoda often manages 5-6 mother baby cohort and not strictly 5 babies.
- The calculation to include the number of Yashodas required to ensure round the clock services allowing space for leave and absence by Yashodas; and to meet the high delivery load period needs. In some cases the lay out of the wards may be such that, more Yashodas are required to cover the maternity wards.

Calculation of Yashoda Requirement

Calculation of Yashoda requirement should be based on:

Total delivery per year	2190
Daily delivery load	2190/365
Daily delivery load is	6
Number of Yashodas required per shift (each Yashoda looks after 6 newborn and mothers)	1
For three shifts	3 Yashoda
Additional 25% to meet the round the clock service	1 extra = total 4 Yashodas

Keeping in view that all the mothers and newborns receive the services of Yashoda, it must be ensured that the duty roster is prepared in such a way that work is distributed among all the Yashodas equitably. All Yashodas will be entitled for the same amount of incentives as per the duty roster.

Additionally it must be ensured that the Yashoda services are available in the ward all 24 hrs without any break. Currently, the three shift timings are: morning duty (0800 hrs -1400 hrs) afternoon (1400-2000 hrs) and night shift (2200-0800hrs).

The supervisory cadre must ensure that the shift timings are readjusted in such a way that there is no gap in service.

5.5.2 Duty allotment to Yashoda

It has been observed that varied standards of duty allotment to Yashodas are adopted by the states, including inter district variation. In Rajasthan the shift is so organized to give every fourth day off to Yashodas. In Orissa Yashodas do 10 days shift duty followed by night duty on rotation basis. In MP every 6th day is given as off day to Yashodas The facility as well as Yashodas seem to have well adjusted to this duty allocation pattern in their respective states.

While the Districts have their rationale for fixing the rotational duty suitable to their context, care must be exercised to ensure that all Yashodas have equal work and equal rest.

The Rajasthan model offers 274 shifts of work and 91 rest days to Yashodas in a year, while in other states Yashodas get to work 313 days of work and 52 rest days. The Rajasthan model seem to facilitate Yashodas to function optimally (since gets rest after night duty) without compromising the quality of work and helps her to balance her personal life. The other three states may explore the possibility of readjusting Yashoda schedule in such a way that she gets optimal number of off days as in the case of Rajasthan, especially since they do not have opportunity to avail any other leave.

Rajasthan duty roaster chart is given as annexure: to demonstrate how the model functions.

5.6 Leave for Yashoda

The preceding paragraphs informed the duty load of Yashoda and organization of rest days in Rajasthan, Orissa and MP. Since this position is not a regular NRHM contractual position, the NRHM leave rules for contractual staff does not apply. The following are the current practice.

In Rajasthan all Yashodas get to work equal number of days (23 days and have 7 days off in month resulting in a total of 91 rest days in a year. **Since they get 7days off in each month, there is no additional casual, medical or other leave permitted.**

If any Yashoda wants to go for short leave due to an emergency situation (2-3 days) she manages with those Yashodas who are in day off shift (rest shift) with prior information to the Child health Supervisor and ward nurse and approval in order to ensure presence of Yashodas in all the shifts. The DCHS and CHS maintain a record for such leave.

In the rest of the states Yashoda/Mamta get 52 days off and work for 313 days in year. They also take additional leave a maximum of 3-4 days with prior permission from the ward nurse and Child health supervisor.

- *Any absence in addition to those mentioned above result in deduction in the incentive on a prorated basis in all the states.*

5.7 Calculating the cost of intervention

The objective of calculating the cost is to understand the overall cost of the intervention as an addition to JSY.

5.7.1 Detailed budget template for Yashoda intervention at District hospital.

Yashoda intervention is not a stand alone process. It is part of the continuum of care approach and an aimed at strengthening JSY by enabling mothers to stay for longer duration at the facility and provide quality newborn care. However, there are state specific variations in the calculation of Yashoda cost currently. (e.g: Only cost of Yashoda incentive is posted to NIPI budget and the rest comes from NRHM /RCH budget (Rajasthan) In MP the Yashoda cost from NIPI budget includes Yashoda incentive, cost of birthing kit, Yashoda consumables and cost of Supervision). The following table is given to help the states to calculate the overall cost of the intervention in practical way and plan for absorption of the costs by the on going NRHM processes at the earliest.

The costs are of two types.

a) **Direct Yashoda cost**

b) **Support cost**

Item	Suggested cost	Remarks
	Direct costs	
Yashoda honorarium	3000-3500 per month	Each Yashoda must get honorarium calculated @ 100 per baby and mother cohort looked after. It is strongly recommended that the incentive does not exceed 300-3500 per month per Yashoda. In order to standardize the honorarium amount as guided, it is suggested that all the states examine their current level of honorarium and Yashoda requirement and their availability at the facility
Yashoda Materials *(Apron, bag, badges, slippers)*	Rs.1000 per Yashoda per year.	For two sets to each Yashoda (some states have included washing allowance as well)
Yashoda capacity building (Though direct costs, Training cost of Yashoda is not stand alone cost. Due to state wide and expansion beyond three focus districts , the cost would be taken up under NRHM RCH training budget) The training cost calculation as per NRHM norms should ensure that: the cost of the venue, food, transport, travel, training aids as required, hiring of AV equipment as required honorarium to resource persons, photocopy requirement if any, flipchart, pen, writing pad to participants, Yashoda **Performance assessment and miscellaneous to meet any unplanned expenditure are included.	Rs.5100 per Yashoda	This item has five components: 1.Training of trainers (3 days at state level) 1.Training of trainers (3 days at state level) 2. Orientation training for 2 days. 3. Induction training of Yashodas for 2 days 4.Refresher training after 6 months for 2 days 5.On the job training –continuous learning -2 sessions of 2 hrs each -skill building and counseling training per month ** it is suggested that a sum of Rupees 100 per Yashoda may be allotted towards hiring of external resource persons for conducting Yashoda performance assessment . In some states assessment is conducted twice a year. It is recommended that one assessment must be conducted per year.
	Support costs (Existing NRHM Process)	
Supervision: **Two Deputy child health Supervisors (DCHS)** **One Child health Supervisor (CHS)** **Matron honorarium**	 @ 7500 PM x2 Rs.10,000 PM Rs.1000 per month	 This position is visualized as temporary one for one year to 18 months till the Yashoda process gets embedded within the hospital system The given costs are indicative only. As resource person and mentor
Training of Supervisory cadre **Untied funds at the disposal of the CHS** **Mother and Baby kit (Also known as 'Yashoda kit' or 'birthing kit' in the states)** **Community group social audit**	Rs.10,000 one time Rs. 5000 Rs.3000 per month Rs 100-150 per baby Rs.3000 per year	DCHS can be part of Yashoda training as well. Both DCHS and CHS require training in management of the interventions including mentoring, Yashoda capacity building, team building, budgeting, using untied funds, monitoring, supervision, and reporting. (2days) Annual CHS refresher training This untied fund at the disposal of the CHS is meant for meeting any immediate needs that other wise would affect the quality of counseling and care for the neonate and mother. E.G: consumables for Yashodas This cost is already part of the on going RCH efforts partially in some states. Effort must be to include the entire cost in the NRHM budget at thee earliest. This fund must be budgeted in order that a group of community members are invited every quarter once by the Hospital committee to have informal discussion with the mothers and Yashodas. The fund may meet the transport, tea and snack expenditure during the visit.

