MIDWIFERY ROADMAP RAJASTHAN

NATIONAL HEALTH MISSION
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MIDWIFERY ROADMAP
RAJASTHAN

Valuable Contributions

The formulation of the Midwifery Roadmap for Rajasthan has been facilitated by the generous inputs of pivotal Stakeholders, who have provided sage strategi guidance, efficacious policy support, and astute implementation oversight. Their unwavering dedication to fortifying midwifery-led care has been a linchpin in shaping this landmark initiative. They are -

- Smt. Gayatri A. Rathore (IAS), Principal Health Secretary (PHS), Government of Rajasthan
- Dr Amit Yadav, Mission Director, National Health Mission (MD-NHM), Rajasthan
- Dr Madhu Rateshwar, Director, Reproductive and Child Health (RCH), Rajasthan
- Dr S. S. Agarwal, Director, State Institute of Health and Family Welfare (SIHFW), Rajasthan

List of Abbreviations

ANC- Antenatal Care

CHC- Community Health Centre

CEmONC – Comprehensive Emergency Obstetric and Newborn Care

CoN – College of Nursing

DH – District Hospital

DMAG – District Midwifery Action Group

FOGSI – The Federation of Obstetric and Gynaecological Societies of India

GNM – General Nursing and Midwifery

GoI – Government of India

HCWs – Health Care Workers

HMIS – Health Management Information System

IAP – Indian Academy of Paediatrics

ICM – International Confederation of Midwives

IMR – Infant Mortality Rate

INC – Indian Nursing Council

LaQshya – Labour Room Quality Improvement Initiative

LDR – Labour, Delivery, and Recovery

LOA – Leave of Absence

LR – Labour Room

MCH – Maternal and Child Health

MDSR – Maternal Death Surveillance and Response

ME – Midwifery Educator

MLCU – Midwifery-Led Care Unit

MNCH – Maternal, Newborn, and Child Health

MoHFW – Ministry of Health and Family Welfare **MS –** Medical Superintendent

MTI- Midwifery Training Institute

NMTI – National Midwifery Training Institute

NHP – National Health Policy

NHM – National Health Mission

NHSRC – National Health Systems Resource Centre

NFHS – National Family Health Survey

NMTF – National Midwifery Task Force

NMTI – National Midwifery Training Institute

NNF – National Neonatology Forum

NPM – Nurse Practitioner Midwife

NPME – Nurse Practitioner Midwifery Educator

OBG – Obstetrics and Gynaecology

OLCU – Obstetric-Led Care Unit

OSCE – Objective Structured Clinical Examination **PIP –** Program Implementation Plan

PNC – Postnatal Care

PW- Pregnant Women

QoC – Quality of Care

RCH – Reproductive and Child Health

RN – Registered Nurse

RM – Registered Midwife

RNC – Rajasthan Nursing Council

SBCC – Social Behavioural Change Communication **SDG –** Sustainable Development Goals

SDH – Sub-District Hospital

SIHFW – State Institute of Health and Family Welfare

SME – State Midwifery Educator

SNCs – State Nursing Council

SNCU – Special Newborn Care Unit

SOMI – Society of Midwives India

SOP – Standard Operating Procedure

SMTF – State Midwifery Task Force

SMTI – State Midwifery Training Institute

STFM – State Task Force for Midwifery

TNAI – Trained Nurses Association of India

UNFPA – United Nations Population Fund

VR – Virtual Reality

WHO – World Health Organization

Table of Contents

Executive Summary

Midwives, when educated, licensed, regulated, and integrated into health systems, can deliver 90 per cent of essential sexual, reproductive, and maternal health services across the life course. Midwives are a high-return investment. Estimates indicate that by 2035, midwives could save more than 4.3 million lives annually by improving 50 health outcomes and increasing satisfaction for women, adolescent girls, and newborns. Yet, there is a critical shortage of skilled health personnel, and training and supervision systems remain inadequate. Estimates suggest a global shortfall of at least 900,000 midwives. Despite this, many national plans do not rely significantly on midwives to deliver reproductive and maternal health services.

This document presents a roadmap for prioritising and scaling up the integration of Nurse Practitioner Midwives (NPMs) into the health system of Rajasthan. The roadmap outlines why fast-tracking the introduction of midwives (referred to as Nurse Practitioner Midwives or NPMs, and their trainers as Midwifery Educators or MEs) within the state's health system will have a significant impact on maternal and newborn health outcomes.

The roadmap highlights key milestones, including the need to formally recognise the NPM role within the health system, a structured policy framework addressing NPM/ME workforce and equity issues, social integration within the broader health system, ensuring quality and safety, and supporting informed policy and funding decisions.

The Midwifery Roadmap for Rajasthan outlines a comprehensive plan to establish and operationalise 1 National Midwifery Training Institute (NMTI) in Udaipur, which is already operational, and 9 State Midwifery Training Institutes (SMTIs) in selected districts such as Kota, Bharatpur, Jaipur, Udaipur, Jodhpur, Bikaner, Ajmer, Sikar, Pali, and Banswara by 2027. These institutes will train 80 MEs and 2,391 NPMs by 2034. The MEs will undergo a 6-month residential training program followed by 12 months of mentorship, while NPMs will complete an 18-month residency program. By 2030, the state aims to deploy trained NPMs to 73 Midwifery-Led Care Units (MLCUs) across high-caseload facilities, including District Hospitals, Community Health Centres (CHCs), and Medical Colleges. These MLCUs will provide 24/7 midwifery-led care, focusing on low-risk pregnancies and promoting physiological childbirth, thereby ensuring respectful, evidence-based maternity care for women and newborns.

By investing in a comprehensive midwifery roadmap, Rajasthan can enhance the overall effectiveness and efficiency of midwifery services and their contributions to maternal and newborn care, ultimately leading to healthier families and communities.

Introduction

In 2018, the Government of India (GoI) took a landmark policy decision towards improving maternal and newborn health with the launch of the Midwifery Services in the country to improve the quality of care and ensure respectful care to pregnant women and newborns. This initiative aims to establish a new cadre of midwives—Nurse Practitioner Midwives (NPMs)—who are skilled by global competencies, as set by the International Confederation of Midwives (ICM) and equipped to provide compassionate, women-centred reproductive, maternal, and newborn health services (RMNCH). The key objective of the initiative is to encourage natural childbirth by fostering a positive birthing experience, minimising unnecessary medical interventions, ensuring respectful maternity care, and institutionalise midwifery-led care within the Public Health system to accelerate progress towards the Sustainable Development Goals (SDGs) related to maternal and newborn health. Despite significant headway, maternal and neonatal mortality remains a pressing challenge in India.

Annually, in India, approximately 24,000 women lose their lives during pregnancy, childbirth, or the postnatal period[i] (2020), and approximately 5.40 lakh infants die within the first 28 days of life (SRS 2020)[ii]. As per the report of the Sample Registration System (SRS) released by the Registrar General of India (RGI), the Maternal Mortality Ratio (MMR) of India declined by 33 points from 130 per 1 lakh live births in SRS 2014-16 to 97 per 1 lakh live births in 2018-20. While this reduction underscores nationwide progress in maternal healthcare outcomes, notable disparities persist across states, with some regions continuing to report higher-than-average MMR.

Under the National Health Mission (NHM), Rajasthan has achieved significant maternal and child health advancements. According to the SRS, the state's MMR has markedly declined from 318 per 100,000 live births in 2007–09 to 113 in 2018-20[iii]. Antenatal care (ANC) coverage has improved, with 55.3% of pregnant women receiving four ANC check-ups (NFHS-5, 2020-21), and institutional deliveries have increased to 94.9%, with 77% occurring in public health facilities (NFHS 5)[iv]. To accelerate progress in maternal and newborn health outcomes, Rajasthan prioritised targeted interventions aligned with evidence-based strategies. By addressing systemicc gaps in healthcare access, quality, and equity, the state can advance its contribution toward achieving the SDGs, including reducing the MMR to below 70 per 100,000 live births and lowering the Neonatal Mortality Ratio (NMR) to at least as low as 12 per 1000 live births, by 2030[v]. Despite these commendable achievements, several challenges persist, underscoring the necessity for a dedicated midwifery initiative in the state, including higher Caesarean Sections. The overall C-section rate in Rajasthan has increased from 8.6 in 2015-16 (NFHS-4) to 10.4 in 2020-21 (NFHS-5), with an increase of 1.1 per cent points in public health facilities.

The high rates of institutional deliveries, while critical for improving maternal health outcomes, have inadvertently intensified workloads for healthcare providers—particularly obstetricians/gynaecologists (OB-GYNs). This strain risks fostering the over-medicalisation of childbirth processes, potentially compromising adherence to evidence-based guidelines—instances of non-recommended practice such as routine episiotomies or unnecessary labour induction. Concurrently, an overload of delivery cases at the facilities may undermine women's access to respectful maternity care (RMC), a fundamental right ensuring dignity, informed consent, and equitable treatment during childbirth. In a systematic review and meta-analysis done in India, which reviewed RMC, it was found that the cumulative prevalence of any disrespectful maternity care was 71.31%, and the most prevalent type of mistreatment was non-consent, followed by verbal abuse, threats, physical abuse and discrimination.[vi]

To promote dignified, evidence-based maternity care, the goi has emphasised "Respectful Maternity Care and Cognitive Development of the Baby" under various initiatives: National Quality Assurance Standard (NQAS), LaQshya.[1], SUMAN, first 1,000 days of a child's life, Mother and Child Protection (MCP) card and Safe Motherhood booklet. However, current nursing and medical curricula lack structured training on respectful, women-centered care.

Midwifery-led models offer a proven, evidence-based solution by ensuring continuity of care, reducing unnecessary medical interventions, and prioritising natural childbirth. Recognising this, the Government of India launched the Midwifery Programme in September 2018, with support from various development partners, including UNFPA.

The Ministry of Health and Family Welfare (MoHFW) has established several National Midwifery Training institutes (NMTIs) across the country to deliver structures and high-quality training to MEs. These educators are subsequently assigned to designated State midwifery training Institutes (SMTIs) of states to train NPMs. Among the designated NMTIs, the College of Nursing (CoN) in Udaipur, Rajasthan, stands out as a leading institution, developed with support from the United Nations Population Fund (UNFPA) and completed two batches of 6 months of MEs training. Since its inception, the NMTI has made steady progress. In January 2023, the inaugural cohort (Batch 1) of 10 Nurse Practitioner Midwifery Educators (NPM-Es) from Rajasthan began training, with completion of the programme targeted for January 2025. In January 2024, residential training for Batch 2 commenced with 8 participants. The state of Rajasthan has designated several SMTIs. In February 2024, 21 NPM learners enrolled at SMTI Jaipur and are expected to complete the 18-month course by August 2025.

While the Midwifery Services Initiative has shown promising outcomes, its long-term success depends on structured policy frameworks that support service norms, career pathways, and professional recognition. Key considerations include establishing clear guidelines for NPM and NPM-E practice, defining the scope of work, and integrating midwifery into national and state health systems.

