



सत्यमेव जयते
Ministry of Health and Family Welfare
Government of India

Guidelines on

MIDWIFERY SERVICES

IN INDIA | 2018





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MIDWIFERY SERVICES

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जगत प्रकाश नड्डा
Jagat Prakash Nadda



स्वास्थ्य एवं परिवार कल्याण मंत्री
भारत सरकार

Minister of Health & Family Welfare
Government of India



Message

In 2015, India became one of the 193 countries to commit to the Sustainable Development Goals (SDGs), which aim to transform the world by 2030 to a more prosperous, more equal, and more secure planet for all. Needless to say, India's responsibility is immense as these ambitious goals cannot be achieved without accelerating progress in one-sixth of the world that resides in our country.

2. For us to be able to ensure healthy lives and promote wellbeing for all, it is critical to focus on improving our core health indicators which include maternal and infant mortality.

3. India has made tremendous progress over the last few decades in increasing institutional deliveries through the National Health Mission. Further, schemes like the Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram have greatly reduced the maternal and infant mortality as well as out of pocket expenditure on child birth. However, it has also led to some overcrowding of secondary and tertiary facilities.

4. Bringing midwifery practices to centre stage can further improve the quality of care around birth and decongest higher levels of facilities. Not only can a strong midwifery cadre provide quality childbirth care to our mothers and newborns, it can also ensure care with dignity and compassion and promote a positive child birthing experience. Approximately 85% of pregnancies and births do not require specialized obstetric intervention. Midwifery-led care can play a critical role in promoting physiological births, and reducing over medicalization.

5. The world over, midwives play a critical role in providing childbirth care and I am happy that our Ministry and Indian Nursing Council are bringing out this guideline for Midwifery Services in India. This is a historic moment for Midwifery in the Country.

6. I am confident that building a strong midwifery cadre and rolling out midwifery services will prioritise quality childbirth care to our mothers and their newborns and play a leading role in achieving our SDGs.

(Jagat Prakash Nadda)

New Delhi,
Date: 7.12.2018

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अश्विनी कुमार चौबे
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GOVERNMENT OF INDIA



MESSAGE

When a pregnant woman enters the health system, she puts her faith in the system to receive high quality services for herself and her newborn. Responding to this faith we have strengthened maternal and child health services in our country under the National Health Mission. Between 1990 and 2015, India has witnessed 77% decline in maternal mortality as compared to a global decline of 44%.

Notwithstanding such a significant decline, accelerated efforts are required to achieve Sustainable Development Goals. This is particularly essential for our Empowered Action Group (EAG) states and Assam, where the health statistics for mothers and children are poorer than the national average.

Recognizing the critical role of skilled midwives, the Government of India has developed these guidelines which aim to strengthen the midwifery services of the country to ensure quality care for every mother and newborn. The Lancet Series on Midwifery (2014) highlights that where midwives are educated, trained and deployed to provide the full scope of the competencies as described by International Confederation of Midwives (ICM), they can provide 87% of the services needed.

I am proud to be a part of this momentous movement of strengthening midwifery led care in India which will play an important role in delivering affordable, accessible and quality healthcare for attaining maximum standards of good health and well-being as a part of the Universal Health Coverage.

(Ashwini Kumar Choubey)

New Delhi
December, 2018



अनुप्रिया पटेल
Anupriya Patel



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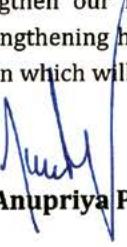


Message

Motherhood is a joyous event, however, high maternal mortality during pregnancy and childbirth is a matter of great concern in India and worldwide. Maternal mortality is also a strong indicator for measuring the attention paid to the health care of the women. In the last couple of decades, India has come a long way in improving maternal health, and MMR has dropped significantly, however, we can and must do more!

Nearly 32,000 pregnant women still lose their lives during pregnancy, intrapartum and post-partum period. There are also disparities in distribution of these deaths based on various socio demographic variables. Furthermore, despite increase in institutional deliveries in India, there is huge inter and intra state variations. There are eight states with institutional delivery rates less than 70% and three states with institutional delivery rates less than 52%. In addition, certain parts of country especially urban areas, are suffering from the over medicalization of pregnancy and delivery care. This situation highlights the undeniable need to have an alternative model of delivery of care especially one that focuses on promoting continuum of care thorough provision of women centric care.

Midwife led care is paradigm shift which can address many of the issues that our country continues to face. This will reduce 'over-medicalization' during childbirth and increase efficient use of resources. Midwifery services can help promote respectful maternal and newborn care. Midwives can introduce a system level shift from fragmented maternal and newborn care which focuses on identification and treatment of pathology, to skilled and compassionate woman-centric care. Introduction of specialized Nurse Practitioners in Midwifery will help strengthen our health workforce, and will go a long way in addressing the country's core need of strengthening human resources for health. It is my privilege to witness this transformative intervention which will steer India towards achieving the Sustainable Development Goals.


(Smt. Anupriya Patel)



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Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare

Dated : 9th December, 2018



FOREWORD

Nurses and midwives account for nearly half of the global health workforce and 38% of the health workforce in India. More often than not, they are the ones to provide the care to the most vulnerable, remote and hard to reach communities in our country, and in many other parts of the world. They are, undoubtedly, a critical arm of the country's health workforce for delivery of primary health care and universal health coverage. Midwifery forms a core element of care that is needed during childbirth, which is one of the most vulnerable periods for a mother and her newborn. Evidence suggests that normal births do not require presence of obstetricians all the time and therefore, can be provided by midwives.

The Government of India has taken a landmark policy decision to roll out midwifery services in the country in order to improve the quality of care and ensure respectful care to pregnant women and newborns. This will create a cadre of Nurse Practitioners in Midwifery who are skilled and competent as per international standards. Eighteen months training would be provided to nurses to create a cadre of midwives who are knowledgeable and capable of providing high quality compassionate women-centered reproductive, maternal and newborn health care services.

These guidelines introduce Midwifery -Led Care units at public healthcare facilities which will improve quality, equity, and dignity in the provision of care and decongest higher level of health care facilities. The initiative will promote natural birthing by promoting a positive child birthing experience. Overall, the initiative aims to develop an enabling environment for integration of midwifery care into the public health system, in order to accelerate the decline of maternal and neonatal mortality and achieve the Sustainable Development Goals for maternal and newborn health.

I congratulate all involved in the development of the Guidelines and look forward to these guidelines being adopted and implemented across the high focus states of India.


(Preeti Sudan)



मनोज झालानी

Manoj Jhalani

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PREFACE

Improving the health of every mother and every child is a key strategic investment for improving overall social outcomes. The Government of India is committed to ensuring quality healthcare for every mother and newborn and thereby reducing maternal and newborn mortality in the country. This is also highlighted in the National Health Policy, 2017 which aims at reducing MMR from current levels to 100 by 2020 and IMR to 28 by 2019.

Skilled and motivated nurse midwives play a key role in achieving positive health outcomes for mothers and children. According to the Lancet series on midwifery, evidence shows that safe and effective midwifery care (which includes family planning) can avert 83% of all maternal deaths, stillbirths and newborn deaths. 24% of pre-term births can be prevented through a model of midwife-led continuity of care, where there is a well-functioning midwifery programme. Midwifery led services can promote continuum of care thorough provision of women centric care, promoting natural birth, ensuring respectful maternal and newborn care and reducing maternal mortality much faster than current average annual reduction.

Following the introduction of LaQshya – Labor Room Quality Improvement Initiative, the guidelines for Midwifery Services in India pave the way for a transformational leap into quality childbirth care which will be available at healthcare facilities much closer to the communities. Recognizing the importance of midwifery care in India, the Ministry of Health and Family Welfare has developed these guidelines to rollout the midwifery cadre in the country. These guidelines entail all areas related to midwifery program such as education, regulation, human resources and career progression, support structures, operational models in aspirational districts and in urban areas and monitoring & research priorities. This guideline is also path breaking in that it provides an opportunity for career progression of nurse midwives through task shifting and strategic skill building.

I am confident that the states will ensure timely implementation of this guideline which aims to strengthen the midwifery cadre of the country thereby positively impacting the maternal and newborn health indicators in the long run.

(Manoj Jhalani)

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PROLOGUE

The Ministry of Health and Family Welfare, Government of India stands committed to ensure the wellbeing of mothers and children which is well demonstrated through its extensive health programmes under the National Health Mission and RMNCH+A strategic approach. The Government of India also recognizes that skilled nurses and midwives are critical to health system strengthening and healthcare delivery which significantly impact the health of women and children.

Global evidence highlights that investment in high-quality midwifery can prevent about two thirds of all maternal and newborn deaths — saving millions of lives every year. Learning from various experiences, the Government of India has taken a key policy decision to strengthen midwifery services in the country. The decisions include the introduction of midwifery led units in health facilities, strengthening of education and training of midwifery educators and providers and facilitating their integration into the health system.

Midwifery-led units in Medical Colleges, District Hospitals, FRU's and CHCs will enable healthy women and their newborns to experience high quality, respectful continuity of care provided by midwives who have been educated and trained to international standards.

Evidence indicates that the optimum duration of post-basic training to acquire needed midwifery skills and competencies is 18 months. Revision of the current Nurse-Midwife Practitioner (NPM) course duration and curriculum also enable the inclusion of the latest evidence-based guidelines for Antenatal Care, Intrapartum, Postnatal care.

The targeted audience for these guidelines are the program managers, state nodal nursing officers, state nursing directorates, nursing midwifery institutions and other key stakeholders. This will be a guiding document for planning, implementation and monitoring the interventions aimed at strengthening the midwifery cadre across the country.

I appreciate the efforts by the Maternal Health Division, Indian Nursing Council and contributing experts towards developing this guideline which is the need of the hour in ensuring that we have confident and competent nurse midwives who will work towards ensuring improved health outcome for individuals; families and communities.

(Vandana Gurnani)



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The guidelines – “Midwifery services in India” have been developed after consultation with various experts from nursing, maternal, newborn and child health divisions’ of the Government of India, regulatory body, professional organizations and various development partners. This document is a culmination of several years of efforts put in by various people who strived to improve midwifery practices in India.

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Baswal
8.12.18

(Dr Dinesh Baswal)

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Message



The Government of India's vision to expand the role of Nurses and Midwives is critical to achieve sustainable development goals. Inspite of exponential rise in institutional deliveries, we are still losing mothers and newborns. In such a scenario, the need is even more to expand the role of nurses and midwives to deliver quality healthcare. According to the lancet series on midwifery, universal coverage of essential interventions that fall within the scope of midwifery practice could prevent 83% of all maternal deaths, stillbirths, and neonatal deaths.

