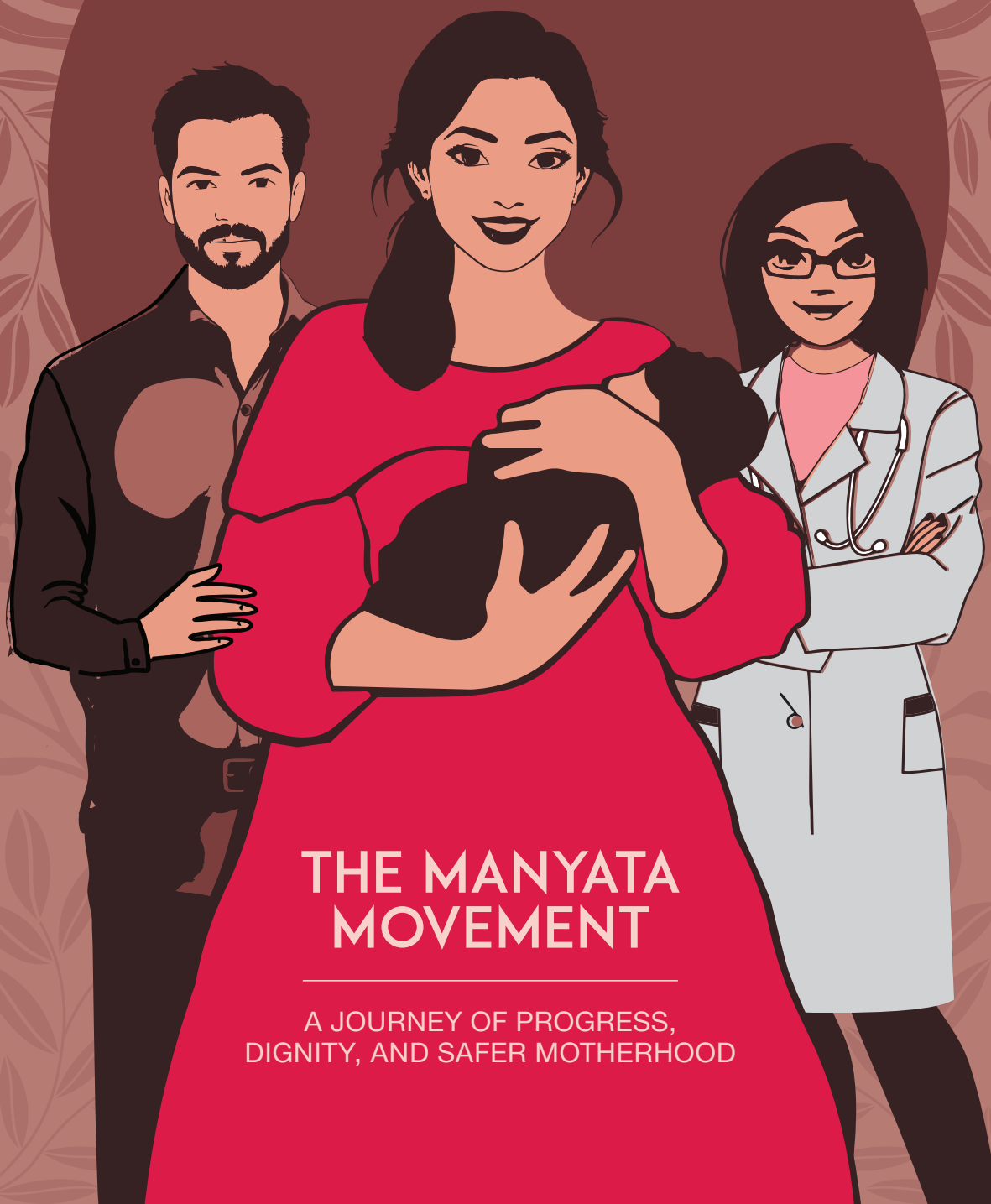
MANYATA™

DON'T FORGET MOMS – A FOGSI INITIATIVE



THE MANYATA MOVEMENT

A JOURNEY OF PROGRESS, DIGNITY, AND SAFER MOTHERHOOD

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PREFACE

The Manyata Movement was born from a simple yet profound vision: to ensure that every woman in India receives safe, respectful, and quality care during one of life's most vulnerable moments—childbirth. What began as a pioneering initiative of FOGSI has now evolved into a national and global quality movement, setting benchmarks for maternal health that extend far beyond clinical care.

At its heart, Manyata is more than a program; it is a promise by every FOGSIANs in India. A promise that the dignity of women will be upheld, that private facilities—where millions of women seek care—will deliver to the highest standards, and that no mother or newborn will be left behind because of where they live or who provides their care.

The vision of The Manyata Movement is to embed quality into the very fabric of maternal and newborn healthcare, creating a culture where excellence is the norm, not the exception. By harnessing partnerships, leveraging digital innovation, and building the capacities of providers, Manyata aims not only to transform individual facilities but to inspire a systemic shift across India and beyond.

As we look ahead, Manyata stands as a testament to what collective will, professional leadership, and evidence-driven innovation can achieve. The movement envisions a future where maternal care is synonymous with safety, respect, and compassion—where quality is not aspirational, but universal.

Dr. Sunita Tandulwadkar

FOGSI President 2025

EDITOR'S NOTE

Within the sanctuary of a mother's care lies the dawn of generations; to safeguard them is to safeguard tomorrow.

For the FOGSI leadership and fellow FOGSIans, the quality journey began as a small pilot, testing whether improvements in clinical care could be sustained in private maternity facilities under real-world conditions. That experiment laid the foundation for something far greater...the Manyata movement! With the support of FOGSI, MSD for Mothers, the MacArthur Foundation, and our partners, Manyata grew into a structured model; aligned with national priorities yet flexible enough to adapt to diverse local contexts.

We believe that "women's health is a nation's wealth". Maternal health has long been a vital indicator of a country's overall health and its contribution to global well-being. While India has made significant progress in the recent decades, ensuring safe, respectful, and high-quality maternal care remains an ongoing priority. Every faltering indicator challenges us to confront gaps and embrace opportunities – to build health systems where quality care is accessible and consistent across all settings, and where solutions are as human-centered as they are data-driven.

Quality in maternal healthcare cannot rest on a single training or a one-off workshop, however well-intentioned. It must live in the routines of practice, reinforced by mentorship and a culture that holds standards as both a compass and a commitment. Sustainable, scalable solutions are the essential mandate to support providers, strengthen systems, and make quality the norm.

Manyata is a realization of this aspiration. By benchmarking against WHO standards adapted to local contexts, it sets clear pathways to quality. Digital platforms extend knowledge to the most remote corners. Robust documentation, feedback systems, and evidence generation ensure learning translates into measurable improvements. Innovative financing mechanisms further support the program's sustainability.

Today, Manyata stands as proof that structured frameworks, accountability, and collaborations can transform healthcare delivery and sustain improvements. Its evolution is not an endpoint but a waypoint – a moment to pause, reflect, and ask: what have we learned, and what remains unfinished? Documenting this journey preserves hard-earned lessons, offers them to the global community, and inspires those walking similar paths.

Our focus has now extended beyond training to creating systems where providers felt ownership and responsibility. These collaborations broadened reach and deepened impact. As the program expanded, its resonance crossed borders with professional associations in other countries expressing interest in adapting the model.

It was with this recognition that we undertook the endeavor of creating this book. Every chapter is a deliberate choice: not to overwhelm with detail, but to convey the essence of what was learned and what might be carried forward.

This book also reflects the role FOGSI has demonstrated as a professional association advancing maternal health at a scale and depth rarely attempted before. By leveraging its network, credibility, and expertise, FOGSI set a precedent for what a professional body can achieve beyond advocacy –creating operational models, fostering accountability, and enabling collaborations that drive systemic change.

Producing this book has been a collective labor. It required us to sift through experiences of over a decade, to identify patterns, and to frame insights in a way that speaks across audiences.

As we invite you to explore the content of this book, we hope it charges you with the conviction that change is possible, even within the most complex systems, and emboldens you to pursue it in your own contexts. Let it also inspire those in healthcare, policy, and philanthropy to imagine new ways of supporting maternal care and sharing knowledge across borders.

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THE MAKING OF MANYATA

QUALITY MATTERS: SETTING THE STAGE FOR SAFER MOTHERHOOD IN INDIA

LOOKING BACK, MOVING FORWARD

Dr. Hrishikesh Pai

INTRODUCTION - A NEW FRONTIER IN MATERNAL HEALTH

Throughout my career as an obstetrician and in my leadership role with the Federation of Obstetric and Gynaecological Societies of India (FOGSI), one aspiration has remained constant: to ensure that every woman in India experiences childbirth that is safe, dignified, and respectful.

India has made extraordinary strides in maternal health. The Maternal Mortality Ratio (MMR) has fallen dramatically—from 556 per 100,000 live births in 1990 to 88 in 2021–22, with several states already surpassing the Sustainable Development Goal (SDG) target of fewer than 70 deaths per 100,000. These numbers represent more than statistics: they embody the thousands of women who have returned home to their families, newborns who survived their first moments, and communities strengthened by the survival of their mothers.

Yet progress has brought us to a new frontier. For decades, the central challenge was bringing women into facilities for childbirth. Today, with institutional deliveries approaching 90 percent, the challenge has evolved: ensuring that the care provided within these facilities is consistently safe, effective, respectful, and equitable. Quality of care is no longer an abstract aspiration—it is the foundation of survival and dignity. Without quality, Universal Health Coverage remains an unfulfilled promise.

INDIA'S PROGRESS – FROM ACCESS TO ASSURANCE

The sharp decline in maternal deaths has been propelled by a series of bold government initiatives that redefined access and affordability of care. The Janani Suraksha Yojana (JSY), launched in 2005, was among the earliest gamechangers. By offering conditional cash transfers and mobilizing Accredited Social Health Activists (ASHA) to accompany women to health facilities, it dramatically increased institutional deliveries and laid the foundation for demand-side reform. Building on this momentum, the Janani Shishu Suraksha Karyakram (JSSK) in 2011 eliminated out-of-pocket expenses by covering drugs, diagnostics, diet, blood, and even transport. For the first time, women and families could expect free care across the continuum of delivery, including cesarean sections, within public facilities.