[1] LaQshya is initiated by M oHFW with an objective to reduce maternal and newborn mortality and morbidity due to occurrence of complication during and immediately after delivery, to improve Quality of Care during the Intrapartum (onset of labour to delivery of placenta) and immediate post-partum care, stabilization of complications and ensure timely referrals, and enable an effective two-way follow-up system to enhance satisfaction of beneficiaries visiting the health facilities and provide Respectful Maternity Care (RMC) to all pregnant women attending the public health facility.

Strengthening career trajectories, leadership opportunities, and formal recognition within India's nursing practice acts will enhance professional legitimacy and retention.

Institutionalising midwifery as an essential component of the healthcare workforce will help ensure safer pregnancies, dignified childbirth, and improved survival outcomes for mothers and newborns. Investment in education, policy alignment, and health system integration will be critical to achieving India's maternal and newborn health goals.

1. Framework for the Roadmap

To streamline the midwifery roll-out, the maternal health division of the Directorate of Medical Health, the Government of Rajasthan, convened a multidisciplinary consultation in August 2024 with experts from various fields. The objective of the meeting was to discuss:

- Strengthening the Midwifery Training Ecosystem to ensure the long-term viability of midwifery training programs.
- Establishing Midwifery-Led care services to promote woman-centred, evidence-based care.
- Streamlining Program management through institutionalising committees for planning and implementation.
- Develop human resource policies to create strategies for integrating specialised nurse practitioners in midwifery into the healthcare system.
- Formulating regulatory and statutory norms applicable to midwifery programmes to establish clear norms and standards for midwifery practice.
- Enhancing Quality Management for training and service provision quality.

Developing a comprehensive midwifery roadmap is essential for establishing a robust and well-structured training ecosystem and streamlining the midwifery profession within the state's health system. It enhances maternal and newborn health outcomes, addresses NPM/ME workforce and equity issues, strengthens integration with the broader health system, ensures quality and safety, and supports informed policy and funding decisions. By investing in a comprehensive midwifery roadmap, Rajasthan can improve the overall effectiveness and efficiency of midwifery services and their contributions to maternal newborn care, leading to healthier families and communities.

The document has been developed by drawing lessons from the current implementation process and the guidance shared by MoHFW. Various tools have been adapted from GoI guidelines and the Indian Nursing Council (INC) documents. The major domains of the midwifery roadmap in Rajasthan include:

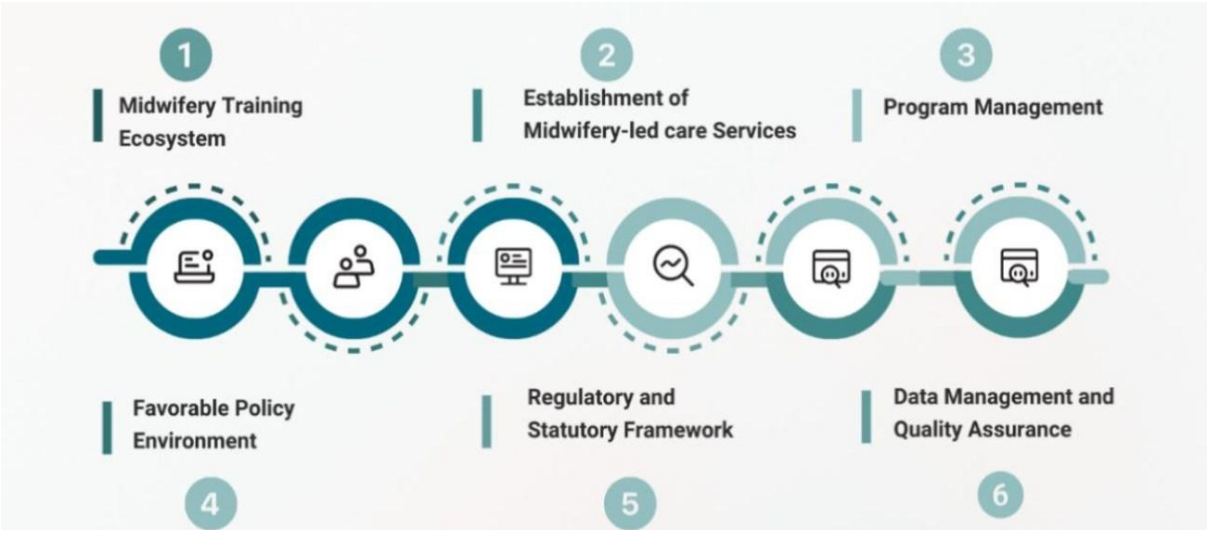

Figure 1: Midwifery Roadmap Framework

2. Roadmap Development and Rollout Plan

The roadmap for the midwifery initiative was developed as a joint effort of the state government, midwives, and midwifery leadership that encompasses a diverse range of stakeholders, including UNFPA, Jhpiego, national and international experts, the Federation of Obstetric and Gynaecological Societies of India (FOGSI), Society of Midwives, Indian Academy of Paediatrics (IAP), Centres of Excellence (CoE), various development partners active within the state, and Community-Based Organisations (CBOs). Within the state government, departments such as Nursing, Maternal Health, Child Health, Family Planning, and Quality, along with directors from state health services, collaborate under the leadership of the Mission Director of the National Health Mission (MDNHM) or the Principal Secretary of Health. This collaborative approach ensures comprehensive and coordinated efforts to enhance midwifery services across Rajasthan.

A structured approach was taken to ensure the roadmap was effective and relevant, as outlined in Figure 2.

Figure 2: Approach of Development of Midwifery Roadmap

1. **Committee Formation:** The SMTF Members are at the core of developing the midwifery roadmap.
2. **Consultation Workshops:** A multi-stakeholder consultation was conducted on 30 August 2024 to formalise the roadmap for implementing the midwifery programme in Rajasthan. The workshop focused on key areas essential for rollout, incorporating lessons from other states. The invited stakeholders included representatives from the state government, the national nursing and midwifery leadership, midwifery educators and practitioners, development partners, and principals from educational institutes providing midwifery education.
3. **Learnings from field and situation Analysis:** Bihar, Odisha, and Punjab roadmaps were reviewed to garner in-depth and detailed insights and understanding. This review provided an overview of successful strategies and essential content necessary for the smooth rollout of the midwifery initiative in Rajasthan. While the learning from these states ensured that best practices were incorporated, unique regional challenges were also considered while developing a roadmap specific to Rajasthan.
4. **Literature Review of Existing Documents and National Guidelines:** National guidelines and documents central to the role of midwifery services in India have been reviewed. These included the Guidelines on Midwifery Services in India, Financial Guidelines for Midwifery, Guidelines on Operationalisation of Midwifery Units, Guidance Note on Selection of Midwifery Educators, Curriculum and Scope of Practice for MEs and NPMs, Midwifery-Led Care Unit (MLCU) Guidelines, and Mentorship Guidelines. This review ensured that the roadmap aligned with national guidelines and best practices.
5. **Review the Indicators Quarterly:** The set indicators were reviewed quarterly by SMTF members.

3. Implementation Plan for Midwifery Programme in Rajasthan

The Government of Rajasthan will establish 10 Midwifery Training Institutes (1 NMTI and 9 SMTIs) in a phased manner to train 80 MEs at the NMTI by 2027 and a total of 2,391 NPMs by 2034. The trained NPMs will be deployed in MLCUs to provide 24/7 midwifery-led services at 153 high-caseload facilities.

Table 1: Midwifery Rollout Plan in Rajasthan (Proposed)

Rajasthan Roadmap	Phase 1 (Current status)				Phase 2				Phase 3			
	2022-2023	2023-2024	2024-2025	2025-2026	2026-2027	2027-2028	2028-2029	2029-2030	2030-2031	2031-2032	2032-2033	2033-2034
National Midwifery Training Institute	1 (Udaipur)											
State Midwifery Training Institute		1 (Jaipur)	3(Kota, Jodhpur, Bikaner)	3(Sikar,Pali, Baswada	3(Bhartpur, Udaipur,Ajmer)	0	0	0	0	0	0	0
		1	4	7	10	10	10	10	10	10	10	10
MLCUs	1 MLCU (UDP)	1 MLCU (Jaipur)	3 approved	3	15	15	15	20	20	20	20	20
	1	2	5	8	23	38	53	73	93	113	133	153
NPMEs	10	8	12	12	12	12	12	12	0	0	0	0
	10	18	30	42	54	66	78	88	88	88	88	
NPMs		21	30	120	210	300	300	300	300	300	300	300
		21	51	171	381	591	891	1191	1491	1791	2091	2391

4. Midwifery Training Ecosystem

4.1 Establishment of NMTIs/SMTIs in Rajasthan

Assessment and Notification of National/State Midwifery Training Institute

As Per the GoIs Midwifery Services guidelines (2018), states can implement midwifery programs at suitable nursing training institutes running M.Sc./B.Sc. Nursing with essential facility upgrades. Rajasthan is already implementing the national pre-service education programme and prioritising nursing institutes with National/State Nodal Centers. These institutes have been enhanced with improved education, clinical processes, teaching infrastructure, IT labs, libraries, demonstration labs, and functional-skill labs.

Following the national guidelines, NMTIs/SMTIs are being established with the following components:

- An additional classroom/seminar room for theory sessions.
- Facility of smart classrooms.
- A well-equipped library with necessary books and GoI modules as per Indian Nursing Council standards.
- A computer lab with functional IT equipment and internet.
- A dedicated faculty room for MEs.
- Accommodation facilities for learners attending the residential training, i.e. Six months for ME and 18 months for NPM.
- A linked LaQshya-certified parent hospital of medical college or district hospital level for competency-based clinical training and midwifery-led services.

The state will also identify additional Community Health Centres (CHCs) or Sub-Divisional hospitals for 4 weeks of community posting during NPM training at the SMTI. Additionally, the training institute will be equipped with

A Virtual Reality (VR) simulation laboratory supported by UNFPA in the state of Rajasthan to enhance the overall quality of the midwifery training.

The identified Government con in Rajasthan will undergo an assessment by representatives of the state Midwifery Taskforce members. The institute and parent hospital wil l be notified as a Midwifery training institute if suitable.

4.2 Strengthening and Up-Gradation of Midwifery Training Institutes

According to the financial guidance for Midwifery, the funds for strengthening NMTIs/SMTIs include upgrading infrastructure, libraries, and skill labs needs, assessment findings, and the NMTI/SMTI projection plan.