In today's dynamic and complex health environment, the role of nurses and midwives is evolving and changing. There is a growing need of well-trained nurses and midwives who are technically sound and specialised in various fields. Strengthening midwifery services can promote continuum of care thorough provision of women centric care thereby impacting key health indicators. In view of this, the Government of India has envisaged expanding the role of nurse practitioners in midwifery by developing these guidelines for strengthening midwifery services.

This platform will not only give these nurse practitioners an opportunity to provide quality respectful maternal and child health care but also the opportunity to exploit their full potential as skilled healthcare providers. Besides expanding their often prototypical facets as caregivers to technically acclaimed managers, it will empower the nurse practitioners in midwifery as leaders in tandem with the global movement of role expansion and empowerment of nurse and midwives.

It gives me immense pleasure for Indian Nursing Council to roll out the nurse practitioner in midwifery programme in India.


Dr. T. DILEEP KUMAR
President,
Indian Nursing Council

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ACRONYMS

CA	Competency Assessment
CAMT	Centres for Advanced Midwifery Trainings
EmOC	Emergency Obstetric Care
FRU	First Referral Unit
GNM	General nursing and midwifery
ICM:	International Confederation of Midwives
ICMR	Indian Council of Medical Research
INC	Indian Nursing Council
MDG	Millennium Development Goal
ME	Midwifery educator
MMR	Maternal Mortality Ratio
MoH&FW	Ministry of Health and Family Welfare
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIHFW	National Institute of Health and Family Welfare
NMR	Neonatal Mortality Rate
NMTF	National Midwifery Task Force
NMTI	National Midwifery Training Institute
NPM	Nurse Practitioner in Midwifery
NPMU	National Programme Management Unit
OSCE	Objective Structured Clinical Examination
RGI	Registrar General of India
RM	Registered Midwife
RMTIs	Regional Midwifery Training Institutes
RN	Registered Nurse
SDG	Sustainable Development Goal
SIDA	Swedish International Development Agency
SNC	State Nursing Council
SNCU	Special Newborn Care Units
SOMI	Society of Midwives, India
SRS	Sample Registration System
TFR	Total Fertility Rate
TNAI	Trained Nurses Association India

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CHAPTER - I

Introduction

Background and Rationale

India has come a long way in improving maternal and newborn health. The Maternal Mortality Ratio (MMR) of India has reduced from 301 maternal deaths per 100,000 live births in 2001–03 as per the Registrar General of India, Sample Registration System (RGI, SRS) to 130 maternal deaths per 100 000 live births in 2014–16 (RGI, SRS). As a result, India has achieved the Millennium Development Goal (MDG) in reduction of maternal and newborn mortality. This momentous achievement has been possible because of various interventions implemented under the umbrella of the National Health Mission (NHM). The NHM has provided much needed impetus towards reduction of maternal and newborn mortality. The total fertility rate (TFR) in India is 2.2 (National Family Health Survey- 4). At the same time, Indian public health system also experienced a rapid expansion of health care delivery infrastructure and phenomenal growth in the number of institutional deliveries. Still, this impressive increase has not led to an expected commensurate decline in maternal and neonatal mortality.

Nearly 32,000 pregnant women each year still lose their lives during pregnancy, childbirth and the postnatal period each year. In addition, 5,90,000 newborns die each year in the first month of life. The neonatal mortality rate (NMR) in India is 24 per 1000 live births whereas the early neonatal mortality rate is 18 per 1000 live births which is a serious cause of concern. Furthermore, there are disparities in distribution of these deaths based on socio-demographic variables such as education, socio-economic class, caste as well as differential geographies. Additional efforts are needed in India to increase Universal Health Coverage and to achieve the Sustainable Development Goals (SDGs) for maternal, newborn and child health.

One of the major contributors towards maternal deaths is poor quality of intrapartum care. As per the Lancet Newborn' series of 2014, the time around labour and childbirth accounts for almost 46% of maternal deaths and 40% of stillbirths and neonatal deaths occur. This suggests the need for improving quality of care during intrapartum period in public and private healthcare institutions.

Two major reasons for poor intrapartum care are either lack of trained service providers or over medicalization of the delivery process. Many pockets of populations within India face an acute shortage of trained human resources. The Rural Health Statistics of 2016 indicate that, against the requirement of 5,510 obstetricians at Community Health Centres across the country, only 1,859 are in place (34%). This is a similar situation for the deployment of paediatricians. This is because of the skewed presence of specialists in urban areas. Aspirational districts in India are further disadvantaged, with eight States having institutional delivery rate of less than 70%, and three States with institutional delivery of less than 52%. This includes the State of Nagaland with an institutional delivery rate of 32%.

Certain other areas of India, especially urban areas, are suffering from the over-medicalization of pregnancy and childbirth. As per the World Health Organization (WHO) guidance 2015, "at a population level, C- Section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates". However, the National Family Health Survey (NFHS-4) reports that C-Section rates in India have increased from 8.2% in 2006 to 17.2% in 2016. There are nine States in the country that currently have State C-Section rates of over 30%. The State of Telangana has experienced an extreme shift to over-medicalisation with a 58% C-Section rate in public facilities and a 75% C-Section rate in private facilities. This situation highlights the undeniable need to have an alternative model of delivery of care.

Disrespect and abuse of women during child birth acts as a deterrent for the women and her family to opt for institutional delivery. The Government of India has stressed "Promoting Respectful Maternity Care and Cognitive Development of Baby" under the LaQshya programme. However, respectful care is missing from the current nursing and medical curriculum.

Midwifery-led care can address these issues by promoting quality, continuity of care through provision of women-centric care and promoting natural birth. This model of care is well supported by global evidence.

Introduction to Midwifery

The provision of midwifery is witnessing long awaited increase in global attention. Recognizing the significant contribution made by midwives worldwide, many countries are giving centre stage to midwives in order to improve quality of care, reduce "over-medicalization" during child birth and increase efficient use of resources.

What is midwifery ?

"Skilled, knowledgeable and compassionate care for childbearing women, new-born infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and their families." (Lancet Series on Midwifery, 2014)

Who is a midwife?

"A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the International Confederation of Midwives (ICM) Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife' and who demonstrates competency in the practice of midwifery." (International Confederation of Midwives, 2015)

Why does India need midwifery?

Global evidence has shown that the introduction of midwifery care has historically translated into the increased availability of quality maternal and newborn health services, and significantly aided the reduction of maternal and newborn mortality and morbidity.

The State of the World's Midwifery Report 2014, which examined the midwifery workforce data across 73 low- and middle-income countries, calls for urgent investment in high-quality midwifery care. The 73 countries represented in the report account for 96% of global maternal deaths, 91% of stillbirths and 93% of newborn deaths. However, these countries have only 42% of the world's doctors, midwives and nurses. Of the 73 countries, only four have the workforce needed to provide the care needed by women and their newborns.

The WHO Statement on C-Section Rates (2015) describes that C-Section are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons. At population level, C-Section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates. This means that approximately 85% of pregnancies and births do not require specialized obstetric intervention. The Lancet Series on Midwifery (2014) notes that 87% of services can be provided by midwives, when educated to international standards. Midwifery care includes the entire continuum of care for women as well as newborn care, breastfeeding, family planning and screening women for HIV infection, tuberculosis and malaria. As midwives are often the first point of contact for women with the health system, early signs of non-communicable diseases can be detected through routine antenatal check-ups.

A Cochrane Review on "Midwife-led continuity models vs other models of care for childbearing women" (2016) provides evidence that midwife-led continuity of care can result in a 24% reduction in pre-term birth, a significant reduction in episiotomy, instrumental birth or use of pain relief while increasing psychological support for women.

In summary "*Midwifery is associated with improved efficient use of resources, and outcomes when provided by midwives who are educated, trained, licensed and regulated, and that midwives were most effective when integrated into the health system in the context of effective teamwork, referral mechanisms and sufficient resources.*" (Lancet Series of Midwifery, 2014)

Thus midwifery care introduces a system level shift from fragmented maternal and newborn care focused on identification and treatment of pathology, to skilled and compassionate woman-centric care.

Experience from Midwifery Care

SWEDEN

Sweden has a rich history of midwifery for over 300 years. It is a vast country with a sparse population making the availability of doctors to rural populations difficult in the past. Systemic midwifery programme was developed and scaled up in the entire country. Sweden's national health strategy includes giving midwives and doctors complementary roles in maternity care and equal involvement in setting public health policy resulting rapid decline in MMR. Currently, Sweden has one of the lowest MMR in the world.

SRI LANKA

During the 1950s, most births in Sri Lanka took place at home with the assistance of untrained birth attendants. By the end of the 1980s though, over 85% of all births were attended to by skilled personnel, mainly community-based midwives. The number of trained midwives increased 20 fold from year 1941 to 2000. These midwives were backed by a good referral system and supportive health policies. MMR of Sri Lanka declined from 600 in 1950 to 30 in 2015.



History of Midwifery in India

Several attempts have been made to formally introduce midwives into India's health system. A post basic course, known as the Nurse Practitioner in Midwifery (NPM) course, was instituted by the Indian Nursing Council (INC). In 2000-2003, with support from the 'India – Australia Training and Capacity Building Project', a curriculum for the NPM was prepared, with the aim to provide nurses with advance knowledge, skills and attitudes which allow them to become safe and competent NPMs who can practice independently in rural areas. The duration of the course was 18 months (including 6 months internship) and was developed using the essential competencies set out by the ICM. The INC also developed midwifery practice and clinical standards. This initiative was pilot tested in the State of West Bengal. Two batches of training were conducted and 12 candidates who passed out of this course were posted as NPMs and were offered a remuneration equivalent to that of Assistant Nursing Superintendent.

The "Inter-Institutional Collaboration between Institutions in India and Sweden for Improving Midwifery and Emergency Obstetric Care (EmOC) Services in India" project 2007-13 was carried out by collaboration between State governments, the Indian Institute of Management – Ahmedabad (IIM-A), the Society of Midwives, India (SOMI), the Trained Nurses Association, India (TNAI), the Advanced Nursing Society (ANS), the White Ribbon Alliance, India (WRAI) supported by the Swedish International Development Agency (SIDA), the Karolinska Institute, and the Swedish Midwifery Association. The objectives of the project were: capacity building to improve midwifery skill; research and advocacy; pilot testing to develop a midwifery focused model of care; policy analysis, and networking. Five Centres for Advanced Midwifery Trainings (CAMT) were established in four States with advance skills laboratories, training equipment, mannequins, audio-visual teaching aids and well-equipped libraries. Fifteen senior faculty members (9 in 1st batch and 6 in 2nd batch) teaching midwifery and maternal health related subjects were nominated by the State governments and were given three months training, part of which was in Sweden. In addition, the tutors were regularly mentored and given additional skill training on site. The project was successful in increasing visibility of midwifery care at policy level and was partially successful in bringing midwifery to the focus of programme managers in the four States. Adequate mechanisms were not put in place for sustainability and scaling-up for systemic integration into the health system.

