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सत्यमेव जयते
Ministry of Health & Family Welfare
Government of India

SURAKSHIT MATRITVA AASHWASAN
SUMAN

Guidelines on Operationalization of Midwifery Units

Transforming Maternity Care

Maternal Health Division,
Government of India

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एल. एस. चाँगसन, भा.प्र.से.
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)
L. S. Changsan, IAS
Additional Secretary & Mission Director (NHM)

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi - 110011

FOREWORD

Maternal health is a cornerstone of any society's well-being, and it is our moral and ethical duty to ensure that every expectant mother in India receives the highest standard of care throughout her journey to motherhood. The launch of Midwifery-Led Care stands as a testament to our unwavering commitment to this noble cause.

Establishing Midwifery Led Care Units (MLCUs) - is a crucial step towards providing high-quality maternal healthcare services in India. These guidelines represent our commitment to achieving the Sustainable Development Goals (SDGs), particularly the goal of reducing Maternal Mortality Ratio (MMR) to 70 by 2030.

Investing in the strengthening of healthcare infrastructure and enhancing the capacity of healthcare providers is not merely an administrative imperative; it is a pledge we make to the countless mothers who entrust their lives and the lives of their unborn children into our hands. MLCUs are a pivotal part of this commitment, offering a model of care that is centered on the well-being of expectant mothers and their newborns. These units are designed to provide comprehensive, evidence-based, and woman-centered care, with skilled midwives playing a central role in ensuring safe and respectful childbirth experiences and ensuring physiological birthing.

Midwives are not just caregivers; they are advocates for women's rights and choices during pregnancy, childbirth, and the postpartum period. Through these guidelines, we are empowering midwives to lead and provide holistic, respectful, and dignified care.

I extend my heartfelt appreciation to all the stakeholders, healthcare professionals, and organizations that have contributed to the development of these guidelines. All the contributor's dedication and expertise have been invaluable in shaping this document, which will undoubtedly serve as a cornerstone for improving maternal healthcare across the nation.

These guidelines are a significant stride towards our shared goal of ensuring that every expectant mother in India receives the best possible care. Let us remain steadfast in our commitment, work collaboratively, and tirelessly strive to provide quality and respectful maternal healthcare to every woman, thus contributing to a healthier and more prosperous India.

(Ms. L.S. Changsan)

'A' Wing, Nirman Bhawan, New Delhi-110011
Tel. : 011-23061723, 23061773, e-mail : lschangsan@nic.in

Meera Srivastava, IRS
Joint Secretary

सत्यमेव जयते

आज़ादी का अमृत महोत्सव

भारत सरकार
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निर्माण भवन, नई दिल्ली-110011
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Nirman Bhawan, New Delhi-110011

Preface

Reproductive, Maternal, Newborn, Child, and Adolescent health (RMNCH+A) is an essential component of the Sustainable Development Goals (SDGs). Improving RMNCH+A requires increased commitment to, and investment in, the health workforce. The State of the World's Midwifery (SoWMy) 2021 report has highlighted the global significance of investing in midwifery care, highlighting its potential to positively transform birth experiences, health outcomes, and the broader healthcare landscape.

Recognizing the pivotal role of midwifery and drawing insights from diverse countries' experiences, the Government of India (GoI) has introduced a new pool of Human Resource as Nurse Practitioner Midwives (NPM), who possess the necessary skills in line with International Confederation of Midwives (ICM) competencies. These NPMs collaborate with Obstetrics & Gynaecology/Medical Officers (OBs & Gyne/MOs) and will be stationed in Midwifery-Led Care Units (MLCUs), which will be established in close proximity to Obstetric-Led Units (OLCUs) in all high case load facilities (Medical Colleges/District Hospitals, Sub District Hospitals/ Community Health Centres) across country.

I would like to thank Maternal Health team, for developing the comprehensive guidelines. These guidelines will represent a pivotal step forward in our journey to enhance the quality of maternal and newborn care in our country and serve as a beacon for healthcare providers, policy makers, and stakeholders across the nation and provides a comprehensive roadmap for the establishment of Midwifery-Led Care Units (MLCUs) within existing infrastructure alongside existing Obstetric-Led Care Units (OLCUs) and also outlines the specifications of the equipment required to ensure quality services.

As we embark on this transformative journey, I trust that these MLCU guidelines, will serve as a valuable resource for all the States/UTs, aiding them in establishing Midwifery led care Units within their respective regions and also contributing to enhancing midwifery services, bringing us closer to our collective objective of ensuring safer, healthier, and more enriching childbirth experiences for every mother and newborn in India.

Meera Srivastava

(Ms. Meera Srivastava)

Tel : 011-23061842, 23061195
E-mail : jsrch-mohfw@gov.in

Dr. Pawan Kumar
MBBS, MD, DNB, MBA
Additional Commissioner, Incharge (MH & Immunization)

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली-110011
GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAWAN, NEW DELHI - 110011

Acknowledgement

The Government of India introduced Midwifery guidelines in 2018, marking a significant stride in addressing the critical issue of high Caesarean section rates, promoting the concept of physiological childbirth, and decongesting the healthcare facilities. These guidelines underscore our commitment to delivering safe, respectful, and woman-centered care to expectant mothers throughout their childbirth journey.

Through investments made under the National Health Mission (NHM), the Government of India has developed an 18-month training curriculum aligned with the International Confederation of Midwives (ICM) competencies. This initiative has led to the creation of a specialized cadre known as Nurse Practitioner Midwives (NPM). These NPMs are stationed in dedicated units and provide care based on the principles of midwifery philosophy.

To ensure a seamless continuum of care and to enhance the childbirth experience, the Government of India is introducing the concept of Midwifery-Led Care Units (MLCUs). These units will be established alongside Obstetric-Led Care Units(OLCU), which are the existing labor rooms in high case load facilities. Trained midwives will be stationed at MLCUs, where they will work according to their defined roles in the Scope of Practice Document. They will also demonstrate a collaborative care model, working in coordination with doctors and nurses, under the overall supervision of Obstetrics and Gynecology Specialists or Medical Officers.

These guidelines have been crafted with the diverse infrastructure, terrain, and human resource availability of all States/Union Territories in mind. It provides guidance on establishing two-bedded and four-bedded MLCUs within existing infrastructure. Additionally, the guidelines outline the provision of Midwifery-Led Outpatient Department (OPD) care and include recommendations for Antenatal exercises. Furthermore, they encompass a list of equipment with specifications, records, registers, and quality standards that must be maintained in MLCUs.

Office : Room No. 522-A, Nirman Bhawan, New Delhi-110011
Tel : 011-23061288, E-mail : drpawan.kumar@gov.in, drpawan.mohfw@gmail.com

With this, I extend my gratitude to Shri Apurva Chandra Secretary (H&FW), Ms L.S Changsan AS&MD, NHM and Ms Meera Srivastava, JS(RCH) for their unwavering guidance and administrative support that helped in taking the midwifery led care services across India.

I deeply acknowledge the support given by the Technical Expert Group comprising of Dr Deepika Khakha , Advisor Nursing division; Dr Himanshu Bhushan, Ex-Advisor, PHA Division, NHSRC, Dr J N Srivastava, Advisor-Q&PS Division, NHSRC; Dr Asha Sharma, INC; Dr Poonam Shivkumar, MGIMS; Dr Ragini Verma, GMC Gujarat; Dr Shrinivas Gadappa, GMC Aurangabad; Dr Padmaja, Telangana; Dr Trupti Desai, Gujarat who participated all deliberations and gave their valuable inputs. I would also thank Dr Kamlesh, Dr Geeta Chibbar from Jhpiego, Dr Evita Fernandes and Dr Radha Reddy from Fernandez Foundation for their insightful contribution . In addition, my heartfelt recognition goes to the Ministry of AYUSH for providing their technical inputs in one of the chapters.

The contributions of my esteemed colleagues Dr Anupama Prasad (Deputy Commissioner MH), Dr Santosh Ojha, Dr Bhumika Talwar, Mr Vivek Singhal, Dr Tushar Purohit, Dr Priyanka Sharma, Dr Himangini Wadhawan, Dr Jagdish Chhimpa and Mr Brahm Kumar Sharma are unwavering in drafting and finalizing these guidelines.

I am sure the states will be benefitted through this document in planning, designing and establishing the midwifery led units and take the midwifery philosophy forward.

(Dr Pawan Kumar)

LIST OF CONTRIBUTORS

MINISTRY OF HEALTH & FAMILY WELFARE (MoHFW)

1.	Shri Apurva Chandra - Secretary, (Health and Family Welfare)
2.	Ms L.S Changsan-AS &MD, NHM
3.	Ms Meera Srivastava, JS(RCH)
4.	Dr P. Ashok Babu, Ex. JS (RCH), MoHFW
5.	Dr Pawan Kumar, Additional Commissioner, In-charge (MH & Immunisation)
6.	Dr Anupama Prasad, Deputy Commissioner, MH
7.	Dr Deepika C. Khakha, Advisor Nursing Division
8.	Dr Padmini Kashyap, Deputy Commissioner, CAC & Aspirational Districts
9.	Dr Santosh Ojha, Lead Consultant, MH division
10.	Mr Vivek Singhal, Lead Consultant, MH division

NATIONAL HEALTH SYSTEM & RESOURCE CENTER (NHSRC)

1.	Maj Gen (Prof) Atul Kotwal, ED
2.	Dr K Madan Gopal, Advisor, PHA
3.	Dr J N Srivastava, Advisor, Q&PS Division
4.	Dr Himanshu Bhushan, Ex Advisor, PHA
5.	Ret. Air Commodore (Dr)Ranjan Kumar Choudhury, Advisor HCT division
6.	Dr Deepika Sharma, Lead Consultant Q&PS division
7.	Dr Chinmayee Swain, Senior Consultant Q&PS division
8.	Mr Prasanth KS, Senior Consultant, PHA
9.	Dr Kalpana Pawalia, Consultant PHA

STATE & DISTRICT EXPERTS

1.	Dr Padmaja, Maternal Health Nodal, Telangana
2.	Dr Shrinivas Gadappa- Prof & HOD, Dept of Obs & Gyne, GMC, Aurangabad
3.	Dr Poonam Shivkumar- Prof & HOD, Dept of Obs &Gyne, MGIMS Wardha
4.	Dr Trupti Desai, Deputy director Nursing, Gujarat
5.	Dr Ragini Verma- Prof & HOD, Dept of Obs &Gyne, GMC Gujarat

6.	Dr Hari, Ex Unicef consultant, Gujarat
7.	Dr GM Premkumar, Medical Officer, GPHC, Kattampoondi, Tamil Nadu
8.	Dr M.F. Mohd. Rifan, Medical Officer, PHC, Karungulam, Tamil Nadu
9.	Dr V Manikandan, Medical Officer, PHC, Tamil Nadu
10.	Dr Sapna Das, Ex.GM, Maternal Health, Uttar Pradesh

DEVELOPMENT PARTNERS & OTHERS

1.	Dr Bhumika Talwar, Maternal Health & Midwifery Specialist, UNFPA
2.	Dr Tushar Purohit, Senior Technical Officer, IPE Global
3.	Dr Priyanka Sharma, Consultant Midwifery, IPE Global
4.	Dr Himangini Wadhawan, Consultant Midwifery, IPE Global
5.	Dr Jagdish Chhimpa, Consultant Midwifery, IPE Global
6.	Mr Brahm Kumar Sharma, M&E Consultant Midwifery, IPE Global
7.	Dr S.K.Sikdar, Ex. Advisor (Maternal health & Family Planning)
8.	Dr Asha Sharma, Executive Committee Member, INC
9.	Dr Rashmi Asif, Independent Consultant
10.	Dr Kamlesh Lalchandani, Deputy Country Director, Jhpiego
11.	Dr Geeta Chhibber, Senior Technical Advisor, Jhpiego
12.	Ms Abhilasha Donald, Senior Program Officer, Jhpiego
13.	Dr Syed Hubbe Ali, Health Specialist RMNCHA, UNICEF
14.	Dr Indie Kaur, Director Midwifery, Fernandez Foundation
15.	Dr Radha, Fernandez Foundation
16.	Dr Aparajita Gogoi, Country Director C3
17.	Dr Aseema Mahunta , Senior Program Officer, C3
18.	Dr Surbhi Seth, Technical Advisor (RMNCHA), JSI

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GLOSSARY

ACRONYM/ABBREVIATION	FULL FORM
ABP	Alternate Birthing Position
ANC	Antenatal Care
AYUSH	Ayurveda Yoga Unani Siddha and Homeopathy
BMW	Bio Medical Waste
C-Section	Caesarean Section
CHC	Community Health Centre
CEmONC	Comprehensive emergency obstetric and newborn care
CTG	Cardiotocography
DH	District Hospital
FHR/FHS	Fetal Heart Rate/ Fetal Heart Sound
FRU	First Referral Unit
GoI	Government of India
HOD	Head of Department
HR	Human Resource
HRP	High Risk Pregnancy
IEC	Information Education and Communication
IPHS	Indian Public Health Standards
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojna
LaQshya	Labour Room Quality improvement initiatives
LDR	Labour Delivery and Recovery
LR	Labour Room
LSAS	Life Saving Anaesthesia Skills
MCH	Maternal and Child Health
ME	Midwifery Educator
MNH	Maternal and Newborn Health
MO/MOIC	Medical Officer/Medical Officer In-charge
M&E	Monitoring and Evaluation
MLAC	Midwifery Led Antenatal Care
MLCU	Midwifery Led Care Unit
M-OT	Maternity – Operation Theatre
NBCC	Newborn Care Corner
NICU	Neonatal Intensive Care Unit
NHM	National Health Mission
NMTI	National Midwifery Training Institute
NPM	Nurse Practitioner Midwife
NQAS	National Quality Assurance Standards

ACRONYM/ABBREVIATION	FULL FORM
OA	Occiput Anterior
OP	Occiput Posterior
OLCU	Obstetric Led Care Unit
OB&GY	Obstetrician & Gynecologist
OPD	Out Patient Department
PIP	Programme Implementation Plan
PMJAY	Pradhan Mantri Jan Arogya Yojna
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PW	Pregnant Woman
QA	Quality Assurance
QI	Quality Improvement
RCH	Reproductive and Child Health
RMC	Respectful Maternity Care
SDH	Sub-District Hospital
SMTI	State Midwifery Training Institute
SN	Staff Nurse
SNCU	Special Newborn Care Unit
SoWMy	State of World's Midwifery
SUMAN	Surakshit Matritva Aashwasan
UT	Union Territory
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

Background:

Midwifery care is based on the understanding that childbearing is a normal physiological phenomenon during reproductive lifecycle. Majority of women are capable of doing physiological birthing without the need for unnecessary medical interventions. Natural birthing with minimal medical interventions and compassionate, respectful maternal care empowers women to make informed choices about their childbirth and gives positive birthing experience to women and their families.