In 2016, the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) introduced a unique model of assured antenatal care on the 9th of every month, inviting voluntary participation from private providers to complement the public system. This was jointly started by the Government of India with Federation of Obstetric & Gynaecological Societies of India (FOGSI) and the National Indian Medical Association (IMA). I had the privilege of being the Secretary General, FOGSI at that point in time when this project was launched. Three years later, the Surakshit Matritva Aashwasan (SUMAN) initiative sought to elevate not only access but also dignity – guaranteeing zero denial of services and embedding respectful maternity care as a standard across facilities.

These reforms were reinforced by the broader Ayushman Bharat program, which expanded comprehensive primary health care through Health and Wellness Centres, while the Midwifery Initiative began training a new cadre of nurse practitioners in midwifery to provide women-centred, globally benchmarked maternity care.

Taken together, these schemes shifted childbirth from homes to facilities, reduced financial hardship, and positioned maternal health as a national priority. They created a policy ecosystem that dramatically improved survival, yet also revealed the emerging challenge: ensuring that the care women received inside facilities consistently met the standards of safety, effectiveness, and respect.

But as access improved, a crucial question emerged: was the care provided in these facilities of assured quality?

PERSISTENT GAPS - THE UNFINISHED CHAPTER

Despite remarkable achievements, India continues to face challenges that cost preventable maternal and newborn lives. Progress has been uneven, with certain states and regions carrying a disproportionate burden. Kerala, Tamil Nadu, and Maharashtra have achieved MMR levels well below the SDG threshold, yet Uttar Pradesh, Madhya Pradesh, and parts of the North-East still record high mortality. These disparities highlight persistent inequities in infrastructure, governance, and resource allocation.

The quality of care in the private sector also remains variable. While large hospitals may match international standards, many small and mid-sized maternity homes operate with inconsistent protocols, limited training, and inadequate emergency readiness. Families often choose private facilities for perceived privacy and responsiveness, especially in urban areas where nearly half of births now take place in the private sector. However, regulation is limited, and quality assurance mechanisms are weak.

Workforce shortages add another layer of risk. Skilled midwives and nurses remain in short supply, and high turnover undermines continuity of care. Gaps in respectful maternity care also persist: women continue to report instances of neglect, poor communication, and lack of privacy—factors that erode trust in the health system. Meanwhile, the rising prevalence of non-communicable diseases such as hypertension and diabetes during pregnancy complicates clinical management and requires integrated approaches that are still evolving.

The conclusion is clear: while India has succeeded in bringing women into facilities, it has yet to guarantee that every facility provides care that is consistently safe, evidence-based, and respectful.

THE PRIVATE SECTOR – A STRENGTH AND A GAP

The private sector, responsible for nearly one-third of institutional deliveries nationally–and close to half in urban areas—has emerged as both a strength and a challenge. Families turn to private providers for shorter waiting times, greater privacy, and perceptions of better service. Yet the absence of strong regulation means that standards vary widely, from state-of-the-art hospitals to facilities operating without adequate emergency preparedness.

Government schemes have rightly focused on expanding access through the public system, but without parallel quality improvement mechanisms in the private sector, half of India's mothers remain outside formal quality frameworks. Any national strategy to achieve safe motherhood must therefore engage private facilities as active partners in transformation.

MANYATA – RAISING THE BAR IN PRIVATE MATERNITY CARE

In this context FOGSI, supported by MSD for Mothers, with technical expertise from Jhpiego, launched Manyata, a quality improvement and certification initiative tailored for India's private maternity sector. **Manyata** aligns with WHO standards and national guidelines, equipping small and medium-sized facilities to deliver care that is safe, evidence-based, and respectful.

The initiative does not merely certify compliance; it fosters a culture of mentorship and continuous improvement. Providers are trained to handle obstetric emergencies, adhere to clinical protocols, and embrace respectful maternity care. Independent evaluations show significant improvements in provider competence, teamwork, and patient satisfaction. Importantly, Manyata has shifted the mindset from seeing quality as a bureaucratic requirement to embracing it as a matter of professional pride and identity.

LESSONS LEARNED – WHAT DRIVES SUCCESS

The Manyata journey offers important lessons for the future of maternal health in India. Perhaps the most significant is the recognition that engaging the private sector is indispensable. With nearly half of all deliveries in urban India taking place in private facilities, it became clear that quality transformation could not be confined to the public system. By working directly with small and mid-sized maternity homes, Manyata created a pathway for structured quality improvement in a sector that had long operated outside formal frameworks.

Another critical insight is that quality improvement is sustained not by certification alone but by mentorship. It is the day-to-day guidance, the reinforcement of evidence-based practices, and the encouragement of teamwork that change the culture of care. Providers who are supported to act swiftly and confidently in moments of crisis–whether managing hemorrhage, preeclampsia, or sepsis–demonstrate how timely action before complications escalate can save lives and inspire professional pride.

Technology, too, has emerged as a powerful enabler. By being "tech-first," Manyata was able to scale quality improvement across diverse and challenging contexts. Digital dashboards, e-learning modules, and virtual mentorship helped facilities navigate the quality journey even when faced with hurdles such as staff turnover, time pressures, or geographic remoteness. Technology turned what might otherwise have been isolated interventions into a continuous cycle of learning and improvement.

Perhaps most importantly, the program has shown that clinical governance must underpin the next phase of progress. Moving beyond checklists and periodic audits, India needs institutionalized systems of accountability, peer review, and continuous learning. Clinical governance provides the scaffolding for quality to become routine–embedded in everyday practice rather than treated as an occasional compliance exercise.

Taken together, these lessons reinforce a simple truth: safe motherhood in India requires more than access to facilities. It demands the active engagement of every sector, the nurturing of a culture of mentorship, the embedding of clinical governance, and the intelligent use of technology to ensure that quality care becomes the norm rather than the exception.

THE ROAD AHEAD – REDEFINING THE STANDARD

The next phase of India's maternal health journey must be defined by quality as routine. Equity must be built into design, ensuring marginalized rural, tribal, and urban-poor populations are not left behind. Infrastructure must reflect respect, embedding privacy and dignity into facility design. Systems must become resilient, capable of withstanding crises without disrupting essential maternal services. And quality improvement must be institutionalized into daily practice through peer learning, continuous feedback, and patient engagement.

This is not the task of the government alone. National leadership sets the vision, but state managers, facility leaders, and professionals must translate it into action, while communities and women themselves hold the system accountable. The Manyata experience has shown that when these elements align, safe motherhood becomes not just an aspiration but a lived reality.

CALL TO ACTION – QUALITY AS INDIA'S PROMISE

India has achieved what once seemed impossible: Bringing nearly all mothers into facilities for childbirth. The unfinished task is to ensure that every facility delivers on its promise of safe, respectful, and equitable care.

The path ahead demands shared responsibility: It requires public and private sectors working together, leveraging digital innovations, and embedding clinical governance into routine practice. It calls for sustained mentorship, regulation, and above all, a cultural shift that places dignity and quality at the heart of maternal health.

Our promise must be simple but profound: That every mother, in every corner of India, will not only have the chance to give birth in a facility, but the assurance that her life, her dignity, and her future will be protected.

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INCEPTION OF THE QUALITY JOURNEY

Dr. Hema Divakar, Dr. Sanjay Gupte

THE BIG PICTURE: WHY QUALITY MATTERS

Maternal health is not just about survival—it's about ensuring women emerge from childbirth healthy, safe, and respected. India has reduced its Maternal Mortality Ratio (MMR) from 384 (2000) to 88 (2022), but reaching the SDG target of 70 by 2030 remains a challenge. Quality of care in the vast private sector is uneven, and this is where Manyata steps in.

WHAT IS MANYATA?

Manyata is a digitally enabled quality improvement and certification program led by FOGSI. It is built on 20 clinical standards, aligned with WHO benchmarks, to ensure safe, respectful maternity care.

It focuses on capacitating the health workforce through adherence to WHO-recommended quality benchmarks. This approach also addresses potential complications, ultimately improving both immediate and long-term health outcomes for mothers and their newborns.

"Quality of care is not optional—it is the difference between life and loss."

Ensuring high-quality maternal care requires more than just a focus on clinical outcomes; it demands a holistic approach that integrates physical, clinical, emotional, and mental well-being. The Manyata initiative embodies this philosophy, taking a comprehensive approach to maternal care by integrating best practices in clinical standards, team-based training, digital innovation, and a focus on women-centric care.

Piloted in 2013 and launched as FOGSI's flagship program in 2017, within a decade and across four programmatic phases, Manyata has made tremendous progress in enabling quality care for more than **3,000 small and medium private facilities** pan-India. Each phase has witnessed strategic process optimizations leading to increased reach and impact.

THE INITIATIVE EMPHASIZES

- Skilled workforce training - Training and capacitating private maternity providers
- Evidence-based practices - Embedding evidence-based practices
- Promoting women-centric, holistic care

"More than a checklist, Manyata is a culture shift—from doing enough, to doing what's best."

THE JOURNEY OF MANYATA

Phase 1 – Pilot (2013–16) 150 facilities tested in Jharkhand & Uttar Pradesh.

Phase 2 – Launch (2017–19) Ownership transitioned to FOGSI; 400+ facilities joined; NABH links were established.

Phase 3 – Expansion (2019–21) World's first Development Impact Bond (DIB) in Maternal Health:

Manyata was part of the world's first Development Impact Bond (DIB) in Maternal Health–Utkrisht (2019-2021), that onboarded 1200 facilities. The program was designed to provide support to small private healthcare facilities in Rajasthan on Joint Quality Standards (JQS) for hospitals, including NABH and Manyata certification. Manyata expanded to states across geographies to connect with another 1200 facilities and engaged with business entities beyond FOGSI to deliver safe delivery modules. A public-private partnership 'LaQshya-Manyata' model was demonstrated in collaboration with Government of Maharashtra and FOGSI to enhance quality of care across registered facilities.

Phase 4 – Scale (2022–24) 1000 facilities from across 26 states; new financing models; regional & global partnerships built:

A pool of 1000 private facilities were onboarded expanding the program to 26 states. A unique "Result Based Financing" model was tested by a group of social entrepreneurs. The Manyata initiative liaised with key state-level private and public stakeholders to demonstrate a saturation model in Solapur Corporation of Maharashtra and state of Manipur for quality of care. This phase also launched the "Uniting for Quality" initiative in collaboration with the AOFOG in five countries across Asia. The phase supported Bangladesh and the Philippines by organizing multi-stakeholder convenings to augment the existing QoC frameworks by integrating clinical standards. existing QoC standards for Manyata were augmented and 4 new standards were added resulting in a revised clinical package. FOGSI has deepened their collaboration with NABH by integrating the Manyata standards into New NABH Standards

Phase 5 – Integration (2025) Manyata standards are now formally embedded into NABH accreditation, aligning with "One Nation, One Standard." In its recent phase, in a step toward institutionalizing maternal healthcare quality in India, 2024 marked the integration of Manyata's standards into the National Accreditation Board for Hospitals and Healthcare Providers (NABH) Certification Programs. Through a strategic collaboration with FOGSI, NABH—India's apex body for accreditation and quality promotion—formally adopted Manyata's maternal health benchmarks. As a result, all facilities offering maternity services and seeking NABH accreditation are now assessed on Manyata standards, embedding respectful, evidence-based maternal care within the national quality assurance framework.