Recently, the INC re-introduced the Post Basic Diploma in Nurse Practitioner in Midwifery, a one year course in midwifery post BSc nursing training. The course was adopted by the States of West Bengal and Gujarat. Examples of past experiences and current on-going midwifery trainings from various States are indicated in Table 1.

Table 1: Examples of Midwifery training courses in India from various States

State	Project	Current situation
West Bengal (2002/ 2011)	India-Australia Training and Capacity Building project" In 2002, the first course of 18 months training in Nurse Practitioner Midwifery started under the India-AusAID project, based on curriculum developed by INC. Twelve posts of NPM sanctioned by the State Government. Total two batches of training conducted. In 2011, West Bengal implemented the One Year Post Basic Diploma in Nurse Practitioner in Midwifery.	Training stopped after two batches. Twelve candidates posted in PHCs and BPHCs.
Andhra Pradesh (AP), West Bengal (WB), Gujarat and Tamil Nadu	Beginning with the NPM course in two States (West Bengal & Gujarat), five CAMT centres were established in four States with 12 month training course. Fifteen senior faculties underwent a three-month advanced tutor course, some of which was in Sweden. In Gujarat, training of NPM for one year led to a separate cadre of NPM equal to Matron class 3.	Midwifery visibility increased, however the initiative was not scaled up.
Telangana (2011/2014/2017)	In 2011, the Professional Midwifery Education and Training Programme were conducted by Fernandez Hospital. In 2014 Fernandez Hospital was accredited to initiate the Post basic Diploma in NPM with 10 seats. In 2017, the Government of Telangana initiated a tripartite partnership between State Government, UNICEF and Fernandez Hospital to train nursing students in midwifery using 18 months course based on ICM competencies. Training of first batch is going on. Training is supported by NHM. Total 126 posts of midwives created by the State Government.	Training is going on.
Madhya Pradesh (2016)	Eighteen months training on Midwifery is going on for four nurses at private institute, Choitram Hospital, based on ICM competencies. No involvement of State Government.	Training is going on.

Key Learnings from the History of Midwifery in India

Before introducing midwifery, it is critical to understand the reasons for partial success/ failure of the earlier attempts to establish midwifery programme in India. Based on the opinions of experts, it was that following facts which affected the success of the midwifery cadre in India:

- ☒ **Role Clarity of NPM and their Integration into the Existing Heath System:** The ill defined roles of midwives, AMNs and staff nurses posed a challenge to integrate midwives as a separate cadre in the health system.
- ☒ **Career Progression of NPMs:** Similarly midwives were introduced into the health system, a career progression pathway was not adequately mapped out making it difficult for the newly introduced NPMs to move forward as an independent cadre.
- ☒ **Lack of Legal and Regulatory Framework:** One of the most important and critical reason affecting the success of the midwifery cadre in India was the lack of regulatory framework. None of the States were successful in establishing a legal framework to protect and guide midwifery programme and allow NPMs to work independently.

- ✓ **Training of Midwives:** A rapid evidence synthesis and a consultation of experts during a National Midwifery Task Force (NMTF) concluded that in order to build competencies of midwives to deliver quality care, additional post basic education and training is needed. This requires an evidence supported 18-month training encompassing both theory and practical sessions as well as competency-based training sessions.

A rapid evidence review of the current one year NPM curriculum and the ICM competencies indicated several areas that require additional time as indicated in Table 2.

Introduction to New Guidelines

Considering the need for trained human resources to provide quality care to 30 million pregnancies every year in India and at the same time recognizing the challenges earlier, it is essential to propose an alternative model of service provision for strengthening reproductive, maternal and neonatal health services in India.

Recognizing that midwifery care in India can further serve as cost-effective and efficient model to provide quality care and reduce over medicalization, the Ministry of Health and Family Welfare (MoH&FW) has developed these guidelines for midwifery care in India.

The present guidelines, prepared based on a series of in-depth consultations with National and International experts, are developed to support various States in roll out of midwifery services. These guidelines will cover all areas related to midwifery programme such as education, regulation, human resources and career progression, support structures, operational models in aspirational districts and in urban areas, and monitoring and research priorities.

These guidelines include the introduction of midwifery model of care for normal births in midwifery-led units of public health facilities. They also include guidance for education and training of midwifery educators and NPM in line with international standards of skills and competencies. They also provide options to integrate this model of care in the current public health system to contribute to achieving the SDGs.



Table 2: Specific areas and/or gaps in the current curriculum in Nurse Practitioner in Midwifery identified that require inclusion and additional time (6 months) to reach ICM standards

Competencies		International Confederation of Midwives (ICM, 2013)	Nurse Practitioner in Midwifery Course Gaps
1	Social, epidemiological and cultural context	Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families.	Additional time required for: <ul style="list-style-type: none"> <i>Human rights, gender-based violence (GBV)</i> <i>Respectful care: non-judgmental, non-discriminatory behaviour</i> <i>Community audit and death case review</i>
2	Pre-pregnancy care and family planning	Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.	Additional time required for: <ul style="list-style-type: none"> <i>Cultural sensitivity/cultural appropriateness</i> <i>GBV, emotional abuse and physical neglect</i> <i>Female genital mutilation</i>
3	Care during pregnancy	Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.	Additional time required for: <ul style="list-style-type: none"> <i>Malaria in pregnancy</i> <i>Birth planning</i> <i>Prevention of smoking, alcohol abuse, drug abuse</i>
4	Care during labour and birth	Midwives provide high quality, culturally sensitive care during labour, conduct a clean and safe birth and handle selected emergency situations to maximize the health of women and their newborns	Additional time required for: <ul style="list-style-type: none"> <i>Provision of safe environment for mother and infant to promote attachment/bonding</i> <i>Evidence indicates lack of skills in addressing pre-eclampsia/eclampsia</i>
5	Postnatal care: women	Midwives provide comprehensive, high quality, culturally sensitive postpartum care for women.	Additional time required for: <ul style="list-style-type: none"> <i>More skills needed in general</i> <i>Attachment and bonding</i> <i>Care for bereaved families</i> <i>Postnatal mental health</i>
6	Postnatal care: newborn	Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.	Additional time required for: <ul style="list-style-type: none"> <i>Skin-to-skin contact, rooming-in</i> <i>Breastfeeding support</i> <i>Care for bereaved families</i>
7	Abortion-related care	Midwives provide a range of individualized, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.	Additional time required for: <ul style="list-style-type: none"> <i>Psychological support</i>



CHAPTER - 2

Goal, Objectives & Principles

Goal

The 'Midwifery Services Initiative' aims to create a cadre of Nurse Practitioners in Midwifery who are skilled in accordance to ICM competencies, knowledgeable and capable of providing compassionate women-center, reproductive, maternal and newborn health care services and also develop an enabling environment for integration of this cadre into the public health system, in order to achieve the SDGs for maternal and newborn health.

Objectives

- To provide access to quality maternal and newborn health services and promote natural birthing by promoting positive child birthing experience
- To promote respectful maternity care throughout pregnancy and child birth
- To identify, manage, stabilize and/or refer as needed, women and their newborns experiencing complications
- To decongest higher level of healthcare facilities
- To expand access to quality maternal and neonatal services in remote areas including pockets of high home delivery rates and urban slums

What is positive childbirth experience?

A positive childbirth experience is defined as one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff. It is based on the premise that most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed or wanted. (WHO)

Broad Principles of the Midwifery Initiative

1. How midwifery services will be organized

- ✓ Midwifery services must first operationalized within the public health system and these guidelines must be used for integrating midwifery cadre into the public health system
- ✓ Midwifery care will be integrated through the introduction of Midwifery-led Care Units, to be established at selected LaQshya certified high case load public health facilities. It is envisaged that midwives must only be involved in providing maternity care based on the scope of work defined by the Government of India. Midwives will be the first point of contact for pregnant women in areas where a midwifery-led unit is functional. At the outset, all pregnant women will be screened by NPMs using well defined criteria. Only women who are identified as being without complications will have access to midwifery-led care.
- ✓ Quality midwifery-led care provides positive outcomes for most women experiencing normal childbirth, and for their newborns, with the identification and referral of women and newborns experiencing complications to higher levels of medical care. Midwifery-led care encourages task shifting from doctors to midwives in relation to promotion and conduction of physiological normal births, and reduces unnecessary interventions including caesarean sections. Pregnant women identified with complications will be referred to a medical officer or specialists for further management. It is critical that strong referral linkages to First Referral Unit (FRU) and Special Newborn Care Units (SNCUs) are established to support Midwifery Care Units. The referral units should be accessible within a short period of time.
- ✓ The NPM will be responsible for the promotion of the health of women throughout their lifecycle, with special focus on women during their childbearing years and their newborns. She will be responsible for providing care to healthy women prior to pregnancy, during pregnancy, childbirth, and the postnatal period (for the mother and her newborn) and will assume responsibility and accountability for his/her practice. NPMs will be able to promote safe, natural birthing processes through providing respectful maternal, newborn and post-abortion care.
- ✓ To facilitate the integration of NPMs into the public health system, current medical and nursing staff, and communities will be sensitized to midwifery care in advance.

2. Who would be a Nurse Practitioner in Midwifery in India?

- ✓ The NPM is a registered nurse-midwife with an additional 18 months of post basic training in midwifery.
- ✓ Generally, 'in service' candidates who are GNMs/BSc level staff nurses with 2 years of experience in maternity care are eligible for 18 months NPM training. This training will enable them to combine high quality clinical skills with evidence-based decision making.
- ✓ While the regular staff selected for training is away for 18 months residential course, replacement with contractual staff shall be considered so as not to compromise service delivery for women and newborns.
- ✓ If contractual candidates are selected for NPM training, their continuity within the system must be secured with the help of a service agreement.
- ✓ The education and training of NPMs must be carried out at accredited NPM Training Institutes recognized by INC. Training must be skill based and should be in accordance to the 'Essential Competencies for Midwifery Practice (2018 Update)' defined by International Confederation of Midwives for a total duration of 18 months.