Key parameters to remember while calculating Yashoda Cost

- Yashoda requirement is calculated based on total delivery per year at the facility
- Each Yashoda should get equal and optimal work and rest. The calculation of shifts may be done accordingly.
- Each Yashoda should get Rupees 3000 -3500 incentive per month.
- The district facility must have at least 6 deliveries per day to support this
- The Yashoda cost includes-both direct and support costs. (Direct costs include: Yashoda incentive, apron, consumables, orientation, on the job training and materials). Support costs such as salary to DCHS & CHS, their capacity building incentive to matron as a resource person).

** Though the states have the flexibility to decide which costs of Yashoda intervention would be met from RCH/NRHM budgets and which from the NIPI budget, the basic premises should be that Yashoda process is not a stand alone one and is a continuation of JSY effort.

5.8 Incentive structure

The incentive for Yashoda may vary depending on the number of deliveries happening at the hospitals.

The number of deliveries will fluctuate per month so the incentive for Yashoda will vary through the year. Although variation is expected, the incentive structure needs to be designed in way which ensures a minimum of Rupees

3000 per month and a maximum of Rupees 3500 per Yashoda. However there are instances where Yashodas get more than rupees 3500 per month based on the delivery load; But have less number of Yashodas. In such cases the states need to revisit and examine the delivery pattern and calculation of Yashoda requirement. Conversely if the facilities have less delivery but more Yashodas, it needs to be rationalized.

In order to ensure quality each Yashoda would ideally lookafter 5-6 newborn and mother co-hort and not more.

5.9 Payment Process

1. Incentives will be paid on monthly basis.

2. Bank account of each Yashoda will be opened in the same bank where account of Institution/RKS is operated.

3. The Child Health Supervisors will prepare monthly summary attendance sheet of each Yashoda based on the Yashoda daily reporting record. **(see annexure for format)**

4. Child Health Supervisor will get the summary attendance sheet verified and approve the payment voucher by the Head Nurse / matron by 3rd day of the following month.

To speed up the payment process it is recommended that the head nurse/matron be authorised to approve the voucher for payment of incentives based on the already approved norms.

5. The Child Health Supervisors will forward the duly approved summary sheet for payment to District/Block accountant / RKS by 4th day of the following month.

6. The funds will be transferred to the designated bank accounts of Yashodas directly latest by the 10th of the following month.

7. The RKS will submit the utilisation certificate to DHS on a monthly basis. The utilisation form will be the same as prescribed under NRHM

5.10 Engaging Yashoda at the CHC/PHC

MP, Rajasthan and Bihar have expanded the intervention to include CHCs ad PHCs. There are CHCs which have fewer deliveries than the PHC and vice versa. While the general framework for implementation of the intervention remains the same as the District level operation, engaging Yashoda in these facilities with low delivery load needs to be addressed from a different perspective. Since the objective of the Yashoda process is to help the mothers and newborn and counsel mothers on basic newborn care during their stay at the facility, managers need to use a different yardstick to engage Yashoda in a CHC/PHC where daily delivery load may be less than five.

In such cases, a local decision may be taken to engage only 1 Yashodas who can assist the mothers to understand the basic newborn care messages and counsel her for 8 hrs during the day. Since she does not have any night duty, she does not get an off day on a weekly basis but will be given two days off in month (one day every fortnight). Again it is a local decision to be made by the Block medical officer/RCHO and the team.

In facilities where the delivery variations are steep, but Yashoda services is required, use a local discretion regarding engagement of Yashodas.

5.11 Supervision at the CHC

Unlike the district hospital there is no separate supervisory cadre within the CHCs to handhold Yashodas. The senior most nurse is expected to give the necessary administrative and logistics support and technical guidance to Yashodas. It is expected that the RCHO/Block medical officer will be overall in charge of the intervention. The Block Maternal and Child Health Coordinator would be responsible for day to day management of the intervention.

The State Program Management Unit will ensure that the senior nurse, RCHO and the rest of the hospital team are oriented well on the role of Yashodas, expectations, deliverables, monitoring, reporting and support required for making the intervention a success within the block context.

Managing Yashoda placement and payment of incentives: Role of SPMU

- Have clarity on the Yashoda calculation method and the rationale.
- Ensure that the data collected on the total delivery of the facility is from the correct source.
- Facilitate the district hospital system to calculate the required number of Yashoda.
- Ensure that each Yashoda get equitable opportunity for rest and work load.
- Ensure that the Child Health Supervisors, nurses, RKS accountant and hospital administrators understand the Yashoda duty roster for calculation of incentive.
- Familiarize yourself with the costs of running the intervention and the costs that are built in the on going NRHM processes
- Incentive structure should be such that each Yashoda gets Rupees 3000-3500 per month.
- *In facilities where the delivery variations are steep, but Yashoda services is required, use a local discretion regarding number of Yashodas.*
- Establish a system to ensure incentive disbursal by the first week of every month.
- Establish a method for documenting the payment process to avoid any ambiguity.
- Orient the Block Medical Officer and the CHC team adequately to support Yashoda intervention and monitor progress.

6 Capacity Building

A number of steps constitute the capacity building process for Yashodas. To enable Yashodas perform optimally the following steps are suggested:

1. Training
2. Support systems and supervision
3. Simple formats and reports
4. Assessment and feedback processes
5. Clarity on the reporting and monitoring processes
6. Learning, sharing and career growth opportunity
7. Recognition and rewards.

Capacity building, in addition to the training, must also include exchange visits, sharing of lessons learned, documentation of best practices etc. Mentoring and supportive supervision at the facility will also contribute to her capacity building.

6.1. Training

Capacity building of Yashoda is a continuous and incremental process that is critical to enhance her effectiveness. The capacity building is seen an empowering process, which will enable Yashoda to gain competencies progressively. Yashodas with certain level of competency could be further trained to become 'newborn care aide 'in the Sick Newborn Care Units and the Stabilization Units in the District hospitals and Block hospitals respectively.