Hence, Government of India (GoI) proposed "Midwifery Care" as an alternative model for strengthening reproductive, maternal and newborn health services. To roll-out the initiative, GoI released the 'Guidelines on Midwifery Services in India' in 2018 to strengthen midwifery education and establishing Midwifery Led Care Units.

The State of the World's Midwifery report (SoWMy) 2021 also states that the investments on midwives in education and training, health workforce planning, management and regulation, as well as providing them with a dedicated Midwifery-led workplace, will facilitate a positive birth experience and improve health outcomes, including reduction in neonatal deaths, preterm births, unnecessary epidural, episiotomy or instrumental births.

Taking into consideration the SoWMy reports recommendations and the lessons learned from midwifery pilots in India, it was concluded that there is a need for establishing dedicated units to provide midwifery led care to pregnant women.

Objective of the Guidelines:

This document will assist in the planning, designing & establishment of Midwifery Unit at identified public healthcare facilities based on the delivery load. It will enable program managers and service providers at the State, District and facility levels to execute and monitor midwifery led care services.

Components of Midwifery care:

The components of midwifery care comprise overall health systems strengthening including establishing Midwifery Units as well. It also includes respectful maternity care, encouraging physiological birthing presence of birth companion and expanding the pool of Nurse Practitioner in Midwifery. The components are also depicted in Figure 1.

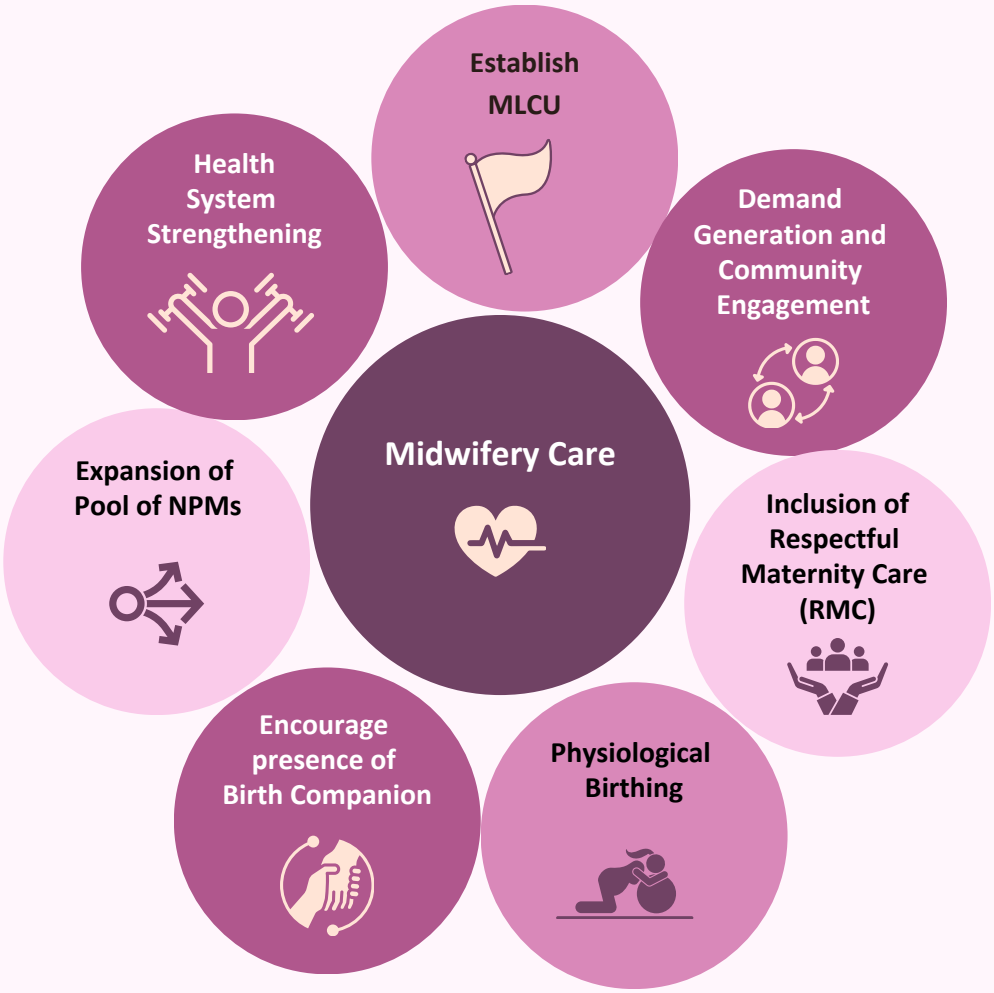
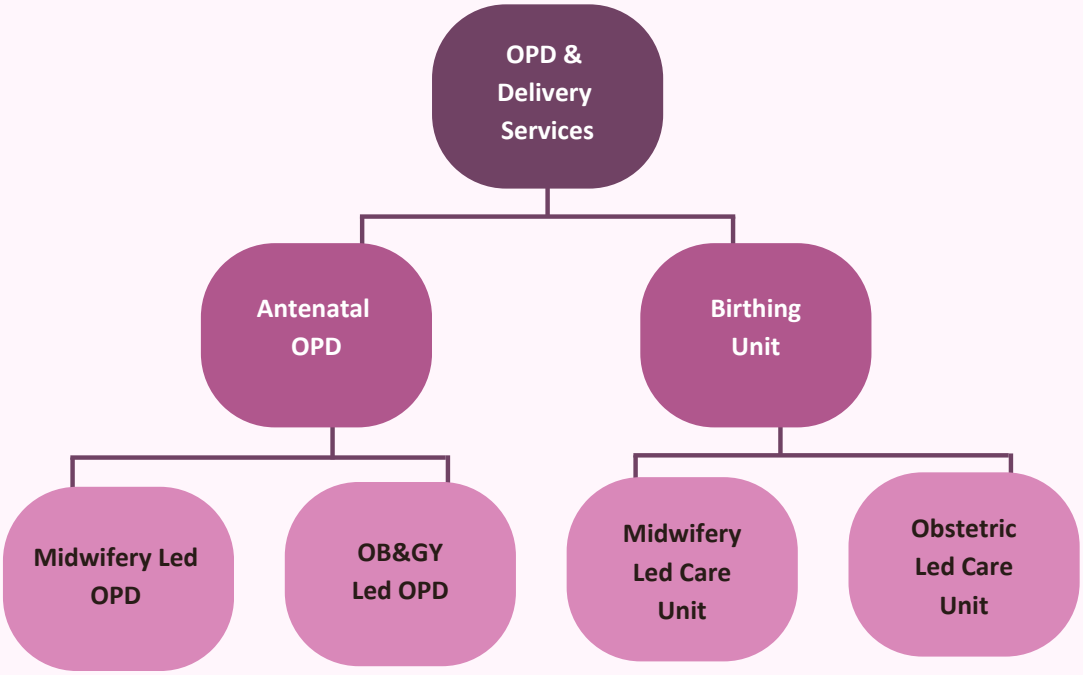


Figure 1. Components of Midwifery care

Framework for Antenatal and Delivery Services:



Types of Birthing Units:

1. Midwifery Led Care Unit (MLCU)

- Midwifery Led Care Unit (MLCU) is a unit where maternity care is provided by Nurse Practitioner Midwives (NPMs) after completing 18 months training at designated State Midwifery Training Institutes (SMTIs).
- The MLCU offers birthing positions of choice (Alternative Birthing Positions) and promotes physiological childbirth for all low-risk pregnant women, besides identifying complications and initiating appropriate management in accordance with the specified Scope of Practice, including referral to the Obstetric Led Care Unit when necessary.
- The MLCUs will preferably be located adjacent to the existing conventional labour rooms and operate under the overall supervision of Medical Officer (MO)/ OB&GY Specialist in the high caseload facilities with minimum 250 deliveries/month viz. Medical College Hospitals, District Hospitals, Sub District Hospitals, Community Health Centers/ CHC FRUs and equivalent facilities. It is to be noted that states should saturate DH/SDH in phase 1 and further may include FRU CHC/CHC in phase 2, based on the requirement.
- These units will be equipped with active birthing equipment's such as birthing mats, birthing balls, birthing chair etc. which may enable pregnant women to choose desired birthing position.

2. Obstetric Led Care Unit (OLCU)

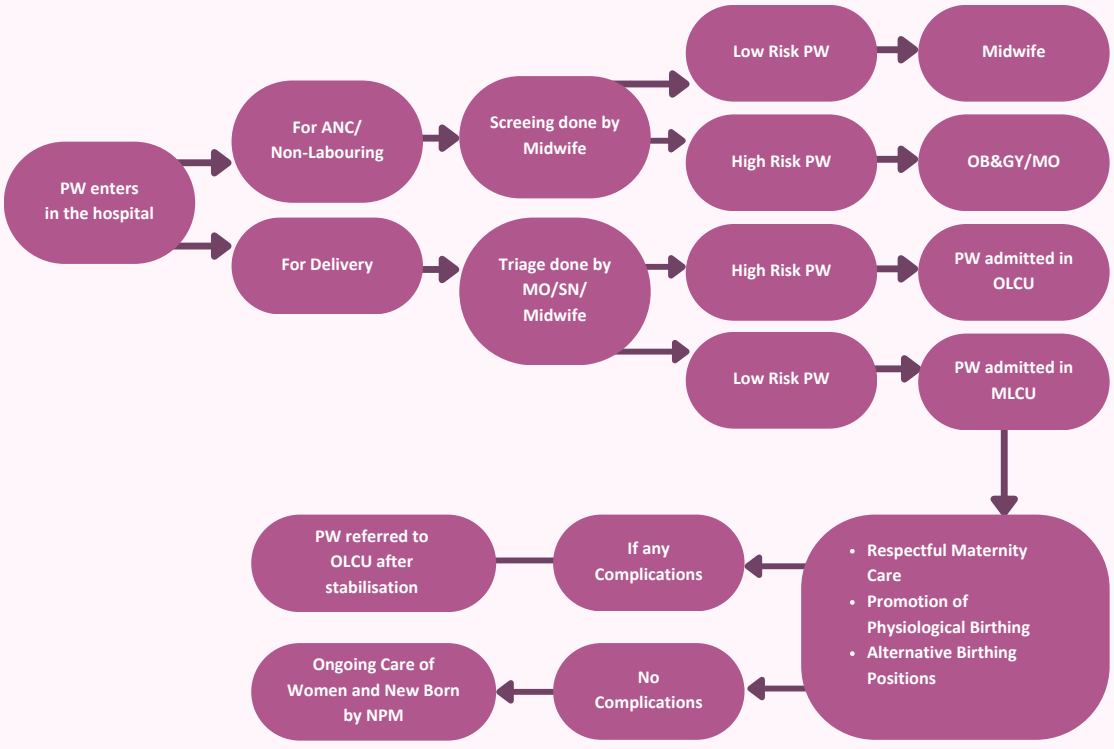
Obstetric Led Care Unit (OLCU), is a unit where a team of Medical Officer/OB&GY Specialist, Anaesthetist, CEmONC/LSAS trained Doctor & Staff Nurses provide obstetric care as well as specialized care to pregnant women who are at a high-risk and have developed complications.

CHAPTER 2: SETTING UP OF MIDWIFERY UNIT

Midwives will conduct triage based on risk stratification into low risk and high risk, based on history, examination and referral notes, and will refer pregnant women accordingly.

Expected flow of patients in a DH/SDH/MCH wing/CHC

MCH expected flow of patients in a DH/SDH/ MCH wing/CHC with integrated MLCU and OLCU



All the units will function under the overall supervision and guidance of the Medical Officer/ OB&GY Specialist

This section discusses organizing maternity service areas to make the environment pregnant women centric. It includes following components.

- **Midwifery Led Antenatal Care (MLAC)**
- **Midwifery Led Care Unit (MLCU)**

A. Midwife Led Antenatal Care (MLAC):

Two types of models can be adopted, based on the availability of NPMs.

- **Model 1:** Midwifery initiative is relatively a newer concept. Considering the limited number of NPMs posted in the initial phase, it is suggested that the NPMs may be first placed with the OB&GY/MO in the existing Gynaecological OPD, where screening can be performed jointly under the supervision of the OB&GY /MO. Once the number of the NPMs as well as the demand for Midwifery services increases, States/UTs may switch to Model 2.

- **Model 2:** The NPMs should be provided a dedicated room preferably near to OB&GY OPD, where they undertake preliminary screening of all the pregnant women. Depending upon the risk assessment **(as placed in the Annexure 1)**, the pregnant women will be sent to the designated OPD operated by Doctors for further examination. All antenatal OPD cases should go to MLAC and after screening by the NPM, the woman will be given complete antenatal check-up along with ANC exercises in MLAC or will be referred to the OB&GY OPD.

Scenario 1: If the pregnant women is at low risk, the NPMs will examine her based on the trimester, which includes **Physical Examination** (measurement of height, weight, blood pressure , local examination (check for anaemia , jaundice, swelling of feet etc.), **Abdominal Examination** (measurement of Fundal height, Fetal lie and presentation, Fetal Movement, Fetal Heart sound (FHS), Nutritional Assessment , Counselling (Diet, Birth preparedness, Involvement of Birth companion, various GoI schemes) and assist & train her on the respective ANC exercises.

Scenario 2: If the pregnant women is at high risk, the OB&GY/MO/ will examine her based on the trimester, which includes **Physical examination** (measurement of Height, Weight, Blood Pressure, Local Examination (check for anaemia, jaundice, swelling of feet etc.), **Abdominal Examination** (measurement of Fundal height, Fetal lie and presentation, Fetal Movement, Fetal Heart sound (FHS) **and Assessment for the high risk as placed in the Annexure 1.** Based on the examination and conditions, ANC exercise will be recommended.

Components of MLAC Screening Area

This area is designated near reception area or any free space available near OB&GY OPD manned by Staff Nurse (SN) or Nurse Practitioner Midwife (NPM)- (if available).

- If the pregnant woman is non-labouring, her screening shall be done in the designated screening area in the OPD block and shall be referred to OB&GY /MO, if PW is high risk.
- If the pregnant woman is labouring, she shall be referred to MLCU for triaging and if the case is an identified HRP, then immediately refer to OLCU without delay.
- The examination room in the OPD/emergency/labour room/or any designated area in the facility will serve as a screening area for risk stratification of pregnant women into low- and high-risk categories, based on history, examination and referral notes.

Waiting Area

- Availability of a dedicated waiting area as well as antenatal examination room.

Counselling and Exercise room

- Facility should develop a counselling and exercise room/demarcated area to teach women different antenatal exercises and yoga during pregnancy. It must be ensured that the privacy of woman is maintained.
- Availability of rope ladder/ rebozo, gym ball, yoga mat should be ensured (placed in the **Annexure 3**)
- Relevant educational material should be available in local language in the form of posters, banner, and hoardings.
- NPM should counsel and teach pregnant women on different types of antenatal exercises, alternative birthing positions, nutrition, healthy diet, healthy lifestyle, adequate rest, maintain personal hygiene, family planning methods, awareness on GoI schemes (JSY, JSSK, PMSMA, PMJAY), Birth preparedness, Linkages for referral transport etc.