- It is envisaged that in the first phase, one National Midwifery Training Institute (for education and training of educators) and five Regional Midwifery Training Institutes (for training of NPMs) would be established and accredited for provision of this course. NPM graduates will be certified by the INC.
- The Nurse Practitioner in Midwifery will be responsible for the promotion of the health of women throughout their lifecycle, with special focus on women during their childbearing years and their newborns. She will be responsible for providing care to women prior to pregnancy, during pregnancy, childbirth, and the postnatal period (for the mother and her newborn). The NPM will be responsible and accountable for his/her practice.

3. An additional 3 months education and training of educators to teach the 18-month NPM course

Educators with previous experience in advanced midwifery education may be selected to undergo a 3 months midwifery educator course. This course will new recommendations – WHO Guidelines on Antenatal Care, Intrapartum Care, Postnatal Care, family planning and safe abortion and post abortion care.

4. Deployment and career progression

At the time of selection of candidates for the NPM course, the State must pre-determine the place of posting (healthcare facility) of these candidates. It is mandatory that the state must issue the posting order before the commencement of the training. Written consent must be obtained from the candidates mandating them to join at the place of posting and also mandating that they continue their services after qualifying as an NPM for a minimum period of six years. Midwives can be posted at remote facilities only after they have developed their competencies for three years at high case load facilities.

During clinical service, NPMs will only provide midwifery care and will not be rotated to other areas of nursing care. This will ensure NPMs retain the specific skills, prevent attrition of NPMs and improve quality of care for women and their newborns. The introduction of NPMs must be associated with a defined career progression path.

5. Regulation, Monitoring and Evaluation

INC and State Nursing Councils (SNCs) would be responsible for certification, regulation and legal protection to the NPMs. The NMTF will develop the monitoring and mentoring framework to support midwives and will also develop a mechanism for independent evaluation of the midwifery initiative.

6. Institutional arrangements

The National and State Midwifery Task Forces will be established under the leadership of the MoH&FW and State governments to steer the Midwifery Initiative. Sub-task groups will be formed to address specific technical issues. International and national collaborations would be established and strengthened for effective roll out of the Midwifery Initiative.



CHAPTER – 3

Strategic Framework

The following model for Midwifery Services in India has been prepared based on key learnings from the current and past experiences as well as in-depth consultations with national and international experts. The model focuses on integration of midwifery services into the public health system.

Selection of Candidates for Nurse Practitioner in Midwifery Training

- In order to be selected for the NPM training programme the candidates must:
 - Have a GNM (General Nursing and Midwifery) diploma from a recognized institute/BSc Nursing degree from a recognized university
 - Be a registered nurse and registered midwife (RN & RM)
 - Have at least two years of experience of conducting deliveries or experience of working in the concerned field
 - A midwife from other countries must obtain an equivalence certificate from INC before admission to this course
- Candidates must pass an Objective Structured Clinical Examination (OSCE) based competency assessment to qualify for the Midwifery Training Programme. Detailed guidelines for the competency assessment would be provided by the National Midwifery Training Institute.
- Candidates must pass an aptitude test in order to qualify for the Midwifery Training Programme. Detailed guidelines for the aptitude test would be provided by the National Midwifery Training Institute (NMTI).
- An entry test may be required to assess literacy skills and comprehension, including language, if the curriculum is presented in a second language.
- It is consistent with an ethical foundation for midwifery practice that a student does not have a current health condition that could be transmitted to the woman and her infant during the usual and customary delivery of health care services. Thus, the student shall be physically fit.

Type of Candidates

- For post basic 18-months residential Midwifery Training Programme, staff nurses from the regular/in-service cadre shall be prioritized. While the regular staff is away during the 18-month course work, replacement with a contractual staff shall be considered so that healthcare services at the level of facility are not compromised.
- However, if the State decides to select/recruit contractual staff nurses for the Midwifery Training Programme, candidates would be expected to agree to six years of service in the field of midwifery practice. NMTF would be expected to share a model agreement for adaptation at the State level. This agreement would also apply to in-service government candidates.

Curriculum and Training Duration

- The current one year NPM course would be revised to 18 months in accordance to the ICM standards. INC would undertake this exercise in consultation with the MoH&FW. The Nurse Practitioner in Midwifery course curriculum would be approved by INC and MoH&FW before roll out of the programme.
- Training curriculum would be based on the "Essential Competencies for Midwifery Practice (2018 Update)" defined by ICM. Training would comprise of theory, simulation as well as practical sessions in clinical areas. The training duration would be of 18 months and it would be a strictly residential training.

Integration of Midwives into the Public Health System

Successful implementation of midwifery programme in any State will depend mostly on successful integration of midwives into the existing health system. It is strongly discouraged to create parallel vertical programme for midwifery. The best way to ensure long term sustainability of midwifery programme is to integrate them into the system.

Posting of Nurse Practitioners in Midwifery

Midwifery-led care Units at high case load facilities

It is envisaged that 'Midwifery-led Care Units' would be established at 'LaQshya' certified high case load public health facilities and candidates trained under the midwifery programme would be posted at these units to provide 24x7 delivery services. It is essential that midwives are posted as a unit and not as individuals, as tangible effect of the midwifery programme on the quality of care can only be established/measured, if Midwifery-led Care Units are set up. Accordingly posting of midwives should be based on the case load of the facility. However the following minimum number must be ensured at corresponding levels of facilities:

- Medical Colleges: Minimum of 16 -18 midwives to be posted
- District Hospital: Minimum of 6-8 midwives to be posted
- Sub District Hospital/ Community Health Centre- Minimum 4 midwives to be posted

The State should ensure posting of the selected candidates at pre-identified 'Midwifery-led Care Unit' before the commencement of the midwifery training. Written consent must be obtained from the candidates mandating them to join at the place of posting and also mandating that they continue their services for a minimum period of three years.

The NMTF would share guidelines regarding the structure and design of the Midwifery-led care unit. Financial support for establishing these units would be provided under the NHM.

Primary Health Centres and Urban Primary Health Centres conducting deliveries

It is envisaged that in the first phase NPMs would only be posted at Medical Colleges/District Hospitals/Sub-district Hospitals/ Community Health Centres. After three years of posting at the Midwifery-led Units, NPMs may be posted at 24X7 PHCs/ Urban PHCs remote locations with high home deliveries/ for a maximum of 3 years, following which they would be posted back at the midwifery-led care units. While posting midwives at remote locations/ Urban PHCs it should be ensured that a minimum of four midwives are posted at such facilities. It is re-emphasized that midwives should not be posted individually and should always be considered as a unit. In such cases, appropriate and adequate incentives must be provided to midwives.

Range of Services to be Provided by Nurse Practitioners in Midwifery

- ⦿ Midwifery facilitates development of gate-keeping mechanism by catering to most of the normal childbirths and referring only the complicated cases to higher healthcare facility.
- ⦿ Midwifery care encourages task shifting from doctors to midwives in relation to promotion and conducting of physiological normal births.
- ⦿ Midwives will be the first point of contact for pregnant women in areas where midwifery-led unit is functional. At the outset, all pregnant women will be screened using well defined exclusion criteria. Only eligible women will have access to midwife-led care.
- ⦿ Pregnant women identified with complications will be referred to a medical officer or specialists for further management. The midwife will follow model of continuum of care to provide services to pregnant women ranging from family planning, ANC, delivery, PNC to safe abortion services. Midwife will promote natural birthing process with Respectful Maternity Care. An overview of the scope of practice would include:

1. General competencies

- Midwives act as advocates for respectful care in pregnancy, labour and childbirth, and post-partum
- Recognize abnormalities and complications and implement appropriate treatment and care
- The midwife will work in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the post-partum period up to six weeks, to facilitate births and to provide care for the newborn
- The midwife will also educate women – individually or in groups – so that they have knowledge about how to have a healthier pregnancy and a better birth
- Midwives plan the care of the mother, and this involves assessing, planning, evaluating and implementing
- Midwives may also work inter-professionally; with doctors, nurses, and other health care providers as part of a maternity care team
- Midwives will teach and mentor others

2. Pre-pregnancy and antenatal care

- Family planning , monitoring the progression of pregnancy
- The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies deviations or complications that may arise in mother and baby, obtains appropriate medical assistance, and implements emergency measures as necessary. When women require referral, midwives will provide midwifery care in collaboration with other health professionals.

3. Care during labour and childbirth

- Promote normal birth with respectful care
- Manage safe and spontaneous vaginal births and prevent complications. Stabilizing emergencies and referral as necessary and provide immediate care of newborn

4. Ongoing care of the women and newborns

- Provide postnatal care for the woman, and newborn including breastfeeding
- Detect, stabilize and refer postnatal complications in woman and newborn
- Midwives will ensure that (unless there are contraindications), the mother has skin-to-skin contact with her baby immediately after the birth, and maintains that for as long as she wants.
- Provide immediate postpartum family planning
- Midwives will work independently and will be supervised and supported by on duty Medical Officer/Specialist when complications are identified. It is critical that well established referral linkages to FRUs and SNCUs are established to support Midwifery Care Units

5. Referral linkages

- Forward linkage with higher healthcare facility
- Backward linkage or integration is limited to building capacities of ANMs, HSCs, PHCs and Health and Wellness Centres staff for early identification of complication and timely referral, or for home deliveries
- Public-private partnerships with established linkages can be explored in hard-to-reach and tribal areas to increase access to healthcare facilities

Administration at the Select Healthcare Facility for Midwifery-Led Healthcare

- The administrative supervisor for the Midwifery-led Care Units would be the Chief Midwifery Officer/ Midwife demonstrating team spirit and leadership qualities. To prepare them for this role, a short training programme on leadership skills would be imparted.
- A supervisor with clinical skills will be preferred for this role to hand hold and understand the clinical challenges of the staff. The supervisor will be directly reporting to the Medical Superintendent of the attached hospital. The supervisor will be responsible for administrative arrangements.

Preparing the Health Care Facility for Midwifery-Led Unit

- Integration of Midwifery service (NPMs) into the public health system would be facilitated by sensitizing State, district and facility level staff and the communities to help smooth integration of midwives.

- Sensitization of obstetricians, pediatricians and medical officers as well as sensitization of field functionaries on roles and responsibilities of the midwifery personnel is critical.

Branding

- Each State can take a lead to promote midwifery care services considering their social and economic demography.