By aligning with national priorities and contributing to the broader goal of Universal Health Coverage (UHC), this collaboration ensures that Manyata's quality standards are widely adopted and sustained—driving meaningful improvements in maternal health outcomes across the country.

IMPACT AT SCALE

- 3,000+ private maternity facilities strengthened
- 24,000 healthcare professionals trained
- 1 million women benefited across 25 states/UTs

BUILDING SUSTAINABILITY & INNOVATION

What started as a grant-funded project is today a self-sustaining social business model.

This shift ensures that resources are allocated based on measurable outcomes, promoting accountability and long-term impact. Simultaneously, the program has established a marketplace aimed at generating demand for quality maternal and newborn care. By fostering a culture in which every stakeholder in the ecosystem prioritizes quality, the program is embedding these standards into the healthcare system nationwide, driving lasting change.

The Manyata initiative is driving innovation through a multifaceted approach incorporating social entrepreneurship, techno-entrepreneurship, and institutional business models, all integral to its sustainability and scale-up strategy. Currently, 20 Centers for Skill Enhancement (CSEs) and Quality Improvement (QI) providers across the country lead capacity building efforts in their respective geographies. The CSEs are led by practicing obstetricians and gynaecologists who are members of FOGSI and serve as social entrepreneurs. FOGSI has strategically identified these professionals and incentivized them to bolster the capabilities of private maternity providers. These entities are actively implementing a Results Based Financing (RBF) model aimed at enhancing the capabilities of local private providers to improve and sustain quality using digital tools.

"Sustainability comes not from funding alone, but from creating value the system itself demands."

Key strategies include

- **Centers for Skill Enhancement (CSEs):** OBGYN-led hubs driving training & entrepreneurship
- **Results-Based Financing (RBF):** Linking payments to measurable quality outcomes
- **Digital Innovations:** Tracking, scaling, and accountability tools
- **Marketplace for Quality:** Creating demand for better maternal & newborn care.

MANYATA 5.0: THE ROAD AHEAD

The current phase goes beyond maternal health into integrated, market-facing models:

- Bundling maternal care with climate action, cancer prevention, and women's health solutions
- Catalytic financing to unlock value across the entire lifecycle of care

The Manyata initiative is building an ecosystem of quality that sustains itself long after direct interventions have achieved the goals. Aimed at ensuring financial sustainability while strengthening strategic partnerships to drive the program's long-term impact, Manyata is showing the way to the rest of the world to design success models for the quality of care.

"Manyata 5.0 is more than a program—it's a movement shaping the future of women's healthcare."

The five strategic pillars—Scale, Demand Generation, and Community Integration; Financial Sustainability; Partnerships and Governance; Technology-Led Quality of Care; and Advocacy, Communication, and Evidence Generation—now drive the Manyata 5.0 phase, shaping the future of women's healthcare.

LAUNCH OF MANYATA: A MOVEMENT FOR EXCELLENCE IN MATERNAL CARE

Dr. Rishma Pai

The first time I held a newborn in my arms as a young gynecologist, I felt a surge of joy that words could never quite capture. The tiny chest rising with its first uncertain breaths, the sharp cry that pierced the silence; it was a moment so raw, so miraculous, that it left me humbled.

And yet, what stayed with me even more than the baby's arrival was the mother's face. Tired, relieved, fearful, but carrying in her eyes a fragile and unmistakable hope. Over the decades of my practice, that look has never left me. It has often made me ask: in the story of birth, why does the mother so often disappear from view?

In India, pregnancy and childbirth are usually told as stories of babies. Their weights, their early cries, the joy of families. But the woman who risked her body, her health, sometimes her life, rarely receives the same attention. Her suffering is normalized, her survival assumed, and her death, should it happen, often silently accepted. I have seen too many women endure preventable complications that could have been avoided with timely, respectful, quality care. Each case pressed into me a conviction that guides me still: ***she matters***.

FROM QUESTION TO COMMITMENT

The conviction that she matters was not mine alone. Within FOGSI, a question had been brewing for years: how do we, as a body of obstetricians and gynecologists, go beyond clinical expertise to fundamentally improve maternal health outcomes in India? Could private maternity facilities, which serve such a significant portion of women, systematically raise the quality of care, and sustain it?

With support from MSD for Mothers and Jhpiego, FOGSI began to explore this question through a small but ambitious pilot in Uttar Pradesh and Jharkhand. It was not just about training providers but about creating a framework of standards, accountability, and recognition. The results were promising. Facilities demonstrated that change was possible when they were equipped and supported. More importantly, it showed us that quality was not an abstract aspiration; it was measurable, teachable, and achievable.

The pilot proved one thing with clarity: if we wanted safe motherhood to be the norm, we had to create a program that was structured, scalable, and sustainable. Out of this realization, and with the dedication of countless colleagues, **Manyata** was born.

ORCHESTRATING A LAUNCH WITH PURPOSE

When I stepped into my tenure as President of FOGSI in 2017, I knew we had a responsibility. We were not merely launching another initiative; we were shaping the identity of FOGSI as a champion of quality maternal care. Manyata had to be more than a program. It had to be a movement.

From the very beginning, my vision was clear: the launch must leave an impression that would last. Every element had to speak not only to the medical fraternity but also to policymakers, influencers, and the wider society. If we wanted the world to believe that India was serious about mothers, the launch had to show it.

The months leading up to the event were intense. Long hours of planning, discussions that stretched late into the evening, colleagues debating over details big and small. At times it felt overwhelming, but it was also exhilarating. Every conversation sharpened the vision further: this would not be a polite unveiling of a logo and a speech. It had to touch hearts, stir minds, and compel action.

We chose Mumbai as the location, at the **FEMM Conference in November 2017**. It was symbolic—the home of FOGSI and a platform with national visibility. We wanted Manyata to arrive on a stage worthy of its ambition.

L-R: Dr. Hrishikesh Pai (Chief Administrator - Manyata & then Secretary General, FOGSI), Dr. Mary-Ann Etiebet (Former Lead, MSD for Mothers), Dr. Hema Divakar (National Convenor - Manyata), Dr. Jaideep Malhotra (Past President, FOGSI - 2018), Dr. Jaydeep Tank (Past President, FOGSI - 2024), Dr. Nandita Palshetkar (Past President, FOGSI - 2019), Dr. Naveen Rao (Former Lead, MSD for Mothers), Shilpa Shetty (cultural icon), Dr. Rishma Pai, (Past President, FOGSI - 2017), Pompy Sridhar (India Director, MSD for Mothers), Dipa Nag Chowdhury (Former Deputy Director, MacArthur Foundation), and Dr. Ameya Purandare (Deputy Administrator - Manyata)

A PROGRAM COMES ALIVE

The launch began with a panel, "*Managing and Improving Maternal Care in the 21st Century.*" It was not designed to be comfortable. We wanted pressing and sometimes uncomfortable questions raised, and they were. Experts, policymakers, and practitioners confronted the realities of maternal health openly. For me, this was important: unless we acknowledged the gaps honestly, the commitment to quality would remain hollow.

Managing and Improving Maternal Care in the 21st Century

The centerpiece was the unveiling of the **Manyata logo** and the screening of **our first awareness film, #DontForgetMoms**. Over 700 gynecologists were in the room that evening, and as the film played, I could sense the silence deepen. It was no longer about statistics or policies. It was about mothers, their stories, and our responsibility as caregivers. Many in the audience were visibly moved.

But I knew awareness alone would not suffice. We needed credibility, visibility, and resonance. So, we invited voices from beyond the medical community. Hon'ble Pankaja Munde, the then Minister of Rural Development, Women and Child Welfare, lent the weight of government endorsement. Popular cultural icons such as Shilpa Shetty and Poonam Dhillon brought a personal, emotional dimension. Their presence was not about glamour but about signaling that maternal health is everyone's cause—doctors, policymakers, celebrities, and society at large.

A snapshot from the #DontForgetMoms film

Hon'ble Pankaja Munde, then Minister of Rural Development, Women and Child Welfare, addressing the audience

Cultural icon, Shilpa Shetty, at the launch

Veteran celebrity, Poonam Dhillon, lending her voice to the cause

The launch culminated with a collective **pledge to #EndMaternalMortality**. Hundreds of hands rose together, committing to the principle that no mother should die while giving life and in that moment, the room was transformed into something larger than an event—it felt like the beginning of a shared movement.

Dignitaries taking the pledge to #EndMaternalMortality

L-R: Leadership from FOGSI, MSD for Mothers, Health Ministry, and influential cultural figures showing support for Manyata

WALKING FOR A CAUSE

The following evening, we carried the message into a more unconventional space with the *She Matters Walk for a Cause*. Doctors, policymakers, advocates, and celebrities walked the ramp together — not in vanity, but in solidarity. It was symbolic: expertise and influence, rigor and reach, all aligned to one purpose.

A glimpse from the She Matters fashion show with FOGSIans, celebrated personalities, and influential figures from all walks of life gathered on stage

Critics may call it theatrical. I call it necessary. Public attention is one of the scarcest resources in maternal health. To capture it, you must engage hearts as well as minds. *The Walk for a Cause* ensured that Manyata's message echoed far beyond the walls of the conference. Media houses picked it up, stories appeared across platforms, and suddenly maternal health was being discussed not only in policy circles but also in living rooms and newsfeeds.

L-R: FOGSI Leaders with celebrated designer, personalities, and influential figures including Saiyami Kher, Shaina NC, Shamita Shetty, Diana Hayden, and Poonam Dhillon

BEYOND A MOMENT

The launch of Manyata was not an end but a beginning. From that stage in Mumbai, the program has grown across India, reaching diverse regions and providers, from large urban facilities to small clinics in remote areas. Its focus on quality improvement has touched thousands of providers and, through them, countless mothers and newborns.