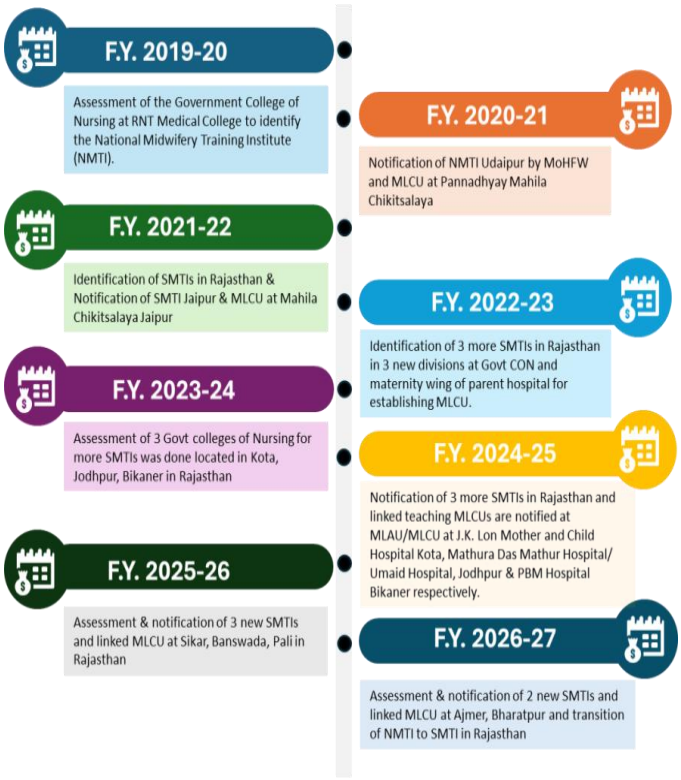

Figure 3: Training Roll Out Plan

Beyond institutional upgrades, the linked hospital will propose additional resources for Infrastructure enhancement and local procurement to support Midwifery practice and assign suitable space to roll out M L C U , which will be near the Obstetric a smooth transition for women with complications to obstetric unit, and better management and coordination between two units.

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unit for the

4.3 Selection and Training of MEs and NPMs

Following the guidelines set by the GoI and the INC, two pioneering courses for midwifery training have been introduced: the MEs training programme, designed to train educators, and the NPM training programme, tailored for midwife practitioners. The MEs training is a 6-month residential training at the training site, followed by 6 months of clinical mentoring of trained educators. The NPM training is for 18 months of comprehensive training at the training sites.

The state has adopted G oI's guidance on the selection process for NPM and ME candidates, which will be facilitated by the Midwifery Selection Committee. Selected candidates, comprising in-service staff. The eligible NHM contractual staff with the conditionality of signing of MoU will be considered during the selection process. The selected in-service and NHM contractual staff will undergo residential competency-based training, further enhancing their skills and expertise.

Selection of NPM and ME Candidates:

To create a pool o f M E s and NPMs, the state of Rajasthan has adopted the following selection process prescribed by the GoI. This meticulous process is facilitated by the State Midwifery Selection Committee, which operates through three specialised subcommittees:

- General Screening Committee: Oversees the initial screening of applicants
- Technical Screening Committee: Assesses the technical expertise of the candidates.
- Examination Committee: Conducts the written examination and interview.

These committees comprise esteemed representatives from the Directorate office, including the Directorate of Reproductive Child Health (RCH), Project Director Maternal Health (PDMH), and Deputy Director (DD), as well as the Registrar of Rajasthan Nursing Council (RNC).

The selection process for MEs and NPMs in Rajasthan involves the following stages:

- Open Advertisement for Recruitment: A public advertisement is released to invite applications for ME and NPM positions.
- Assessment Process: A competency-based entrance examination - a three-part assessment comprising:
  - A written examination
  - An Objective Structured Clinical Examination (OSCE)
  - An interview

The Candidates who successfully clear the assessment process undergo training at the NMTI or SMTI.

The entrance examination for the selection process is divided into two parts, with a total score of 100 marks: 60 marks for the written test and OSCE and 40 marks for the interview. The key components include:

a. Written Test (40%): The 2-hour examination consists of multiple-choice questions and short essays covering antenatal, intrapartum, postnatal care, complication management, and neonatal care. Candidates are assessed on their technical proficiency and fluency in written English.

b. OSCE (20%): The OSCE evaluates candidates through direct observation across a series of clinical stations, where they are tested on practical skills against standard checklists, like managing postpartum haemorrhage, eclampsia, newborn resuscitation, and performing abdominal examinations. This allows for a precise and reproducible assessment of clinical competence.

c. Interview (40%): Candidates who pass the written test and OSCE undergo an interview, which includes:

- **Motivational Screening (20%):** This assesses the candidate's passion for women's health, commitment to completing the 18-month residency programme, willingness to serve as a midwifery care practitioner, and alignment with the programme's goals.
- **Aptitude Assessment (20%):** Candidates are evaluated on communication skills, leadership qualities, client advocacy, team spirit, and proficiency in spoken English.

d. Additional Selection Considerations (State-specific):

- Candidates must have at least 2 years of experience working in labour rooms and a minimum of 5 years of service remaining before superannuation.
- Pregnant or lactating candidates may be considered, provided they consent to participate in the demanding programme.
- Candidates are counselled on the GoI initiative on Midwifery and the responsibilities of MEs.
- The MEs and NPMs must sign a commitment declaration regarding their future posting as MEs.
- Ensuring only the most qualified and committed candidates are selected in this process.

4.4 Curriculum and Training:

The INC-recognised NPM and ME courses are 18 months long, adhering to ICM standards for lateral entry of nurses as midwives. The training curriculum follows the "Essential Competencies for Midwifery Practice" (2018 update) defined by ICM. In Rajasthan, the training includes theoretical instruction, simulation-based learning in low fidelity skills lab, VR technology for virtual simulation, and practical sessions at clinical sites.

4.4.1 Midwifery Educator Programme Overview

A pool of MEs with the ability to train NPMs as per the WHO/ICM competencies will be trained at NMTI Udaipur and the regulations of the RNC. This includes regular monitoring by the state, which allows continuous assessment of the programme's effectiveness and incorporates lessons learned into subsequent phases. Additionally, built quality assurance mechanisms and care are maintained consistently throughout the training programme. The overview of the ME programme is detailed in Figure 4.

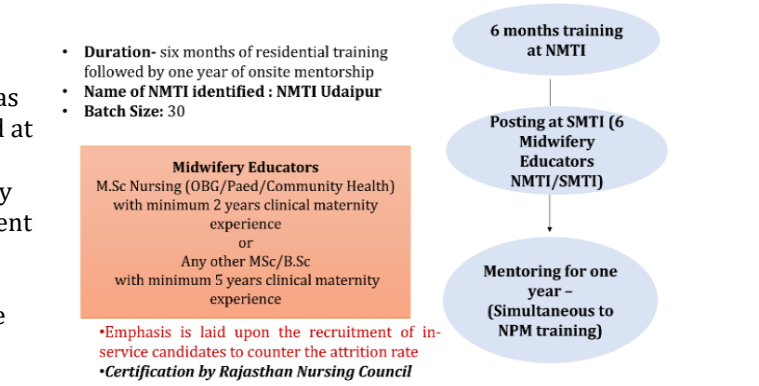

Figure 4: Overview: Training of Midwifery Educators at NMTI

4.4.2 NPM Programme Overview

The NPM programme is an 18-month residency programme, which includes 12 months of residency education and training followed by 6 months of intensive practicum/internship. The program emphasises a shift towards women-centred and respectful midwife-led care, highlighting the midwives' scope of practice. Figure 5 provides details on the NPM training.

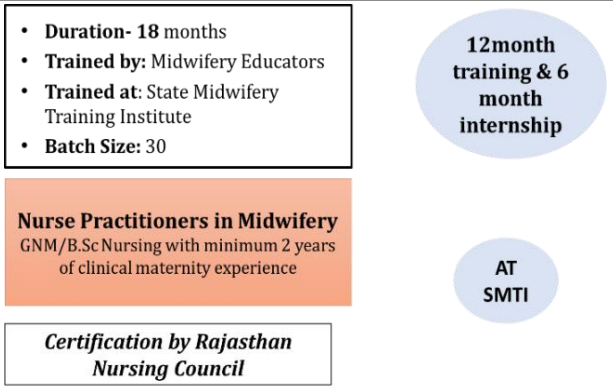

Figure 5: Overview: NPM Programme at SMTI

4.5 Mentoring Mechanism - Academic Continuous In-Service

Mentorship is the cornerstone of the Midwifery initiative, playing a vital role in developing the skills and leadership of MEs and NPMs. It goes beyond knowledge acquisition, emphasising practical application, compassionate care, and the development of educational competencies.

Mentorship of newly trained NPMs is critical for establishing midwifery-led care in high-caseload, LaQshya-certified delivery points. After deployment to their assigned facilities, qualified NPMs will undergo a 12-month mentorship under the guidance of SMTI-based.

The Process of Mentoring of ME:

- As ME mentorship takes place within the course duration, the parent NMTI will be responsible for continuous assessment and evaluation to track each mentee's progress.
- During the six-month training at NMTIs, MEs gain hands-on experience, followed by a 12-month mentorship at SMTIs.
- This phase provides personalised guidance in real-world settings, allowing MEs to strengthen their individual portfolios through one-on-one interviews, facilitate NPM training, and establish midwifery-led care services at designated clinical sites linked to SMTIs.
- During the mentorship, MEs will serve in dual roles, being posted at the SMTI and acting as educators for NPMs and the linked hospital for midwifery services at the MLCU.
- A qualified pool of MEs, including international MEs, will conduct onsite mentoring using a standardised tool.
- A minimum of five onsite visits will be conducted, with additional visits based on the needs and preparedness of the SMTI.
- Financial support for mentorship will be proposed in the NHM Program Implementation Plan (PIP).

Figure 6: Quality Assurance of Training

Mentoring of NPM: Mentoring newly trained N P M s is critical for establishing midwifery-led care in high-caseload, LaQshya-certified delivery points. After deployment at their assigned facilities, qualified NPMs will undergo a 12-month mentorship under the guidance of SMTI-based MEs.

The mentorship process will include one-on-one discussions for individualised, practice-focused guidance, followed by onsite group mentoring sessions on predefined midwifery clinical competencies, as outlined in the Midwifery Mentoring Guidelines. Groups of six to ten MEs or NPMs will be mentored together, except for one-on-one interviews. The mentorship approach will incorporate portfolio-based learning and reflective practice.

In collaboration with academic and clinical practice partners and the RNC,
onsite continuing nursing professional Development (CNPD) programmes will be conducted regularly at all midwifery training institutes. Additionally, virtual mentoring sessions will be held monthly to track clinical accomplishments.