B. Midwifery Led Care Unit

- The concept of MLCU has to be ingrained from the planning phase itself, for new DH/CHC/MCH wings. As per the revised IPHS standards each facility must identify a space adjacent to the existing labour room and establish a Midwifery Led Care Unit.

Principles of establishing MLCUs

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 existing conventional birthing unit and labour room functional in high case load facilities i.e. District hospital, MCH wings and FRU CHCs will establish Midwifery Led Care Unit (MLCU).
- MLCU will be a stand-alone model but in close proximity to the conventional labour room. It will coexist with the existing maternity unit (In the event of a labouring woman requiring comprehensive emergency obstetric care, she may be transferred immediately to the adjoining OLCU).

The MLCU shall be developed in accordance with the LDR protocols where pregnant woman is admitted during active phase of labour and observed for at least 2-4 hours in the immediate postpartum period before being transferred to the ward. On an average, one LDR unit is expected to support two pregnant women for childbirth within 24 hours.

Requirement of Beds:

The minimum recommended number of beds for setting up of an MLCU at a public healthcare facility is determined by the facility's delivery load. The calculation of beds for MLCUs is to be done as below.

Bed calculation for MLCU (synchronized with IPHS 2022)

Number of deliveries	Number of LDR beds
100 to 200	4 (2 MLCU + 2 OLCU)
201 – 400	6 (3 MLCU + 3 OLCU)
401 – 600	10 (4 MLCU + 6 OLCU)
> 600	15 (6 MLCU + 9 OLCU)

State to ensure saturation of high case load facilities (DH/SDH/FRU CHC) in initial phase

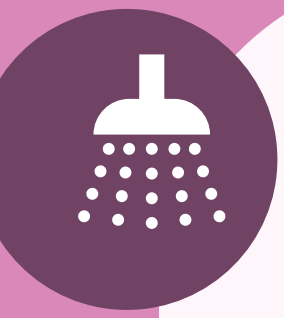
A suggestive infrastructural design for 2 bedded and 4 bedded layout is placed in the Annexure 2

Infrastructural Requirements:

Each midwifery unit shall have the main birthing area, area for ambulation and exercise, attached bathroom & a working area including newborn care corner.

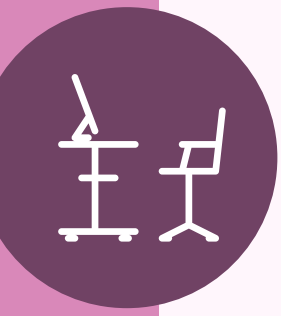
Area for ambulation and exercise

- This area should have yoga mat, gym ball, rebozo or rope ladder, kitchen height platform, railing for support etc.
- Privacy should be maintained through curtains at main door and between the beds.
- Informational videos may be displayed on an LCD/Plasma screen.



Bathroom with shower

- An attached toilet with wash basin, geyser for hot water and facility for shower all in functional order should be present.
- There should be railing on both sides of toilet for support and tiles of the floor of the toilet should be rough/matt finish.
- Bathroom should be wide enough to allow entry of emergency equipment and support person.
- A functional ceiling fan to dry the bathroom after use should be in place.



Working Area for staff

- This includes working platform for Midwives/Staff nurse to keep registers and formats in under-storage cabinets.
- There should be closet for pregnant women and family to store personal belongings.
- Cupboard for staff to store documents.
- This area should be covered with curtains from main midwifery unit area.

Hand Washing area

- Hand washing area should have steel sink, which is wide and deep enough to prevent splashing and retention of water.
- Elbow-operated taps with 24x7 running water supply.
- A functional geyser for hot water.
- Soap dispenser with soap.
- Hand washing protocol should be mounted on the wall above the hand washing area.

Biomedical Waste Management

- Bio Medical Waste Management should be done as per the revised BMW guidelines 2016 and other subsequent amendments.

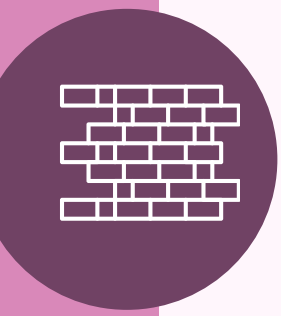
Newborn Care Corner (NBCC)

- Each midwifery unit should have dedicated newborn care corner with working space on three sides and with necessary equipment for resuscitation, as per operational guidelines on Facility Based New-born Care- 2014 by Government of India.

Space Requirement

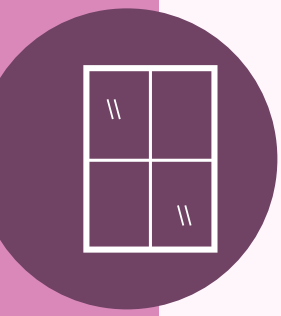
As per “IPHS standards for Sub district & District Hospital 2022 guidelines”, total space required for two bedded MLCU is approx. 225-250 square feet (15’x15’). It includes 2 birthing units along with one toilet.

These are suggestive space requirements. However, facilities may develop units as per local context following these guiding principles.



Colour of walls

- Light colours give soothing impact and stimulate cortical activity which releases oxytocin and provide a positive experience to the physiological birthing.
- The suggestive colour for the MLCU walls (INTERIOR/ EXTERIOR) is pink.



Windows

Natural light plays significant role in birthing process as it supports body’s natural circadian rhythm and an integral part of MLCU.

- Labour room should have windows to allow natural light while protecting privacy of women.
- Windows should be positioned to allow view of natural surroundings with internal blinds or provision of frosted glasses.

Lighting

- Allow light from windows in controlled manner through curtains or frosted glasses to mimic natural home lights.
- Do not use artificial bright LED light or blue light after dark.
- As per “IPHS standards for Sub district & District Hospital 2022 guidelines”, 100 lux lights for the ambiance and 300 lux shadow less lights for procedure area are suggestive.
- The MLCU lighting shall be dimmable. Darkness induces the body to produce melatonin, which enhances oxytocin synthesis. Oxytocin is the hormone responsible for uterine contractions during labour. To induce non-medicated labour, a conducive environment supported by infrastructural design is essential. (Reference document- IPHS 2022- SDH-DH guidelines: Volume-1).

Beds

- LDR beds may be used instead of labour tables as mentioned in LaQshya guidelines, and shall be placed on the side of room, close to wall, to ensure feeling of security and safety. Keep space between wall and bed to perform procedures, when needed in order to provide space to perform alternative birthing positions.
- The existing birthing beds may also be modified with the aluminium rods, which support labouring women to bear down.
- Furniture to support alternative birthing positions, such as armless chair, birthing stools etc. should be ensured.

Side railings

- Railings on the side walls support pregnant women during walking and bearing down efforts.
- Kitchen height platform is useful to women for support and during bearing down effort. It also ensures that trays and other equipment stay hidden under side cabinets.

Music

- Music therapy helps to decrease sensation of pain and anxiety in antenatal as well as labouring women. It also reduces need of post-partum analgesia.

Visual Focal Points

- Cheerful images of pregnant women and children, artwork depicting pregnant women with baby, natural scenes may be used to provide positive distraction from the labouring pain to women.

Space for Movement and exercise

- Physical movements like walking and exercise during labour help pregnant women to cope with strong and painful contractions and at the same time facilitate gentle passage of baby through the birth canal.
- Research supports that active movements may shorten duration of labour, is an effective form of pain relief.
- There must be enough space for the woman in labour to walk supported by her birth companion.

List of Equipment and Supplies for Midwifery Unit:

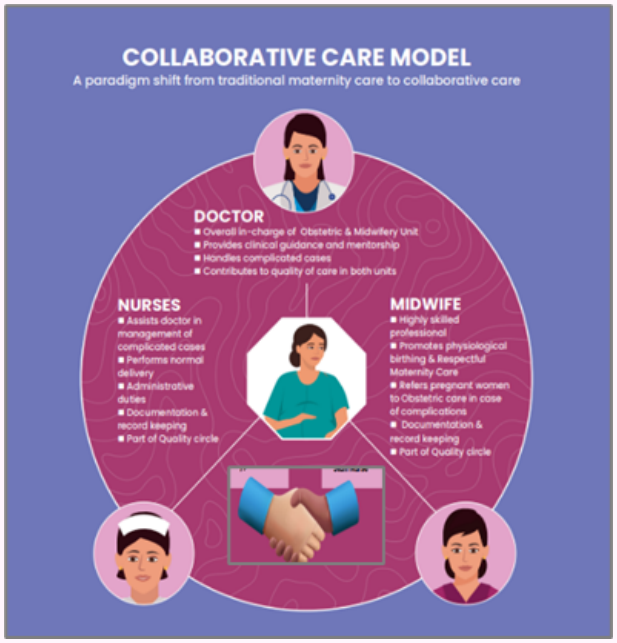
The technical specifications and use of the equipment is placed in Annexure 3.

Equipment and Supplies for Two bedded Midwifery Unit		
S.No.	**Title**	**Quantity**
1	LDR birthing bed (with facility to support various birthing positions)	2
2	Gym ball	2
3	Peanut ball	1
4	Yoga mat	2
5	Rebozo with ceiling hook	1
6	Armless chair	1
7	Soft pillow	2
8	Wooden rolling pin for acupressure	1
9	Hot gel-based packs	2
10	Bean bag	1
11	Floor mat	2
12	Cold pack bag	1
13	Wall clock	2
14	Delivery tray	4
15	Episiotomy tray	2
16	Emergency drug tray	2
17	Basin bowl	2
18	Baby weighing scale	2
19	Birthing chair	2
20	Birthing stool	2
21	Digital thermometer	2
22	Fetal doppler / Fetoscope	2
23	Glucometer hand-held	2
24	Mobile spot light	2
25	Neonatal resuscitation kit with size ‘0’ and ‘1’ masks	2
26	Pulse oximeter – Table top	1
27	Pulse oximeter – Finger tip	1
28	Sphygmomanometer	2
29	Stethoscope	2

CHAPTER 3: OPERATIONALIZING MLCU SERVICES

The following are the key steps to establish and operationalize MLCUs:

1. Sensitization of all stakeholders on the philosophy of Midwifery led care services.
2. Identify healthcare facilities for the establishment of Midwifery-Led Care Units (MLCUs). These units should have distinct physical spaces from other care units, featuring a separate entrance door and reception area when feasible. The determination of the requisite birthing rooms should be based on the annual number of births.
3. Conduct community mobilization activities and mid- and mass-media activities to enhance the acceptability of NPMs/MLCUs, increasing the awareness and utilization of their services.
4. Conduct site specific advocacy in the selected health facility including all technical staff involved in provision of maternity services.
5. Provide the basic required equipment and ensure regular supply of medicines to support midwifery services.
6. Ensure availability of trained manpower.
7. Provide onsite clinical supervision/mentorship at the facility by senior clinical supervisor/mentor for practicing NPMs.
8. Set up M&E and reporting system and conduct regular review of data and key results e.g. monthly meetings.



Midwifery Services: a collaborative care model

- Coordination between MLCU and OLCU is crucial for ensuring positive childbirth experience. Obstetric-led unit and midwife-led unit should develop shared vision of providing highest quality care to pregnant women and newborn.
- Collaboration between NPMs, Obstetricians, Paediatricians and Medical Officers In-charge (MOIC) /SN requires confidence, trust and effective communication.
- When effective collaboration occurs, the specialists can extend their contribution to the care of women and newborns experiencing complications and requiring specialized care.
- NPMs can also be involved in the care of women with high-risk pregnancies, pregnancy related complications, and women/newborns as part of the multidisciplinary team. In these situations, the overall accountability rests with the OB&GY/MOIC of the hospital/health center.
- For cases that develop complications (as per the scope of practice), a clearly defined referral mechanism, customized as per the local settings, has to be ensured.
- There should be clear policies and procedures for transfer to an obstetric unit or nearest higher-level facility. Linked tertiary care facilities should support DH, SDH & equivalent and CHC level midwifery units to expedite the referral process. There should be a clear understanding on indications and procedures for transfer to an obstetric unit or nearest higher-level facility.
- For the success of collaborative care model, it is vital that triaging is done at the time when a pregnant woman enters the healthcare facility.
- The senior most midwife at the facility/ a senior midwife may be designated as the Nodal officer who shall maintain a liaising between MLCU and OLCU and Paediatric units (SNCU, NICU) in order to deliver the quality collaborative care.

NPMs should only be engaged in providing maternity care services as per the "Scope of Practices for Midwifery Educators and Nurse Practitioner Midwife" document by the Government of India.

Indications for referral:

A prompt referral should be made for:

- A pregnant woman with any high-risk factor/s.
- Development of complications anytime during labour/ delivery.

Once the High-risk pregnancies identified the PW have to refer to the OLCU, based on the criteria, placed in **Annexure 1 and 4.**

Human Resource Norms

For quality service delivery, an adequate number of competent HR is required for providing best possible care during pregnancy, delivery and postpartum period.

Table: Human Resource Norms for MLCU

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 + leave adjustment)	2	4 NPMs (1 Midwives per shift for 3 shifts + leave adjustment)
	201 - 400	6	3	8 (2 SN per shift + leave adjustment)	3	8 NPMs (2 Midwives per shift for 3 shifts + leave adjustment)
	401 – 600	10	6	8 (2 SN per shift + leave adjustment)	4	12 NPMs (3 Midwives per shift for 3 shifts + leave adjustment)
	>600	15	9	12 (3 SN per shift + leave adjustment)	6	16 NPMs (4 Midwives per shift for 3 shifts + leave adjustment)
Security staff	Existing staff					
Cleaning staff	Existing staff					
Housekeeping staff	Existing staff					

Roles and Responsibilities

1. Head of Department – OB&GY/ Medical Superintendents/ Facility in charge/MO

- Supervision and support to NPMs & MEs posted in MLCU at the hospital attached with SMTI, as well as ensuring collaboration between MLCU & OLCU and other departments.
- Orienting the facility staff about midwifery led care, the dedicated unit (MLCU) and role of midwives in the care of pregnant women and new-borns. Nurture and advocate midwifery philosophy of care with women, their families and other professional colleagues in the hospital.
- To ensure that midwives (MEs and NPMs) are supported to practice as per their defined scope of practice (pre pregnancy, antenatal, intrapartum and postnatal).
- To ensure midwifery unit gets required support staff (such as Sweeper, Guard, Nursing orderly/Ward boy), and all logistics and supplies regularly.
- Handling and managing inter and intra-departmental issues.
- Ensure smooth coordination between maternity service providers such as doctors, nurses, pharmacists, lab technicians and midwives in all areas of work.
- Monitoring and periodical review of MLCU indicators with constructive feedback and continuous quality improvement for midwifery services at MLCU.
- To ensure continuous learning for midwifery staff of MLCU and OLCU on the latest GoI guidelines.
- Provide cross learning opportunities for doctors to work alongside midwives.
- To ensure that all budgetary requirements for Midwifery Unit are well represented in State NHM PIP.