Financial Arrangement for Setting up Midwifery-Led Care Units

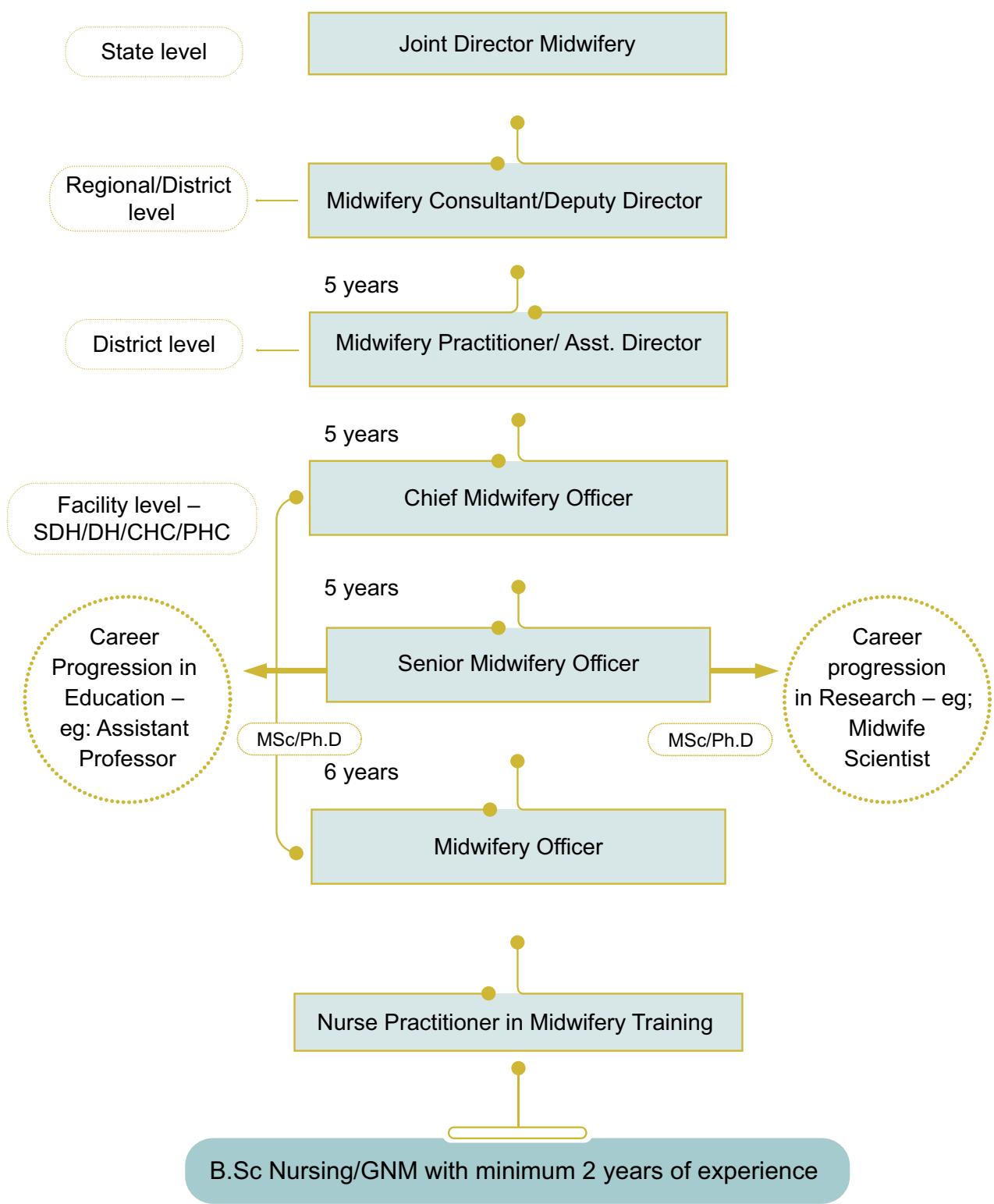
- Financial support for establishing these units would be provided under NHM through the annual programme implementation plans for NHM.

Career Progression of Nurse Practitioner Midwives

- NPMs will have a clear line of career progression defined in line with the current nursing cadre. After completing the training, s/he shall be posted as Midwifery Officer. S/he shall be posted at higher level than the Nursing Officer/Staff Nurses of similar qualification and experience and shall be given additional increments. Those posted in Aspirational Districts and hard-to-reach areas shall be given suitable allowances. However, the selected candidate has to go through a mandatory competency assessment at regular intervals (at the time of selection, completion of the course and then subsequently every year linked with Annual Performance Appraisal and before promotion).
- The recruitment / service rule shall include competency test and competency assessment would also be a critical part of the Annual Performance Appraisal. To encourage strong and willing candidates to join midwifery services and to attract experienced senior nursing staff working in midwifery, the respective State governments can build special incentives in place and invite open nominations. However, an in-service staff shall be preferred for this course.
- An indicative/ suggestive career progression path for midwives is outlined below which could be adapted to suit State specific context and requirements:



Fig.1: Illustrative Career Progression Pathway for Nurse Practitioner Midwives



Regulation and Certification of Nurse Practitioner Midwives

- The ultimate aim of regulation is to allow nurse midwives to practice autonomously and provide full range of midwifery care efficiently. Currently, INC is regulating the midwives in the country. Further, INC is in the process of amending the 1947 Act. Under the new amendment, INC will be renamed as 'Indian Nursing and Midwifery Council'.
- **Revised NPM Curriculum:** The revised NPM course curriculum approved by INC and MoH&FW shall be implemented uniformly at all training institutes to achieve all relevant competencies
- **Certification:** Examinations to be conducted as per the criterion given by INC which include internal and external assessment.
- A Post Basic Diploma will be awarded upon successful completion of the midwifery training. The diploma will confirm that:
 - The candidate has completed the prescribed course of Post Basic Diploma in Midwifery;
 - The candidate has completed the prescribed clinical experience;
 - The candidate has passed the prescribed examination conducted by the INC recognized State Nursing Examination Board/University.
- Post-certification, the SNC will be able to register the pass candidates with additional qualification. Live register will be maintained in SNCs for all the State registered NPMs.
- SNC will be responsible to call these (pass) candidates (will be called Midwifery Officer in the document now) every 5 years for re-registration. Each re-registration is linked to the promotion of the Midwifery Officer after passing the competency assessment.
- The SNC, through INC, must involve the MoH&FW at State level during the CA tests. A third party evaluation of the entire CA test process is recommended to be done every time. The report shall be shared with the Maternal Health Division, MoH&FW.





CHAPTER - 4

Education and Training of Nurse Practitioners in Midwifery

Education and training of the Nurse Midwifery Practitioners would be conducted at the National and Regional Midwifery Training Institutes identified by the NMTF. The NMTI would fundamentally focus on a three-month training of midwifery educators. Midwifery educators in turn would then be engaged for the 18-month training of NPMs at the Regional Midwifery Training Institutes (RMTIs).

National Midwifery Training Institute

For the Midwifery programme, the National Midwifery Training Institute shall be established in an existing College of Nursing which has the necessary infrastructure such as Maternal and Child Health labs, classrooms and other facilities such as a library. The training institute would be further strengthened through collaborations and partnerships with various international and national institutions of repute for transfer of expertise, student exchange programmes, faculty learning, research activities, innovations etc. The Government of India with the support and criteria defined by the NMTF would identify the National Midwifery Training Institute. Maternal Health Division, MoH&FW has established National/State Nodal Centres of nursing excellence under the Pre-Service Education strengthening programme. The centres have been accredited under the programme and have been found to fulfil the above mentioned criteria. In view of this, and in order to build upon the Government of India past investments on these institutions, it is suggested that the Kasturba Nursing College at Wardha, Maharashtra, should be strengthened as the National Midwifery Training Institute. However, the National Midwifery Task Force may identify any other centre that meets the criteria for the National Institute.

Key Requirements of the National Midwifery Training Institute

- College of Nursing comprising of:
 - Parent hospital for hands on training
 - Skill laboratories/Simulation laboratories
 - One additional classroom/seminar room for conducting theory training
 - Library with all the necessary books and Gol modules as per the Indian Nursing Council guideline
 - Computer laboratory with all necessary equipment

- One additional room as office of Midwifery staff
- Accommodation facilities for midwifery educators
- Labour room of the attached parent hospital must be LaQshya certified. The facility should have delivery load of more than 3000- 4000 deliveries/year and also have a 100- bedded MCH wing.
- Adequate set of equipment and instruments as per LaQshya and Standardized Labour Room guidelines.
- Required drugs and consumables for family planning programme and newborn care should also be available for example, Intrauterine Contraceptive devices, vitamin K, zero dose vaccinations such as Hepatitis B etc.
- A dedicated and motivated team.

Roles and Responsibilities of National Midwifery Training Institute

The primary role of the NMTI is to conduct training of Midwifery Educators (ME) who would further be posted to train NPMs at identified Regional Training Institutes. The key responsibilities of the NMTI are outlined below:

- Engage appropriate faculty for training of Midwifery Educators in collaboration with National Midwifery Task Force.
 - In the past, in order to establish the Centres for Advanced Midwifery Trainings (CAMT), certain candidates were trained as midwifery tutors. During the engagement of the faculty for the training of Midwifery Educators, priority should be given to such candidates who have already undergone trainings as midwifery tutors, provided they meet the competency assessments as per WHO Midwifery Educator Core Competencies (2011).
 - Foreign nationals will be given temporary license by INC for tutoring (theory and clinical), research and voluntary work in the area of midwifery.
- Conduct national level training of Midwifery Educators
 - NMTI would conduct 3 months training of Midwifery Educators in order to strengthen their technical knowledge, clinical skills and facilitation skills. The training curriculum should be aligned to the WHO Midwifery Educator Core Competencies (2011) and the evidence in the latest WHO guidelines.
 - Midwifery Educators would be trained by a judicious mix of expert International and National level trainers.
 - Additionally, the midwifery educators will also undergo internal assessors and service provider's trainings under National Quality Assurance Programme & LaQshya- Labor Room Quality Improvement Initiative.
- NMTIs could also be involved in direct training of Nurse Practitioner Midwives
- Monitoring and supportive supervision of the RMTIs and the Midwifery Initiative. NMTI is expected to act as the repository of the information and data received from the RMTI including attendance, feedback, OSCE scoring and share regular updates with the National Midwifery Task Force.
- Research and Evaluation of the Midwifery Training Programme – the NMTI will position itself in the fields of both basic and applied research in Midwifery care. They will be the epicentre for Midwifery care research through activities such as:

- a. Conducting trainings on research principles
 - b. Participating in cross learning research programmes with other research institutions
 - c. Providing small grants or scholarships to budding student researcher
 - d. Undertaking fellowship programmes for midwives
- ⦿ Establish strong collaborations with international/ national institutes

Monitoring of NMTI: The National Midwifery Task Force would monitor the activities of the NMTI.