Induction training upon recruitment, continuous hands on training; refreshers training etc are to be carefully planned and designed to keep updating her knowledge and skills. Capacity building, in addition to the above training, must also include

- Exchange visits
- Sharing of lessons learned
- Documentation of best practices
- Mentoring and supportive supervision at the facility
- Access to certification courses and distance learning courses

The above will contribute to career progression, motivate Yashodas and likely to reduce drop out rates.

Continuing Education, skill up gradation and integration: In the future, this critical support mechanism will be integrated into the NRHM process and scaled up to other parts of the state and health facilities. In turn, their capacity building activities need to be given an organized structure under the state training mechanism such as SIHFW or another appropriate institutional mechanism. However, the district must ensure that a pool of trainers are available within the district by building the capacity of ANMTCs, who can strengthen the continous learning processes of Yashodas.

Capacity building activities need to be given an organized structure under the state training mechanism such as SIHFW or other appropriate institutions. The districts must strengthen the ANMTCs as part of resource pool with the district.

6.1.1 Preparation for training of Yashoda

- **Identification of trainers:** The trainers will be identified from among the medical and nursing staff of the hospital, the nearest nursing college, and ANM training school.

Nursing staff and experienced ANM should be used as core trainers.

Include counsellors, to build counselling skills of Yashodas.

- Hold one initial plenary meeting with the facilitators/trainers/resource persons beforehand so they understand the overall requirement of the program and the contents.
- Provide them with an overview of Yashoda concept note and explain the expected roles and responsibilities of Yashoda.
- Make decisions on venue, food, and hand out materials, training aids and other logistics arrangements.
- Get the necessary budget approved and government letter to concerned person for participation.
- Have core trainers prepare training schedules for their respective districts.

6.1.2 Development of trainer's manual/facilitator's guide

- All the required training materials have already been developed during the pilot phase, under the guidance of competent technical expert and other partners at the State level (SIHFW, Medical college/Nursing college any other specialized agencies) field tested, translated in local languages and available for use.

- The child health supervisors should ensure that the available materials are used as much as possible and make local adaptations as required.

6.1.3 Making training practical

Keeping in mind that Yashoda is a non –clinical support worker, the training materials have been prepared. Therefore, the methodology should be practicum based and participatory. The training methodology should focus on both technical content of the counselling as well as the communication aspects. Yashodas to be trained to use the flipbook appropriately while interacting with the mothers

6.1.4 Documentation of the training/ training report

The trainings must be well documented to make appropriate changes in
subsequent trainings. The documentation should clearly mention: Relevance of content, usefulness of the training aids and methodology, what additional information could be introduced, duration, meeting the expectations of the participants and achieving session objectives. The Child Health Supervisor or the senior nurse will prepare an evaluation of the trainings and analyze them as a means to improve the quality of training.

6.1.5 Training of trainers

The Yashoda intervention has been scaled up to cover the entire state in Rajasthan and Bihar; 15 of the 30 districts in Orissa and selected CHCs in the focus districts of MP .This requires that a pool of dedicated trainers are available in each district, to ensure that Yashoda capacity building happens in an smooth way . The State program unit need to identify team of 3 trainers from each district, preferably a medical doctor (gynecologist, a nurse, and a counselor). A three day training of trainers program would be essential to bring them to understand the roles of Yashoda and develop the training methodology using participatory approaches

6.1.6 Orientation training

This is not envisaged to impart detailed knowledge, but designed to orient the newly recruited Yashoda to become confident to work in the hospital context. The orientation should be provided within the first two or three days of joining of the Yashoda. This will be for a maximum of 2 days and half of the sessions must be conducted in the ward for practical lessons. The objectives include:

- To become familiar with the hospital environment, the medical, nursing and other paramedical staff, labour room/ ward, laboratories and other facilities within the hospital.
- To orient them with basic information on newborn care, breastfeeding, supplemental nutrition, postnatal care of the mothers, counselling on immunization, and possible birth spacing options.

6.1.7 Induction training

The purpose of conducting the induction training after 2-3 months of joining the Yashoda team is to provide them with basic information and skills to handle the job well. Experience has shown that the two months of work exposure help Yashodas to understand and participate in the training in a more practical way.

6.1.8 Refresher training

Two day refresher training must be conducted after 6 months of work experience. The supervisors would have gathered good understanding of the skills and competencies of each Yashoda and will be bale to guide them better during the refresher training. The State program unit needs to ensure that appropriate refresher training materials are procured and the district level trainers are available to conduct the trainings.

6.1.9 On the job training/continuing education

Building skills of Yashoda is a continuous process and not a one time effort.

Organizing structured training regularly is expensive and time consuming. For continuous performance improvement, a learning environment needs to be created within the workplace. The supervisors must ensure that on the job trainings are structured based on the needs of the Yashodas every month and the content are balanced to provide technical information along with the skill building.

The primary responsibility of the Yashoda being counseling the mothers on various aspects of newborn care and care for self, the continuous learning sessions should focus on improving counseling skills of the Yashodas.

In addition to the child health supervisors, staff nurses/senior nurses posted at the facility, doctors (paediatrician and gynaecologist), nursing tutor, family planning counsellors, nutrition councelors, RCH counsellors and public health nurses should be invited as resource persons for the continuous learning sessions and demonstrations. At least two sessions in a month for a duration of 1,5 to 2 hours need to be organized towards this.

The doctors and nurses are expected to provide comments on the progress/competency of the Yashoda to the supervisors during the ward rounds.

The child health supervisor or the deputy child health supervisor must note down the feedback/ comments/suggestions given by the doctors on performance of Yashoda and take action to ensure quality improvement.

- The selection of the topics should be based on the feedback given by the gynaecologist/ paediatrician and mothers along with supervisors' observation of the quality of counselling by Yashodas.

- Analysis of the filled pre and post test format and interviews with the mothers are the other tools that could help to choose the topics. (See annexure for pre and post test format)

- The CHS and DCHS should discuss with Yashodas on a regular basis to identify issues faced by them during their interaction with the mothers, document and use them in the training for practical examples.

- Each session has to be repeated twice to involve all the Yashodas, taking into account the duty shifts.

- The CHS must send the identified topics for the current month and proposed for the following month with names of the resource persons in her monthly communication to the State program unit and seek their feedback and input.

Managing Yashoda trainings –Role of State Program Unit

- Make a training calendar for entire range of trainings for the year broken into quarters and share with the Secretariat.

- Develop a checklist for monitoring of the training as planned and identify local resources for monitoring the quality of the training in consultation with the district administration.

- Develop a list of pool of trainers from the district and ensure the right mix of trainers is available for all trainings including counsellors; review the suitability of the trainers to modify the content and deliver the training as required.