2. Midwifery Educators (ME)/ Nurse Practitioner Midwife (NPM)

2.1. Clinical Roles (as given in Scope of Practice for NPMs)

A. Pre-pregnancy Care (Sexual and Reproductive Health)

- Provide Family planning counselling and services.
- Provide Pre-conception care and counselling.
- Perform measures in prevention and screening for Sexually Transmitted Infections and advice treatment based on the syndromic management approach.

B. Antenatal care

- Detect and confirm pregnancy, estimate gestational age from history, physical examination and advice on laboratory test from the recommended list of investigations.
- Monitor the progression of pregnancy.
- Assess fetal and maternal wellbeing.
- Promote and support healthy behaviours that improve women's wellbeing including ANC exercises.
- Provide antenatal education and anticipatory guidance related to pregnancy, birth, breastfeeding, parenthood, and postpartum family planning.
- Detect, manage, and refer women with complicated pregnancies (High risk pregnancies)
- Counsel the woman and her family and facilitate the preparation of a Birth preparedness and complication readiness plan.
- Provide counselling on pregnancy options and care to women with unintended or mistimed pregnancy.
- Provide counselling and post abortion care to women.
- Line listing of all the pregnant women who are at high risk and do their follow up.

C. Care during Labour and birth (Intrapartum Care)

- Confirm onset of labour.
- Provide supportive respectful care to women in normal labour at term and in immediate postnatal period (e.g. explain and facilitate alternate birthing positions, birth companionship as chosen by women, facilitate informed choices/rights-based care).
- Identify complications during labour, childbirth and the immediate postpartum period, and provide immediate management and referral when indicated.
- Assist physiological birthing processes leading to a safe birth, active management of the third stage of labour for the prevention of postpartum haemorrhage.
- Provide immediate essential new-born care (warmth, early initiation of breastfeeding, delayed cord clamping, vitamin K, eye and cord care)
- Perform neonatal resuscitation when indicated.
- Identify new-born complications, perform immediate management and when indicated, initiate timely referral.
- Perform and repair episiotomy based on evidence-based indications with the woman's consent.
- Repair perineal, vaginal and vulval lacerations (excluding 3rd /4th degree or complicated tears).

D. Ongoing care of women and new-borns (Postpartum Care)

- Provide postnatal care that focuses on continuing health assessment of woman and neonate, health education, support for breastfeeding, detection of complications and provision of family planning services.
- Support maternal and infant bonding and healthy childrearing practices.
- Identify postpartum complications, perform immediate management and when indicated, initiate referral promptly.
- Identify postnatal complications in the woman and new-born, provide immediate management and when indicated, initiate referral promptly.
- Counsel on postpartum family planning services.
- Provide anticipatory guidance on birth planning and complication readiness for the woman and new-born including recognition of danger signs in both.

2.2 Additional Roles & Responsibilities

MEs

- The MEs will play a dual role for supervising & mentoring the NPMs during their clinical practice sessions, alongside performing clinical practice themselves at MLCU at the hospital attached with SMTI.

NPMs

- Development of duty roster, monitoring and record keeping for day-to-day activities of MLCU.
- Coordination for ensuring regular supplies and logistics in MLCU.
- Coordination with facility I/C-HOD OB&GY, Medical Superintendent/ MO for smooth functioning of MLCU.
- Ensure that NPMs practice as per their roles defined in the Scope of Practice document including alternative birthing position, physiological birthing, respectful maternity care etc.
- Conflict resolution and smooth internal coordination.
- Maintaining Quality Standards in MLCU.

Staff Nurses

- Staff nurse will be posted in Obstetric led unit and support Doctors/Obstetricians for handling the cases admitted in obstetric unit including high risk cases.
- She will liaison with Midwives posted in MLCU for clinical case management and referral wherever required.
- Ensure collaborative care model is implemented in tandem with MLCU and respectful maternity care is delivered to the patient/woman in both settings.

All the units will function under the overall supervision and guidance of the Medical officer/ OB&GY Specialist / CEmONC/LSAS trained Doctor.

CHAPTER 4: ANTENATAL & INTRAPARTUM YOGA/EXERCISES

Need for the Yoga/Exercises during Pregnancy

Throughout pregnancy, the body experiences various physical and mental changes. Yoga and other exercises during pregnancy helps to keep a body and mind healthy and it facilitates healthy breathing and comfortable labour. It helps to:

1. Reduce stress level.
2. Improve the quality of sleep.
3. Increase the strength, flexibility, and endurance of muscles around the pelvic region.
4. Decrease lower back pain.
5. Decrease nausea.
6. Decrease carpal tunnel syndrome.
7. Decrease headaches.
8. Reduce risk of preterm labor.
9. Lower risk of intrauterine growth restriction (condition that slows the baby's growth).

Guidelines of Yogic Practice:

Each pregnancy is unique, even within the same woman. It is advisable to constantly listen to the body and modify the Exercises/Yoga practices according to the trimester of the pregnant women/ health condition particularly when attempting new yoga postures/ exercises. It is not necessary to perform all the exercises/asana in the same sequence. The focus should be on keeping proper posture & breathing and should be performed under proper guidance or supervision of health care providers.

- **First trimester:** Pregnant women should start with some breathing practices and loose movements like neck, shoulder and ankle.
- **Second trimester:** Pregnant women should do some stretching exercises, but all movements should be practiced under the strict supervision.
- **Third Trimester:** Bhadrasana, Shashankasana and other hip opening exercises may be performed to help ease the delivery process.

Guiding principles:

- Exercise/Yoga should be practiced in a quiet and calm atmosphere.
- PW should be empty stomach after emptying bowels and bladder.
- Use Yoga mat, mattress for Yoga practice.
- Light and comfortable cotton clothes are preferred.
- Exercises/Yoga shall be performed in a slow and relaxed manner.
- Breathing should always be through the nostrils unless instructed otherwise.
- More attention should be paid to pelvic floor awareness in all Asanas and Pranayama practices.
- Do not jerk the body when practicing exercise/yoga.
- Focus should be on stability and strength, rather than flexibility and endurance.
- Avoid Asanas compressing the uterus (e.g. forward bending or closed twist) or asanas overstretching the abdominal muscles (e.g. backbends).
- Avoid lying flat on your back if you feel dizzy, sweaty, nauseous, or short of breath. Avoid raising your hands above head if dizzy when standing.
- Avoid Kapalabhati kriya or any such straining cleansing practices.
- In pranayama avoid Bhastrika and Kumbhaka (retention of breath). Practice slow breathing techniques, such as the Yogic deep breathing, Anuloma Viloma, Ujjayi and Bhramari to bring focus, reduce stress, anxiety, and preparation for child birth.
- Yoga session/exercise should end with deep silence/meditation/ Sankalpa Shāntipatha.

Note:

- Inverted postures should be prevented during pregnancy, as it inverts the flow of blood from the pelvic area. Also, because pregnant women often experience low blood pressure, inversions can cause dizziness.
- During pregnancy, women's body release a hormone called relaxin, which softens the joints of the body, making them susceptible to dislocation, if stretched extensively.
- The expectant mother should refrain from practicing prolonged supine lying postures, as the weight of uterus and baby will extend pressure on vena cava, the vein, transporting blood from lower body to the heart.

*For details, please refer guidelines on **"Yoga for pregnant women"**, by Ministry of AYUSH.

CHAPTER 5: ALTERNATIVE BIRTHING POSITIONS

Introduction:

One of the essential components of respectful maternity care is woman's freedom to choose birth positions of her choice. Various evidence shows that mobility during the first and second stages of labour impacts both the woman's comfort level and the speed of labour progress wherein lack of woman's choice in birthing position is recognized as a barrier to some women's use of facility-based childbirth care.

Global evidences from WHO & other Midwifery associations suggests that supporting position changes as well as supporting women to assume the birth position of their choice enhances the maternal comfort and promote optimal foetal positioning. It is therefore important that any particular position is **not forced on the woman** and she is encouraged and supported to adopt any position that she finds most comfortable.

The evidence suggests that upright birth positions during the second stage of labour reduce the need for epidural anaesthesia, the length of active pushing phase in second stage, severe perineal trauma, episiotomy, abnormal fetal heart rate patterns, and instrumental vaginal births. However, upright positions may also be associated with increased risk of estimated blood loss greater than 500 ml and second-degree tears, though most evidence is of low certainty and the woman's choice of birth position should not be restricted based on this evidence.

In addition:

- X-ray evidence shows that actual dimensions of the pelvic outlet become wider in squatting and kneeling/hands-knees positions.
- Movement and upright positions help the baby with rotation and descent during the second stage.
- Gravity is the greatest aid in helping the baby's descent.
- Movement and upright positions can help with the frequency, length, and efficiency of contractions and the descent of the baby.
- Birth may be perceived as less painful when not lying on the back, women feel more in control when they can choose the birth position and may have higher satisfaction and more positive birth experience.

In contrast, in the supine/lithotomy position, the uterus compresses the major blood vessels, reducing uterine blood flow, possibly contributing to fetal hypoxia/birth asphyxia. Moreover, the traditional supine position during labour has known adverse effects such as supine hypotension and more frequent fetal heart rate decelerations. In any position other than supine/lithotomy there is less risk of compressing the aorta/vena cava and thus better oxygen supply to the baby, which leads to lowered risk of abnormal fetal heart rates and lower risk of emergency caesarean for fetal distress.

Resources needed to support women to assume the position of their choice

1. **Provider education:** Building provider's competence and confidence to support a range of birth positions can help to create more client-centered maternity services that may be associated with better satisfaction and utilization of facility childbirth services.
2. **Preparation of women:** Counselling pregnant women and family members needs to be done during antenatal and intrapartum period by the health care providers regarding different types of birthing positions. Where necessary, midwives may demonstrate the positions and encourage women to adopt it, if she is comfortable.
3. **Additional props:** Upright positions do not necessarily require additional props (e.g. birth cushions). However, facilities should have additional equipment/props viz a viz birthing/squat stools, birthing chairs, birth cushions etc. as placed in the Annexure 2.
4. **FHR Monitoring devices:** Stethoscope, Handheld Doppler, Cardiotocography (CTG) should be available for intermittent fetal monitoring during various phases of labour.
5. **Infrastructure changes:** Overcrowded labour/delivery rooms with little space and privacy may hinder a woman's ability to assume the position of her choice during birth. It is important to ensure adequate private physical space for the woman and her companion during second stage.

Provider adaptations needed when women choose alternative birth positions

Over time, obstetric care shifted from supporting women in the birth position, they spontaneously assumed to requiring women to give birth in a supine/lithotomy position and this requires over medicalization. Midwives facilitate a physiologic labour process by supporting women to assume the birth position of their choice, and minimise interventions when there is not a clear medical/obstetric indication. Midwives need to learn how to adapt their care to facilitate assisting birth in upright birth positions chosen by women.

Hand Manoeuvres

The mechanisms of labour (main movements of the fetus) are unchanged regardless of the birth position the woman chooses: Descent, flexion, internal rotation of the head, extension of the head, restitution, internal rotation of the shoulders, and lateral flexion. Hand manoeuvres when assisting the birth will, however, change depending on the birth position the woman chooses. Midwives must therefore consciously remember why they carry out the hand manoeuvres so they can adapt them based on the woman's birth position.

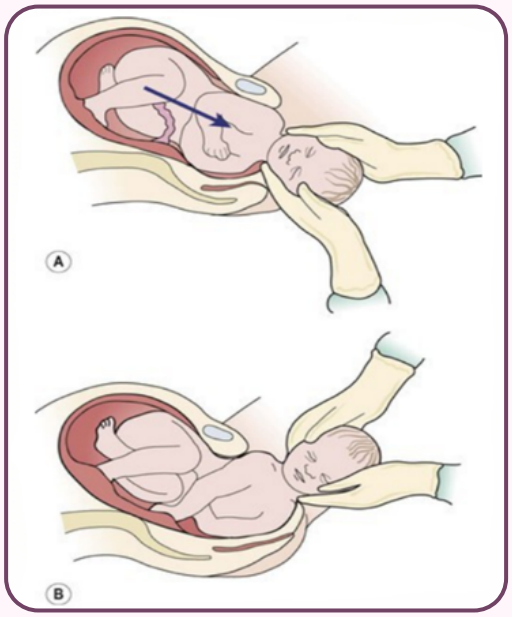


Figure 2. Delivery of Shoulders

1. As the head is being born, the midwife, if right-handed, places the left palm over the infant's occiput during a contraction to keep the head flexed and to control and, if necessary, slightly slow progress. If in Occiput Anterior (OA) position, head flexion should be maintained by applying pressure **towards the woman's back.** If in Occiput Posterior (OP) position, head flexion should be maintained by applying pressure **towards the woman's abdomen.**
2. Simultaneously, the midwife places the curved fingers of the right hand against the dilating perineum, through which the infant's brow or chin is felt. This hand will protect the perineum and also keep the baby's chin close to its chest.

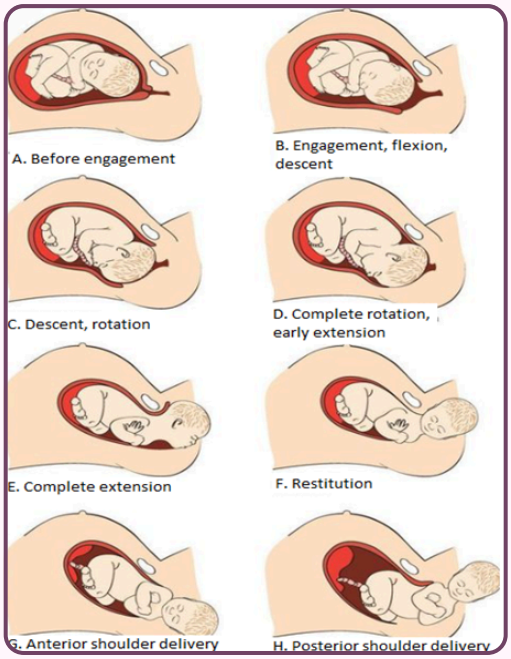


Figure 3. Cardinal movements in labour

3. After the baby's head has turned spontaneously (restitution), the midwife places hands on either side of the baby's head and applies gentle traction **towards the woman's back** to deliver the anterior shoulder (see A in Figure 2).

4. After the anterior shoulder is delivered, the midwife applies gentle traction **towards the woman's abdomen** to deliver the posterior shoulder (see B in Figure 2).