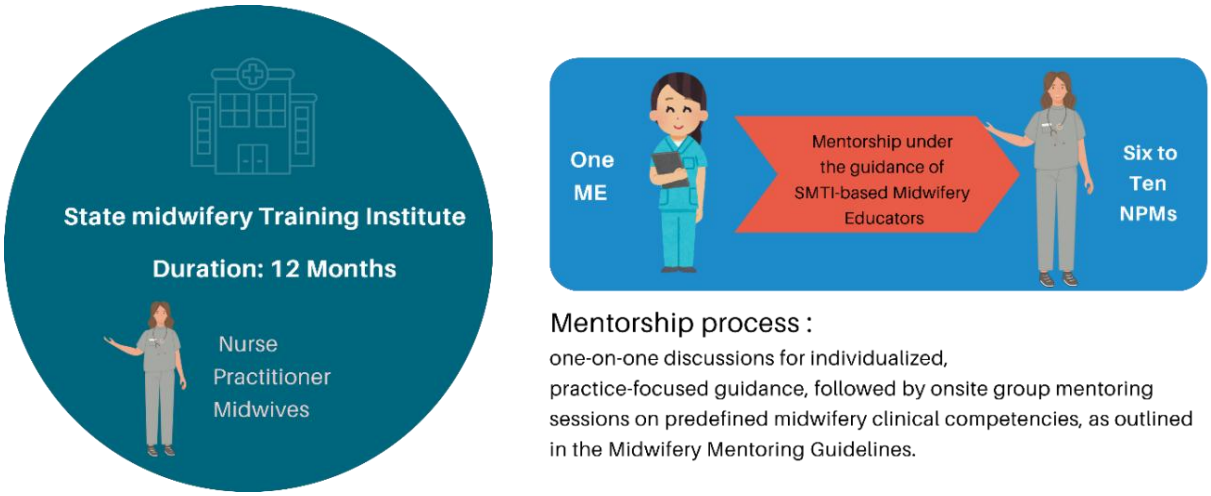

Figure 7: 12-Month Mentoring of NPM/ME

Mentoring Process:

The initial three months of the mentorship programme will concentrate on cultivating specific International Confederation of Midwives (ICM) clinical competencies and establishing a robust clinical practice framework at the State Midwifery Training Institute (SMTI)/National Midwifery Training Institute (NMTI) affiliated parent hospital or proposed First Referral Units (FRUs).

Mentee ME/NPMs will benefit from monthly on-site mentorship visits during this formative period. The frequency of mentoring for Midwife Educators (MEs) and Nurse Practitioners in Midwifery (NPMs) will be as follows:

- Initial three months: Monthly visits
- Subsequent periods from 4th month onward: Bi-monthly visits, followed by quarterly visits

This initial quarter will also be dedicated to preparing SMTIs / FRUs for the commencement of NPM training or establishing MLCUs in FRUs. Mentors will conduct regular performance reviews, utilising standardised skill checklists to assess mentees' clinical practice skills. They will provide targeted support to facilitate the development of new skills, ensuring alignment with ICM essential competencies.

Mentors must complete a comprehensive competency assessment of mentees' general and specific practice skills, informed by ICM standards. Focused mentoring will be tailored to address specific areas, as outlined below:

Month - 1
Objective: *Onsite orientation of local stakeholders, gap analysis and support for initiating midwifery services with a focus on the day of birth (triage, admission in labour, labour, childbirth, immediate postnatal care for the woman and baby)*
• Introduction, on-site sensitisation meeting • Identify OBGYN and nursing champions in the clinical sites to support the new cadre and the midwifery model of care (follows advocacy at various levels – include demand side work to ensure sufficient caseload of 'normal clients') • Establish an inter-professional team to develop norms, standards, and systems for collaborative practice, including systems to monitor the effectiveness of the collaborative practice • Conduct a baseline assessment with the six SMTI mentees / in-charges / managers on training infrastructure, clinical practice site and midwifery services – and co-develop an action plan to establish/improve the MLCU, including a plan to monitor and update the plan weekly • Work with in-charges /managers / QI team to introduce the monitoring and evaluation framework specific to the MLCU, establish a baseline for quality indicators, and co-develop an action plan to improve quality and ensure the quality of data to follow indicators • Establish systems to ensure continuity of care along the pregnancy-intrapartum-postnatal continuum • Achieve consensus with clinical staff on best practices to apply on the day of birth • Model respectful, woman-centred midwifery care on the day of birth • Provide clinical mentoring for NPME mentees - focus on care on the day of birth, applying evidence-based practices for normal births and consulting with a senior provider/OBGYN for referring women with identified complications • Mentor other MLCU staff to adopt best practices on the day of birth for the mother-baby day • Weekly meetings: Reflections with NPMEs; review logbooks and portfolios • Set up a WhatsApp group
Month - 2
Objective: *Review and update facility action plans and NPME IDP; clinical mentoring support competency assessment; focus on ANC and PNC; PPFP counselling*
• Reflections with educators, NPME trainees, in charges/managers, QI team, and midwifery champions to review facility action plans, data and quality indicators, collaborative practice, and continuity of care - identify progress, wins, and challenges to update plans • Clinical mentoring - continued focus on intrapartum care • Focus on phasing in midwife-led ANC clinic, Triaging area, Childbirth education area,

- Clinical Mentoring- Support in running antenatal clinics alongside doctors, triaging and childbirth education areas.
- Clinical mentoring support during antepartum and intrapartum care
- Competency assessment for the management of the first stage of labour, care of 2nd Stage, the physiological third stage of labour and AMTSL with clients
- Competency assessment for providing antenatal health education comprehensive ANC with clients
- Feedback meeting: Reflections with educators
- Weekly meetings: Reflections with educators; review plans, logbooks and portfolios

Month - 3

Objective: *Clinical mentoring support to build readiness for management of Pre-eclampsia and eclampsia and PPH; clinical competency assessments*

- Clinical mentoring – focus on the management of common obstetric emergencies: PPH, PE/E
- Clinical mentoring - Monitoring foetal well-being and responding to foetal compromise
- Guide and feedback on performing obstetric emergency drills in teams in the MLCU - PPH and Pre-Eclampsia/Eclampsia and NBR
- Reflections with an inter-professional team to assess collaborative practice, effective (and ineffective referrals) gaps and develop action plans to address
- Ongoing Clinical Mentoring support- in running ANC, Labor and birth and PNC
- Competency assessments for identification and referral of sick newborn
- Feedback meeting and reflection with educator's review plans, logbooks and portfolios
- Review of records, data and QI areas
- Microteaching sessions (NPME must be assessed competent if clinical skill)
- Begin preparing for first group students (+ details and tools)
- Start preparations for implementing an 18-month NPM course: developing a training calendar, preparing lesson plans, organising skills work, etc.
- Work with con staff and others on orientation to the 18-month NPM course

Month - 4

Objective: *Clinical mentoring support, clinical training, and competency assessments on outstanding areas; support to commence implementation of 18-month NPM course*

- Clinical mentoring, selected complications such as shoulder dystocia
- Ongoing Clinical Mentoring- Support in Labor and birth and PNC
- Clinical mentoring: Support in performing clinical skills-episiotomy, perineal assessment and repair
- Competency assessment for the management of common obstetric emergencies: PPH, PE/E
- Competency assessment of clinical skills- Newborn care and assessment
- Review of the NPM curriculum (expand), defining roles and responsibilities, developing a teaching and clinical roster (MLCU)
- Feedback meeting and reflection with educators; review plans, logbook and portfolio • Review of data and M and E indicators: MLCU

Month - 5

Objective: *Clinical mentoring support, focus on PPFP and PAFP and clinical competency assessments*

- Competency assessment of clinical skills- Newborn care and assessment, selected complications such as shoulder dystocia
- Reflections with educators, NPM trainees and obstetric champions to identify progress, wins, and challenges

- Provide clinical mentoring support in family planning counselling and services focusing on PPFP. (All except sterilisation)
- Competency assessment of clinical skills- Episiotomy, perineal assessment and suturing
- Clinical Mentoring- Support in running all MLC areas
- Review of data and M and E indicators: MLCU
- Set up meetings with in-charges /managers /QI team at the facility to evaluate data, discuss progress and challenges specific to the MLCU
- Ongoing support for antepartum, intrapartum and post-natal care
- Feedback meeting and reflection with educator; review plans, logbook and portfolio

Month - 6

Objective: *Clinical mentoring support, ongoing clinical competency assessments and educator competencies support*

- Competency assessment -consolidating skills
- Clinical support- Midwifery care and abortion-related services (Bereavement counselling, referral to specialists for safe abortion services, post-abortion family planning counselling, provision of select PAFP methods)
- Clinical Mentoring- ongoing support in running antenatal clinic, triaging and childbirth education. •

  Clinical mentoring- ongoing support for antepartum and intrapartum care, PNC
- Assess classroom teaching and skills demonstration sessions by educators. Provide handholding support for the effective implementation of NPM training
- Clinical Mentoring- Support in running all MLC areas
- Feedback meeting and reflection with educator; review plans, logbook and portfolio

Month - 7 to Month - 12

The overall objective of these 6 months of the mentorship period will be to:

- Assess and further strengthen clinical competencies, as required, so that mentees demonstrate increased confidence and competence in working independently with clients in MLCUs
- Ensure mentees complete their logbooks and demonstrate competence in managing caseload as per the logbook
- Mentees can evaluate the available evidence and be able to advocate for change in practices (as appropriate)
- Support NPMEs to teach and train NPMs
- Assessment of NPM training by the NPMEs to set standards
- Review progress, wins, and challenges in running MLCU with other facility staff
- Evaluate the functioning of the NPM educators within an inter-professional team and the effectiveness of the collaborative practice- discuss challenges and wins, identify new champions
- Take client feedback for the overall experience of care
- Close the mentorship period by reviewing the individualised development plan and overall group plan.

At SMTIs and NMTIs, the mentoring will include educators' competency during the visit. The mentors will follow the core mentorship principles of confidentiality, respect and non-hierarchical communication.

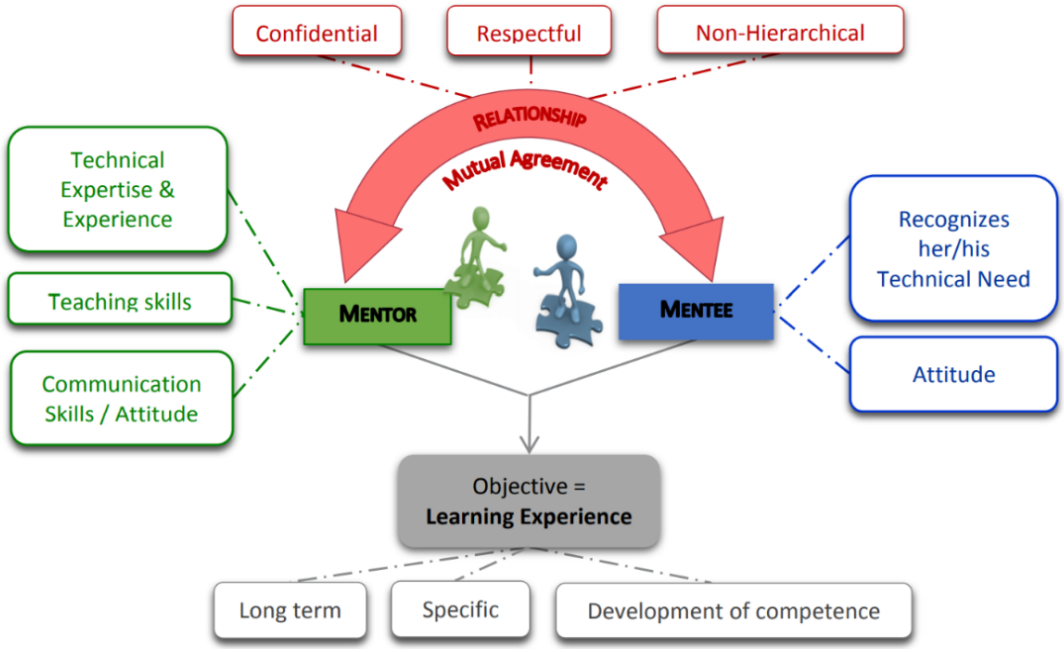

Figure 8: Clinical Mentoring Program Guide

4.6 Quality Assurance of NPMs and ME Training

The Nursing Division of Rajasthan has adopted the INC quality framework to establish robust monitoring and assessment mechanisms for midwifery education, ensuring its implementation across all NMTIs and SMTIs. The framework in Figure 8 is designed to assess multiple components, including infrastructure, human resources, educational and clinical training processes, and feedback mechanisms.