- Coordinate with the District Child Health Manager/District Maternal and Child Health Coordinators/DPM for all logistics and conducting the training.

- Ensure that the appropriate training materials are available with you in advance.

- Establish a mechanism to ensure that the trainings are conducted as planned and assess the quality of training (E.g: external monitoring/DCHM)

- Ensure that the Child Health Supervisor (CHS) or Deputy CHS document the processes (including preparation, trainers, content, schedule, methodology, what worked and what did not work , short comings , learning) and share it with NSPU.

- Establish a system for receiving and sending feedback to the DCHM/CHS regarding the training conducted by analyzing the report. Develop a methodology for getting feedback from the Yashodas on the usefulness of the materials and methodology

- Assess periodically and update the requirement of training and IEC materials requirement and plan the process of procuring /producing them

- Based on the analysis, identify those facilities where Yashodas would require additional training and plan for it.

6.1.7 Periodic Internal Assessment and feedback

It is essential to assess the technical knowledge and counselling skills of Yashoda every six months, to gauge whether she has acquired the expected standard to function effectively. This will be a useful input for the refresher training as well.

Towards this, the Child Health Supervisor needs to coordinate the assessment process. This could be conducted by the nurse matron and the ANMTC tutors, preferably by those who had provided the induction training. The assessment tools will be prepared in consultation with the nurse matron at the facility. The assessment tools will target both knowledge and skills related to the various components including newborn care, mother care, and breast feeding support, counselling for care after discharge, feeding practices, family planning options, immunization and general support. (**See annexure for suggested criteria for assessment)**

It is critical that after each assessment, all Yashodas must be given feedback on their performance and indicate aspects of strengths and weaknesses.

Feedback and recognition: It is critical that after each assessment, all Yashodas must be given feedback on their performance and indicate aspects of strengths and weakness.

State Program Management Unit should ensure that the Supervisors are adequately trained in giving feedback appropriately.

It is likely that some Yashodas perform better than the others. A system for monitoring the performance must be established by the child health supervisor.

The purpose and criteria must be informed to Yashodas with transparency.

Incase of performance below the expected level, Yashoda must be informed during the monthly meeting. Additionally during the on the job training sessions, those poorly performing Yashodas should be given more attention to bring them on par with the better performing Yashodas.

In case of consistent poor performance, the hospital competent authorities will decide on strategies for retaining/removing the Yashodas. In the same token, well performing Yashodas should be recognized and or rewarded in the Hospital monthly meetings chaired by the CDMO/CMHO and in the ward. This will be a big motivating factor to the voluntary worker.

6.1.8 Refresher training

This training is planned to be held after 3-6 months of the induction training, aimed at providing an intensive revision of the technical and practical aspects related to their work. The District level trainers will conduct this training. The Child Health Supervisor (CHS) and the Deputy Child Health Supervisor (DCHS) will also be trainers and coordinate the entire process.

7 Supervision

7.1 Overall supervision

Overall supervision is provided by the ADMO /medical superintendent identified by the CDMO/CMHO/ PMO in the district hospitals as the case may be in each state. In the case of CHCs, the RCHO could provide the overall leadership to manage the intervention

This includes:

- Yashoda engagement, approval of payment norms, and incentive disbursal, purchase of the supplies and consumables, monthly progress report, regular performance review, grievance redressal and related administrative matters.
- In the NIPI focus districts, the District Child Health Managers/Maternal and Child Health Coordinators will assist the ADMO/Medical Superintendent in discharging/coordinating all the above functions and day to day operations.

In districts other than the NIPI focus districts, the Hospital Managers or a person identified by the CMHO could be responsible for the above.

7.2 Child Health Supervisor (CHS) and Deputy Child Health Supervisors (DCHS)

Yashodas are supervised and supported by the Child Health Supervisor (CHS) and two Deputy Child Health Supervisors (DCHS) so that for each shift there is one supervisor available. The Yashoda intervention is in the initial stages and therefore requires intensive supervisory support, especially in facilities which have shortage of nursing staff. The position of the DCHS is a temporary one to give intensive handholding for technical issues to the Yashodas in the first year. As the Yashodas gain competency and the Yashoda process gets embedded in the hospital system this position will be phased out. The DCHS are selected through a district process.

Yashoda intervention requires a skill mix that brings a balance in the management and technical supervision and support. Accordingly, it is suggested that the DCHS will be from the nursing stream, preferably a retired nurse/ ANM/LHV; because of their understanding of the functioning of the health system and can begin to support the Yashodas from day one. The CHS on the other hand requires more managerial skills and could be from the social sciences background.

7.3 Child Health Supervisor

The Child Health Supervisor has the overall responsibility to manage the intervention effectively. **CHS also functions as shift supervisor and need to be located in the ward**. While she provides certain support to the DCHM and DPM, **her primary responsibility is in the ward** and providing overall supervision for the intervention.

The CHS is expected to do at least one or two night shifts in a week. Towards that in cooperation and support from the DCHS and ward nurse, she will:

- Develop an activity cum progress report for the quarter and share it with the State program unit.
- Send monthly progress report to the State Program Management Unit.
- Plan with the DCHS and ward nurse for themes for Yashoda on the job training, coordinate the training and ensure the schedule is completed.
- Oversee that the duty rosters, attendance and leave registers of Yashoda are maintained properly.
- Verify the daily record sheet filled by Yashoda and cross checked by the DCHS.
- Prepare the monthly summary attendance sheet for payment of incentive and submit via (**as applicable in the respective state**) the District Child Health Manager/ the District Accounts Manager for approval of the Principal Medical Officer/Chief Medical Officer and processed by Rogi Kalyan Samiti Accountant.
- Follow up on timely payment of incentive to Yashoda and matron/nurse.
- Liaise with the hospital manager and other hospital authorities for ensuring support services for the Yashoda including space and toilet facilities.
- **Ensure that Yashodas are not assigned duties by the nurses, , for which they are not trained and in particular, clinical work by the nurses or doctors. In instances where such duties are assigned , CHS must take it up with the Matron and correct the situation.**

- Establish an official grievance redressal process with the CDMO/CMHO.
- Establish a formal mechanism with the hospital manager for sorting out day to day issues in the ward maintenance.
- Collate the daily reports with assistance from the DCHS and analyse the same for progress and deficiencies for further correction and action. (e.g: If you find that there is considerable difference in the number of babies receiving zero dose immunization (polio and BCG) vis a vis total number of live births, it requires immediate action)
- Interview two mothers on a weekly basis using a questionnaire to understand the levels of client satisfaction and ensure that the DCHS conducts similar interviews with two other mothers. Collate the report and use the information in the monthly review meeting by the CDMO/PMO as the case may be and send copy of the report to the State Program Management Unit.
- Participate in the monthly review meeting held by the Chief Medical Officer/PMO and highlight the improvement in newborn care services by Yashodas by using monthly reports.