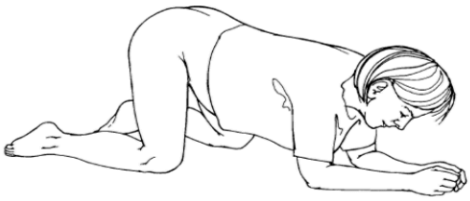
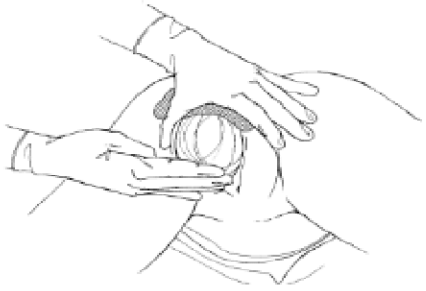
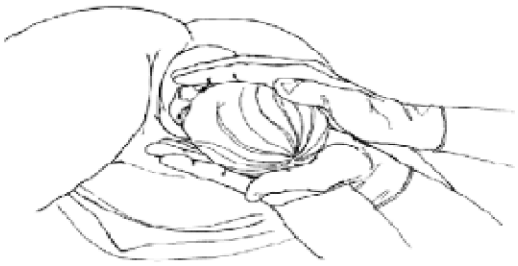
Hands-and-knees	Semi-sitting
	
Perineal support	Perineal support during normal vaginal birth
	
Pulling gently upward to deliver the anterior shoulder	Pulling gently downward to deliver the anterior shoulder
	
Pulling gently downward to deliver the posterior shoulder	Pulling gently upward to deliver the posterior shoulder
	
Supporting the baby during birth	Supporting the baby during birth
	

Figure 4. Hand Manoeuvres

Tips for hand manoeuvres when assisting birth in positions other than supine/lithotomy

If in OA position, maintain head flexion **towards the woman's bottom/ back**

- If squatting or sitting, you will keep the head flexed downward as with birth in a semi-sitting or supine/lithotomy position.
- If side-lying, you will keep the head flexed either to the right or left, depending on which side the woman's back is.
- If on hands and knees, you will keep the head flexed upward.
- If the woman is standing or kneeling and the midwife is positioned behind the woman, you will keep the head flexed upward.
- If the woman is standing or kneeling and the midwife is positioned in front of the woman, you will keep the head flexed downward as with birth in a semi-sitting or supine/lithotomy position.

Deliver the anterior shoulder by gently pulling the baby **towards the woman's bottom / back**.

- If squatting or sitting, you will deliver the anterior shoulder by applying gentle traction downward as with birth in a semi-sitting or supine/lithotomy position.
- If side-lying, you will deliver the anterior shoulder either by applying gentle traction to the right or left, depending on which side the woman's back is.
- If on hands and knees, you will deliver the anterior shoulder by applying gentle traction upward.
- If the woman is standing or kneeling and the midwife is positioned behind the woman, you will deliver the anterior shoulder by applying gentle traction upward.
- If the woman is standing or kneeling and the midwife is positioned in front of the woman, you will deliver the anterior shoulder by applying gentle traction downward as with birth in a semi-sitting or supine/lithotomy position.

Deliver the posterior shoulder by gently pulling the baby **towards the woman's abdomen.**

- If squatting or sitting, you will deliver the posterior shoulder by applying gentle traction upward as with birth in a semi-sitting or supine/lithotomy position.
- If side-lying, you will deliver the posterior shoulder either by applying gentle traction to the right or left, depending on which side the woman's back is.
- If on hands and knees, you will deliver the posterior shoulder by applying gentle traction downward.
- If the woman is standing or kneeling and the midwife is positioned behind the woman, you will deliver the posterior shoulder by applying gentle traction downward.
- If the woman is standing or kneeling and the midwife is positioned in front of the woman, you will deliver the anterior shoulder by applying gentle traction upward as with birth in a semi-sitting or supine/lithotomy position.

Fetal monitoring during second stage

- Continuous cardiotocography is not recommended for assessment of fetal well-being in healthy pregnant women undergoing spontaneous labour.
- Intermittent auscultation of the fetal heart rate with either a Doppler ultrasound device or Pinard fetal stethoscope is recommended for healthy pregnant women in labour.

For healthy women at low risk, hand-held Doppler devices should be used to facilitate intermittent auscultation of the fetus when the woman's chosen birth position makes auscultation with a Pinard fetoscope difficult. If these devices are not available, then midwife should explain to the woman that she needs to change position while fetal monitoring is attempted. After monitoring is completed, the midwife should support the woman to assume the birth position of her choice.

Limiting interventions during labour and birth that restrict mobility

There is a significant desire to promote normality during labour and birth, by both providers and women. For healthy women in spontaneous labour who are at low risk and being cared for by midwives, interventions that may restrict mobility e.g. intravenous fluids, should only be considered when there is a clear medical/obstetric indication with demonstrable benefits.

Placement of the baby after birth

After birth, the new-born should be placed directly in contact with the mother's skin. Skin-to-skin contact is associated with decreased time to the first feeding, improved breastfeeding initiation and continuation, higher blood glucose level, decreased crying, and decreased hypothermia. In many cases, women will spontaneously lie on their backs once the baby is born, which will facilitate placement of the new-born on the woman's abdomen/chest. When the woman chooses to stay in an upright birth position, such as hands-and-knees, midwives will need to be creative in finding ways to ensure that the baby can be placed in skin-to-skin contact with her mother.

Active management of the third stage of labour

In many cases, women will spontaneously lie on their backs before delivery of the placenta, if the woman remains in a position where counter-traction during controlled cord traction is difficult, the midwives should still give a uterotonic as part of active management of the third stage of labour.

Which alternative birthing position is ideal?

The evidence is not strong enough at this point to recommend one birthing position over another. There is also no one "right" position for an individual woman during second stage, and it is likely that the woman will change positions during second stage. However, flexible sacrum positions appear to be more helpful to normal vaginal birth, and upright positions may help the baby to move down the birth canal and rotate, and improve labour progress. All positions have advantages and disadvantages.

During the second stage:

- Women should be assisted, supported and encouraged to move freely and use the upright and mobile positions they find most helpful in enhancing their comfort and sense of control.
- Midwives can be proactive in demonstrating and encouraging different positions in labour if the woman appears to be positioning herself on the bed because she feels this is what is expected of her.
- Because it is unethical for a provider to use coercion or force to achieve a birth position, providers should clearly communicate with the woman the reason for requesting a change in position should it be necessary because labour is not progressing OR to ensure adequate fetal monitoring, provide interventions, or because the perceived risk is greater than the benefits of allowing free choice of a position.

Common alternative birthing positions

1. Squatting Position:

- The woman is urged to squat comfortably, and to lower her body in such a way that she is going to sit on an imaginary chair until her hips are parallel to the ground.
- In the squatting position, a woman's weight rests mainly on her feet, but her knees are markedly bent. To maintain balance, a woman may want the support of a companion, birthing chair, chair, birthing ball, or the end of a bed.

Advantages

- Widens pelvic outlet: Increases pelvic diameter by more than 10% (up to 2 cm). There is radiographic evidence that there is some separation of the lower end of the symphysis pubis in the squatting position, resulting in a 28 % increase in pelvic area.
- Takes advantage of gravity.
- May enhance rotation and descent.
- May play a role in reducing labour pain.
- Effective in shortening the second-stage of labour.
- Allows the sacrum to move freely without restriction.
- May be helpful if the pregnant women do not feel the urge to push.
- Requires less bearing down effort.
- Allows the pregnant woman the freedom to shift her weight for comfort.

Disadvantages

- It widens the pelvic outlet but may diminish the pelvic inlet.
- May promote too rapid expulsion, leading to perineal tears.
- May be uncomfortable.
- May be difficult to get on to an ordinary bed (a birthing bed with squatting bar helps).
- May be difficult for the midwife to see the perineum.
- May be uncomfortable for the midwife if the woman is squatting on the floor.
- May not be familiar to the midwife, who may need to adjust his or her technique for delivery.

2. Lateral /Side Lying

- The pregnant women are advised to lie on either side. She may be propped up by peanut ball or pillows, or supported by a companion.

Advantages

- Allows the sacrum to move freely without restriction.
- Useful to slow down a very rapid second stage (precipitate labour).
- May lower the risk of perineal trauma.
- Favourable if the woman has high blood pressure.
- May be used in conjunction with epidural anaesthesia.
- May reduce backache.
- Easier to relax between pushing effort.

Disadvantages

- Gravity neutral position.
- May not be familiar to the birth attendant, who may need to adjust his or her technique for delivery.
- Is unfavourable if you need to speed second stage.

3. Standing Upright

- When standing, the midwives support the pregnant woman to keep her feet slightly apart and avoid locking her knees to keep the pelvis tucked in.
- The woman may place one foot on a small step stool. This takes some of the weight off of her lower back. In this position, the woman may experiment with different heights to see what is comfortable.
- A low stool, the seat of a chair, or the side of a tub are good options. This position can be best used with a support nearby, either an object, wall, or birth companion.
- Counters or sturdy chairs are great to lean on and put weight into while the woman rolls and rotates hips.

Advantages

- Allows the sacrum to move freely without restriction.
- Contractions can become less painful and more productive.
- Aligns the baby with the pelvis and helps with descent.
- May increase the pregnant woman's urge to push (bear down) in the second stage of labour.
- Is associated with the lowest risk of anal sphincter injuries during childbirth.

Disadvantages

- Not typically recommended for the woman feeling lightheaded.
- May be hard work for support person.
- May be inconvenient for the birth attendant to see or assist the process of birth in this position.
- May not be familiar to the birth attendant, who may need to adjust his or her technique for delivery.

4. Hands and Knees

- The midwife asks the pregnant woman to kneel slowly. She may keep her chest on the floor or bed.
- The woman's weight should be mainly on her knees, and possibly on her arms, hands, or upper chest.
- Consider using pillows or the support of a companion if the woman's arms, torso or legs become fatigued.

Advantages

- This position widens the pelvic inlet when the knees are spread apart. It can be used to help reposition a posterior baby. This position brings the baby forward and reduces pressure on the cervix.
- Allows the sacrum to move freely without restriction.
- May reduce backache.
- May improve chances of intact perineum.

Early Labour

- Hands and knees help the baby to reposition if the baby is in occiput posterior position.
- This position may encourage cervical dilation.

Late Labour

- It reduces pressure on the women's cervix if it is swollen. The position can be used for back labour.

Disadvantages

- Gravity-neutral.
- Pregnant women may find it difficult to maintain the position for long periods.
- May be inconvenient/difficult for the birth attendant to check fetal heart rate.
- Is unfavourable if you need to speed second stage.
- May not be familiar to the birth attendant, who may need to adjust his or her technique for delivery.

5. Semi-sitting/upright sitting

In semi-sitting position, the bed is elevated to 45 degrees or more with her knees apart. In sitting upright position, the woman sits straight up on a bed, chair, or tool, e.g., birth seat, toilet.

Advantages

- May facilitate second stage when compared to lying flat.
- Slight gravity advantage over lying flat.
- May play a role in reducing labour pain.
- Woman able to view birth.
- Woman can see the birth attendant, which is reassuring.
- Convenient for the birth attendant and for fetal monitoring.
- May be necessary for interventions (forceps, episiotomy, etc.)
- Easy to get into on bed or on delivery table.

Disadvantages

- May restrict free movement of the sacrum when more room is needed in the pelvis.
- Possible supine hypotension.
- May slow passage of head under pubic bone.
- Restricts the woman's efforts, which could prolong delivery.
- Leg cramps common.

6. Kneeling

The woman kneels with her trunk upright or palms on ball/cushion/bed.

Advantages

- Allows the sacrum to move freely without restriction.
- Relieves pain of contractions.
- Eases back pressure.
- May improve chances of intact perineum.
- Shortened the second-stage of labour.

Disadvantages

- May be inconvenient/difficult for the birth attendant to check fetal heart rate.
- May not be familiar to the midwife, who may need to adjust his or her technique for delivery.

CHAPTER 6: REPORTING, MONITORING, & BUDGETING

MLCU Reporting

All MLCUs will maintain registers and reports as per the standardized record keeping protocol recommended and followed in Obstetric Units currently (which covers majority of antenatal, intra-natal and postnatal period for both mother and child). However, following additional components on midwifery practices shall be captured and analyzed periodically. The data from midwifery unit will be clubbed with the main labour room register at the end of every month for complication and facility level reporting.

Monitoring indicators

S. No	Indicators	
1.	% of Deliveries conducted in Midwifery unit out of total deliveries in the facility	**Numerator:** No. of Deliveries Conducted at MLCU. **Denominator:** Total Deliveries conducted at the Facility.
2.	% of Deliveries conducted in Midwifery unit at night (8 PM to 8 AM)	**Numerator:** No. of Deliveries Conducted in MLCU at night (8 PM to 8 AM). **Denominator:** Total Deliveries conducted at MLCU.
3	% of Referrals to obstetric unit (OLCU)	**Numerator:** No. of Referrals to obstetric unit (OLCU). **Denominator:** Total Admissions in MLCU.
4	% of PW who underwent C Section out of those referred	**Numerator:** No. of PW referred who underwent C-section. **Denominator:** No. of Referrals to obstetric unit by MLCU.
5	% of Newborn who required Neonatal Resuscitation	**Numerator:** No. of Newborns who required Neonatal Resuscitation. **Denominator:** Total Live Births at MLCU.
6	% of Births which happened in Alternative Birthing Positions	**Numerator:** No. of Births at MLCU in Alternate Birthing Position. **Denominator:** Total Births at MLCU.
7	% of Episiotomies conducted at MLCU	**Numerator:** No. of Episiotomies conducted at MLCU. **Denominator:** Total Deliveries conducted at MLCU.
8	% of Perineal tear reported at MLCU	**Numerator:** No. of Perineal Tear Reported. **Denominator:** Total Deliveries conducted at MLCU.

Apart from these, the existing Labour Room Formats also need to be filled, as placed in the Annexure 5.

Budget:

State may propose budget in budget head **RCH.1 Maternal Health, S.No. 8-Midwifery Initiative** for Infrastructure strengthening, equipment and miscellaneous activities.

S. No.	Component	Justification	Estimated Cost
1.	Strengthening infrastructure	Infrastructure renovation to support setting up of Midwifery led birthing unit or Antenatal OPD. This may include recreating partitions to assign a separate unit, assuring privacy through curtains or frosted glasses over the windows, cabinets for patients and birth attendant, establishing safe bathroom facilities, any other modifications depending on the requirement and the gaps identified as per the standard checklist. Electrification (electrical equipment's, lights, music system, etc.), renovation/construction of toilet in MLCU.	State may propose budget as per actual gap assessment.
2.	Equipment	This includes procurement of equipment's as per the GoI guidelines. (MNH tool kit for labour room & Guidelines for Standardization of LR at delivery points).	
3.	Furniture	This includes procurement of furniture (such as sofa, chair, benches, curtains etc.) and other logistics.	
4.	Miscellaneous	Includes uniforms for Midwives, MLCU registers, IEC material, etc.	

States/UTs may procure the above-mentioned items, subjected to their procurement norms.

CHAPTER 7: QUALITY ASSURANCE IN MLCU

Quality is the core component of healthcare performance as it focuses on its functioning, the care patients receive, and the user's experience. To improve the quality continuously in healthcare institutions all elements must be measured systematically. Considering the importance of quality, accountability, and improvement, the Ministry of Health and Family Welfare, Govt. of India has launched the LaQshya program in 2017. LaQshya focused on improving the quality of care provided to pregnant women during the birthing process and working towards ensuring effective, safe, and patient/beneficiary-centred care in the Labour room (LR) and Maternity- operation theatre (M-OT).