As I reflect, what fills me with pride is not only what Manyata has achieved but how it has become a shared legacy. Each FOGSI president and leader since has nurtured it, strengthened it, and taken it further. Like a child that grows with the care of a village, Manyata has thrived because it was never the vision of one person alone. It was born of conviction, shaped by collective effort, and carried forward by the belief that mothers deserve better.

CLOSING REFLECTIONS

Launching Manyata was one of the most meaningful moments of my presidency at FOGSI. It taught me that real change demands both evidence and emotion, structure, and symbolism. It reminded me that while policies and protocols are vital, movements are built on inspiration, shared commitment, and the courage to do things differently.

Today, as I look back, I see Manyata not just as a program but as FOGSI's child — nurtured year after year, shaped by every leader's care and commitment, and grown into a movement that now stands tall. What began as a delicate bud has blossomed into something larger than any one of us, bearing fruit in the form of healthier mothers and a promise fulfilled.

And in that, I find the answer to the question that haunted me years ago: the mother does not have to disappear from the story of birth. With Manyata, she is finally at its heart.

MSD FOR MOTHERS – THE GLOBAL VISION

Ms. Pompy Sridhar

When MSD for Mothers was launched in 2011, it carried an ambition that was both bold and deeply human: to help end preventable maternal deaths around the world. For too long, maternal mortality had been seen as an inevitable tragedy in many parts of the world, rather than an urgent public health priority that could be systematically addressed. MSD for Mothers set out to change that perception, by bringing the scale, resources, and innovation of a global health care company into collaborations and grantmaking that would improve maternal health outcomes. Since then, MSD for Mothers has reached more than **34.9 million women in over 70 countries**, working with a diverse group of collaborators, including governments, non-profit organizations, quality improvement experts, advocates, and other innovators to help end preventable maternal mortality.

This commitment is firmly aligned with the **Sustainable Development Goals, particularly SDG 3**, which calls for ensuring healthy lives and promoting well-being for all. Within that framework, reducing maternal mortality is recognized as a core indicator of a society's progress in health equity. Yet achieving this goal requires more than expanding access to services. It requires ensuring that women receive high-quality, respectful, and dignified care when they are at their most vulnerable. Global aspirations must always be translated into local realities. For a country as large and diverse as India, where maternal health outcomes are shaped by complex and fragmented systems, this translation is especially critical.

Since 2013, MSD for Mothers has taken a comprehensive approach to advancing the quality of private maternity care in India to meet women's maternal health needs. Our goal is to expand the pool of high-quality facilities available to women and to payors and contribute to India's efforts to achieve Universal Health Coverage. We follow core principles that are true to our values: taking women-centered approaches, expanding access to quality care using the power of digital technologies, and unlocking innovative financing mechanisms for long-term sustainability.

The role of MSD for Mothers has been to act as a catalyst: not by duplicating or substituting for government programs, but by strategically complementing them, closing quality gaps, and demonstrating a scalable model that can **advance public health goals**. This approach is particularly evident in India, where the **Manyata** initiative has evolved into both a national model for quality maternal care and a global reference point for what systemic improvement can look like.

At the center of our MSD for Mothers strategy lies what we call the ***Mom Effect***. This concept reflects a profound truth: when mothers survive and thrive, the benefits ripple across generations. A healthy mother is more likely to raise healthy children, to contribute productively to her family's livelihood, and to strengthen the social and economic fabric of her community. Conversely, the loss of a mother during childbirth is not only a personal tragedy but also a devastating social and economic setback for families. Evidence shows that children who lose their mothers are more likely to suffer malnutrition, drop out of school, and face diminished life chances. Improving maternal health is

therefore not only about saving lives today—it is an investment in the well-being of entire communities and the prosperity of future generations.

MSD for Mothers frames its work through three interconnected pillars: women, providers, and health systems. This holistic lens recognizes that sustainable change does not come from a single intervention. It comes from strengthening the ecosystem around women, so that every point of contact—from the provider who delivers care to the system that sets standards—reinforces safety, dignity, and respect.

The first pillar is **providers**. Providers are the frontline of maternal care—the trusted professionals who guide women through pregnancy, childbirth, and postnatal recovery. In India, nearly half of all deliveries take place in private facilities. Many of these are small, independently run nursing homes and maternity centers that remain outside the purview of formal regulation. While these facilities are critical to serving millions of women, they often lack standardized protocols, consistent training or mechanisms of accountability. Addressing maternal mortality in India therefore requires engaging this vast and fragmented private sector. Manyata was designed to do precisely this. Recognizing the potential of professional organizations, Manyata was developed in collaboration with the Federation of Obstetrics and Gynecological Societies of India (FOGSI), as it translated WHO-aligned quality standards into tools, protocols, and training methods that resonated with Indian providers. By recognizing quality improvement efforts through certification, Manyata creates an ecosystem where professional pride and credibility drive improvements in care. The association with FOGSI has been particularly significant, as it ensures that this change is led by obstetricians and gynecologists themselves, making quality not an external imposition but a professional standard embraced from within.

The second pillar is **women**. For too long, maternal health has been defined in narrow clinical terms, overlooking the **lived experiences of women**. Quality cannot be assessed solely by medical outcomes; it must also be defined by whether women feel respected, supported, and safe throughout their care. Respectful maternity care is therefore central—encompassing dignity, privacy, informed consent, and compassionate communication. Equally important is attention to women's mental health, recognizing that childbirth is not only a physical process but also an emotional and psychological journey. By embedding these dimensions into definitions of quality, maternal health shifts from being provider-driven to truly woman-centric. Manyata itself is anchored in the belief that care must be both evidence-based and woman-centered, ensuring that women's dignity is protected alongside their health.

The third pillar focuses on **health systems**. Sustainable maternal health improvements cannot rest on individual providers or facilities alone; they require systemic shifts that embed quality into the very fabric of health care delivery. In India, this has meant not only advocating for favorable policy changes, designing innovative financing mechanisms, and generating evidence, but also ensuring that **private sector integration** moves from theory into practice. MSD for Mothers has played a catalytic role in this process—working with the National Accreditation Board for Hospitals and Healthcare Providers (NABH) under the Quality Council of India (QCI), the country's apex body for accreditation and quality promotion, to ensure that small and mid-sized private facilities, long outside formal regulation, are brought into the fold. What began as exploratory conversations has now matured into active endorsement and collaboration, with NABH integrating Manyata standards to make accreditation systems more comprehensive and reflective of real-world provider contexts. In doing so, MSD for Mothers has helped embed quality improvement into national systems, strengthening accreditation as a lever for systemic change and shaping a health systems approach where quality becomes a permanent expectation across both public and private care.

India has been central to MSD for Mothers' global story. Nearly 35 percent of the women we have reached so far globally are from India, where more than **10 million women** have directly benefited from our initiatives. This scale of impact demonstrates the significance of India not only as a beneficiary of global strategy but also as a contributor to global evidence. The lessons learned here are shaping global discussions on how maternal health can be improved in diverse and fragmented settings.

One of the defining strengths of MSD for Mothers' work in India has been its commitment to **localization**. International standards and evidence are essential, but they must be adapted to context. In India, the challenge was not access—more than 80 percent of deliveries are institutional—but standardization. The variability in care, especially in the private sector, required solutions tailored to local realities. Manyata was shaped with this knowledge in collaboration with FOGSI. Leveraging peer networks, professional recognition and incremental certification were used to create a culture of continuous improvement. This locally owned model has since generated lessons that are feeding back into global maternal health discourse, demonstrating how solutions developed in one context can inform and inspire action worldwide.

Today, Manyata stands as one of the world's largest maternal health quality improvement initiatives. It has evolved from a pilot project into a movement, with a footprint that spans diverse geographies and health systems. Its success lies not only in the clinical improvements it drives but also in the behavior change it fosters: quality has become a mark of pride, something providers voluntarily strive for. Manyata is not a standalone intervention but a **market-shaping approach**. By creating standards, recognition, and demand for quality, it has influenced the behavior of facilities and providers far beyond its immediate participants.

The importance of this work can be seen in the broader trends in India's maternal health outcomes. Between 2010–12 and 2020–22, India's Maternal Mortality Ratio declined from 178 to 88 per 100,000 live births. This decline reflects a wide array of government initiatives, community efforts, and systemic reforms. Yet quality improvement programs such as Manyata, which have operated at national scale and engaged the critical private sector, have been an integral part of this progress. The model blends equity, sustainability, and innovation—making it one of the rare examples of maternal health improvement that combines professional leadership, financial viability, and systemic integration.

A particularly pioneering dimension of MSD for Mothers' work in India has been the application of innovative financing to advance maternal health. The Utkrisht Development Impact Bond (DIB) in Rajasthan was the world's first maternal health DIB and marked a critical turning point in Manyata's journey. Anchored in Manyata's quality standards, the DIB created a results-based structure in which payments were tied to facilities achieving verifiable benchmarks in maternal care standards. By aligning the interests of private capital, philanthropic funders, and technical partners, the model enabled private facilities to improve the quality of care. For us, this was testament that outcome-based financing can embed accountability, align incentives, and catalyze systemic change. For Manyata, it was validation that its standards could be scaled through innovative mechanisms, moving beyond a programmatic intervention toward a replicable model of quality improvement. The success of the Utkrisht DIB did more than deliver results in Rajasthan—it also provided the impetus to continue exploring bold approaches to sustainability.

Building on this momentum, MSD for Mothers helped shape Manyata's sustainability framework by supporting a new generation of obstetricians and gynecologists who were eager to embrace social entrepreneurship and strengthen the capacity of private maternity providers. Central to this approach are the Centers of Skill Enhancement (CSEs)—innovative, practitioner-led hubs run by FOGSI members who serve as both clinicians and social entrepreneurs. By combining results-based financing with local leadership, the model embeds accountability, fosters innovation, and empowers

healthcare institutions to deliver quality maternal care at scale. In doing so, it not only sets a new benchmark for healthcare development but also demonstrates a rare moment in public health where sustainability is no longer an aspiration, but a reality being systematically built into the system.

Strategic funding has also been a powerful lever in strengthening the effort towards quality care. MSD for Mothers took the crucial first step of investing in quality maternal health at a time when it was not seen as an attractive or mainstream priority. This early commitment not only gave Manyata the momentum to demonstrate proof of concept but also helped galvanize the broader ecosystem. Today, donors as well as corporate social responsibility arms of leading organizations, are beginning to channel resources into quality of care because they see the tangible value and measurable outcomes Manyata has delivered. The program itself has emerged as an aggregator—bringing together diverse funding streams and translating them into scaled, coordinated action. This shift reflects how catalytic investments, when strategically deployed, can transform the funding landscape, attract new players to the table, and position maternal health quality as a shared agenda.