Information on these components is regularly shared with the state to enable consistent performance tracking and adherence to midwifery education and practice standards.

5. Establishment of Midwifery Led Care Services

Midwife-Led Care (MLC) services in the Outpatient Department (OPD) and Birthing Unit ensure seamless, continuous care for women throughout pregnancy, birth, and postpartum. The integration of midwifery-led services begins with structured workflows that enable midwives to lead antenatal care in the OPD, conducting routine check-ups, screenings, and health education while collaborating closely with other healthcare professionals. Establishing clear referral pathways is essential to ensure the timely transfer of women from low-risk to higher-level care when complications arise during pregnancy or labour.

Coordination between the OPD and birthing units allows for continuity of care, with midwives managing antenatal visits and deliveries to promote

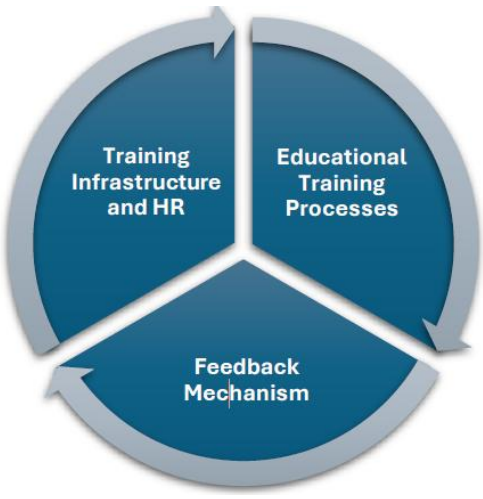

Figure 9: Key Component of Establishment of Midwifery-Led Care Services

A patient-centred experience. For the low-risk pregnant woman, the MEs and NPMs will conduct ANC consultation at midwifery-led OPD.

The OPD services include ANC examination of pregnant women based on the trimester, which include:

- Physical Examination (height, weight, blood pressure measurement, local examination (check for anaemia, jaundice, oedema of feet, etc.)).
- Abdominal Examination (measurement of Fundal height, Foetal lie and presentation)
- Foetal Movement, Foetal Heart sound (FHS), Nutritional Assessment, counselling (Diet, Birth preparedness, Involvement of Birth companion, various goi schemes) and assistance and training pregnant women on the respective ANC exercises.
- Enabling the MLCU services with iot devices as and when logistics are available.

Considering the scope of practice for high-risk pregnant women, the examination will be done in collaboration with the OBGY/ Medical Officer (MO) and the ANC, which includes a Physical examination (measurement of Height, Weight, Blood Pressure, Local Examination (check for anaemia, jaundice, swelling of feet etc.)), abdominal examinatio n (measurement o f fundal height, Fetal lie and presentation, fetal movement, fetal heart sound (FHS) and Assessment for the high risk. Based on the examination and conditions, ANC exercise will be recommended.

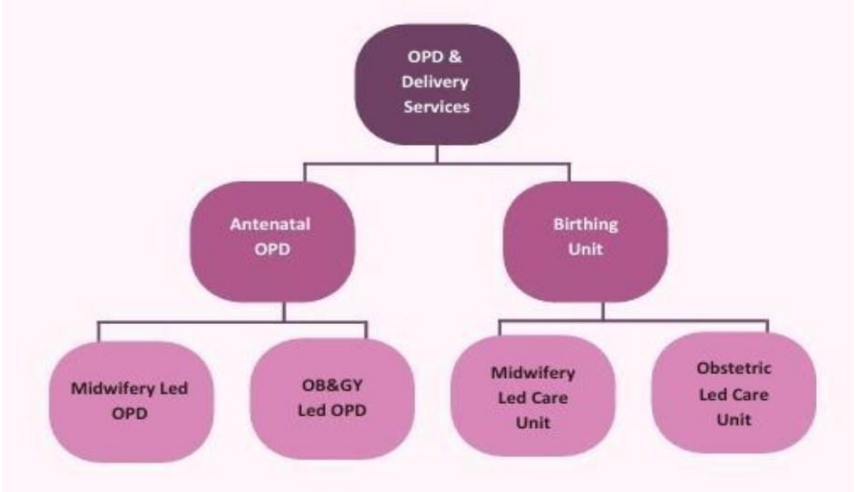

Figure 10: Workflow Alongside Midwifery-Led Service Area (MLCU Guideline)

5.1 Identification and Establishment of MLCUS at the Attached Clinical Practice Site of NMTI/SMTI

Identification and Establishment of Midwifery Led Antenatal Unit (MLAU) and MLCU

The Midwifery Led Care (MLC) services offer routine ANC care and consultation by midwives, birthing services (Alternative Birthing Positions (ABP)) and promote physiological childbirth for all low-risk pregnant women, besides identifying complications and initiating appropriate management by the specified Scope of Practice, including referral to the Obstetric-Led Care Unit (OLCU) when necessary.

Per the revised Indian Public Health Standards (IPHS), each facility must identify a space adjacent to the existing labour room and establish an MLCU. The establishment and designing of MLCU integrated within the maternity units of the existing health facilities in India will be based on the following cardinal principles:

- The state will establish MLAU and MLCU in the existing conventional birthing unit as per the Labour Delivery and Recovery (LDR) concept and labour room functional in high case load facilities, i.e. District hospitals, Maternal and Child Health (MCH) wings, and First Referral Unit (FRU) CHCs will establish a MLCU.

- MLCU will be alongside the conventional labour room. It will co-exist within the existing maternity unit (in the event of a woman in labour requiring comprehensive emergency obstetric care, she may be transferred immediately to the adjoining OLCU.
- The MLCU shall be developed by the LDR protocols where a pregnant woman is admitted during the active phase of labour and observed for at least 2-4 hours in the immediate postpartum period before being transferred to the ward. On average, one LDR unit of MLCU is expected to support two pregnant women for childbirth within 24 hours.

In Rajasthan, the midwifery rollout will prioritise high-need areas for intervention, focusing on regions with high maternal and neonatal mortality rates (Kota, Bharatpur, Jaipur, Udaipur, Jodhpur, Bikaner, Ajmer, Sikar, Pali, and Banswara), regions with inadequate maternity services, and facilities with a high delivery load. These priority regions will receive targeted support for establishing MLCUs and deploying trained NPMs. This strategic approach aims to establish 153 MLCUs, ensuring midwives provide high-quality, women-centred maternal and newborn care.

The civil department of Rajasthan will follow IPHS Guideline 2022 and MLCU guidelines to integrate the establishment of MLCU in the MCH wing. The new facility must identify a space adjacent to the existing labour room to establish an MLCU in a high caseload facility.

Bed Allocation for MLCU:

The Midwifery-led-care services will be operated under the overall supervision of a MO/OBGY Specialist in the high caseload facilities with a minimum of 250 deliveries/month, viz. Medical College Hospitals, District Hospitals (DH), Sub District Hospitals (SDH), CHCs/CHC FRUs and equivalent facilities. Based on the requirement, states should saturate DH/SDH in Phase 1 and may include FRU CHC/CHC in Phase 2.

These units will be equipped with active birthing equipment such as birthing mats, birthing balls, chairs, etc., enabling pregnant women to choose their desired birthing position. The delivery load determines the minimum recommended number of beds for setting up an MLCU at a healthcare facility. As per state projection, 80 MEs and 2391 NPMs are required to establish midwifery-led services in Rajasthan. The calculation of beds for MLCU is to be done as below:

Table 2: Bed Calculation for MLCU (Synchronised with IPHS 2022)

Numbers of Deliveries	Number of LDR Beds
100 to 200	**4 (2 MLCU + 2 OLCU)**
201 to 400	**6 (3 MLCU + 3 OLCU)**
401 to 600	**10 (4 MLCU + 6 OLCU)**
> 600	**15 (6 MLCU + 9 OLCU)**

(*Source-IPHS guideline 2022)

Human Resource Management for Midwifery Led Care and Dual Role of ME

Delivering quality care requires sufficient skilled professionals to ensure the best possible support during pregnancy, childbirth, and the postpartum period. Ongoing training and professional development are key components of HR management in midwifery-led care. The qualified NPMs will be posted as the primary workforce for midwifery-led care services. Additionally, in teaching MLCUs, the MEs will have a dual role.

The duty roster of midwives should cover the clinical service area, i.e. MLAU, MLCU, and Postnatal Care (PNC) services, which the Nursing Superintendent and Medical Superintendent oversee. NPMs and MEs will play a vital role in the success of midwifery-led care by ensuring that midwives are well-trained, supported, and motivated to deliver safe, effective, and compassionate care to women and their families.

Human Resource	Number of Deliveries (Per Month)	Total LDR Beds	OLCU LDR Beds	Staff Nurses	MLCU LDR Beds	Midwives
Staff Nurses and Midwives	100 – 200	2	2	4 (1 SN per shift adjustment)	2	4 NPMs (1 Midwives per shift for three shifts + leave adjustment)
	201 – 400	6	3	8 (1 SN per shift adjustment)	3	8 NPMs (2 Midwives per shift for three shifts + leave adjustment)
	401 – 600	10	6	8 (2 SN shift + leave adjustment)	4	12 NPMs (3 Midwives per shift for three shifts + leave adjustment)
	>600	15	9	12 (3 SN per shift + leave adjustment)	6	16 NPMs (4 Midwives per shift for three shifts + leave adjustment)
Security Staff	Existing Staff					
Cleaning Staff	Existing Staff					
Housekeeping Staff	Existing Staff					

(*Source- MLCU guideline)

Human Resource Norms for MLCU

Referral Mechanisms, Systemic Linkages and Interprofessional Collaboration

Establishing effective collaboration, referral mechanisms, andsystemic linkages in an mlcu is essential to ensure seamless, high-quality care for women and newborns. Collaboration begins with clear communication protocols that foster strong partnerships among midwives, obstetricians, paediatricians, anaesthetists, and other healthcare professionals.

NPMs should only provide maternity care services as per the "Scope of Practices for Midwifery Educators and Nurse Practitioner Midwife" document by the goi. This involves checking vital signs (blood pressure, pulse, temperature, and respiration), foetal well-being (foetal heart rate and movement), and obstetric history to categorise cases based on urgency and risk factors.