To further strengthen the maternity services provided by healthcare institutions the MLCUs and OLCUs are envisaged. To ensure the effectiveness, efficiency, equity, patient safety in the care provided in MLCUs, it is pertinent to introduce quality standards in line with existing LaQshya Standards. The National quality standards for MLCU complete the gamut of maternity services provided by public healthcare facilities, ensure standardization, adjust focus on what needs to be improved, improve beneficiary's experience, and boost staff's motivation for better performance.

The framework and measurement system used to draft the MLCU standards aligned with LaQshya standards. In this guideline, only a broad statement of standards under 8 Areas of concern (Service provision, Patient Rights. Inputs, Support services, Clinical services, Infection Control, Quality Management systems, and Outcomes) is given. The measurable elements and an assessment tool kit will be provided later as part of LaQshya under NQAS framework.

The Quality Standards for MLCU is placed in the **Annexure 6.**

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MLCU
Annexures

Annexure 1

Criteria for Admission to Midwifery Unit

Name of Mother:	Date (dd/mm/yy) & Time (__am/pm):
LMP: EDD:	POG (wks):
Name of Midwife doing assessment:	
Name of Resident/Obstetrician / Doctor doing assessment:	
Gravida / Parity:	Blood Group (ABO Rh):

If none of the following criteria is present, women can be admitted to Midwifery Unit

Maternal Characteristics

- ☐ Maternal Age <17 or >40 years
- ☐ Height <145 cm
- ☐ Weight on admission >70 Kg
- ☐ Parity 5 or above

Past Obstetric History of

- ☐ PPH
- ☐ Difficult/Assisted Delivery or prolonged labour
- ☐ Neonatal death or still birth
- ☐ Previous CS
- ☐ Eclampsia
- ☐ Manual removal of placenta
- ☐ Repair of 3rd/ 4th Perineal Tear

Current Medical Problems

- ☐ Hypertension
- ☐ Diabetes
- ☐ Cardiac diseases
- ☐ Connective tissue diseases
- ☐ Liver/Renal diseases
- ☐ Pulmonary diseases
- ☐ Thyrotoxicosis
- ☐ Neurological disease
- ☐ Myomectomy
- ☐ Laparotomy with uterine scar
- ☐ Pelvic Floor Repair (OASI)
- ☐ Orthopedic surgery (which may restrict her mobility)
- ☐ Uterine Repair
- ☐ Heart Surgery

Current Antenatal Problems

- ☐ Anaemia< 9 gm/dl
- ☐ Urine Albumin > +1
- ☐ GDM
- ☐ Breech or Any other mal presentation
- ☐ Multifetal pregnancy
- ☐ Hypertension in pregnancy (>140/90)
- ☐ Antepartum Haemorrhage
- ☐ Estimated fetal weight <2.2 kg or >3.5 kg
- ☐ PROM
- ☐ Post-dated pregnancy >40 weeks
- ☐ Pre-term labour confirmed
- ☐ Presenting with diminished or loss of fetal movement
- ☐ Temperature >100 F
- ☐ Hypo or Hyperthyroidism
- ☐ Rh –ve pregnancy

Problem Detected during Labour

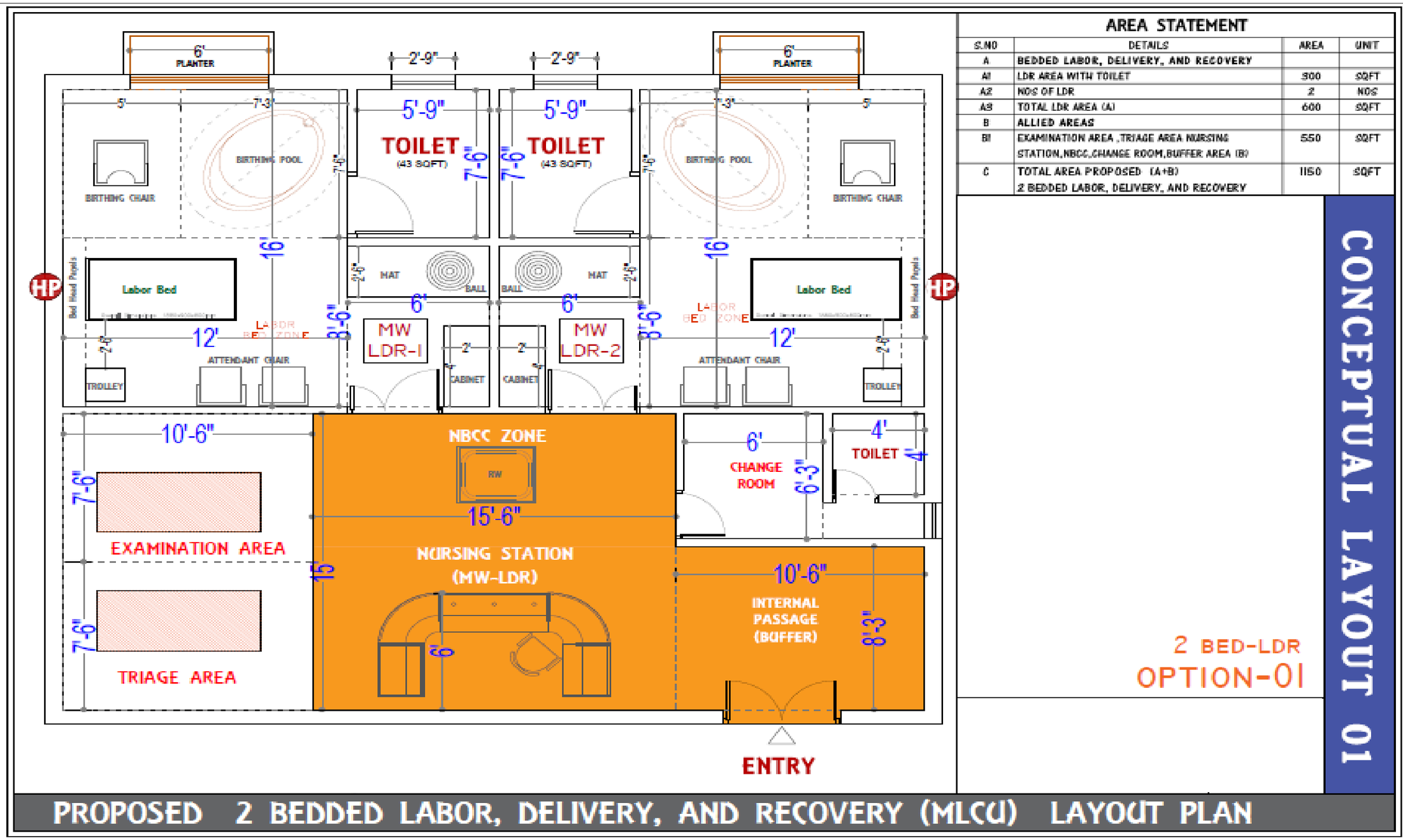
- ☐ Maternal vital signs, i.e. the **pulse** (more than 100/min), **BP** (>140/90 mmHg)
- ☐ and **temperature** (>38˚C), cross the normal limits.
- ☐ Meconium-stained liquor
- ☐ FHR <110, >160 bpm
- ☐ Maternal Heart Rate >120 bpm
- ☐ Blood-stained liquor
- ☐ Unengaged head >6 hrs duration
- ☐ Induction of Planned labour
- ☐ Non-engaged fetal head in primi at term
- ☐ Cephalo pelvic disproportion (CPD)
- ☐ Cord/hand prolapse
- ☐ Pre-eclampsia/Eclampsia
- ☐ Severe Anaemia (Hb<7g/dl)

Signature of NPM Signature of Resident/Obstetrician/MO

Annexure 2

Suggestive Architectural Layouts for Two-Bedded and Four-Bedded Midwifery Units

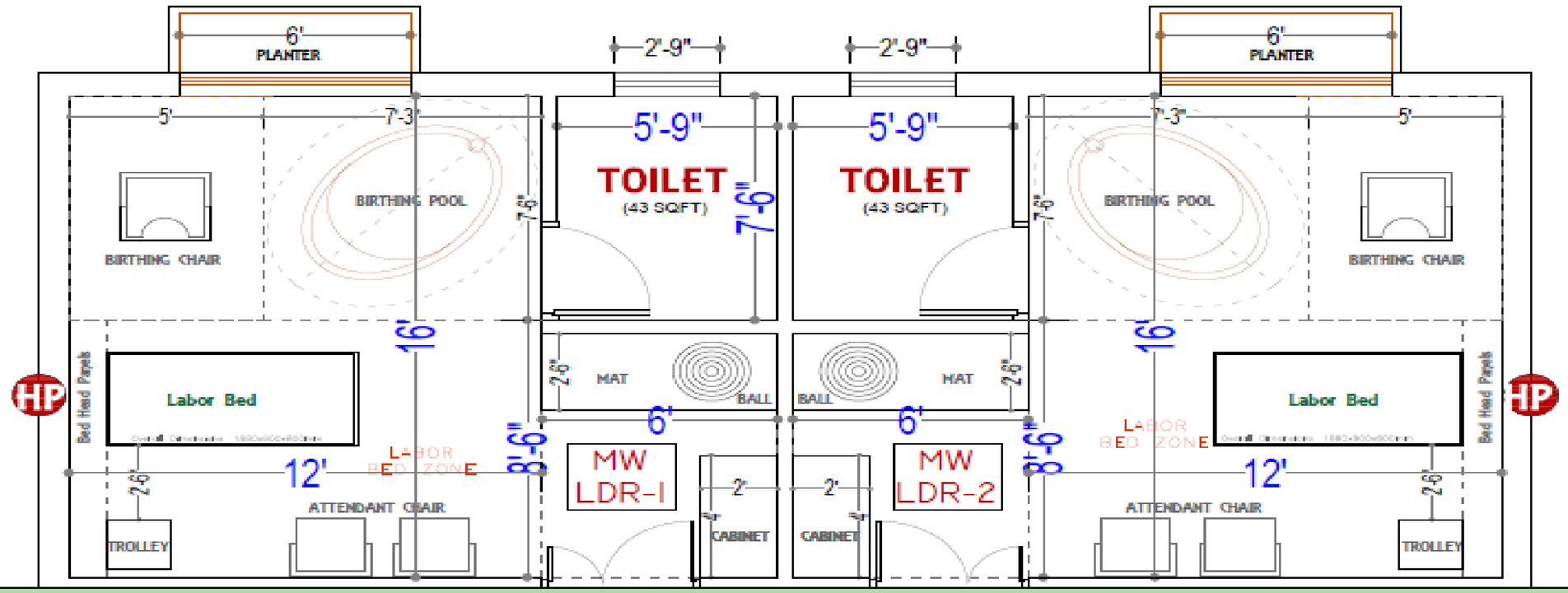
Design 1 – Two-Bedded Midwifery Unit



AREA STATEMENT

S.NO	DETAILS	AREA	UNIT
A	BEDDED LABOR, DELIVERY, AND RECOVERY		
A1	LDR AREA WITH TOILET	300	SQFT
A2	NOS OF LDR	2	NOS
A3	TOTAL LDR AREA (A)	600	SQFT
B	ALLIED AREAS		
B1	EXAMINATION AREA ,TRIAGE AREA NURSING STATION,NBCC,CHANGE ROOM,BUFFER AREA (B)	550	SQFT
C	TOTAL AREA PROPOSED (A+B) 2 BEDDED LABOR, DELIVERY, AND RECOVERY	1150	SQFT

PROPOSED 2 BEDDED LABOR, DELIVERY, AND RECOVERY (MLCU) LAYOUT PLAN



AREA STATEMENT

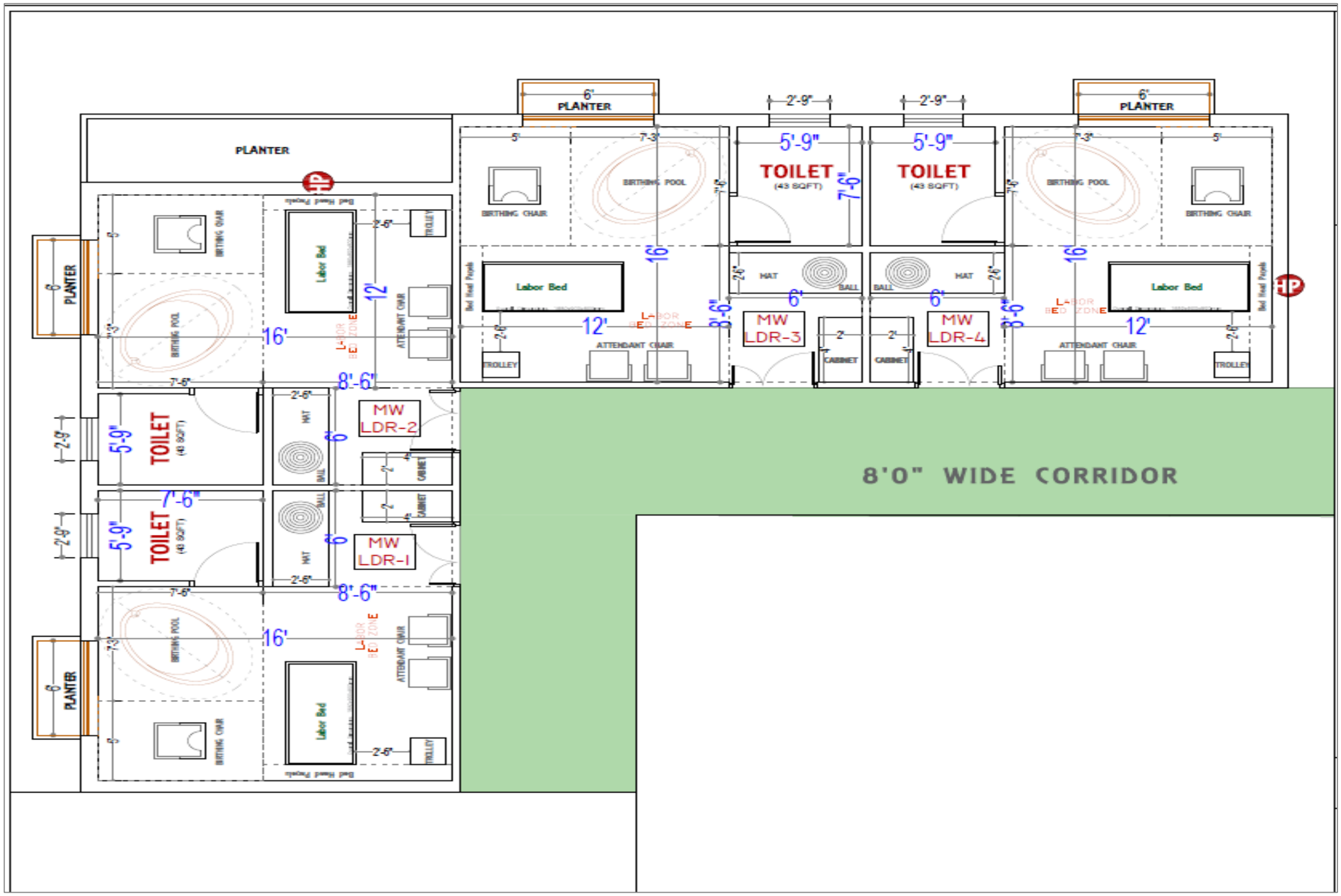
S.NO	DETAILS	AREA	UNIT
A	BEDDED LABOR, DELIVERY, AND RECOVERY		
A1	LDR AREA WITH TOILET	300	SQFT
A2	NOS OF LDR	2	NOS
A3	TOTAL LDR AREA (A)	600	SQFT

2 BED-LDR
OPTION-02

CONCEPTUAL LAYOUT 02

PROPOSED 2 BEDDED LABOR, DELIVERY, AND RECOVERY (MLCU) LAYOUT PLAN

Design 2 – Four-Bedded Midwifery Unit



Annexure 3

Use of MLCU Equipment

1. Floor mats or yoga mats

The mother can practice general relaxation techniques (for example, progressive muscle relaxation, and breathing techniques etc.), music, yoga, mindfulness training and audio analgesia (for example, listening to calming sounds such as waves during labour).