Collaboration has been at the heart of MSD for Mothers' strategy to transform maternal health, with the initiative playing the role of an enabler to bring together diverse stakeholders whose combined expertise can achieve far more than any single actor alone. This approach is rooted in the recognition that maternal health is shaped by interconnected medical, social, and systemic factors—and therefore requires equally interconnected solutions.

Manyata too is a clear demonstration of this ethos. At its core, it is powered by a coalition of collaborators, each contributing a distinct layer of value. With FOGSI leading at the helm, the initiative is supported by a consortium of partners, convened by MSD for Mothers, to lend varied expertise, creating a fertile environment for its integration and scale.

Such partnerships exemplify the spirit of **Sustainable Development Goal 17**, which emphasizes "Partnerships for the Goals." Manyata illustrates how global funders, local professional societies, technical agencies, accreditation bodies, governments, and innovators can collectively advance maternal health. The program demonstrates that collaboration is not simply about pooling resources but about orchestrating complementary strengths to embed quality at scale. For MSD for Mothers, this has become a defining way of working: enabling partners to lead, building local capacity, and fostering ecosystems where quality and sustainability can thrive. In doing so, it has shown that the pathway to safer motherhood is best paved together.

Looking ahead, the focus will be on seeding new ideas, sustaining proven models, and scaling successful approaches to reach more women and providers. The task is not only to preserve the gains achieved so far but also to expand them responsibly, ensuring that quality improvement becomes deeply embedded within India's maternal health landscape. By nurturing innovation at the ground level and building pathways for long-term adoption, the aim is to create a self-sustaining cycle of progress that continues to grow stronger with time.

Our priorities for the coming years are clear. We will continue to forge partnerships to invest in local leadership, strengthening the capacity of professional bodies and provider networks to own and expand quality of care. We will deepen our support for digitization and real-time monitoring of quality metrics, ensuring that data becomes a driver of continuous improvement. We will also continue to generate and share evidence on what works, building the knowledge base needed to inform policy and practice at scale. Importantly, we will continue to harness the untapped potential of the local private sector, which provides care for a majority of women, ensuring its strengths are fully leveraged

for impact. And we will persist in advancing our three-pillar strategy—providers, women, and health systems—so that every woman, everywhere, receives the respectful, safe, and high-quality care she deserves around pregnancy and childbirth.

When we improve maternal health, we do more than save lives—we lay the foundation for healthier societies. By integrating models like Manyata with innovative financing mechanisms and system-wide collaborations, MSD for Mothers is helping ensure that today's mothers not only survive childbirth but also thrive beyond it. Manyata is not just a program—it shows how global vision and local action can come together to transform maternal health. For India, it is a story of innovation, collaboration, and sustainability. For the world, it is a powerful demonstration that ending preventable maternal deaths is both possible and within reach. And as we look to the future, the call is clear: let us bet on strong accreditation systems, ensuring that women—wherever they choose to seek care, public or private—receive the quality they deserve.

THE STORY OF LAQSHYA-MANYATA: WHOLE IS GREATER THAN THE SUM OF ITS PARTS!

Dr. Nandita Palshetkar, Dr. Parag Bhamare

"Why can't we make things simple for women? Why can't the same quality of care be assured across public and private setups? Why can't we have one set of standards with a single aspiration–to not let any woman face adversities during the most beautiful time in her life? And if we can, how do we make it happen?"

These searching questions are more than rhetoric; they reflect a quiet truth about India's maternal health system–a story of extraordinary progress intertwined with unfinished business. In the past two decades, institutional deliveries nearly doubled, rising from 39% in 2005–06 to 88% in 2019–21 (NFHS surveys). Government schemes like Janani Suraksha Yojana played a decisive role in this transformation, saving thousands of lives and opening hospital doors to millions of women who once gave birth at home. As things improved on the access front, the Lancet Global Health Commission warned, poor-quality care causes more preventable maternal and newborn deaths than lack of access itself. This insight was concurrent with the momentum to a new wave of Quality of Care (QoC) initiatives in India over the last decade.

In 2017, two ambitious programs emerged: LaQshya, driven by the Ministry of Health and Family Welfare (MoHFW) to raise standards in public health facilities, and Manyata, spearheaded by FOGSI with Jhpiego's technical support to bring quality improvements to private maternity setups. Both were rooted in a shared vision–evidence-based standards, hands-on mentoring, and certification for safe and respectful care. Both initiatives were unfolding with great energy–one strengthening the public system with focus on infrastructure and the other empowering the private sector with focus on clinical excellence–yet on parallel tracks of the same journey that every woman experiences as one. Together, they were building important foundations for quality, but their greatest potential lay in convergence. Bringing these efforts side by side offered the possibility of a shared promise: that every woman, wherever she sought care, could feel equally safe, respected, and supported during childbirth. What was missing was not intent, but a bridge–something that could unite public and private efforts into a single, simple assurance for every woman: that her care would meet the same standard, everywhere.

Stepping into this void, Maharashtra, a state with a vibrant mixed health system, demonstrated a willingness to forge a unified path. With leadership from the Federation of Obstetric and Gynaecological Societies of India (FOGSI), crucial technical assistance from Jhpiego, and the readiness of the state government, a new vision became a reality. In 2019, leaders in Maharashtra chose to ask a simple but revolutionary question: why should the quality of a woman's childbirth depend on whether she steps into a government hospital or a private clinic? The state quietly rewrote the script of maternal health in India.

LaQshya–Manyata emerged as the bridge no one thought possible. Rather than reinventing yet another program, Maharashtra did something bold: it stitched together two of the country's strongest yet siloed frameworks. On one side was the government's LaQshya initiative from 2017, which focused on facility standards in public hospitals—ensuring functional labor rooms, infection

control, and patient-friendly systems. On the other side was FOGSI's Manyata, also launched in 2017, which sharpened clinical practices in private maternity homes—from labor monitoring and neonatal resuscitation to respectful maternity care.

By fusing these together into a comprehensive package of 26 standards—16 clinical and 10 facility—the state created something truly new: a unified quality framework cutting across India's famously mixed health system. At its heart, LaQshya–Manyata promised more than protocols—it promised that childbirth could be safe and respectful, whether in a crowded district hospital or a small neighborhood clinic. And with that, Maharashtra became the first state to turn an old question into a new answer - showing the rest of India that public and private health systems don't have to be rivals, but partners in delivering life's most important promise.

A LEADERSHIP THAT MATTERS

The integration did not happen overnight. It required vision–and a leader who could make it her mission. The then **President of FOGSI, Dr Nandita Palshetkar** recognized that unless the public and private systems were harmonized, women would continue facing a fragmented experience of maternity care. She made LaQshya–Manyata her flagship initiative and set about doing the painstaking work of building consensus. Under her leadership, FOGSI mobilized obstetricians across the state, Jhpiego provided technical expertise, and the government offered readiness to formally back the effort.

It was a diplomatic balancing act, reassuring private providers that this was not a government intrusion but rather a program owned by their professional body, while convincing policymakers that this was not duplication but a convergence aligned to national priorities. Her relentless advocacy created a coalition strong enough to elevate the initiative to the state level. The effort culminated, when the Hon. Health Minister of Maharashtra officially launched LaQshya–Manyata; publicly recognizing it as a unique bridge between public and private systems. It was the first time a state government gave such endorsement to a professional association-led quality assurance program, marking a historic shift in India's maternal health journey.

FROM STANDARDS TO PRACTICE

The LaQshya – Manyata governance framework was layered but practical: a State Steering Committee, District Quality Assurance Committees, and facility-level committees ensured oversight at every level. Certification was rigorous—facilities had to hit at least 85% compliance across all 26 standards, validated by joint Government-FOGSI assessments. By 2023, more than 200 private maternity facilities across 26 districts had been certified, showing measurable gains in clinical practices, infection prevention, informed consent, and respectful maternity care.

The path, however, was far from simple. It demanded meticulous work to merge Manyata's clinical standards with LaQshya's facility standards, tailoring them to be both aspirational and practical for the realities of the private sector. Crafting the standards was just the first step; getting them vetted and accepted by private stakeholders, government officials, and frontline practitioners presented a new set of challenges. This was followed by the immense task of building new Quality Improvement (QI) mechanisms and upgrading existing Quality Assurance (QA) systems to align with the harmonized norms.

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IMPACT

In a small maternity home in Pune, a nurse recalls the moment it all began to feel different: "Before, I used to panic when a woman started to bleed heavily. Now, after the drills, I know what to do. I don't just react—I act." Her words capture the quiet but powerful transformation LaQshya–Manyata set in motion.

Though large-scale outcome data is still being gathered, the early signs of change are vivid on the ground. In facilities that once struggled, partographs are being filled out regularly, newborn resuscitation is performed with confidence, and lifesaving interventions for postpartum hemorrhage are no longer left to chance. Beyond skills and protocols, the physical environment of childbirth has also changed—labor rooms have become fully functional, infection prevention protocols more consistent, and even basics like biomedical waste management and patient-friendly amenities no longer overlooked.

For women, these changes translate into something very simple yet profound: a safer, more respectful experience, regardless of where they sought care. For perhaps the first time, the quality of maternity care did not hinge solely on the signboard outside the facility.

INFLUENCE

The ripple effects of LaQshya–Manyata have extended far beyond maternity wards. At its heart, the program began to redefine how quality is governed in India's maternal health system. Clinical standards, once the near-exclusive domain of professional bodies, are now woven directly into the fabric of state-led assurance frameworks. This represents a quiet but critical shift—from parallel efforts, often voluntary and sector-specific, to an integrated model where clinical excellence is central to government stewardship.

The influence has been economic, too. By aligning with NABH, LaQshya–Manyata-certified facilities gained credibility that positioned them for national accreditation. This legitimacy translated into potential incentives: hospitals could become eligible for higher reimbursement rates under PM-JAY and could even be more appealing to private insurers. Quality, once thought of as an aspiration or moral imperative, could actually become as asset with financial value attached.

It also altered the professional landscape. Nurses and midwives who once felt peripheral found themselves at the center of new skill-building opportunities. Through simulation exercises, structured mentorship, and certification programs, a new culture of confidence began to take hold. "Earlier, I was always waiting for the doctor. Now in an emergency, I know what I can do until help arrives," said a midwife from a rural facility in Raigad. For the workforce, quality improvement stopped being abstract policy–it became empowerment.