- Ensure that the capacity building efforts including trainings take place as planned.
- Establish a mechanism in cooperation with the Child Health Manager and State Program Management Unit for performance assessment of the Yashodas and DCHS.
- Monitor performance of Yashoda in consultation with ward nurse and Deputy Child Health Supervisors.
- Organise structured meetings with the DCHSs to get feedback on Yashoda performance and issues that affect the quality of service.
- Establish a system in consultation with the CDMO, DCHM and NIPI State Program Unit for assessing performance of the DCHS.
- Suggest aspects that can be improved using the untied funds and send the proposal via the hospital manager or the appropriate authority for approval
- Participate in district PIP planning meetings and give input related to newborn care issues

Leave for the CHS:

The Child Health Supervisor is recruited under NRHM procedure and all the leave rule applicable for NRHM contractual staff will be applicable in their case as well. While CHS interacts directly with CDMO/CMHO/PMO and get her leave sanctioned, she must inform the matron regarding the leave and make appropriate supervisory arrangements with the Deputy Chid Health Supervisors and DCHM.

Supervision is a coordinated effort

- Supervising the intervention is a team effort. CHS and DCHS need to enlist the support and cooperation of the hospital manager and nurses in a structured way.
- The Yashodas are at the lower end of the decision making chain, and do not have the authority to make the system work. But by creating certain processes, Yashodas can be empowered which in turn will facilitate better quality of care to the newborn and make the management of the maternity ward more efficient.
- Develop a checklist related to day to day management of the ward (e.g: privacy and cleanliness in labour room, ward, visiting hours, garbage collection timing, disposal facilities, security, functionality of the toilet and water availability).

Train Yashodas to record information related to the above on a printed register, which could be taken up for discussion with the hospital manager by DCHS/CHS for ward improvement.

7.4. Deputy Child Health Supervisor

For ensuring smooth functioning and effective technical supervision it is proposed to have two Deputy Child Health Supervisors. They, apart from assisting the CHS for effective supervision and mentoring of the Yashodas, will also ensure that Yashodas get appropriate support within the ward. The two DCHS in turn do day and night shifts to supervise the Yashodas. This position is visualized as a temporary position for a period of one year. The states may review the value addition and decide on extention of the position or otherwise.

They have the responsibility to:

Develop a monthly work plan based on the quarterly work plan developed by the CHS

- Be with the Yashodas in the ward and provide on the job supervision.
- Support Yashodas both by way of demonstration and teaching, especially for supporting breast feeding, taking sick newborn to doctor or nurse, and counselling mothers.
- Ensure that the Yashodas are giving correct, gender sensitive, and complete messages to the mothers on newborn care and care for self. Also ensure that the Yashodas are observant that no discrimination takes place within the ward. (e.g: willfull negligence of female child, not immunizing, not breast feeding, abandoning the girl child etc.)
- Develop the daily duty roaster for Yashodas and maintain the attendance register.
- Ensure that each Yashoda understands the rationale for filling the daily register and the format is completed.
- Assist the CHS for collating the daily register data for preparing the monthly report.
- Organise on the job training as planned in consultation with the CHS and nurse.
- Review performance of Yashodas on an ongoing basis and give feedback to the Yashodas and CHS.
- Get feedback from mothers/families.
- Ensure the required logistics and administrative support in cooperation with the nurses.
- Help the Yashodas to document some of the experiences in the ward. (e.g: saving the under weight newborn; helping mother and family members to give up some harmful newborn care practices; advocacy with the male members for kangaroo care for newborn)
- Provide support to the hospital for immunization of newborn on Sundays and Holidays as guided by the CDMO/CMHO.
- Any other support required by the CHS/Yashodas/Ward nurse.

The role of the Deputy Child Health Supervisors may be summarized as follows:

Daily Activities

- Supervision of Yashoda work including counselling; attendance and checking quality of daily record filling by Yashodas.
- Interaction with the ward nurse for ensuring support services for the Yashodas.
- Monitoring the duty assignment of the Yashodas are limited to the non clinical functions only.
- Skill building of Yashodas through demonstration.
- Application of post test format.
- Supporting the ward nurse as required.
- Taking up operational issues with the hospital manager and CHS on a daily basis for improvement.

Weekly Activities

- Interviewing of the mothers on a sample basis.
- Collating the daily report.
- Check the progress vis a vis the monthly plan and discuss with the CHS.
- Once in two weeks collate the pre an post test format results and share it with the CHS for analysis.

Monthly Activities

- Assisting the CHS in making the monthly report for review by PMO and sending it to the State Program Management Unit.
- Assist the CHS for collating the attendance sheet for incentive payment of the Yashodas.
- Discuss with CHS on the performance quality and progress of the Yashodas and assist in performance assessment.
- Assist the CHS in identifying topics and resource persons for the on the job training of the Yashodas.
- Helping the Yashodas to document some of the experiences.

Leave for DCHS: DCHS are currently getting one day off in each week. Being a hospital based position the decision regarding additional leave may be made by the CHMO/RKS.

Assessment of Performance of supervisory cadre:

The assessment of the Deputy Child health Supervisor has to be undertaken every six months and conducted very objectively. The State Program Management Unit needs to develop the appropriate tools in consultation with the CHS and the hospital team for such assessment with the involvement of external members.

Performance assessment of the CHS: Thought the CHS appointment is done by the NRHM, and annual performance review is carried out, programmatically a system for assessing their performance must be established by the State Program Management Unit (SPMU). The tools may be developed in consultation with the hospital team, DHS and SHS.

Managing Supervisors-Role of State Program Management Unit

- Facilitate the development of an annual work plan by the CHS broken into quarterly activities.
- Establish mechanism for tracking the activities and progress.
- Fast track the appointment of the CHS and DCHS by rigorous follow up with the State/District Health Societies where it is still in progress.
- Ensure that DCHS have counselling skills and are willing to do night duty.
- Make a comprehensive tour plan for each facility with deliverables during each visit and share it with the CHS.
- Make a trip visit report giving clear observation points, progress, gaps and next steps and share it with the CMHO and give feedback to the CHS.
- Ensure that the Supervisors trainings are scheduled as planned documented and reported.
- Develop a annual performance assessment process for DCHS and CHS in consultation with the CDMO/CMHO.
- During your visit to the facility have formal interaction with the hospital administration, the CHS, hospital managers, DCHM and DPM for sorting administrative or logistics problems for Yashodas and supervisors.