2. Cotton dupatta, Mulmul cloth or a soft cotton cloth of two and half meters in length

- It helps pregnant women to opt variety of positions and for relaxation.
- Used as a leverage to help support the mother's weight, so all the pressure isn't on the support person.

Can also be used in simple techniques to turn baby into optimal fetal positions and speed up slowed labour.

3. Soft cotton saree of five and half meters as a ceiling hook for Rebozo

This is to help with active birth as shown in the previous picture to help the mother assume various labour positions.

4. Gym balls size 55 and 65 cm

- These are useful for women with heights ranging from 4'8" to 5'6".
- Reduces pain and anxiety.
- Reduces use of pethidine.
- Easy foetal rotation and descent.
- Shorter duration of labour and enhanced maternal satisfaction and well-being.
- An opportunity to use an upright position.

Encourages various types of movement and mobility.

5. Peanut ball

- A peanut ball when placed in between the mother's legs, opens the pelvis.
- Used for mothers who are exhausted and need to relax.
- For better resting position than lying on the back when mobility is restricted due to use of epidural.

Aids in alignment of the fetus for birth from occipital posterior to occipital anterior.

6. Armless chair

- Helps to adopt squatting or sitting position.
- Flexes the knees and opens the pelvis, promotes gravity to help the baby descend.
- Facilitates the upright position and provides comfort to mothers in labour.

Protective against routine episiotomies and Kristeller manoeuvre/fundal pressure, which are not a recommended practice.

7. Wooden rolling pin

This is helpful for back massage as a non-pharmacological pain-relieving method for mothers in labour.

8. Pair of socks with two tennis balls

9. Soft Pillows

Provides comfort while mother adopts various positions.

10. Hot gel-based pack

Can effectively relax tired muscles and help with pain reduction, improving blood circulation and relaxing muscles.

11. Cold pack

To apply on the mother's lower back. A cool cloth can also be used to wipe the mother's face during labour.

12. Basin bowl

Helps to store water for warm compress.

Technical Specifications for MLCU Equipment

S. No.	Title	Specifications
1	LDR birthing bed (with facility to support various birthing positions)	• Dimensions: Overall approximate size 1880 -2160 mm (L) * 900 - 1010 mm (W) * 550 mm to880 mm (H) (with option of manual adjustable height of the bed). • User Interface-Electro-mechanical. • Power input- 220-240V AC,50 Hz fitted with Indian plug.
2	Gym ball 	• Standard Size:55 cm/ 65cm/75cm/ 85 cm. • Material: Non-toxic PVC/ rubber. • Weight holding capacity: up to 150 kg. • Anti-burst mechanism and stable valve. • Should be supplied with an adaptor and a manual pump.
3	Peanut ball 	• Size: 45 cm/ 55cm/ 65cm. • Material: Non-toxic PVC/ rubber. • Weight holding capacity: up to 150 kg. • Anti-burst mechanism and stable valve. • Should be supplied with adaptor and manual pump.
4	Yoga mat 	• Size: 170 x 70 cm (L x W) or more. • Material: soft and non-slippery top surface with good grip. • Skin friendly non-toxic durable, lightweight. • Portability: Easily foldable/ rollable durable material.

S. No.	Title	Specifications
5	Rebozo with ceiling hook 	• Material: High tensile strength soft cotton. • Weight/ Load capacity: Should be able to hold weight up to 150 kg.
6	Armless chair 	• Furniture item
7	Wooden rolling pin for acupressure 	• Material: Non-traumatic material.
8	Hot gel-based packs 	• Electric warm gel bag with auto cut. • Material: Natural rubber latex. • Capacity: 1000ml - 1500 ml. • Portability: Easy to carry.

S. No.	Title	Specifications
9	Bean bag 	• Size: Height: 125-150 cm. Width: 120-140 cm. • Material: Should be waterproof and washable. • Weight holding capacity: up to 150 kg.
10	Floor mat 	• Size: 180 x 120 cm. • Material: Soft and non-slippery top surface with good grip. • Should be foldable in 3-sections.
11	Cold pack bag 	• Type: Pouch type sealed container. • Reusable. • Easy to carry with no leakage.
12	Wall clock 	• Battery-operated digital wall clock.

Annexure 4

Criteria for referring Pregnant Women to OLCU

Maternal and Newborn conditions that an NPM can perform independently, in collaboration or refer

Maternal care					
Condition		Triage / Identify	Manage independently	Manage collaboratively	Refer
Pre-pregnancy morbidities – type I/II DM; hypertensive disorders; obesity (BMI>35); cardiac disease; history of poor obstetric outcome (including perinatal death); mental illness; history of cervical or uterine surgery (including C-section); current alcohol or drug use/dependency; history of placental abruption, cervical incompetence, recurrent spontaneous abortion (3 or more), trophoblastic disease, obstetric fistula, PPH>1000 ml and medical disorders of pregnancy		✓			✓
Multiple pregnancy	Diagnosed in pregnancy	✓			✓
	Diagnosed in second stage of labour	✓	✓	✓	✓
Common discomforts in pregnancy		✓	✓		
Gestational DM	MNT	✓	✓	✓	
	Metformin				✓
	Insulin				✓
Anaemia during pregnancy	7-9 gm%	✓	✓	✓	
	<7 gm%	✓			✓
Syndromic management of chlamydia and gonorrhoea during pregnancy, labour, and postnatal period	Diagnosis	✓	✓		
	Initial management	✓	✓		
	Non-responsive infections				✓
Syphilis during pregnancy, labour, and postnatal period	Counselling and testing	✓	✓		
	Treatment	✓		✓	✓
HIV during pregnancy, labour, and postnatal period	Counselling and testing	✓	✓		
	Management of drugs, disease and infections	✓			✓
	PMTCT	✓			✓
Hepatitis B or C during pregnancy, labour, and postnatal period		✓			✓
Syndromic management of vaginal infections (candidiasis, BV, trichomoniasis, warts, herpes) during pregnancy, labour, and postnatal period		✓	✓	✓	
	Initial treatment	✓	✓		

Maternal care						
Condition			Triage / Identify	Manage independently	Manage collaboratively	Refer
UTI during pregnancy, labour, and postnatal period	Recurrent infection		✓			✓
Acute pyelonephritis during pregnancy, labour, and postnatal period			✓			✓
Non-obstetric infections during pregnancy, labour, and postnatal period like Kochs, COVID, H1N1			✓			✓
Malaria during pregnancy, labour, and postnatal period	Uncomplicated		✓		✓	
	Severe		✓			✓
Hypertensive disorders during pregnancy, labour, and postnatal period	Gestational HTN		✓		✓	
	Non-severe PE		✓		✓	
	Severe PE / Eclampsia	Stabilization, loading dose of MgSO4	✓	✓	✓	✓
		Antihypertensive drugs			✓	✓
		Definitive management	✓			✓
Size – date discrepancy in pregnancy			✓		✓	✓
Reduced kick count in 3rd trimester			✓		✓	✓
Intrauterine foetal death			✓			✓
Antepartum haemorrhage (bleeding in later pregnancy and labour)			✓			✓
Foetal distress	Initial management		✓		✓	
	Late decelerations, persistent foetal distress		✓			✓
Pre-term labour / birth	Antenatal Corticosteroids (ACS)		✓	✓		✓
	Preterm Delivery		✓			✓
Cord prolapse	First stage		✓			✓
	Second stage		✓		✓	

Maternal care						
Condition			Triage / Identify	Manage independently	Manage collaboratively	Refer
Prolonged first stage of labour due to:	Dehydration		✓	✓		
	Immobility, lack of a companion, anxiety		✓	✓		
	Pain	Non –pharmacological pain management	✓	✓		
		Pharmacologic pain management	✓		✓	
	Amnionitis		✓		✓	✓
	Non-obstetric infection		✓		✓	✓
	OP, asynclitism		✓		✓	✓
	Frank/Complete breech with flexed head, chin anterior		✓			✓
	Inadequate uterine activity		✓		✓	✓
	CPD/Obstruction		✓			✓
	Arm, brow, chin posterior, transverse, footling, frank/- complete breech with poorly flexed head		✓			✓
Prolonged second stage of labour due to:	Birth position, companion, anxiety		✓	✓	✓	
	Has indications and meets criteria for vacuum-assisted birth		✓			✓
	Inadequate uterine activity		✓		✓	✓
	CPD/Obstruction/Malposition or malpresentation requiring caesarean birth		✓			✓
Primary PPH (within the first 24 hours after birth)	Initial management		✓	✓		
	SL/IM/IV uterotonic drugs		✓	✓	✓	✓
	Bimanual compression of uterus		✓	✓	✓	✓
	Balloon tamponade for atonic uterus		✓	✓	✓	✓
	Aortic compression for PPH		✓	✓	✓	✓
	Prescription and administration of fluids		✓	✓	✓	
	Refractory PPH		✓			✓
	Vulval/perineal haematoma		✓			✓
	Inverted uterus		✓			✓
	Ruptured uterus		✓			✓
Lacerations	Episiotomy repair		✓	✓		

Maternal care						
Condition			Triage / Identify	Manage independently	Manage collaboratively	Refer
	Repair of 1st and 2nd degree lacerations		✓	✓		
	Repair of 3rd and 4th degree and cervical lacerations		✓			✓
Retained placenta / fragments	Manual removal		✓		✓	
	Manual removal (Already separated placenta)		✓	✓	✓	✓
	Morbid adherent placenta (placenta accreta)		✓			✓
Postnatal fever / complications	Postpartum endometritis	Initial management	✓	✓		
		Ongoing care	✓		✓	✓
	Pelvic abscess		✓			✓
	Peritonitis		✓			✓
	Breast engorgement		✓	✓		
	Mastitis		✓		✓	✓
	Breast abscess		✓			✓
	Wound abscess, wound seroma or wound haematoma		✓			✓
	Wound cellulitis		✓			✓
	Obstetric fistula		✓			✓
	Deep vein thrombosis		✓			✓
	Pulmonary embolism		✓			✓
Obstetric shock	First aid management		✓	✓		
	Definitive management		✓			✓
Puerperal sepsis	First aid management		✓	✓		
	Definitive management		✓			✓
Secondary PPH (following the first 24 hours after childbirth)	Initial management, stabilization		✓	✓		
	Definitive treatment		✓			✓
Postnatal mental health problems	Postpartum ''blues''		✓	✓		
	Postnatal depression		✓		✓	✓
	Postnatal psychiatric disorders (e.g. bipolar psychosis)		✓			✓

Maternal care						
Condition			Triage / Identify	Manage independently	Manage collaboratively	Refer
Bleeding in early pregnancy	First aid management, stabilization		✓	✓		
	Threatened abortion		✓		✓	✓
	Ectopic pregnancy		✓			✓
	Complete abortion		✓		✓	
	Incomplete abortion	Digital removal of POCs from the vagina/open cervical os	✓		✓	✓
		Definitive management (NPM to assist the certified MTP provider with evacuation of POCs)	✓			✓
	Missed abortion		✓			✓
	Molar pregnancy		✓			✓
MTP	Counselling about pregnancy options		✓	✓		
	Medication abortion (NPM to assist certified MTP provider with the procedure)		✓		✓	✓
	Aspiration abortion (NPM to assist certified MTP provider with procedure)		✓		✓	✓
FP	Counselling for informed, voluntary choice			✓		
	IUCD (postpartum, interval and PAIUCD)			✓		
	LAM			✓		
	COCs			✓		
	POPs & Centchroman			✓		
	Injectables (MPA)			✓		
	Emergency contraception			✓		
	Fertility awareness methods			✓		
	Tubal ligation					✓
PAP / VIA	Normal findings		✓	✓		
	Abnormal findings		✓			✓
Breast examination	Normal findings		✓	✓		
	Abnormal findings		✓			✓

Newborn care					
Condition		Identify	Manage independently	Manage collaboratively	Refer
Asymptomatic (without symptoms) babies classified as at risk of infection	Membranes ruptured more than 18 hours before birth	✓		✓	
	Mother is being treated with antibiotics for infection	✓		✓	
	Mother has fever greater than 38ºC	✓		✓	✓
	Mother has confirmed maternal colonization with Group B streptococcus without adequate antibiotic therapy during labour	✓		✓	✓
	Mother is infected with HIV and/or syphilis and/or hepatitis B/ and or COVID-19	✓		✓	✓
	Mother started tuberculosis treatment less than two months before birth	✓		✓	✓
Minor disorders of newborn		✓			✓
Neonatal immunization			✓		
Care of the high risk newborn	Feeding of high-risk newborn	✓	✓	✓	✓
	Insertion/removal/feeding - Naso/Oro gastric tube		✓		
	Administration of medication – oral/parenteral		✓	✓	✓
	Neonatal drug calculation		✓	✓	
	Oxygen administration		✓		
	Care of neonate in incubator/warmer/ventilator			✓	
	Care of neonate on phototherapy			✓	
	Organize different levels of neonatal care		✓		
	Transportation of high-risk newborn		✓		
	Newborn screening of babies for congenital malformation	✓	✓		✓