6 Ministry of Health and Family Welfare (MoHFW), Government of India. LaQshya—Labour Room Quality Improvement Initiative: Operational Guidelines. 2017.

7 FOGSI/Jhpiego. Manyata standards for private maternity facilities: 16 clinical standards and verification approach. Program description and assessment details. 2020–2022.

8 National Family Health Survey (NFHS-5) 2019–21: Institutional births increased to 88.6%. Key indicators compendium.

9 National Health Authority. PM-JAY overview and package/payment design; linkages with accreditation and provider incentives.

10 NABH/HOPE and AB PM-JAY Quality Certification pathways aligning entry-level certification with reimbursement incentives.

11 National Health Systems Resource Centre (NHSRC). Janani Suraksha Yojana (JSY) program evaluation and maternal mortality implications.

12 Medical Dialogues. Maharashtra launches LaQshya–Manyata; state partnership with FOGSI to standardize quality in private maternity care. 2020.

13 Express Healthcare. Innovative collaborations to make Maharashtra a safer place for childbirth: LaQshya–Manyata overview and PPP framing. 2019.

14 Healthy Newborn Network/WHO. Standards for improving quality of maternal and newborn care in health facilities: eight-domain framework. 2016.

15 Delaney MM et al. Does quality certification work? Assessment of Manyata implementation and adherence to standards in private facilities. 2022.

IMPLICATIONS

The implications of this experiment reach far beyond Maharashtra's borders. Within the state, the road ahead is focused on depth - ensuring that high-quality maternal care is not confined to selected districts but reaches every corner, urban and rural alike. Other large states with a prominent role for private maternity care - Uttar Pradesh, Bihar, Madhya Pradesh - are already watching closely, testing the possibility of adapting the model to their own health systems.

Nationally, the future lies in tying quality standards into India's fast-evolving digital ecosystem. By embedding LaQshya–Manyata into tools like NABH's HOPE platform and the Ayushman Bharat Digital Mission, monitoring could shift from sporadic visits to real-time dashboards. Policymakers, for the first time, would be able to see quality not as a snapshot but as a moving picture, guiding decisions with live data.

And globally, the message is clear. For countries across Asia, Africa, and beyond that grapple with the complexities of mixed health systems, Maharashtra's story offers a blueprint. By bringing together government stewardship, professional leadership, and accreditation alignment, LaQshya–Manyata demonstrated that fractured systems can, in fact, converge. The deeper implication is both simple and universal: when silos collapse and public and private efforts harmonize, women finally receive what they should have always been assured - a safe, dignified, and respectful experience of childbirth.

TO BE CONTINUED

In the beginning, the story of LaQshya–Manyata was framed by unsettling questions: *Why can't same quality care be assured across public and private setups?* And if we can, how do we make it happen? By the time Maharashtra launched this bold experiment, those questions had begun to find their answers. LaQshya–Manyata did more than merge two programs; it reimagined what maternal care could look like in a country where public and private often walk separate paths. It showed that quality doesn't have to be fragmented, that governance can embrace both clinical standards and facility systems, and that financial and professional incentives can be aligned toward a single goal.

Its true achievement is not just the 200-plus facilities certified or the new standards written—it is the quiet but transformative shift from seeing quality as optional to treating it as non-negotiable. For India, this was a declaration that "One Nation, One Standard" in maternal health is not only possible but practical. And for the world, particularly nations grappling with mixed health systems, Maharashtra's blueprint lights a pathway forward: integration over isolation, collaboration over silos, dignity over disparity.

In the end, LaQshya–Manyata turned rhetoric into reality. The questions remain—but now, they are no longer haunting. They are guiding. And they point toward a future where every woman, everywhere, has the same simple, powerful assurance when she goes into labor: that her care will be safe, respectful, and of the highest quality, no matter the door she enters.

ACKNOWLEDGEMENT

With gratitude and respect, this story honors the **late Dr. Aparna Shrotri** for her pivotal role to make LaQshya–Manyata a shared standard for quality, and in doing so, turning collaboration into care for countless mothers.

THE TECHNICAL BACKBONE OF MANYATA

FORMATION OF NPMU: THE FULCRUM FOR THE INITIATIVE

Dr. Ameya Purandare, Dr. Samita Bhardwaj

During the launch of the Manyata initiative, FOGSI's leadership recognized the need for a dedicated structure that would drive the program forward with coherence, scale, and operational efficiency. To meet this need, FOGSI established the National Program Management Unit (NPMU) with support from the MacArthur Foundation—the operational and strategic backbone of the initiative—to ensure that efforts across training, quality improvement, and certification were aligned, well-coordinated, and sustained over the long term.

NPMU was created to address key challenges that arise in scaling Manyata across diverse geographies and service providers. Manyata's ambition to improve maternal care in private healthcare settings required a structured approach to managing data, engaging stakeholders, and ensuring that the program's objectives were met consistently. NPMU was tasked with providing technical, managerial, and governance support to facilitate the initiative's growth, uphold the integrity of quality standards, and enable programmatic agility in responding to emerging challenges.

One of NPMU's core responsibilities is to maintain accurate records of all registered providers. Functioning as the central coordinating entity, NPMU manages the entire data ecosystem of the initiative. It tracks where each facility stands in its quality improvement journey, schedules assessments, appoints qualified assessors, records assessment outcomes, issues certificates, and sends timely reminders for recertification. By maintaining this structured database, NPMU ensures that the program remains accountable, consistent, and responsive to provider needs.

It also includes overseeing digital quality assurance (QA) tools, ensuring that data collection, documentation, monitoring, and reporting processes are streamlined and reliable. NPMU also manages financial processes, from tracking transactions to ensuring transparent reporting—all of which are critical to the credibility and sustainability of the program.

From its office within FOGSI's headquarters in Mumbai, NPMU has supported program outreach efforts, including organizing sessions at conferences, hosting stalls, and conducting local awareness activities. These efforts have been critical in building momentum for the program, expanding provider participation, and strengthening the network of trained assessors available to conduct facility evaluations.

A key component of NPMU's operations is ensuring the credibility and impartiality of the certification process. To this end, NPMU manages the recruitment, training, and evaluation of assessors who undergo structured training before conducting assessments. The firewall maintained between quality improvement (QI) and quality assessment (QA) processes safeguards the integrity of the program, ensuring that certification is based on objective evaluation and that the Manyata certificate is widely respected for its rigor.

In addition to data management and governance, NPMU coordinates closely with FOGSI's Centres of Skill Enhancement (CSEs), which serve as quality improvement hubs across the country. These centers onboard facilities, provide training, and support facilities in implementing best practices.

NPMU plays a vital role in governance by organizing and hosting periodic meetings where key programmatic decisions are made. These governance forums allow stakeholders to review progress, resolve grievances, and ensure that the program remains aligned with its strategic objectives. By facilitating open channels for leadership involvement, NPMU helps ensure that challenges are addressed promptly and solutions are effectively implemented.

NPMU's role extends to engagement with both internal and external stakeholders. It represents the initiative in discussions with government bodies, development partners, and healthcare providers. By serving as the face of the program from FOGSI's side, NPMU builds trust, facilitates partnerships, and advocates for the integration of quality care in maternal health services.

NPMU has also played a significant role in facilitating collaborations such as the LaQshya-Manyata public-private partnership in Maharashtra, where it coordinates assessments between government and private providers. Similarly, its partnership with NABH has expanded the reach of Manyata's standards by training assessors in alignment with national accreditation requirements, helping integrate quality assurance frameworks across healthcare systems.

Looking ahead, NPMU's role remains critical not only in sustaining program operations but also in positioning Manyata for broader engagement with stakeholders. The dedicated unit within FOGSI creates opportunities to formalize communication protocols, host virtual refresher training sessions, and build mechanisms for feedback and reporting that ensure continuous learning. It also holds potential as a strategic platform to engage with external partners, pitch the program's value, and explore pathways for sustainable financing and program expansion.

By embedding operational excellence, data-driven management, and structured governance within its framework, NPMU has laid a strong foundation for scaling maternal healthcare improvements. The unit stands as a central pillar in the Manyata initiative's efforts to ensure that every mother receives safe, respectful, and high-quality care—a commitment that continues to guide its work toward long-term sustainability and impact.

FROM PLANS TO PRACTICE: OPERATIONALIZING QUALITY OF CARE IN MATERNAL HEALTH

Dr. Suranjeen Prasad

INTRODUCTION

While Governments are committed to safe motherhood and reducing preventable mortality and morbidity among pregnant women and newborns. Adopting a Universal Health Coverage and clinical governance framework for maternal health services would ensure a systematic and integrated approach to provide access to institutional births, guarantee quality services, and enable regular review of clinical responsibility and accountability. This ultimately improves the quality and safety of maternal and neonatal health services, ensuring optimal outcomes for mothers and newborns.

FOGSI and the local governments are entering into a unique partnership initiative that would establish uniform standards of care across all maternity institutions. Since standards mainly focus on clinical care, patient safety, and quality, they would benefit patients visiting these hospitals and significantly contribute to reducing maternal and newborn mortality and morbidity.

With the government's dynamic leadership, guidance, and support, this innovative approach to ensuring quality care during childbirth for all mothers will help further reduce maternal and newborn mortality and morbidity in the district.

CLINICAL GOVERNANCE

The concept of clinical governance emerged in the 1990s within the UK's National Health Service[1], and various models of clinical governance exist in high-income countries[2]. While no single definition is universally accepted, it can be described as "a strong framework that emphasizes shared accountability to maintain and enhance the quality of services and outcomes for both patients and staff."[3] Typical elements across different models include accountability, a culture that values quality and safety, and the use of data that is "relevant to organizational goals, timely, accurate, valid, reliable, and complete."[4]

1 Halligan A, Donaldson L. Implementing clinical governance: turning vision into reality. BMJ [Internet]. 2001 Jun 9 [cited 2025 Sep 11];322(7299):1413–7. Available from: https://www.bmj.com/content/322/7299/1413

2 Phillips CB, Pearce CM, Hall S, Travaglia J, De Lusignan S, Love T, et al. Can clinical governance deliver quality improvement in Australian general practice and primary care? A systematic review of the evidence. Medical Journal of Australia [Internet]. 2010 Nov 1 [cited 2025 Sep 11];193(10):602–7. Available from: /doi/pdf/10.5694/j.1326-5377.2010.tb04071.x

3 Clinical Governance A Guide to Implementation for Healthcare Professionals Third Edition.

4 Ramsay A, Magnusson C, Fulop N. The relationship between external and local governance systems: the case of Health Care Associated Infections and medication errors in one NHS trust. Qual Saf Health Care [Internet]. 2010 Dec 1 [cited 2025 Sep 11];19(6):e45–e45. Available from: https://qualitysafety.bmj.com/content/19/6/e45

The national and state governments have initiated several programs to guarantee universal access to maternity services[5]. These efforts focus on providing quality antenatal care (ANC) and institutional deliveries by ensuring that services are available and accessible, including subsidized transportation for women to reach health facilities and for referrals.