Funding Mechanism: The funds required for the NMTI can be divided into the following major heads:

- ⦿ One time grant for strengthening the centre
- ⦿ Operational costs for running the centre
- ⦿ Training cost for Midwifery educators

All above costs are proposed to be met by the Government of India initially for two years from Central funds. Funding mechanism to be reviewed after two years.

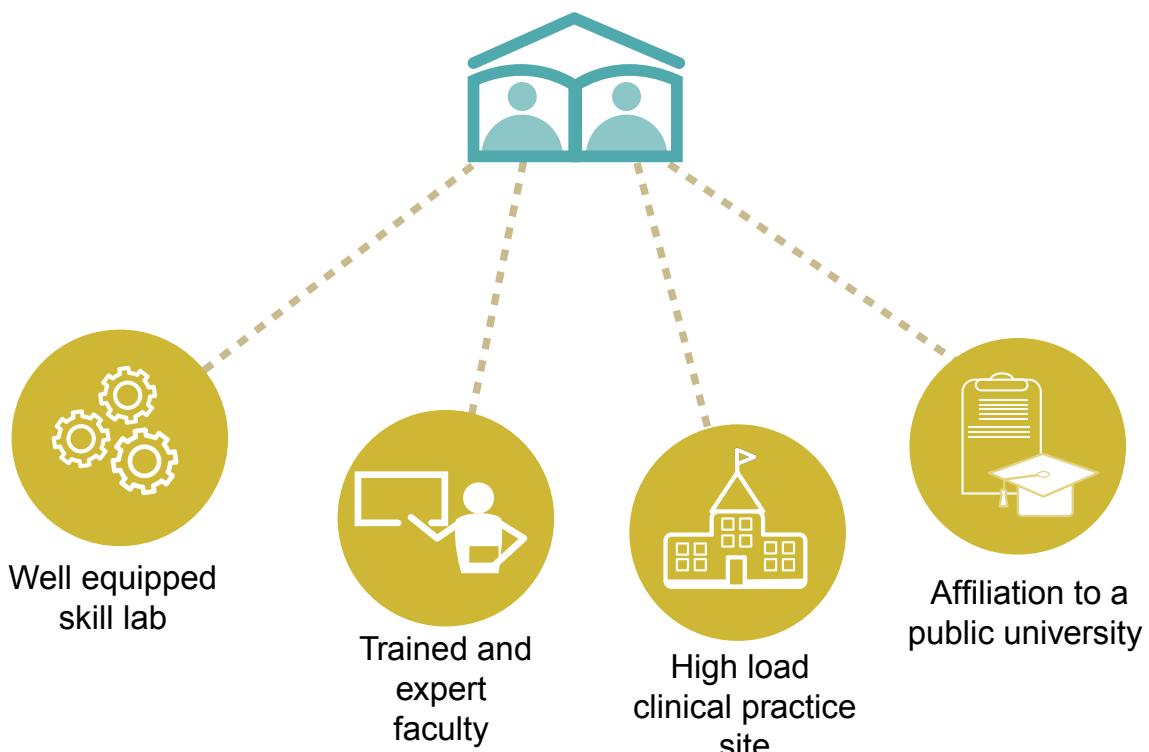
Accreditation: Accreditation of the NMTI would be conducted at the outset and every 2 years based on criteria defined by the National Midwifery Task Force.



Regional Midwifery Training Institutes

The Ministry of Health and Family Welfare, Government of India, plans to establish five Regional Midwifery Training Institutes, in existing Colleges of Nursing ,established under the pre- service education strengthening programme, which would offer the specialist NPM course to the selected candidates. The essential criteria for setting up of a Regional Training Institute for Midwifery would include state-of-art training infrastructure, access to a functional Obstetric department, attached high load clinical practice site, pool of trained educators and midwifery experts, willingness to initiate a new course and affiliation to a public university for certification of graduating midwives. It is envisioned that these RMTIs will serve as model teaching institutions and pedagogic resource centers for the midwifery training.

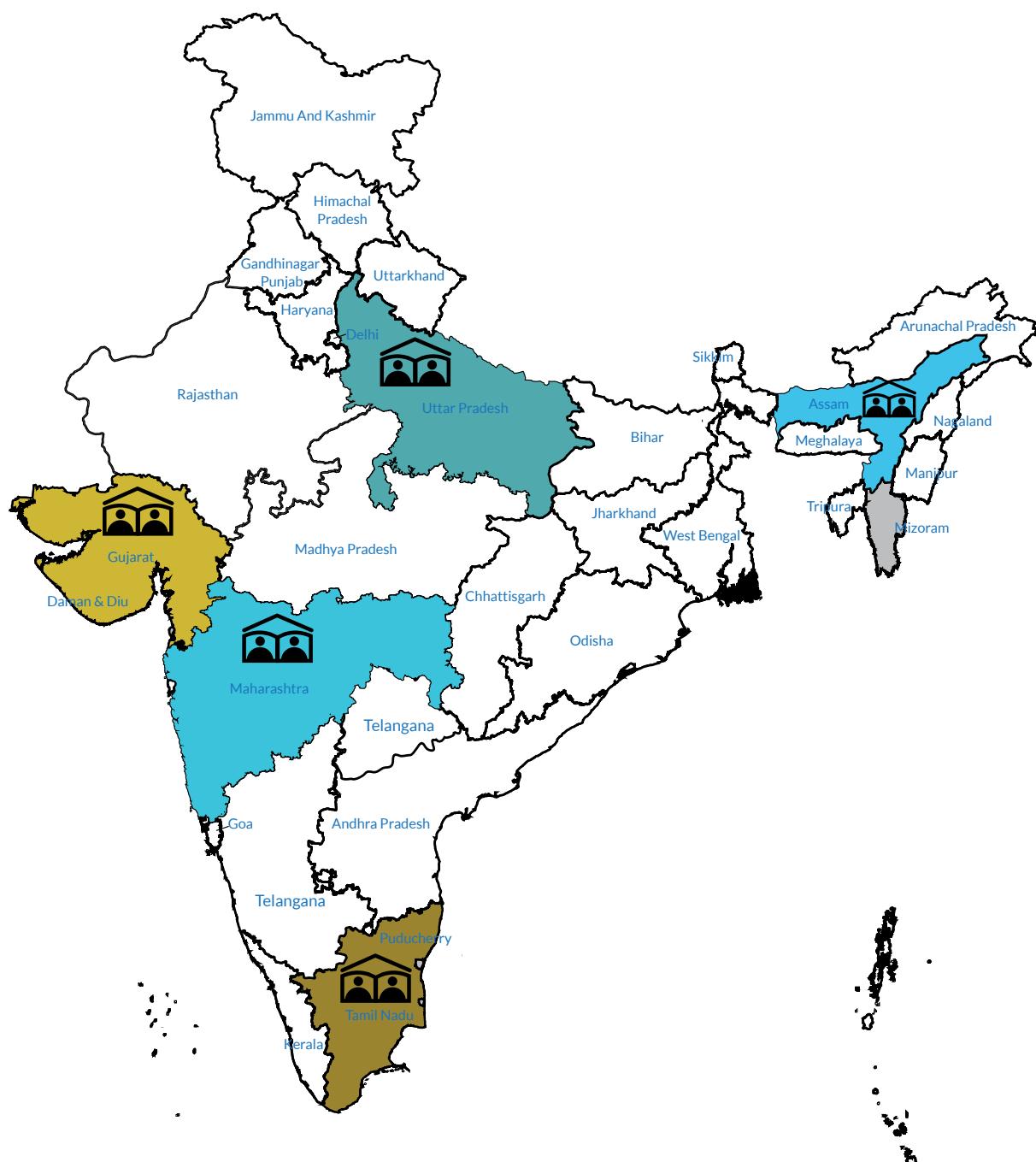
Fig 2. Essential Criteria of a Regional Midwifery Training Institute



In the first phase, the following five Nodal Centres may be upgraded into Regional Midwifery Training Institutes:

- Regional College of Nursing Guwahati, Assam
- Kasturba Nursing College, Wardha, Maharashtra
- Government College of Nursing, Vadodara, Gujarat
- College of Nursing, Madras Medical College, Chennai, Tamil Nadu
- College of Nursing Varanasi, Banaras Hindu University, Uttar Pradesh

Fig 3. Locations of Regional Midwifery Training Institutes



Although the above mentioned institutes have been identified currently, the commitment of the State Governments to implement the midwifery programme would be the deciding factor for development of these State Nodal Centres into RMTIs. Additionally/ alternatively, the remaining State Nodal Centres could be converted into RMTIs if the respective State Governments showcase their commitments to the introduction of Midwifery Programme

Key Requirements for the Regional Midwifery Training Institutes

The Regional Midwifery Training Institutes where the NPM course is being established should comply with requirements as defined below

- College of Nursing comprising of:
 - Parent hospital for hands on training
 - Skill laboratories/ Simulation laboratories
 - One additional classroom/seminar room for theory sessions
 - Library with all the necessary books and GoI modules as per the Indian Nursing Council guideline
 - Computer laboratory with all necessary equipment
 - One additional room as office of Midwifery staff
 - Accommodation facilities for midwifery educators attending the 18 months training course
- Labour room of the parent hospital must be LaQshya certified. The facility should have delivery load of more than 3000- 4000 deliveries/year and also have a 100-bedded MCH wing.
- Adequate set of equipment's and instruments as per LaQshya and Standardized Labour Room guidelines.
- Required drugs and consumables for family planning programme and newborn care should also be available e.g. Intrauterine Contraceptive Devices, Vitamin K, zero dose vaccinations such as Hepatitis B etc.
- A dedicated and motivated team.