8 Monitoring

8.1. Record keeping and reporting

A daily record register will be filled and signed by all the Yashodas working in the three shifts to have continuity in the record. This will be checked and signed by the Deputy Child Health Supervisor each day. The Child Health Supervisors must ensure that the record is filled by the Yashoda in their respective shifts in a day to have complete data on each mother and newborn. (**See annexure for record format**).

- To ensure quality, CHS must make sure that Yashodas understand the relevance of each column filled and importance of recording the data. The same will also be used for training them and to inform them of their contribution each week during feedback session.

Pre and post feed back form:

This tool apart from giving information on client satisfaction will also be useful to understand effectiveness of the counseling by Yashodas in improving the knowledge of the mother. This will have set of questions divided in two parts. Yashodas will administer the first part to the mother prior to delivery or within four hours after delivery. The same questions given in the second part will be asked by the Deputy CHS or the CHS prior to the departure of the mother, who is expected to have received counseling from Yashodas.

The feedback form will specifically collect information from i) mothers having first delivery and (ii) mothers having subsequent deliveries. The Child Health Supervisors will collate the information on fortnightly basis and a) share it with the District Child health manager and nursing staff and b) use the information for mentoring the Yashoda and c) seeking suggestion for improvement from the head nurse /matron to improve quality. **(see annexure)**

While the above are hospital level processes, a state level scaling up requires rigorous follow up of the implementation at every level and appropriately trained personnel at the district and block level handle the monitoring effectively. While the day today monitoring is managed by the trained managers, establishment of a state level structure to monitor the implementation from the policy perspective is important.

As a process of continuum of care the district ASAH coordinator could have the lead responsibility to monitor the implementation at the district level, ably supported by the child health supervisor, district maternal and child health coordinator. At the Block level the Block maternal and child health coordinator could take up the responsibility to monitor the Yashoda intervention.

8.2. Informal community monitoring of quality care at the facility-Involving clients: Local Women's Visiting Group for social auditing

Several potential outcome are expected out of the Yashoda interventions including longer duration of stay of mothers, more mothers initiating immediate and exclusive breast feeding, improved immunisation, increased number of mothers get informed on basic newborn care, nutrition and feeding practices, increased utilisation of outreach services such as immunization, referral services etc. in those villages that utilise the services of the hospital. The intervention is monitored at different levels in the hospital for achieving these expected outcomes.

It is recommended that, involving the community in informal monitoring of the services periodically will bring value addition to the process by way of enhanced ownership and informal promotion of the hospital services. This could be facilitated by establishing a process, which engages a group of local women to visit the hospital periodically and interact with the mothers, Yashodas and the nurses on the various issues related to care given to newborn and the mothers. This will give them a chance to see the hospitals by themselves, observe the improvements, make their suggestions in the visitor's register, thereby contributing to promoting improving quality of services. The first Visitors Committee could start with the District Collector' spouse/prominent woman member of Zilla Parishad as the Chairperson.

While this group does not have any legal position, they carry the good will of the community and could contribute to enhanced community appreciation of the efforts of the hospital. The District Hospital authorities could explore establishing this mechanism by inviting a mix of women Panchayat members/self help groups/village sanitation committee, from the villages to visit the hospital periodically. This event could be facilitated by the District Child Health Manager by providing the appropriate budget and logistics arrangements.

Managing monitoring processes-role of State Program Management Unit

- Ensure that the monitoring mechanism, reporting relationship and methods are communicated to the CHS, DCHM and DPM without ambiguity.
- Make a schedule for receipt of the various reports related to Yashoda intervention from the facilities and for forwarding the same to the state.
- Give feedback to the CHS and DCHS on the progress and plan the support you can give for improving performance as required.
- Keep the CDMO/ADMO/DPM in the loop for receiving monthly Yashoda review meeting reports as well as sharing progress reports.
- Dialogue with the State Health Society for incorporating the Yashoda indicators in the state HMIS.
- Ensure that a social auditing of the processes through local women's group is established and appropriate budget is kept.

Institutional mechanism

9

9. Institutional mechanism:

Within the Hospital:

Yashoda gets both administrative and logistics support as well as technical support from the hospital team. On day to day basis, she is supervised and monitored by the CHS and mentored by the DCHS/the nurse/matron. The CHSs are responsible for all the administrative and logistics support and supportive supervision to the Yashoda and acts as mentor. The nurses provide technical guidance to Yashoda during regular ward rounds, give feedback on Yashoda performance and support the supervisor on the administrative aspects.

The medical officers (Paediatrician and Gynaecologist) support Yashoda capacity building through hands on training and feedback during ward rounds on a day to day basis. The Medical Superintendent and DPMU (through the hospital manager and the District Child Health Manager) together provide overall supervision and management support to the Chief Medial Officer.

At State level:

For managing the expansion to cover the entire state requires well established institutional mechanism that would be constantly assessing the intervention and providing policy and other required support. SPMU must ensure that the management structure is clearly articulated and roles and responsibilities at the various levels are communicated effectively. For example, In order to strategically link the Yashoda process to the ASHA process and institutionalize the Yashoda process, the State ASHA Coordinator could be the state node for coordinating the Yashoda intervention and re-designated as ASHA –Yashoda coordinator.

The SPMU has the additional responsibility of ensuring that the administrative and program implementation guidelines and office orders organized and disseminated to the field without any delay and provide clarification s necessary incase of ambiguity.

In addition to the state level mechanism such as State Coordination Committee, appropriate institutional structure must be established at the district /block level and even at the facility level. For example, though CMHO is the overall supervisor and RKS is the decision making body at the facility level, both have inadequate time to get involved in the day to day management of the Yashoda intervention. Formation of a hospital committee at the district hospital with the matron/senior nurse, District maternal and child health coordinator, hospital manager and Yashoda child health supervisor will enable the Yashodas and supervisors to know their focal point within the hospital for grievance redressal and day to day operational support related to implementation.

Expansion to cover the state also requires special skills for managing the budget and leveraging the resources. A specific nodal finance person at the state level may be engaged to manage the finances including, calculating the overall intervention cost, tracking expenditure, documenting the payment of incentive profile, use of untied funds and building local capacity to understand the management of the finance aspects.