Clinical governance is a framework aimed at enhancing management, accountability, and the delivery of high-quality healthcare[6]. We suggest an approach to reinforce clinical governance to upgrade maternal and newborn care standards.

Approach for clinical governance:

Practices and Tools	Description	Frequency
Hospital management: Creates the systems, standards and culture of clinical accountability and responsibility		
1. Performance standards	▪ A set of tools (Dakshata / Manyata) that define facility readiness to prevent and manage selected complications and good hospital management practices (e.g., infection prevention, clinical governance, client feedback). ▪ Six sessions of training for all clinical professionals.	Quarterly self-assessments, with an action plan to address gaps Once a year peer assessment from another district
2. Maternal and neonatal death reviews and near-miss reviews (facility)	▪ Support facility level maternal and perinatal death tracking, reporting and review. ▪ Support the MPDSR review at the district level by ensuring all maternal deaths (and at least 25% perinatal deaths) have a verbal autopsy in place within a week.	Monthly at facility and district level
3. Classification of births and caesareans	▪ Support institutions to classify births as per the Robson's criteria and review the cesarean section rates.	Quarterly at each facility
Ward/unit management: Sets the processes and procedures to deliver high-quality clinical care safely and efficiently		
4. Emergency drills	▪ Maternal and neonatal emergencies are simulated to practice emergency responsiveness, improve teamwork, maintain skills and resolve possible delays (e.g., client flow, emergency trolleys).	Once a quarter at each delivery point, and as often
5. Clinical dashboards	▪ Color-coded charts display the most important clinical and operational indicators, chosen by each unit/ward. They are used by staff to assess their performance and to act when sub-optimal performance is indicated.*	Weekly in big hospitals with over 50 deliveries Monthly in others Wall charts
Clinicians: Provide high-quality clinical care safely and efficiently in compliance with clinical policies and standards		
6. District working group for maternal and neonatal health	▪ Pause and reflect (every quarter): Clinicians, managers of facilities, primary health care workers meet once a quarter to discuss how best to reduce avoidable morbidity and mortality for mothers and newborns. ▪ Review (monthly): Each district decides on local interventions and tracks them every month.	Quarterly and monthly
*Interventions include: active management of the third stage of labor (AMTSL), which includes the provision of a uterotonic for postpartum hemorrhage prevention[7]; management of severe pre-eclampsia/eclampsia with magnesium sulfate[8]; provision of one or more doses of antenatal corticosteroids to women delivering between 24 to 34 weeks to prevent respiratory distress syndrome in newborns[9]; and initiation of breastfeeding for all live births within one hour of birth[10].		

Table 1: Hospital-based tools and approaches by level in all institutions both public and private

5 Press Release:Press Information Bureau [Internet]. [cited 2025 Sep 11]. Available from: https://www.pib.gov.in/PressReleasePage.aspx?PRID=2113800

Quality of Care around childbirth averts maternal and perinatal mortality and morbidity

Enhancing care quality is crucial for safeguarding patient safety and speeding up declines in mortality and morbidity. To avoid preventable maternal and neonatal deaths, every pregnant woman and newborn must receive skilled care during birth, with clinical and non-clinical interventions based on evidence, provided in a compassionate and supportive environment. Global data shows that improved quality of care during childbirth could prevent up to 1.49 million maternal and newborn deaths and stillbirths each year[11], greatly boosting survival rates. Most maternal deaths[12] (over 70%) are due to complications requiring facility-based treatment, such as postpartum hemorrhage, hypertensive disorders, sepsis, and abortion-related issues. Consequently, enhancing the quality of facility-based delivery care presents significant opportunities to reduce maternal and perinatal mortality.

Standards of care improve quality of care in the public health maternity units

To enhance the quality of care during childbirth, the Government of India (GOI) launched "Dakshata,[13]" meaning adroitness, aimed at improving intrapartum and immediate postpartum care. Dakshata involved competency-based training focused on the most impactful practices during childbirth, the introduction of the Safe Childbirth Checklist (SCC), and post-training follow-ups to ensure adherence to standards. Subsequently, the government implemented the LaQshya[14] standards as part of the National Quality Assurance Standards, targeting maternity units. These standards are now mandatory for all facilities providing C/BEmONC care. Since the private sector accounts for a significant share of critical maternity services in the state, establishing a similar quality improvement program within private hospitals is essential. The inconsistent quality of care in the private sector, along with the lack of standardized procedures, can hinder effective management of labor complications and jeopardize the health of pregnant women and new mothers.

6 Macfarlane AJR. What is clinical governance? BJA Educ [Internet]. 2019 Jun 1 [cited 2025 Sep 11];19(6):174. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC7808043/

7 WHO recommendations on Antenatal corticosteroids for improving preterm birth outcomes

8 Early initiation of breastfeeding [Internet]. [cited 2025 Sep 11]. Available from: https://www.who.int/tools/elena/commentary/early-breastfeeding

9 Bhutta ZA, Das JK, Bahl R, Lawn JE, Salam RA, Paul VK, et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? The Lancet [Internet]. 2014 Jul 26 [cited 2025 Sep 11];384(9940):347–70. Available from: https://www.thelancet.com/action/showFullText?pii=S0140673614607923

10 Cresswell JA, Alexander M, Chong MYC, Link HM, Pejchinovska M, Gazeley U, et al. Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis. Lancet Glob Health [Internet]. 2025 Apr 1

11 Bhutta ZA, Das JK, Bahl R, Lawn JE, Salam RA, Paul VK, et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? The Lancet [Internet]. 2014 Jul 26 [cited 2025 Sep 11];384(9940):347–70. Available from: https://www.thelancet.com/action/showFullText?pii=S0140673614607923

12 Cresswell JA, Alexander M, Chong MYC, Link HM, Pejchinovska M, Gazeley U, et al. Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis. Lancet Glob Health [Internet]. 2025 Apr 1 [cited 2025 Sep 11];13(4):e626–34. Available from: https://www.thelancet.com/action/showFullText?pii=S2214109X24005606

13 A strategic initiative to strengthen quality of intra-and immediate postpartum care Operational Guidelines DAKSHATA Empowering Providers for Improved MNH Care during Institutional Deliveries. 2015.

14 LaQshya Guidelines [Internet]. [cited 2025 Sep 11]. Available from: https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCH_MH_Guidelines/LaQshya-Guidelines.pdf

Manyata as standards for quality of care in maternity units

Currently, the private sector primarily depends on self-initiated quality improvement efforts, such as CMEs for specialists on clinical updates and guidelines. Nursing staff rarely have access to these opportunities. Existing quality assurance mechanisms in the private sector are limited, focusing on standards with restricted reach. Manyata is a quality improvement and certification program open to private health institutions offering obstetric and perinatal services. Its goal is to decrease maternal and neonatal deaths and morbidities, while also providing a positive birthing experience, thereby reducing disparities in maternal and neonatal health outcomes. This is achieved by ensuring all private sector institutions involved in childbirth follow standard clinical practices. FOGSI, with technical assistance from Jhpiego and support from MSD for Mothers, is working closely with over 1800 private health facilities across Maharashtra, Uttar Pradesh, Rajasthan, Jharkhand, Karnataka, and Tamil Nadu to ensure adherence to quality standards in private hospitals.

In 2019, Manyata program got big success through public private partnership with the Government of Maharashtra. The state of Maharashtra pioneered an unprecedented integration of the two programs through LaQshya–Manyata[15]. This initiative aligned private maternity facilities with the government's LaQshya framework while embedding Manyata's clinical standards, thereby creating a unified model of quality across both public and private domains.

LaQshya–Manyata was rolled out in Maharashtra from 2019 onward as a joint initiative of the state government and FOGSI, with Jhpiego as technical partner.

By 2023:

- The program had been introduced across 26 districts.
- More than 200 private maternity facilities had undergone assessments and received LaQshya–Manyata certification.
- Facilities demonstrated measurable improvements in both clinical and facility-level standards.

A Statewide campaign to ensure that all maternity hospitals which offer Comprehensive/Basic Emergency Obstetric and Newborn services (C/BEmONC) both in the public and private sector adhere to quality standards. FOGSI and Jhpiego will work closely with other partners and NHM, Meghalaya to take forward the activities.

15 FOGSI's Manyata is complementing Government efforts towards achieving Maternal Health goals - Times of India [Internet]. [cited 2025 Sep 11]. Available from: https://timesofindia.indiatimes.com/fogsis-manyata-is-complementing-government-efforts-towards-achieving-maternal-health-goals/articleshow/97162856.cms

Bottlenecks for Standardized Care in Maternity Homes	▪ Public & private sector work independently ▪ Lack of focus on Quality of Care in MNH in private sector ▪ Standardized QoC not uniform across sectors ▪ Non-availability of benchmarks for QoC in private sector
Objectives	▪ Public and private facilities accept and adhere to accepted clinical and facility standards ▪ A comprehensive quality improvement and assurance program that provides support to both public and private hospitals ▪ District Working Groups for safe motherhood
Key Processes / Strategy	▪ Establish a multi-stakeholder collaborative District Working Group for safe motherhood ▪ Capacity building of private staff through utilization of district training infrastructure ▪ Capacity building of assessors from public and private sector for assessments ▪ Formalizing the institutional mechanism for this initiative
Outputs	▪ Dist. Working group for safe motherhood formalized with representation from varied stakeholders ▪ Standardized quality of care available in both private and public maternity hospitals ▪ Technical and the operational guidelines for the initiative agreed upon and officially endorsed ▪ 80% of the facilities are covered and are undergoing certification process for QoC either by LaQshya or Manyata
Outcome	• Uniform standards of care to be followed by both public and private sector • Self-regulation to private sector hospitals • Coordination amongst private and public sector for safe motherhood • Reduction in the maternal and newborn mortality and morbidity in selected districts/ blocks of Assam

Figure 1: Schematic Representation of the Initiative

1. What is a Safe Motherhood Working Group?

This would be the support system to the quality assurance unit to ensure that the standardized Quality of Care is available to the beneficiaries across the state in public and private maternity hospitals. It would ensure meetings on a regular basis (preferably every month) to monitor the progress of the campaign and suggest timely interventions as required. This group would review the dashboards of MNH indicators for the public and private sector on a regular basis. This will also discuss the participation of private sector doctors in PMSMA (Pradhan Mantri Surakshit Matritva Abhiyaan), conduct joint maternal and infant deaths and cesarean audits, and cross referrals of the patients to and from public and private maternity hospitals.