Roles and Responsibilities of Regional Midwifery Training Institutes

- To select/engage midwifery tutors and ensure that they have undergone three months training at the NMTI.
- To conduct 18 months training of Nurse Practitioner Midwives, the trainer: trainee – 1:3.
- Post training follow up and mentoring visits to provide onsite mentoring and handholding support to trained faculty
- Monitoring the progress of Midwives activities in targeted institutions of their catchment.
- Share regular feedback with MoH&FW and NMTI and initiate corrective actions if required.
- To embrace research and evidence based activities for midwifery care

Table 3: Selection of Educators to participate in three-month NPM –Educator course at NMTI are outlined below:

Selection Criterion for the 3 months midwifery educator course :	
Education & Experience	Be a registered nurse and midwife (RN & RM); M.Sc. Nursing with specialty in obstetrics and gynaecology with minimum 2 years of clinical maternity working experience; or Nurse practitioner in Midwifery with B.Sc. Nursing with 2 years of clinical experience ; Good communication skills; Open eligibility criteria(for Private and Government candidates)
Competency Assessment	A periodic competency assessment (CA) will be done at the time of joining and at regular intervals. CA will be part of annual performance appraisal also.
Remuneration	Salary starting at the level of Assistant Professor(level 11)
Availability	The midwifery trainer will need to ensure her/his presence for getting trained, providing training and continued monitoring and supervision
License or Registration	Each midwife educator is responsible for providing a copy of the license or registration to the Head of the Institute every time it is renewed

Roles and Responsibilities of Midwifery Educators at the Regional Midwifery Training Institutes

- Midwifery Educator will ensure that trainee midwives are exposed to 40% theory and at least 50% practice in the first year of the programme.
- ME will follow a set curriculum to provide details of content in theory, practice, and internship along with lesson plans for standardized training.
- ME will also be in charge of keeping a record of every midwife. A copy of the same will remain with the midwife as well. This will be managed as a joint responsibility to ensure participatory learning.
- Considering the complexities of certain topics in the course curriculum (as part of midwife competencies), an obstetrician or senior doctor/nurse midwife from related field can be invited as a guest lecturer.
- Once midwives are placed at Midwifery-led Units, ME will provide facility based mentoring.
- To maintain competency, each ME will continue to provide midwifery care to women and their infants.
- ME would be required to continuously update their knowledge and participate in professional development activities relevant to midwifery education

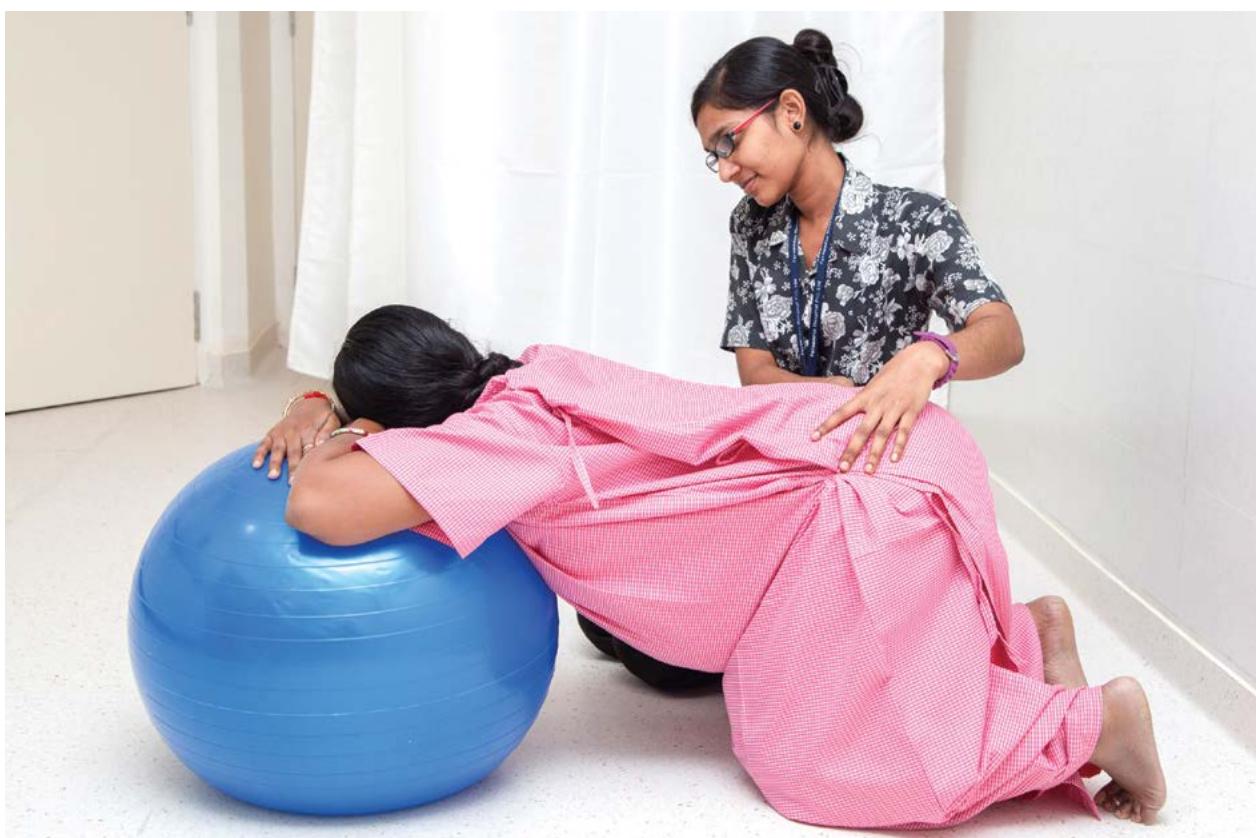
Accreditation of the RMTIs would be conducted initially as well as every 2 years based on criteria defined by the National Midwifery Task Force.

Budgetary Guidance

Funds required for strengthening and functioning of RMTIs are proposed to be met from NHM funds as follows:

- One-time grant for strengthening the RMTI is proposed to be budgeted under the NHM Annual Programme Implementation Plan of the respective State, where the RMTI is located.

A midwife providing a yoga session during an antenatal visit.



- Operational expenses of the RMTI and costs towards 18 months' training for Midwives at RMTIs are proposed to be met from the course fee from participants. For participants sponsored by respective State/UT Governments, the course fee is proposed to be budgeted under NHM PIP of the respective State/UT.

Course Curriculum

The ICM proposes the Midwifery course curriculum (last updated in 2018). The current course curriculum of the NPM course would be revised by INC and MoH&FW as per the course curriculum defined by the ICM with WHO guidelines. The revised curriculum would be followed for training of NPMs across national and regional midwifery training institutes. The training curriculum will be based on **four ICM Essential Competencies based on the guidelines shared by the ICM in 2018:**

- **COMPETENCY # 1:** General Competencies: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families. They facilitate normal birthing process in institutional and community setting. They also assess the health status and screen for health risks and promote general health and well-being of women and infant. They prevent and treat common health problems related to reproductive and early life. They also provide care for women who experience physical and sexual violence and abuse.
- **COMPETENCY # 2:** Pre-pregnancy and antenatal: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting. Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.
- **COMPETENCY # 3:** Care during labour and childbirth: Midwives provide high quality, culturally sensitive care during labour, and promote physiological labour and childbirth. They manage safe spontaneous vaginal birth and prevent complications, and provide care to the newborn immediately after birth.
- **COMPETENCY #4:** Ongoing care of women and newborns: Midwives provide comprehensive, high quality, culturally sensitive postnatal care for healthy women and healthy newborn infant. They promote breastfeeding, detect and treat postnatal complications and manage the problems in newborn infants. They also provide family planning services.



CHAPTER - 5

Institutional Arrangements

The implementation of midwifery will be guided by task forces at the National and State level and supported by the midwifery action group at the district level. The key features of task forces and the action group at each level are given below:

National Midwifery Task Force: A National Midwifery Task Force would be constituted in order to steer the Midwifery Initiative. The task force include representation from all stakeholders such as MoH&FW, INC, NHSRC, NIHF, development partners such as WHO and UN organizations, SOMI- India, FOGSI, Jhpiego, Fernandez Hospital, and other experts in midwifery. The NMTF would be supported by a National Programme Management Unit (NPMU) for Midwifery. This team of experts will be responsible for overall implementation of midwifery services in the country. Funding support would be provided to NMPU to implement the decisions of the NMTF through NHM. The NMTF will meet frequently in the first two years of inception and then at least once every quarter. This task force will be constituted by the Maternal Health Division, MoH&FW.

State Midwifery Task Force: The respective State task force will be responsible for implementation of midwifery training and care provision in their respective State under the guidance of the National Task Force. At the State level, the task force would be chaired by the Principal Secretary (Health) with the Mission Director (NHM) as a co-chair. The other members of the task force are : Director-General Health Services/Director, Public Health; Additional Director/General Manager, Family Welfare, Medical Services and Medical Education; Director-Training/ SIHFW; Director-Nursing; Principal State Nodal Centre for Midwifery; State Programme Officer – Maternal Health and Nursing; representatives from Nursing and Midwifery teaching institutes; State Nursing Council; Head of Departments :Obstetrics and Paediatrics; Principal College of Nursing; Regional Director – Health Services from related regions; Chief Medical Health Officer from related districts; General Administrate Department , professional associations and development partners. This team will meet every six months or earlier if required and as requested by the chairperson. However, the committee can invite any other member as deemed appropriate by the chairperson.

District Midwifery Action Group: The District Midwifery Action Group will be more action oriented. The committee will be responsible for implementation of midwifery services in the respective district. At the district level, the action group would be chaired by the District Magistrate/Commissioner with the District Development Officer/ Deputy Commissioner as co-chair. The other members of the task force are CMO/CDHO/MOH, Civil Surgeon/CDMO; Principal Government Nursing Institute; RMO (I/C); Head of Department, Obstetrics and Gynaecology, Medical College Hospital; Obstetrician and Gynaecologist, District Hospital; Superintendents, Sub-divisional hospitals where midwifery is implemented; District Public Health Nursing Officer (DPHNO); Nursing Superintendents, Department of Obstetrics and Gynaecology, Medical College Hospital; Nursing Superintendents, District Hospital; Taluka/Block level health officers. There would also be representatives from nursing and midwifery associations in the district with any other invited member deemed appropriate by the chairperson. The Principal Government Nursing Institute will coordinate all meetings along with private institutes, in order to standardize clinical practices. RCH officer will work as the nodal person. The Committee will meet at regular interval of two months. However, the committee can invite any other member as deemed appropriate by the chairperson.