Annexures

Annexure:

Yasoda Daily Reporting Format

Yasoda Daily Reporting Format										
Sl No	Name& Address	Age	Parity	BPL(Y/N)	Date& Time of Admission(to hospital)	Date& Time of Delivery	Livebirth/Still birth	Sex of Baby	Weight of Baby	Type of delivery(Normal or Ceasarian)
1	2	3	4	5	6	7	8	9	10	11
Signature of Yasoda										

Any problem at Birth	Date&Time of initiation of Breast Feeding	Vaccination (Polio or BCG or Both)	Date&Time of Discharge from hospital	Counselling to mother (Y/N)	Duration of stay(Hours)	Any problem with Baby	Any Problem with Mother	Signature of DY CHS	Sig of CHS	Remark(Referral/returned/Death/others)
12	13	14	15	16	17	18	19	20	21	22
Signature of Yasoda										

Annexure:

Yashoda duty roster /work schedule - Rajasthan model

This chart shows how the work distribution is equal for all and adequate rest is given to all Yashodas.

Note: On day one a set of Yashodas will get rest even though they have not started the work. It will get adjusted as the days go by.

On day 2, the morning shift person will do evening and the evening person will do night and the night person gets rest. The cycle gets repeated in the same sequence for the remaining days of the month.

Date	Days	Shifts of Yashoda			
		Morning	**Evening**	**Night**	**Rest**
1	Monday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
2	Tuesday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
3	Wednesday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
4	Thursday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
5	Friday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
6	Saturday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
7	Sunday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
8	Monday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
9	Tuesday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
10	Wednesday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
11	Thursday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
12	Friday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
13	Saturday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
14	Sunday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
15	Monday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
16	Tuesday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
17	Wednesday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
18	Thursday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
19	Friday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
20	Saturday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
21	Sunday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
22	Monday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
23	Tuesday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
24	Wednesday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
25	Thursday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
26	Friday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
27	Saturday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2
28	Sunday	Yashoda 2	Yashoda 3	Yashoda 4	Yashoda 1
29	Monday	Yashoda 1	Yashoda 2	Yashoda 3	Yashoda 4
30	Thursday	Yashoda 4	Yashoda 1	Yashoda 2	Yashoda 3
31	Wednesday	Yashoda 3	Yashoda 4	Yashoda 1	Yashoda 2

Annexure:

Suggested Criteria for Assessing the Performance of Yashoda

<table>
<tr>
<td>1. General
Attendance, punctuality, personal cleanliness
Alertness in the ward
Ability to manage the crowd in the wards
Ensuring cleanliness in the ward including the toilets</td>
<td>2. Behaviour
Group dynamics – working with Yashoda/Peers
Friendliness and interaction with the women admitted in the ward and their family
Interaction with the nurses and other hospital staff</td>
</tr>
<tr>
<td>3. Technical knowledge
Post partum care of mother
Assisting in breastfeeding
Basic care of the newborn and danger signs
Immunization</td>
<td>4. Skills acquired
Wrapping the baby, temperature reading, cord care
Assisting in breastfeeding
Counseling skills</td>
</tr>
<tr>
<td>5. Communication Skills
Ability to communicate verbally to the mother and her family
Communication with other Yashodas, supervisors and nurses.
Ability to clarify doubts to mother and appropriate use of the BCC/IEC materials while communicating with the mother</td>
<td>6. Reporting
Regularity, clarity of reporting and comprehensiveness</td>
</tr>
</table>

Annexure: 6

Pre and Post Evaluation of Yashodas role

.shoda's_Questionnaire_Adesh[1]

राजस्थान सरकार
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन, स्वास्थ्य भवन, जयपुर

मातृ एवं शिशु स्वास्थ्य संबंधित प्रश्नोत्तरी
(गर्भवती/प्रसूता से पूछ कर यशोदा द्वारा भरा जाने हेतु प्रपत्र)

अ. सामान्य जानकारियाँ

गर्भवती/प्रसूता का नाम व पति का नाम	:	.... /	
महिला की आयु	:	....	दिनांक तथा समय ....
क्या आशा साथा आयी है ?	:	हाँ/नहीं	यदि हाँ, तो आशा का नाम ....

क्र.सं.	प्रश्न	विकल्प
1.	आपकी प्रसव पूर्व कितनी जाँचे हुई थी ?	(1) एक (2) दो (3) तीन से अधिक (4) एक भी नहीं
2.	यह आपका कौनसा प्रसव है ?	(1) पहला (2) दूसरा (3) तीसरा (4) चौथा या अधिक
3.	आपने गर्भावस्था के समय टी.टी. के कितने टीके लगवाये थे ?	(1) एक (2) दो (3) एक (बूस्टर) (4) शून्य
4.	आपने गर्भावस्था के दौरान आयरन की कितनी गोलियाँ खाई ?	(1) एक भी नहीं (2) 30 से कम (3) 30–60 (4) 60–90 (5) 90 से अधिक (6) पता नहीं है।/ याद नहीं
5.	आपको संस्थागत प्रसव के लिये किसने प्रेरित किया ?	(1) स्वयं आये (2) आशा (3) ए.एन.एम. (4) रिश्तेदार/परिवार (5) अन्य

ब. प्रसव पूर्व तथा प्रसव पश्चात् मूल्यांकन हेतु प्रश्न

क्र. सं.	प्रश्न	विकल्प	प्रसव पूर्व मूल्यांकन +	प्रसव पश्चात् मूल्यांकन ++
1.	आपके अनुसार महिला को प्रसव पश्चात् चिकित्सालय में कितने समय तक रूकना चाहिये ?	(1) 24 घण्टे से कम (2) 24 घण्टे से अधिक (3) पता नहीं है।		
2.	प्रसव पश्चात् माँ को खतरे के लक्षण क्या–क्या है ?	(1) अधिक रक्त स्त्राव (2) दौरे पड़ना (3) बदबूदार स्त्राव (4) तेज बुखार (5) शरीर पर सूजन (6)अन्य (7)पता नहीं।		
3.	आपके अनुसार नवजात शिशु को प्रसव के कितने समय बाद स्तनपान प्रारम्भ कराना चाहिये ?	(1) 1 घण्टे के भीतर (2) अन्य (3) पता नहीं		
4.	स्तनपान नवजात के लिये क्यों आवश्यक है ?	(1) यह स्वास्थ्यवर्धक होता है। (2) यह आवश्यक नहीं है। (3) यह हानिकारक है। (4) पता नहीं है।		
5.	6 माह तक शिशु को क्या आहार देना चाहिये ?	(1) केवल स्तनपान (2) अन्य		
6.	जन्म के समय नवजात शिशु का वजन कितना होना चाहिये ?	(1) 2.5 किलो या अधिक (2) 2.5 किलो से कम (3) पता नहीं।		
7.	नवजात में खतरे के क्या–क्या लक्षण होते है ?	(1) शरीर का ठंडा पड़ जाना (2) टीकारण न करवाने से होने वाले रोग (3) संक्रमण हो जाना (4) स्तनपान न करवाना (5) पता नहीं।		