In the Medical College Hospital setup, the midwives and doctors will conduct triage based on risk stratification into low-risk and high-risk categories. In contrast, the midwives will conduct screening and triaging in district hospitals or lower centres. They will assess pregnant women based on history, examination, and referral notes and refer them accordingly. The expected flow of patients follows a structured pathway in medical college hospitals, DHs, SDHs, MCH wings, and CHCs with integrated MLCUs and OLCUs. The referral will be done per the scope of practice and MLCU guidelines. The brief of handling low-risk and high-risk pregnancies in midwifery-led care is as follows:

- **Low-risk pregnancies:** Pregnant Women with no complications are managed within the MLCU under midwifery-led care by NPM and ME. They receive regular assessments, guidance on labour progress, comfort measures, and continuous emotional support.

- **High-risk pregnancies:** Women showing signs of complications—such as hypertension, severe anaemia, abnormal foetal heart rate, preterm labour, excessive bleeding, or signs of infection—are identified and referred to obstetricians for collaboration.

6. Programme Management

6.1 Setting Up of Institutional Mechanisms

To ensure the successful implementation and scale-up of the midwifery initiative in Rajasthan, robust institutional mechanisms must be established. These mechanisms will involve coordination between the State Health Department (Non-Gazette), State Nursing Council, NHM, and Midwifery Training Institutes (NMTI/SMTI).

The implementation of midwifery will be guided and overseen by State Midwifery Task Forces at the 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:

State Midwifery Task Force Committee (SMTF)

The State Midwifery Task Force, chaired by the MDNHM, oversees the implementation of midwifery training and services in Rajasthan. The members of Rajasthan SMTF include Director RCH, Director SIHFW, Director Non-Gazette, Additional Director RCH, SPM, PDMH, Deputy Director Non-Gazetted, Registrar RNC, Principal SMTI, NMTI, MS/OBGY specialist of clinical site and State Head UNFPA and Jhpiego. The members should meet every three months. If required, additional members can be involved in the midwifery rollout.

District Midwifery Action Group (DMAG)

The District Midwifery Action Group (DMAG) needs to be formed in all districts with National/State Training Institutes to implement midwifery services at the district level. Chaired by the CMHO and co-chaired by the RCHO, it includes the Principal and Controller, DAM, DPM, Principal of con, Medical Superintendent (MS) of the Clinical site, Clinical coordinator/ OBGY, N/SMTI Coordinator, and midwifery representatives. The meetings are held every two months, coordinated by the CMHO, with the flexibility to invite other members as needed. The DMAG members should convene every quarter, while new members can be invited occasionally as per the midwifery rollout plan.

Institution-level Coordination Committee:

The Coordination Committee at Nursing Colleges and Medical Institutions oversees the smooth functioning of midwifery education and services. Chaired by the MS and co-chaired by the Principal of the College of Nursing, the committee includes members such as Medical Preceptors, faculty from the College of Nursing, the Head of the Department (HOD) of Obstetrics and Gynaecology, the Nursing Superintendent, the In-charge of the MLCU, MLAU, MEs, and NPMs.

The committee meets monthly to ensure the effective implementation of midwifery training and services, with the flexibility of inviting additional members as necessary to support its objectives.

6.2 Functioning of NMTIs/SMTIs

6.2.1 Roles and Responsibilities of Institutes

SIHFW	• **Responsible for the promotion and advertising of the NPM and ME programmes.** • **Conducts general screening, technical screening, and the entire examination process.** • **Organises and facilitates all meetings related to the selection, training, and implementation of the midwifery program.** • **Successfully completed the selection process for two batches of NPMs and three batches of MEs.**

Nursing Division	• **Issues joining letters and relieving letters to selected candidates based on merit.** • **Responsible for the deployment and posting of trained midwives in healthcare facilities.** • **Oversee the cadre formation and career progression of MEs and NPMs.** • **Provide complete guidance to SMTIs and NMTIs regarding midwifery course implementation.** • **Ensures adherence to national and state-level nursing policies related to midwifery.**
Maternal Health Division	• Prepares the budget for the midwifery program, covering institutional training, clinical training, human resources, and programme strengthening. • Submits midwifery-related budgets in PIP and SPIP (State Program Implementation Plan). • Conducts visits to all MLCU sites to monitor progress and ensure implementation as per guidelines. • Supports the alignment of midwifery services with national maternal and newborn health priorities.
Directorate of Medical Education	• Regulates academic and training institutions involved in midwifery education. • Ensures the accreditation and standardisation of midwifery training programs. • Facilitates the recruitment and deployment of trained midwives in healthcare facilities.
RNC	• Facilitate Institutional Statutory Clearance by providing course recognition. • Enroll learners and conduct a summative assessment of the NPM and NPME Programme • Issue mark sheet, provisional certificate and diploma certificate. • Conduct inspection of quality education and evaluation process • Issue additional qualification and licensing NPMs and MEs for practice.
NMTI	• Conducts specialised training programs for MEs. • Implement academic planning, facilitate training using Learning Resource Package (LRP) training modules and ensure competency-based education. • Provide mentorship and capacity-building support for SMTIs. • Conduct periodic competency assessments. • Host Continuous Professional Development (CPD) Programme.
SMTI	• Implement midwifery training programs under the guidance of NMTI. • Facilitates hands-on clinical training for NPMs. • Collaborates with parent hospitals for practical skill development and assessments. • Provide mentorship and capacity-building support for MLCU. • Host Continuous Professional Development (CPD) Programme.
Linked Parent Hospital with MLCUs	• Serves as the primary clinical training site for midwifery trainees. • Ensures adequate exposure to midwifery-led care models. • Supports the integration of trained midwives into hospital-based maternal and newborn care services.

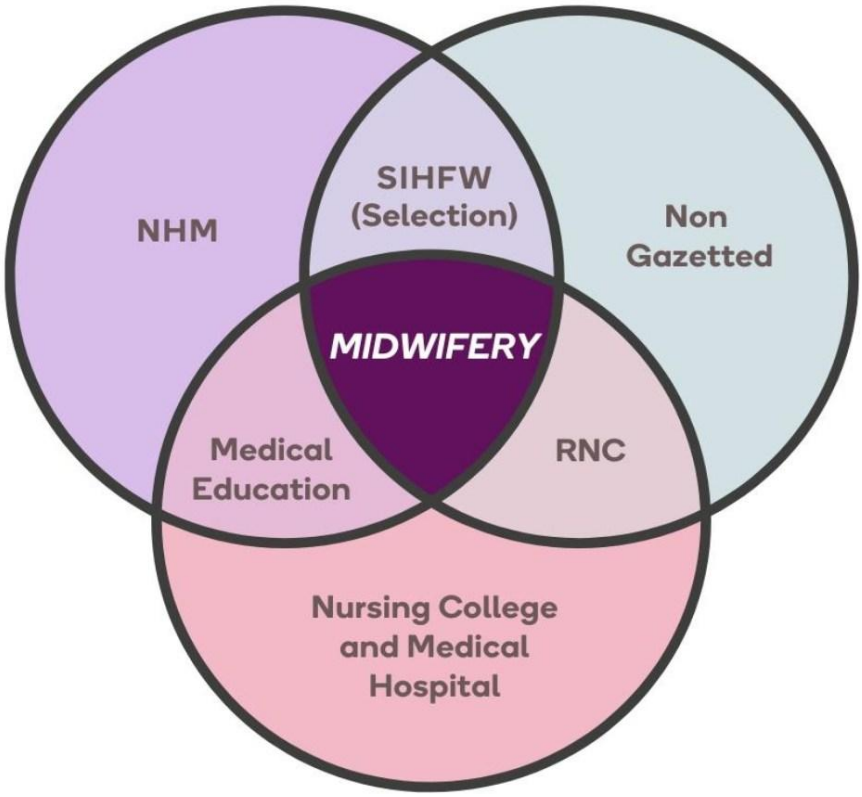

Figure 11: Operational Framework

1. **NHM -**
   Responsible for budgeting, monitoring MLCU implementation, aligning midwifery services with national priorities, and submitting budgets in PIP/SPIP.
2. **Nursing College and Medical College -**
   A) NMTI: Responsible for ME training, academic planning, and mentorship for SMTIs, ensuring competency-based education.
   B) SMTI: Conducts NPM training, facilitates hands-on clinical training, and supports MLCU capacity building.
   C) Medical College - MS/HOD is responsible for MLCU operations and overall case management, ensuring it functions as the primary clinical training site, provides midwifery-led care exposure, and integrates trained midwives into maternal and newborn care services**.**
3. **Non-Gazetted -**
   Responsible for the deployment and posting of MEs and NPMs, overseeing their cadre formation and career progression, ensuring adherence to midwifery policies, and guiding SMTIs and NMTIs in course implementation.

6.2.2 Functioning of NMTI, SMTI and Linked MLCUs:

A coordination committee oversight the Functioning of NMTI/SMTI and MLCU in linked hospitals and responsible personnel (coordinator) ensure smooth operations, quality training, and effective service delivery.

Various Supporting Roles at SMTI and NMTI -

- The principal of Nursing College (N/SMTI) supports academic and administrative governance.
- The Institute administration will identify the Principal of CON or faculty with administrative rights or HOD OBGY from the clinical site as NMTI/ SMTI Coordinator.
- The NMTI/ SMTI Coordinator ensures coordination with all departments, addresses challenges, and is the key contact person for rolling out Midwifery Education.

- Further, the NMTI/SMTI Coordinator will identify a batch coordinator among a group of posted MEs for each new batch.
- The batch coordinator leads training, curriculum implementation, mentorship, logistics management, scheduling, and handling trainee records.
- MEs lead the training as per the INC curriculum. Conduction of formative and summative assessment and competency tracking.
- Initially, International Midwifery Educators (IMEs), renowned experts in midwifery services and education aligned with International Confederation of Midwives (ICM) standards, will assume the role of batch coordinators.
- Following the appointment of Midwife Educators (MEs) to National Midwifery Training Institutes (NMTIs) and State Midwifery Training Institutes (SMTIs), IMEs will progressively transfer primary responsibilities for training, clinical coaching, and mentoring to the deployed MEs.
- IMEs, state experts and developing partners will train MEs to assume their responsibilities with confidence and competence, ensuring the sustainability and quality of midwifery education and training
- The coordination committee team monitors training effectiveness, adherence to standards, and interprofessional collaboration.

Various Supporting Roles in MLCU Linked Hospitals -

- MS/HOD plays the administrative role and supports the integration of midwifery services in the hospital.
- MEs manage 24/7 midwifery-led care services, training, supervision, and mentoring of NPMs. They are responsible for compiling and submitting monthly service delivery reports to hospital administration.
- Medical Preceptor support in the establishment of 24/7 midwifery-led care services, supervision and mentoring of MEs and NPMs. Facilitate interprofessional collaboration by sensitising other OBGY/MO about midwifery-led care services.
- The in-charge of the MLAU and MLCU facilitates nursing-midwifery collaboration and reviews monthly service statistics, ensuring resource availability.
- MOs (Obstetricians/Residents) function as clinical collaborators for identified high-risk cases, referral linkages and case management. Periodically review service statistics.
- The Nursing Superintendent oversees the duties of NPMs, including managing their duty roster.