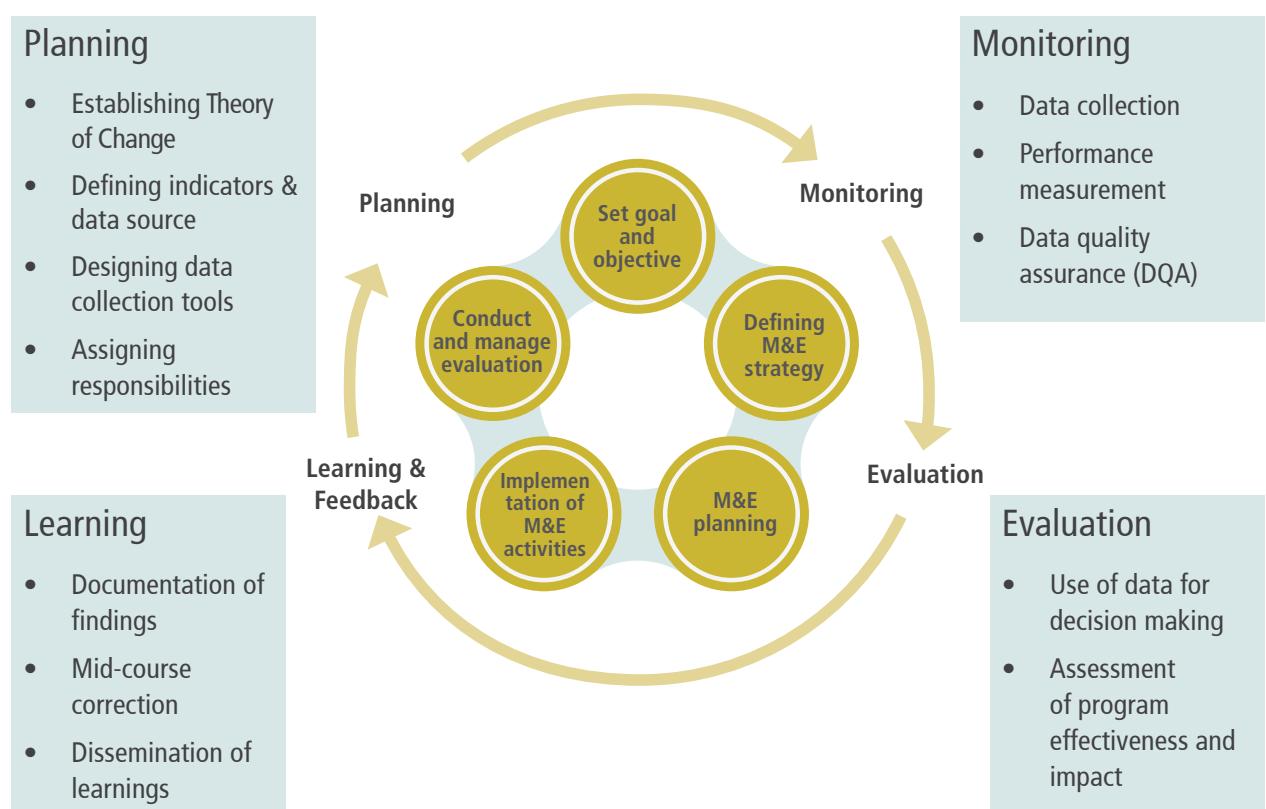


CHAPTER - 6

Monitoring, Evaluation & Quality Assurance Mechanism

The Midwifery Initiative of the Government of India aims to follow the programme monitoring and evaluation cycle as outlined in figure 4 below. The critical feature of this cycle is independent evaluation of the programme by external agencies (selected by the National Midwifery Task Force), in addition to regular monitoring. This will enable the Government of India to learn from the first phase of the programme and modify the programme accordingly during the subsequent phases. The Initiative also advocates for an inbuilt quality assurance mechanism.

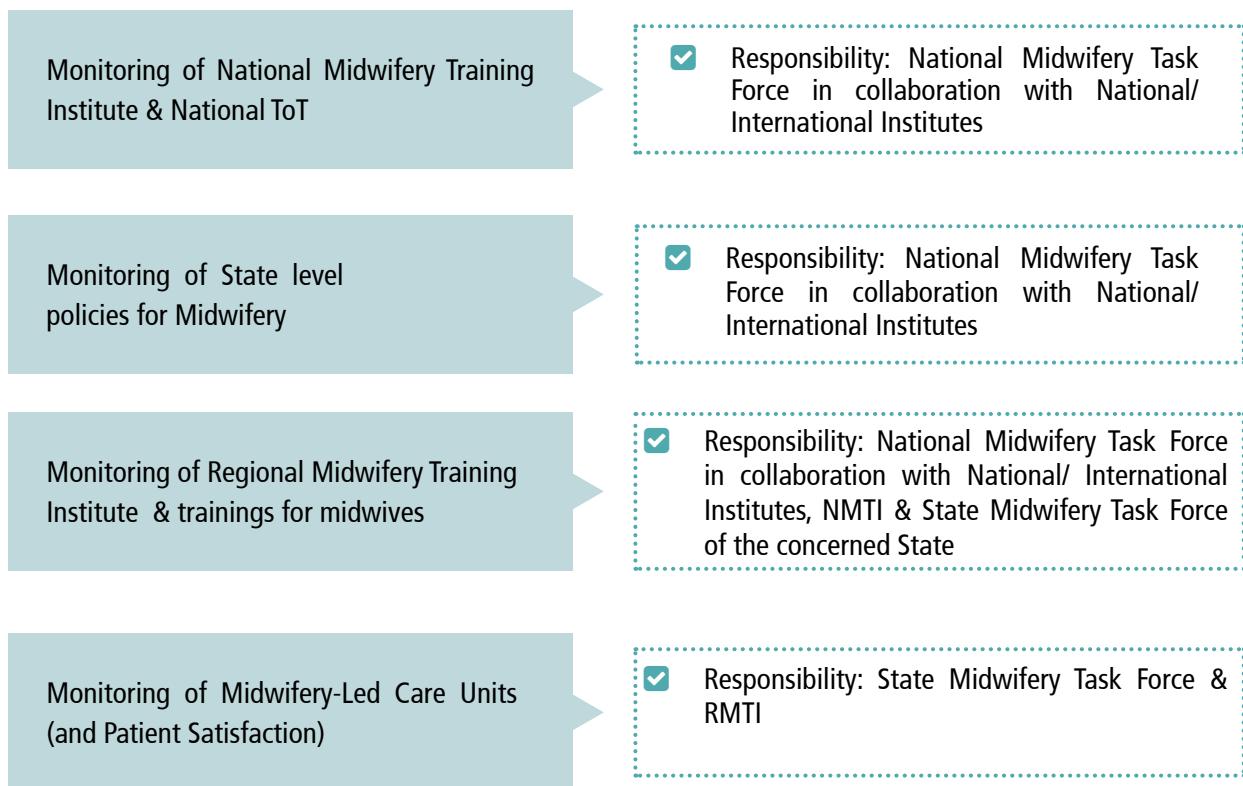
Fig. 4: Programme Monitoring and Evaluation Framework



Monitoring of Midwifery Initiative

Regular monitoring is the cornerstone for success. It is critical that all aspects of the programme are monitored including training institutions, training and health facilities providing service delivery etc. Figure 5 below outlines the different aspects of the midwifery training programme that require monitoring as well as the organizations/institutions responsible for monitoring the programme.

Fig 5. Aspects of the Midwifery Training Programme



Key Monitoring Parameters

A detailed monitoring framework comprising of checklist and monitoring indicators would be developed by the NMTF. Some of the key parameters that would essentially guide the monitoring framework are given below:

At the National Level - National Midwifery Training Institute

- Monitoring of the Midwifery training programme based on the ICM framework
- Accreditation of the Midwifery Training Institute
- Monitoring of the training of midwifery educators for the 'Midwifery Training Programme'
- Capacity assessment and hand holding of Regional Training Centres for professional midwifery course being provided by the NMTI
- Research and Evaluation activities undertaken by the National Institute

At the state level

- ⦿ Monitoring of State level policies: for setting up of the State Midwifery Task Force Monitoring and follow up on state service rules, and defined salary scales for midwives respectively
- ⦿ Monitoring and follow up on career & promotion pathway for midwives in the State
- ⦿ Monitoring and follow up on defined scope for practice for NPMs
- ⦿ Monitoring and follow up on the selection and posting norms for midwives
- ⦿ Monitoring and follow up on the issued posting orders for trained NPMs at identified health facilities
- ⦿ Monitoring and follow up on the State made provisions for the Midwifery-led Care Units

At the level of Regional Midwifery Training Institute

Continuous strengthening of the RMTI to offer professional midwifery course in the State

- ⦿ The institute to develop a midwifery educator pool as per ICM standards
- ⦿ The institute to adapt and design the midwifery course curriculum (in local language)
- ⦿ To ensure the quality of professional midwifery course as per ICM standards
- ⦿ Examination shall be conducted by the SNC
- ⦿ Certification & registration of trainees by respective State nursing councils
- ⦿ The institute has sensitized Hospital Superintendents and Medical Officers (of training and mentoring sites) on role of midwives and ICM competencies
- ⦿ Activities related to Post training mentoring and coaching at pre-determined intervals
- ⦿ Refresher trainings being provided by the institute at pre-determined intervals

Monitoring of Midwifery-Led Care Units (and patient satisfaction)

- ⦿ Creation and strengthening of the Midwifery-Led Care Units
- ⦿ Staff and community at health facilities are sensitized about roles and functions of NPMs
- ⦿ Overall integration of midwives into the units
- ⦿ Supportive supervision and refresher trainings of NPMs
- ⦿ Service delivery by NPMs
- ⦿ Referral linkages for the Midwifery-Led Care units
- ⦿ Patient satisfaction and overall outcomes of the Midwifery-Led Care Units

Evaluation of Midwifery Initiative

National/international organizations/institutions would be given responsibilities for internal and external evaluation of the Midwifery Initiative by the NMTF. This would include evaluation of National training Institute, Regional training institutes and the Midwifery-Led Care Units.

Baseline assessment of the facilities where the Midwifery-Led Care Units would be set up should be ensured so that impact of the midwifery initiative at these units and neighboring communities may be determined.

The evaluation team could comprise of experts from National Health Systems Resource Centre (NHSRC), National Institute of Health and Family Welfare (NIH&FW), INC, Indian Council of Medical Research (ICMR), Regional Nursing Colleges (for other State/cross-evaluation method) National and International collaborating Institutes/organizations etc. The task forces will be responsible for deciding the composition and Terms of Reference for the team of evaluators according to the level. The MoH&FW supported Common Review Mission will also be utilized to evaluate the key components of the programme.

Quality Assurance Framework

The National Task Force in collaboration with INC, NHSRC and partner organizations will set up a quality assurance framework for the midwifery programme. This would include accreditation and quality certification mechanisms for National and Regional Training Institutes. While LaQshya certification of labour rooms and operational theaters of the facilities where Midwifery-Led Care Units are being established would be mandatory, an additional component for LaQshya certification of the Midwifery-Led Care Units would also be developed for certification and accreditation of the units.



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