Annexure 5

Existing Labour Room Formats

Format I

Labor Room Register

Yearly S. No.	Monthly S. No.	Client Details								Obstetric History				Admission Details															Details of Interventions for Delivery			
		Registration No.	MCTS No.	Name & Age	Husband's/Father's/Guardians Name	Address & Contact No. (Mobile No.)	BPL/JSY/MBS Registration (Yes/No)	Aadhar Card No.	Bank Details	ASHA name & Contact No.	LMP/EDD	Gravida/Parity/Abortion/Living Children (GPLA)	Previous LSCS (Yes/No)	Other previous complications (Yes/No; if 'Yes' then provide details)	Date	Time	Direct in Labor (Yes/No)	Gestational age (in weeks)	Investigations										Referred (Yes/No ; if 'Yes' then details of referred facility)	Identified as High Risk Pregnancy (Yes/No ; if 'Yes' specify)	Partograph filled (Yes/No)	* Inducted (Yes/No)	* Augmented (Yes/No)	Inj. Dexamethasone (Yes/No)
																			BP	Temp	FHR	Proteinuria	Hb gms %	Blood Group	HIV	Syphilis	Malaria	Hep B	Hep C					

*Induction and Augmentation to be done only at FRUs with C-section facility (Unnecessary Induction and Augmentation should not be done

Please fill in 'NA' if column is not applicable

Labor Room Register

Details of Interventions for Delivery		Inj. Magnesium Sulfate (Yes/No)							
		Episiotomy (Yes/No)							
		AMTSL (Yes/No)							
		Oxytocin IM (Yes/No ; if 'No' then specify any other uterotonic used)							
		Delayed cord clamping (1-3min (yes/No))							
		Antibiotics (Yes/No)							
		Blood Transfusion (Yes/No)							
Details of Delivery		Date							
		Time							
		Type of delivery (Normal/Assisted Delivery (Instrumental/Vacuum) Caesarean)							
		If Caesarean, Specify Indications							
		Conducted by							
		Delivery outcome Mother (Alive /Maternal Death)							
	Baby	Single / Multiple							
	Baby	Term (Full term/ preterm / post term)							
	Baby	Alive/Fresh Stillbirth / Macerated Stillbirth / Newborn Death							
Information about Baby		Identification No.							
		Sex (Male / Female / Other)							
		Weight (Kgs)							
		Dried immediately after birth (Yes/No)							
		** Resuscitation required (Yes/No)							
		Brest feed within 1 hours (Yes/No ; if 'No' then mention time)							
		Vitamin K1 given (Yes/No)							
	Vaccination (Yes/No)	BCG							
	Vaccination (Yes/No)	OPV							
	Vaccination (Yes/No)	Hep B							
Complications	Mother	Complication (APH; PPH; Pre-Edampsia; Eclampsia; Sepsis; Obs. labor; Prolonged labor; Others (specify))							
	Baby	Complication (Sepsis; Asphyxia; LBW; Pre Maturity; Others (specify))							
In case of Referral	Mother	Reason							
	Mother	Referred to							
	Baby	Reason							
	Baby	Referred to							
Condition of mother and baby at discharge		Date and Time							
	Mother	BP							
	Mother	Temp							
	Mother	Bleeding PV (Yes/No)							
	Baby	Temp							
	Baby	Feeding (Yes/No)							
	Baby	Respiratory rate							
Postpartum family Planning		Counselling (Yes/No)							
		Method chosen (LAM; Condoms; Injectable; PPIUCD; Male Sterilization; PPS; Others (Specify))							
		Date of method adopted							
Addition Info. /Follow up details		Signature of LR I/C							

**States may consider including steps of newborn resuscitation: Position, Suction, Stimulation, Reposition, Bag & Mask Ventilation.

Please fill in 'NA' if column is not applicable

Labour Room Register

Year SN	Month SN	Client Detail	Obstetric History	Admission Details	Detail of interventions for Delivery	Details of Delivery	Information about Baby	Complications	In case of referral	Condition of the mother and baby at discharge	Postpartum Family planning	Addition Info./ Follow up details
1	2	3	4	5	6	7	8	9	10	11	12	13
		Registration No. MCTS No. Name and age Husband's/Fathers/ Guardians Name Address Mobile No. BPL/MBS reg: Y/ N Aadhar No. Bank details ASHA's name & contact no.	LMP/EDD Gravida Parity Abortion Living children Previous LSCS (Y/N) Other previous complications:	Date Time Direct in labour ☐ **Gestational age (in weeks)** BP Temp FHR Proteinuria Hb gms % Blood Group HIV Syphilis Malaria Hep B Hep C **Referred From** Identified as High Risk ☐ Specify:	**Partograph Filled** ☐ **Inducted*** ☐ **Augmented*** ☐ **Inj. Dexamethasone** ☐ **Inj. Magnesium Sulfate** ☐ **Episiotomy** ☐ **AMTSL** ☐ Yes ☐ No ☐ **Type of Uterotonic** Oxytocin IM ☐ If others, then specify: Delayed cord Clamping (1-3 min) ☐ Antibiotics ☐ Blood transfusion ☐	Date Time **Type:** Normal ☐ Assisted Delivery (Instrumental, Vacuum, etc.) ☐ Caesarean ☐ **If caesarean, Indication:** Conducted By: **Mother:** Alive ☐ Maternal Death ☐ **Baby:** Single ☐ Multiple ☐ Term ☐ Preterm ☐ Alive ☐ Still birth: Fresh ☐ Macerated ☐ New born death ☐	**Identification No** **Sex:** Male ☐ Female ☐ Other ☐ **Weight (Kgs):** **Dried** immediately after birth Yes ☐ No ☐ **Resuscitation required**** Yes ☐ No ☐ Breast feed within 1 hour Yes ☐ No ☐ If not, mention time: Vitamin K1 given Yes ☐ No ☐ Vaccination done BCG ☐ OPV ☐ Hep B ☐	**Mother:** APH ☐ PPH ☐ Pre-eclampsia ☐ Eclampsia ☐ Sepsis ☐ Obs. labour ☐ Prolonged labour ☐ Others (specify): **Baby:** Sepsis ☐ Asphyxia ☐ LBW ☐ Pre Maturity ☐ Others ☐ (specify):	**Mother:** Reason Referred to **Baby:** Reason Referred to	Date and time of Discharge **Mother:** BP Temp Bleeding PV **Baby:** Temp Feeding Respiratory Rate	Counselling Yes ☐ No ☐ **Method chosen:** LAM ☐ Condoms ☐ Injectable ☐ PPIUCD ☐ Male Sterilization ☐ PPS ☐ Others ☐ Date of method adopted	**Signature of LR I/C**
		Registration No. MCTS No. Name and age Husband's/Fathers/ Guardians Name Address Mobile No. BPL/MBS reg: Y/ N Aadhar No. Bank details ASHA's name & contact no.	LMP/EDD Gravida Parity Abortion Living children Previous LSCS (Y/N) Other previous complications:	Date Time Direct in labour ☐ **Gestational age (in weeks)** BP Temp FHR Proteinuria Hb gms % Blood Group HIV Syphilis Malaria Hep B Hep C **Referred From** Identified as High Risk ☐ Specify:	**Partograph Filled** ☐ **Inducted*** ☐ **Augmented*** ☐ **Inj. Dexamethasone** ☐ **Inj. Magnesium Sulfate** ☐ **Episiotomy** ☐ **AMTSL** ☐ Yes ☐ No ☐ **Type of Uterotonic** Oxytocin IM ☐ If others, then specify: Delayed cord Clamping (1-3 min) ☐ Antibiotics ☐ Blood transfusion ☐	Date Time **Type:** Normal ☐ Assisted Delivery (Instrumental, Vacuum, etc.) ☐ Caesarean ☐ **If caesarean, Indication:** Conducted By: **Mother:** Alive ☐ Maternal Death ☐ **Baby:** Single ☐ Multiple ☐ Term ☐ Preterm ☐ Alive ☐ Still birth: Fresh ☐ Macerated ☐ New born death ☐	**Identification No** **Sex:** Male ☐ Female ☐ Other ☐ **Weight (Kgs):** **Dried** immediately after birth Yes ☐ No ☐ **Resuscitation required**** Yes ☐ No ☐ Breast feed within 1 hour Yes ☐ No ☐ If not, mention time: Vitamin K1 given Yes ☐ No ☐ Vaccination done BCG ☐ OPV ☐ Hep B ☐	**Mother:** APH ☐ PPH ☐ Pre-eclampsia ☐ Eclampsia ☐ Sepsis ☐ Obs. labour ☐ Prolonged labour ☐ Others (specify): **Baby:** Sepsis ☐ Asphyxia ☐ LBW ☐ Pre Maturity ☐ Others ☐ (specify):	**Mother:** Reason Referred to **Baby:** Reason Referred to	Date and time of Discharge **Mother:** BP Temp Bleeding PV **Baby:** Temp Feeding Respiratory Rate	Counselling Yes ☐ No ☐ **Method chosen:** LAM ☐ Condoms ☐ Injectable ☐ PPIUCD ☐ Male Sterilization ☐ PPS ☐ Others ☐ Date of method adopted	**Signature of LR I/C**

***Induction and Augmentation to be done only at FRUs with C-section facility (Unnecessary Induction and Augmentation should not be done).**
****States may consider including steps of newborn resuscitation: Position, Suction, Stimulation, Reposition, Bag & Mask Ventilation.**

Summary Table

Month and Year (MM/YY)	No. of Deliveries (total)	Type of Deliveries			Direct In Labor Cases	Live Births (total)	Stillbirths (total)	Total Partograph filled	Oxytocin IM given	Episiotomy done	Total Inducted	Total augmented	Maternal complication identified			Inj. MgSO4 administered	Inj. Dexamethasone administered	Blood Transfusion done	All three vaccine (BCG, Hep B, OPV) given before discharge	Newborn complications identified				Family Planning Acceptors (total)	Maternal Deaths (total)	Newborn Deaths (total)	Referred Out	
		Normal	Assisted	CSection									PIH/E	PPH	Obst. Labor					Pre-term	LBW	Asphyxia	Resuscitation required				Mother	Newborn
Total																												

Annexure 6

National Quality Assurance Standards for Midwifery Led Care Unit

National Quality Assurance Standards for MLCU	
Reference No.	**Area of concern - A. Standard Statement**
Standard A1	The facility provides Curative Services.
Standard A2	The facility provides RMNCHA Services.
Standard A3	The facility provides Diagnostic Services.
Area of concern - B. Patient Rights	
Standard B1	The facility provides the information to care seekers, attendants & community about the available services and their modalities.
Standard B2	Services are delivered in a manner that is sensitive to gender, religious and cultural needs, and there is no barrier on account of physical economic, cultural, or social reasons.
Standard B3	The facility maintains privacy, confidentiality & dignity of patient, and has a system for guarding patient related information.
Standard B4	The facility has defined and established procedures for informing patients about the medical condition, and involving them in treatment planning, and facilitates informed decision making.
Area of concern - C. Inputs	
Standard C1	The facility has infrastructure for delivery of assured services, and available infrastructure meets the prevalent norms.
Standard C2	The facility ensures the physical safety of the infrastructure.
Standard C3	The facility has established programme for fire safety and other disaster.
Standard C4	The facility has adequate qualified and trained staff, required for providing the assured services to the current case load.
Standard C5	The facility provides drugs and consumables required for assured services.
Standard C6	The facility has equipment & instruments required for assured list of services.
Standard C7	Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff.
Area of concern - D. Support Services	
Standard D1	Facility has a defined and established procedure for effective utilization, evaluation and augmentation of competence and performance of staff.
Standard D2	The facility has defined procedures for storage, inventory management and dispensing of drugs in pharmacy and patient care areas.
Standard D3	The facility provides safe, secure, and comfortable environment to staff, patients and visitors.

Standard D4	The facility has established programme for maintenance and upkeep of the facility.
Standard D5	The facility ensures 24X7 water and power backup as per requirement of service delivery, and support services norms.
Standard D7	The facility ensures availability of clean linen to the patients.
Standard D10	The facility is complaint with all statutory and regulatory requirements as required by local, state, and central government.
Standard D11	Roles & Responsibilities of administrative and clinical staff are determined as per govt. regulations and standards operating procedures.
Area of concern - E. Clinical Services	
Standard E1	The facility has defined procedures for registration, consultation, and admission of patients.
Standard E2	The facility has defined and established procedures for clinical assessment and preparation of treatment plan.
Standard E3	The facility has defined and established procedures for continuity of care of patient and referral within and outside the healthcare facility as required.
Standard E4	The facility has defined and established procedures for nursing care.
Standard E5	The facility has a procedure to identify high risk and vulnerable patients.
Standard E6	The facility ensures rationale for prescribing and use of medicine.
Standard E7	The facility has defined procedures for safe drug administration.
Standard E8	The facility has defined and established procedures for maintaining, updating of patients' clinical records and their storage.
Standard E12	The facility has defined and established procedures of Diagnostic Services.
Standard E13	The facility has defined and established procedures for Blood Bank/Storage Management and Transfusion services.
Standard E16	The facility has defined and established procedures for End-of-life care and Death.
Standard E17	The facility has established procedures for Antenatal care as per guidelines.
Standard E18	The facility has established procedures for Intra-natal care as per guidelines.
Standard E19	The facility has established procedures for Postnatal care as per guidelines.

Standard E20	The facility has established procedures for Newborn, Infant and Child as per guidelines.
Standard E21	The facility has established procedures for Abortion and Family Planning as per guidelines.
Area of concern - F. Infection Control	
Standard F1	The facility has infection control programme and procedures in place for prevention and measurement of hospital associated infection.
Standard F2	The facility has defined and implemented procedures for ensuring hand hygiene practices and antisepsis.
Standard F3	The facility ensures standard practices and materials for Personal protection.
Standard F4	The facility has Standard Operating Procedures for processing of equipment and instruments.
Standard F5	Physical layout and environmental control of the patient care areas ensures Infection Prevention.
Standard F6	The facility has defined and established procedures for segregation, collection, treatment, and disposal of Bio Medical and hazardous Waste.
Area of concern - G. Quality Management	
Standard G1	The facility has established organizational framework for Quality Improvement.
Standard G2	The facility has established system for measuring the patient and employee satisfaction/experience.
Standard G3	The facility has established internal and external Quality Assurance programmes as applicable.
Standard G4	The facility has established, documented implemented and maintained Standard Operating Procedures for all key processes and support services.
Standard G 5	The facility maps its key processes and seeks to make them more efficient by reducing nonvalue-adding activities and wastages.
Standard G6	The facility has defined its mission, values, Quality Policy & objectives & prepared a strategic plan to achieve them.
Standard G7	The facility seeks continual improvement by practising Quality method and tools.
Standard G9	The facility has established procedures for assessing, reporting, evaluating, and managing risk as per the risk management plan.
Standards G10	The facility has established clinical Governance framework to improve the quality and safety of clinical care processes.
Area of concern – H. Outcome	
Standard H1	The facility measures Productivity Indicators and ensures compliance with State/National benchmark.

Standard H2	The facility measures Efficiency Indicators and ensures to reach State/National Benchmark.
Standard H3	The facility measures Clinical Care & Safety Indicators and tries to reach State/National benchmark.
Standard H4	The facility measures Service Quality Indicators and endeavours to reach State/National benchmark.

Ministry of Health & Family Welfare
Government of India