6.2.3 Safety, Security, Meals and Accommodation of Trainees

As per GoI guidelines, the Principal of NMTI/ SMTI or Coordinator will be the nodal and key contact person. S/He will manage all external stakeholders and regularly communicate with the state. Further, one batch- coordinator will be identified among MEs to manage and coordinate.

Safety and Security: The existing con safety and security policy will be applicable to the NPM and NPME programmes. Implementing safety protocols, coordinating with security personnel for round-the-clock surveillance, and addressing any trainees' security concerns will be taken care of by college authorities. The principal will conduct a periodic review of the surveillance system.

Accommodation and Infrastructure Management: The institute is responsible for identifying accommodation services for 30 learners. Considering the availability of additional rooms, the con can arrange accommodation in the hostel for single or double occupancy. In the absence of a hostel facility, the institute needs to identify group accommodation in rented premises as per GoR guidelines within the permissible range. The accommodation facility should be clean and well-illuminated, and essential furniture for reading and storage, along with a single bed, shall be made available. As a long-term plan, the institute should develop or renovate hostel facilities for an additional 30 learners of NPM/ME courses.

Meals: Three meals, i.e. Breakfast, lunch and dinner, will be provided by the college as per goi guidelines. Midmorning and evening tea can be served during the snack break in college.

Dress Code for NPMs and MEs: The uniform for NPMs and MEs shall follow a professional colour scheme, consisting of two shades of deep lilac. Footwear must be black, ensuring a standardised and professional appearance.

Trainee Well-Being and Grievance Redressal: A well-being clinic and immunisation session will be conducted before clinical posting. The batch coordinator will arrange a well-being session for the trainee.

Any grievances will be disclosed to the batch coordinator, vice principal, or principal. The college authority shall follow an appropriate mechanism and take appropriate action to redress the grievance.

Monthly review mechanisms will be established to ensure accountability, and the designated ME will report to the Principal of NMTI/ SMTI. Additionally, periodic assessments and feedback from trainees will be incorporated to improve educational and residential facilities continuously.

6.3 Budgetary Guidance for the Midwifery Initiative

The budget for the midwifery initiative will be aligned with the State PIP under NHM. Referring to the financial guidance of goi, the state will develop budgetary guidelines under the midwifery initiative. The budget will be proposed in State PIP.[2] In 3 significant sections, namely - institute strengthening (NMTI/SMTI strengthening and MLCU development), training budget for NPM and NPMEs, HR and mentoring under the Midwifery initiative. The State PIP will propose additional costs per the requirement to support the midwifery rollout plan.

6.4 Midwifery Roadmap Implementation

The Maternal Health division of GoR will follow the developed road map for establishing MLCUs in the CEMONC SUMAN centre under the midwifery initiative in Rajasthan. Additionally, the Nursing Division will train the projected NPMs in their respective division or districts as per state NPM need projection. The developed roadmap will be followed for quarterly review during the SMTF meeting. The set indicators will be referred to for a review of the midwifery rollout in Rajasthan.

7. Favorable Policy Environment

To ensure the successful integration of NPMs and MEs into Rajasthan's healthcare system, the state government will undertake a series of strategic measures. Formal recognition of NPMs and MEs as a distinct cadre within the nursing workforce will be established through state directives. For position creation and career progression, NPMs will be designated as midwifery officers for the entry point, and NPMEs as midwifery educators, with pathways to leadership positions at the district and state levels. A comprehensive performance management system will be introduced, including mandatory competency assessments every 3–5 years and annual appraisals with feedback from competent authorities to foster continuous professional development.

To further support career advancement, transfer protocols will be designed to maintain the continuity of midwifery-led care services. Provision for study leave and higher education will be made available to NPMs and MEs. Through these initiatives, the Government of Rajasthan is committed to creating a supportive and motivating environment for midwives, enabling them to deliver high-quality, respectful care to women and their families across the state.

7.1 Post-Training Deployment of Qualified NPMs and MEs

Training MEs and NPMs will be deployed in notified SMTI/NMTI and MLCU. At least six MEs are required to facilitate ME training at NMTI to maintain the 1:5 ratio, and six MEs must run NPM training at SMTI. At the NMTI level, 2 International MEs will initially be posted along with Six MEs. The MEs will perform dual roles during their service as they need to continue their clinical practices apart from facilitation of theory and clinical supervision in the clinical site.

[2] The State Programme Implementation Plan (PIP) for health and family welfare services under National Health Mission (NHM) funding specifies the strategies to be deployed, budgetary requirements and aimed health outcomes

The NPMs will be deployed at LaQshya/NQAS/SUMAN notified Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities to manage alongside MLC services. Their primary responsibility will be to provide continuum care, including pre-conceptional counselling services, OPD-based antenatal midwifery care, intrapartum services, postnatal services and family well-being care services.

The state will issue directives to assign trained NPMs exclusively to dedicated Midwifery-led services in antenatal OPD and labour rooms/MLCU. Under no circumstances should NPMs or MEs be rotated to other departments.

Written consent will be obtained from the candidates, mandating them to join at the place of posting with a requirement of continuing services for a minimum period of three years.

Figure 12: MLCU Guideline

The successful implementation of the midwifery programme depends on the seamless integration of midwives into the existing health system. Based on the FRUs caseload, a minimum of 16 midwives at medical colleges, 6-10 midwives at DHs, and at least four midwives at SDHs or CHCs, the postings of midwives should be determined. The state will ensure that selected candidates are posted to pre-identified MLCUs immediately after completing 18-month training.

The preference will be given to medical college after saturation of DH/SDH/ high case load CHC.

Transfer and Higher Education:

The transfer protocols for NPMs and NPMEs will adhere to existing HR norms, with specific consideration given to midwifery-led services and training centres.

NPMs will be posted exclusively to LaQshya, NQAS, and SUMAN-notified CEmONC facilities where MLCUs are functional. Furthermore, NPMs will always be posted in groups, as stipulated by the norms, to ensure the uninterrupted functioning of midwifery-led care services on a 24/7 basis.

In contrast, NPMEs will be posted to cons that offer NPM or NPME programmes and have linked MLC services at the parent hospital. NPMEs will assume a dual role, managing clinical services with NPMs.

In exceptional cases, the state expert committee will consider voluntary transfer and/or posting as per existing HR rules.

Clinical Duty:

The NPMs and MEs will adhere to a predetermined duty roster to ensure seamless delivery of MLC services. The duty roster wil l be prepared by in-charges and approved by metron, the nursing superintendent and the medical Superintendent in advance. All midwives, including NPMs and MEs, must participate in shift duties at the clinical site.

By the duty roster, MEs will rotate through duties at the NMTI/SMTI while managing the clinical site. To ensure continuity of care, midwives must be on-call for a minimum of 24 hours every 15 days or as per hospital policy. The shifts of the midwives will follow the posted hospital's shift duty norms, as outlined below.

- Morning shift: 08:00–14:00 •
  Evening shift: 14:00–20:00 •
  Night shift: 20:00–08:00
- General shift/college duty for MEs[3]: 08:00–17:00 •
  On-call duty: 24 hours every 15 days

During the active training batches clinical posting, at least one ME and the trainee must be assigned each shift to fulfil clinical requirements. Midwifery preceptors and medical preceptors can be additionally identified for competency-based clinical training.

7.2 Career Progression

An additional career progression for NPMs and MEs, aligning with the current nursing cadre, has been proposed. After completing the training, NPMs are appointed as Midwifery Officers, positioned one grade higher than Nursing Officers. They also receive an increment to reflect their advanced roles and responsibilities.

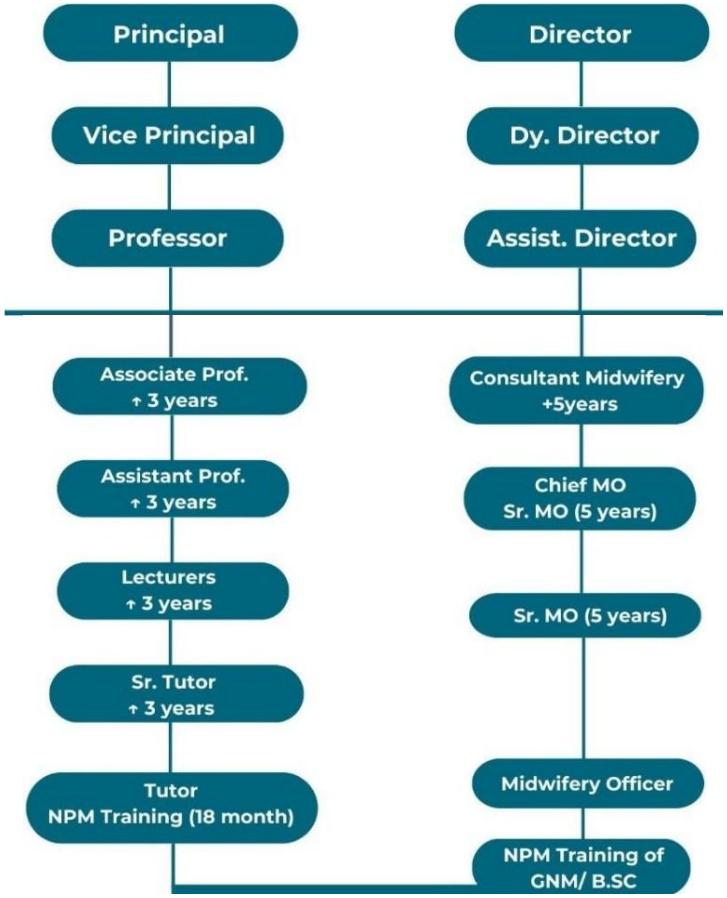

*Figure 13: Proposed Career Progression of MEs and NPM (*source- Guidelines on Midwifery Services in India)*

The flowchart illustrates that the career progression pathway for NPMs and MEs outlines a clear hierarchical structure across facility-level positions to state-level leadership roles.

[3]Applies only for Midwifery in charge and Midwifery educator posted on college duty as per duty roster. Any changes should be intimated, and approval should be sought by respective midwives.

7.3 Performance Management

The GoR's annual appraisal mechanism for in-service employees will apply to NPM and MEs. Yearly feedback from competent authorities will supplement the existing performance management of human resource rules. In addition, the NPM and ME must undergo a mandatory competency assessment conducted by the nursing division in collaboration with State and National Midwifery training every three to five years. This assessment will coincide with the critical career milestone year preceding promotion. The competency assessment will include -

1. Knowledge evaluation through MCQs and case-based assessment 2.
   Clinical skill appraisal via OSCE focusing on five critical skills
3. Behavior/attitude assessment using case-based reflection and self-assessment rating scales

On satisfactory performance and scoring passing marks, the NPM and MEs will be promoted to the next level as per their educational qualification and available positions. To recognise and motivate outstanding midwifery professionals, the state plans to identify high-performing midwifery champions and honour them with certificates of appreciation at district and state levels during significant occasions such as Republic Day (26th January) and Independence Day (15th August). Furthermore, these exceptional individuals will be nominated for the prestigious National Florence Nightingale Nurses Award, organised by the Government of India.