Page 1 of 2

क्र. सं.	प्रश्न	विकल्प	प्रसव पूर्व मूल्यांकन +	प्रसव पश्चात् मूल्यांकन ++
8.	नवजात को प्रसव के कितने समय बाद नहलाना चाहिये ?	(1) तीन दिन बाद (2) अन्य (3) पता नहीं		
9.	नवजात/शिशु को दस्त लगने पर क्या करना चाहिये ?	(1) उसे ओ.आर.एस. का घोल देते रहना चाहिये तथा उसे स्तनपान/ ऊपरी तरल आहार जारी रखते हुए चिकित्सक को दिखाकर दवा देनी चाहिये। (2) अन्य (3) पता नहीं।		
10.	नवजात को सामान्यतः क्या–क्या बीमारियाँ हो सकती है ?	(1) निमोनिया (2) दस्त (3) संक्रमण (4)नाल में संक्रमण (5) पीलिया (6) शरीर का नीला पड़ना (7) अन्य/ पता नहीं।		
11.	शिशु को किस आयु से ऊपरी आहार देना प्रारम्भ करना चाहिये?	(1) 6 माह पर (2) अन्य (3) पता नहीं।		
12.	बच्चों को कौन–सी छः जानलेवा बीमारियों से टीकाकरण द्वारा बचाया जा सकता है ?	(1) गलघोंटू (डिप्थीरिया) /काली खाँसी (कुकर खाँसी)/तान (टिटनेस) /खसरा (मिजिल्स) / टी.बी.(तपेदिक) /पोलियो (2) अन्य (3) पता नहीं।		
13.	नवजात शिशु को गर्म रखने के लिये क्या सर्वोत्तम है ?	(1) उसे गर्म कपड़े में लपेटकर माँ से चिपकाकर रखना (2) बच्चे को कपड़े में लपेट कर माँ से अलग रखना (3) पता नहीं।		
14.	दो बच्चों में कम से कम कितना अन्तराल होना चाहिये ?	(1) एक वर्ष (2) दो वर्ष (3) तीन वर्ष या अधिक (4) पता नहीं।		
15.	क्या आप जानती हैं कि लिंग चयन करवाना दण्डनीय अपराध है यह अपराध करने एवं करवाने वाले के लिए 3 वर्ष तक की सजा एवं 5 लाख तक के आर्थिक दण्ड का प्रावधान है ?	(1) हाँ (2) नहीं (3) अन्य (4) पता नहीं।		
16.	आपके विचार से अस्पताल में प्रसूता की देखभाल व सहयोग के लिये अस्पताल की तरफ से कोई स्वैच्छिक कार्यकर्ता चाहिये?	(1) हाँ (2) नहीं		
17.	क्या आप यशोदा की सेवा से संतुष्ट है ?	(1) बहुत संतुष्ट (2) संतुष्ट (3) कुछ असंतुष्ट (4) पूरी तरह से असंतुष्ट (5) सेवा नहीं ली		

नोटः 1. + प्रसव पूर्व मूल्यांकन प्रसव से पूर्व या प्रसव के 4 घन्टे के भीतर यशोदा द्वारा भरा जायें।
2. ++ प्रसव पश्चात् मूल्यांकन अस्पताल से छुट्टी से पूर्व सुपरवाइजर द्वारा भरा जायेगा

हस्ताक्षर यशोदा .... **हस्ताक्षर सुपरवाइजर** ....
नाम यशोदा .... **नाम सुपरवाइजर** ....
दिनांक .... **दिनांक** ....

Annexure:

Yashoda Tasks

Frequency	Activities		
Every 2-4 hourly during the shift	• Check and assist in starting breastfeeding within 30 minute after delivery • Assist the mother to keep the baby clean, dry and well covered • Check that the ward is not crowded • Check if any new pregnant woman is admitted and assist in registration and bed preparation	• Check breastfeeding of every newborn and assist mother for successful breastfeeding • Check the temperature of the baby and record • Ensure that the newborn is not given any feed other than the breast milk	• Check the pad of mother for bleeding • Check the temperature and general status of mother • Record the parameters for mother
Daily routine activities	• Take over from the earlier shift • Interact with the CHS about the progress and problems • Accompany the doctor/nurse during clinical rounds • Follow the instructions given by nurse/doctor • Check the cleanliness of the ward and toilet and take necessary steps to ensure cleanliness • Complete the reporting sheet with information on each delivery including still birth and verify with the nurse's register for accuracy • Handover to the Yashoda coming in next shift about each of the babies and mothers • Check if the form for birth registration is filled properly for each live birth	• Ensure immunization of the babies before discharge • Check breastfeeding status of each newborn • Basic assessment of the newborn and inform if any problem noticed • Counsel mothers on breastfeeding and basic newborn care	• Ensure mothers and their family members are counseled about mother's diet, rest, and contraception • Basic assessment of the mother for problems • Assist mothers in getting the JSY entitlement
In case of emergency	• Inform the nurse/doctor • Inform CHS	• Take necessary basic steps as demonstrated during training	• Follow the instructions of the nurse/doctor
For administrative/ incentive/ logistics related issues	• Inform CHS and follow the instructions	• May contact the Medical Superintendent, Hospital Manager or DCHS depending on the matter	

Annexure:

Incremental Technical Input for Yashoda

After a week	At the end of the first month	By the third month	At the end of six months
• Hospital staff and services, and facilities including wards, labor room, OT, Laboratory & admission procedure • Understand about their roles and responsibilities • Be familiar with the rules and regulations of the hospital • Be familiar with some of the essential aspects of newborn care as per the initial orientation	• How to assist the mother in admission, registration, and bed preparation • Basic preparation of the pregnant woman before she goes into the labor room • Basic newborn care: - Temperature maintenance and wrapping the baby appropriately - Cord care - Keeping the baby dry, clean and warm • Basic care of the mother - Change the pads - Diet • Checking temperature of the baby and mother • Counting respiratory rate • Support the mother to start breastfeeding • When to call the nurse or doctor for assistance	• Acquire competency in assisting and counseling for breastfeeding • Address breastfeeding problems • Identify danger signs in the newborn - Hypothermia Identification and care - Respiratory distress - Jaundice • Care of the low birth weight baby - Feeding low birth weight babies - Kangaroo mother care • Counsel the mother - About care during immediate post delivery period - Diet, rest, contraception • Advice at discharge - Information on contact person for follow up and in emergency - Immunization, exclusive breastfeeding, supplementary feeding	Gain skills in addressing all the aspects mentioned so far and additionally: • Identify neonatal sepsis • Care of sick newborn • Measure pulse rate of the mother

NIPI – A Child Health Program to Achieve MDG 4

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