8. Regulatory Framework in Rajasthan

The regulatory framework aims to protect expecting mothers by reserving the title "NPM" for individuals who meet established standards of practice. This ensures that only qualified practitioners are recognised as midwives, enhancing the quality of care provided. Additionally, the framework utilises regulatory processes to ensure midwives' continuing competence and professional development, supporting them in working to their full scope of practice and maintaining high standards within the profession.

Short Title and Commencement as per INC Corrigendum 2020:

I. The Regulations as per the Indian Nursing Council for NPM and ME are described as the - NPM Programme, Corrigendum, Regulations, 2020. (refer The Gazette of India Indian Nursing Council {NPM Programme, Corrigendum}, Regulations, 2020) and NPM Educator Programme, Corrigendum}, Regulations, 2023
II. These Regulations shall come into force from the date of initiation of the programme in the state, as notified in the Gazette of India.

8.1 Notification and Accreditation of National and State Midwifery Training Institutes

The Government (State/Centre/Autonomous) nursing teaching institution offering degree programmes in nursing having parent hospitals with maternity services and neonatal units along with identified primary, secondary and tertiary health care facilities are selected for providing midwifery training. Currently, five B.Sc. Nursing training colleges in Rajasthan are identified as midwifery training institutes, namely NMTI Udaipur, SMTI- Jaipur, SMTI Jodhpur, SMTI Kota, and SMTI Bikaner.

The notified NMTI and SMTI shall get recognition from the RNC to start the NPM and NPME programme before the commencement of academic courses as a statutory requirement.

The INC suitability will be applied using the national portal. Under Section 13 of the INC Act, 1947, a statutory inspection will be done by INC to assess the suitability of the availability of the teaching faculty's clinical and infrastructural facilities in conformity with the regulations framed.

The NMTIs and SMTIs must propose to avail the affiliation cost of INR 10,000 payable to RNC every year and obtain suitability approval from the INC at INR 1,00,000. The amount will be included in the PIP under the NHM RCH Flexipool.

8.2 Examination Scheme for NPM and ME

Rajasthan's examination authority and registration body is RNC, approved by the INC. The examination scheme for ME and NPM programmes is as follows.

Scheme for ME Training:

The trainee MEs are expected to undergo three competency-based summative assessments during six months of intensive residential training at the National Midwifery Training Institute. During the training, i.e., at the end of three months, the educators are expected to undergo a competency-based examination conducted at NMTI Udaipur. The trainee MEs will appear for the second assessment at the end of six months of training, followed by the final evaluation at the end of 18 months.

The examination pattern for the three-month exam would be similar to the examination pattern for the second assessment and final examination at the end of 18 months.

Scheme for NPM Training:

Trainee NPMs undergo two competency-based summative assessments in dddddd18 months of residential training at SMTI. A midterm assessment is conducted at the end of 12 months at SMTI centres or examination centres. At the end of the six-month internship, trainees undergo a final evaluation at the end of the 18-month training programme.

8.3 Examination Scheme of ME and NPM Programme

Course/Paper	Int. Ass. Marks	Ext. Ass. Marks	Total Marks	Duration (in hours
ME Program				
Theory (Modules 1,2,3 and 4)	*25*	*75*	*100*	*3*
Practical- Midwifery	*50*	*50*	*100*	
Grand Total	*75*	*125*	*200*	
NPM				
Theory 1 (module 1)	*25*	*75*	*100*	*3*
Paper II (Module 2 and 3)	*25*	*75*	*100*	*3*
Total	*50*	*150*	*200*	
Practical- Midwifery	*100*	*100*	*200*	
Grand Total	*150*	*250*	*400*	

(*Source-Gazette NPM curriculum and NPME Curriculum)

Examiners for Practical Examination:

The practical examination for NPM and ME will follow the same pattern, consisting of OSCE and Direct Observations of Practice (DOP).

- During the practical examination, a panel of three examiners composed of two MEs (one internal and one external) and one medical preceptor (the midwifery examiners, as well as the medical preceptor, must be involved in teaching the program and be familiar with the curriculum) for DOP. A maximum of 20 learners' DOP can be done in a single day. For both the programs, i.e. NPM and NPME, two days will be designated for completing the DOP of 30 learners.
- The OSCE will be conducted by five designated OSCE evaluators, moderated by one external examiner or subject matter expert as OSCE moderator. In a single day, 30 learners of OSCE can be conducted. If all the learners' OSCE cannot be conducted in a single day, the OSCE station should be changed for the next day.

For further details on assessment, INC examination guide six can be referred to.

Supplementary Examination:

- Failed candidates (ME/NPM) will appear for the supplementary examination after six weeks in the board exam, failing either theory or practical.
- Number of attempts – 3

8.4 Certification of NPM and ME Programme

Certification of NPM and NPM Educator will be done by the RNC. The RNC will register NPM and NPME as additional qualifications. The certifications of both the courses are as follows:

A. Title – Nurse Practitioner in Midwifery (NPM)

- To earn the esteemed title of NPM, the learner must complete the 18-month Nurse Practitioner in Midwifery program course. The learner, NPM, has
  - O completed 90% of the theoretical instruction hour.
  - O 100% of the practical instruction hours before awarding the certificate. O Passed with a minimum of 70% in internal and external assessment.

B. Upon fulfilling these requirements, learners are awarded The Nurse Practitioner in Midwifery (NPM) title is awarded Title – NPME

- The title of NPME is conferred upon successful completion of the 18-month NPME program subject to the following conditions -
  - O Attendance of 90% in theory instruction hour
  - O Attendance of 100% of the practical instruction hours
  - O achieving a minimum of 70% or above marks in internal and external theory and practical examinations.
- Upon meeting this requirement, the learners are awarded the title of NPME.
- A provisional certificate of partial completion is issued upon passing the interim assessment at six months.

C. Registration of NPM and ME Program

- **License/Registration:** The RNC will register NPMEs and NPMs as additional qualifications.
- **Renewal of registration:** Registration of the MEs and NPMs will be done by the Rajasthan state nursing Council per guidelines issued by the Rajasthan Nurses and Midwives Registration Council. The renewal will be based on the competency assessment linked to further promotion every five years.

8.5 Scope of Practice for NPMs and ME

The gazette of Scope of Practice of NPM and ME issued at the national level has been adopted by the Government of Rajasthan and is being followed in the state. The MEs and NPMs will have prescriptive rights and practice in the Midwifery OPD, MLCU, Postnatal Unit and family welfare centre.

9. Data Management and Quality Assurance Mechanism for Midwifery Led Care Services

A strong data and monitoring mechanism for the midwifery initiative in the state of Rajasthan will play a vital role in ensuring the quality and safety of patient care. Currently, the data management syste m f or d ata collection at the facility level is partially implemented, and it does not have a structured structure for review and planning at the district or state levels.

In this roadmap, we propose to have a robust data management and quality assurance system to track the progress of the initiative in the state and improve the care provided by midwives. This will facilitate optimal resource allocation through regular review at the state, district and institute levels (NMTI and SMTIs).

The data management and quality assurance system for the midwifery initiative in the state of Rajasthan will be regulated around two major domains, i.e. Quality of education and quality of clinical services. This system will continuously track information on the quality of training provided in the NMTIs and SMTIs, focusing on infrastructure, educational process assessment, and feedback from the students and educators.

The quality of care provided at the clinical site will be ascertained by monitoring the service statistics on maternal and newborn health indicators, including data on complications, referrals, respectful care, and any adverse events. The data will be captured at each stage of the continuum of care provided by the midwives.

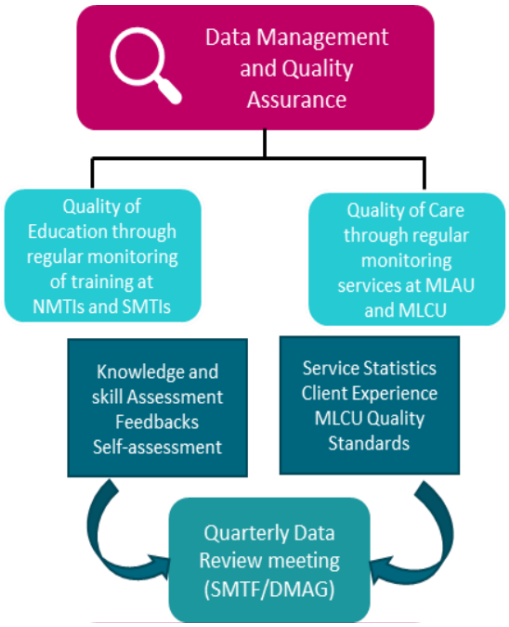

Figure 14: Depicts Key Domains Identified for Implementing the Data Management Under the Midwifery Initiative in Rajasthan

Measuring the Progress and Outcomes of the Midwifery Program

Continuous monitoring of the programme's progress is crucial to ensure the success, outcome and impact of midwifery services in the state. Goi, in the MLCU guidelines, suggested indicators to ensure that the programme would achieve its objectives and deliver quality service to the clients. These indicators include clinical outcomes and service delivery. Additionally, measuring client satisfaction is equally important to ensure the quality of care provided by midwives so that the holistic picture of the programme's performance can be tracked.

List of Indicators

- Percentage of deliveries conducted in the midwifery unit out of total deliveries in the facility • Percentage of deliveries conducted in the midwifery unit at night (8 PM to 8 AM)
- Percentage of referrals to the obstetric unit
- Percentage of Pregnant women who underwent C-section out of those referred • Percentage of newborns who required neonatal resuscitation
- Percentage of births which happened in alternative birthing positions • Percentage of episiotomies conducted in MLCU
- Percentage of perineal tear at MLCU
- Percentage of pregnant women satisfied with the services provided by midwives • Percentage of pregnant women who want to return to midwives for services
- Percentage of pregnant women receiving antenatal care from midwives

Tracking the above indicators for midwifery services will ensure that the quality of care is reviewed using service statistics at MLAU and MLCU, as well as client satisfaction and compliance with quality-of-service standards. Additionally, the regular data review meetings will ensure that this data is used for planning and making decisions for improvement. This will ensure that midwifery services are made more effective, efficient, and accountable, providing excellence in maternal and infant care.

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Sources

List of Documents

Name of the Document	QR Code (Available Online)
1. NHM Guidelines on Midwifery Services in India	
2. Financial Guidelines for Midwifery India	
3. Scope of Practice for Midwifery in India	
4. Gazette NPM Educator	
5. Gazette of NPM Program – Part II	
6. Gazette of NPM Program – Part III	
7. Operational Guidelines	
8. MLCU Guidelines – FINAL	
9. Mentoring Guidelines	
10. INC Quality Assurance Framework for SMTI and NMTI	

[I] https://www.unicef.org/india/what-we-do/maternal-health
[ii] https://pmsma.mohfw.gov.in/about-scheme/
[Iii] https://censusindia.gov.in/census.website/
[Iv] https://mohfw.gov.in/sites/default/files/NFHS-5_Phase-II_0.pdf
[V] https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality
[Vi] Ansari, H., and Yeravdekar, R. (2020). Respectful maternity care during childbirth in India: A systematic review and meta-analysis. *Journal of Postgraduate Medicine*, *66*(3), 133-140.


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