2. Digital platform for Process and Data Management

Under the initiative, multiple interventions are envisaged to be undertaken within the stipulated time frame, and the impact of interventions is required to be simultaneously measured through verifiable indicators in real time. Therefore, efficient reporting of the status of activities and achievement of targets is critical for the success of the initiative. A dedicated Monthly Progress Reporting (MPR) format with the data entry module and the dashboard has been created in the digital platform for this purpose. All indicators need to be reported by the private health facility monthly after verification from respective facility teams.

To ensure optimal and effective use of program data, an IT platform, which provides effective and efficient data management systems with inbuilt analytics, has been developed. The IT platform will help:

- Streamline and make the on-boarding and registration process easy and less effort-intensive
- Leverage technology for delivering competency development intervention through e-learning and other electronic resources
- Streamline the process of data collection, analysis and its use for developing insights into the program, make necessary amendments and design future programs.
- Integrate a QI process flow management system
- Integrate assessment and certification management system
- Establish a post-certification surveillance mechanism

Similarly, the public health facilities will continue to report monthly and would be coordinated by the development partners working in these geographies.

CONCLUSION

In pursuit of safer motherhood and improved neonatal outcomes, integrating clinical governance into maternity care through a district-wide approach like Manyata offers a transformative pathway. By fostering accountability, standardizing care practices, and promoting data-driven decision-making, this strategy strengthens the quality and reliability of maternal health services across both public and private institutions. The collaborative efforts of FOGSI, Jhpiego, and local governments, supported by national health programs, ensure that every childbirth is met with competent care, timely interventions, and a culture of continuous improvement. Ultimately, this model not only enhances institutional readiness but also reinforces the commitment to reducing preventable maternal and newborn mortality, making quality care a universal reality. LaQshya – Manyata replication in Other States–such as Uttar Pradesh, Bihar, and Madhya Pradesh, where private maternity facilities played a critical role, could adapt the model.

ANTEPARTUM CARE: A HEAD START

PRE-PREGNANCY AND INTERPREGNANCY CARE: PAVING THE WAY FOR A HEALTHY MOTHER AND NEWBORN

Dr. Parag Biniwale, Dr. Surekha Tayde

INTRODUCTION AND CARE AREA OVERVIEW

Pre-pregnancy care provides a crucial window to screen for chronic conditions, update immunizations, review medications, and promote healthy behaviors. Interpregnancy care builds on this by addressing complications from prior pregnancies and supporting appropriate care for future ones. Together, these interventions significantly improve maternal and neonatal outcomes and empower women to make informed, proactive reproductive health decisions. Manyata standards are currently addressing antenatal, intrapartum, and postnatal care. The care ideally should start in pre-pregnancy period to prevent many critical issues that may arise during pregnancy, if not managed earlier. As the scope of the quality initiative expands, this key area of clinical care will be added to ensure continuum across the life stages.

RATIONALE AND FUTURE OBJECTIVE FOR INCLUSION INTO MANYATA STANDARDS

"Preconception care is proactive healthcare—screen, counsel, and optimize before pregnancy for the best outcomes."

Pre-pregnancy care is defined as a proactive healthcare service aimed at identifying and modifying biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, before conception occurs.[1] Pre-pregnancy and interpregnancy care are vital components of comprehensive reproductive healthcare aimed at optimizing outcomes for both mother and child. Expanding the scope of the Manyata standards by investing in pre-pregnancy and interpregnancy care will not only save lives but also reduce long-term healthcare costs and improve the overall quality of life for women and children.

WHO has estimated that, globally 810 women die every day from preventable causes related to pregnancy and childbirth, with most deaths occurring in low-and middle-income countries. Many of these adverse outcomes are linked to unaddressed medical conditions, inadequate birth spacing, or lack of preconception care. Studies have shown that nearly 50% of pregnancies worldwide are unplanned, whereas more than one in seven of unintended pregnancies occur in India, limiting the opportunity to modify risk factors before conception.[2] Moreover, short interpregnancy intervals less than 18 months have been associated with increased risks of preterm birth, low birth weight, and maternal anemia.

India has made considerable progress in reducing maternal and neonatal mortality however, challenges remain in fully addressing preventable mortality through the continuum of care across life stages. According to NFHS 5, 23% of women (15–49 yrs) are overweight, 19% are underweight,

1 American College of Obstetricians and Gynecologists (ACOG). Prepregnancy Care. ACOG Committee Opinion No. 762. Obstet Gynecol. 2019;133:e78–89.
2 State of World Population 2022 report, UNFPA

and 53% are anemic. Additionally, 6% and 5% of women (15–49 yrs) have high sugar and blood pressure levels, respectively.[3] Evidence shows that optimizing health before conception through interventions like folic acid supplementation, chronic disease control, birth spacing, and vaccination can reduce adverse pregnancy outcomes by up to 30–50%, especially in resource-limited settings. A comprehensive approach that strengthens interventions across preconception, antenatal, intrapartum, and postnatal periods have the potential to avert up to 71% of neonatal deaths equating to 10.9 million lives and around 33% of stillbirths, according to global estimates.[4]

Recently, a preconception care initiative in tribal and non-tribal blocks of Nashik demonstrated that women receiving structured interventions—such as folic acid supplementation, anemia treatment, deworming, and behavioral care—experienced significantly lower rates of preterm births (11.2% vs. 15.0%) and low birth weight infants (9.2% vs. 11.3%) compared to control areas.[5]

The Wings trail, with an intervention package delivered during preconception, pregnancy, and early childhood reduced low birth weight and stunting at 24 months. Pregnancy and early childhood interventions alone had lower but important effects on birth outcomes and 24-month outcomes.[6]

Awareness and utilization of preconception care remain limited. There is a critical need to scale up comprehensive pre and antenatal care across the continuum and hence the potential for inclusion into Manyata.

The goal is to optimize maternal health and create the best possible conditions for conception, fetal development, and pregnancy outcomes (Table 1).

Figure 1: Preconception and pregnancy period within the life course

Objectives of Pre-pregnancy Care

S. No.	Objective	Description
1.	Risk Identification	Identify existing medical, genetic, lifestyle, or psychosocial risk factors that may affect future pregnancies.
2.	Health Optimization	Improve maternal health by managing chronic conditions (e.g., diabetes, hypertension, thyroid disorders) before conception.
3.	Nutritional Support	Assess and improve nutritional status, including supplementation with folic acid, iron, and other key micronutrients, and aim to achieve ideal body weight.
4.	Immunization Review	Ensure immunity to infections like rubella, varicella, hepatitis B, and offer other vaccines as needed.

3 NFHS-5

4 Bhutta, Zulfiqar & Das, et al (2014). Can Available Interventions End Preventable Deaths in Mothers, Newborn Babies, and Stillbirths, and at What Cost? The Lancet. 384. 10.1016/S0140-6736(14)60792-3.

5 Prabhakarrao Doke P et al, Implementation of preconception care for preventing adverse pregnancy outcomes in rural and tribal areas of Nashik District, India. Prev Med Rep. 2024 Jun 9;43:102796

6 Taneja et al. Impact of a package of health, nutrition, psychosocial support, and WaSH interventions delivered during preconception, pregnancy, and early childhood periods on birth outcomes and on linear growth at 24 months of age: factorial, individually randomized controlled trial (WINGS Trial) BMJ. September 2022

5.	 Medication Safety	Review current medications and eliminate or adjust teratogenic drugs and switch to safer drugs.
6.	 Genetic Counseling	Offer genetic risk assessment and carrier screening when indicated based on personal or family history.
7.	 Lifestyle Modification	Counsel on cessation of tobacco, alcohol, and illicit drug use; encourage healthy habits such as exercise and balanced diet.
8.	 Fertility Planning	Guide on optimal timing and spacing of pregnancy and provide contraception advice if delaying conception.
9.	 Mental Health Assessment	Screen for depression, anxiety, or other mental health disorders, and initiate appropriate support or referrals.
10.	 Education and Empowerment	Educate women and couples about reproductive health, pregnancy planning, and shared decision-making in care.

Table 1: Objectives of Pre-pregnancy Care

Key clinical components of Pre-Pregnancy and Interpregnancy Care[7]

Medical History, Risk Assessment, Physical Examination

A comprehensive medical history and risk assessment forms the foundation of pre-pregnancy care. It involves a detailed evaluation of chronic medical conditions and genetic risks for conditions such as thalassemia or other hemoglobinopathies. Screening for conditions such as depression, anxiety, medication review, and the obstetric history can influence the management plan for future pregnancies. A thorough physical assessment including measurement of the Body Mass Index (BMI) is crucial.

Investigations and Screening: Determining the woman's blood group and Rh factor, assessing hemoglobin levels, screening for infectious diseases enable tailored care and interventions to optimize pregnancy outcomes.

Lifestyle Modifications: Effective lifestyle modification is a cornerstone of pre-pregnancy care, aimed at optimizing maternal health and reducing the risk of adverse pregnancy outcomes. Key components include:

- **Nutrition:** Adequate micronutrient intake is essential prior to conception. Folic acid supplementation at a dose of 400 to 800 micrograms per day is recommended at least 3 months prior, to reduce the risk of neural tube defects. Additional supplementation with iron, calcium, and vitamin D should be considered based on clinical and laboratory evaluation of nutritional status.
- **Weight Management:** Attaining and maintaining an optimal Body Mass Index (BMI) before pregnancy is critical.

7 WHO Policy Brief ,Preconception care: Maximizing the gains for maternal and child health, 2013.

- **Substance Use:** Complete cessation of tobacco, alcohol, and illicit drug use is strongly advised, as these may be linked to a higher incidence of miscarriage, fetal growth restriction, congenital anomalies, and poor neonatal outcomes.
- **Physical Activity:** Regular, moderate-intensity exercise should be encouraged.
- **Environmental Exposures:** Exposure to teratogenic substances and harmful chemicals, including pesticides, heavy metals, and certain occupational toxins—should be minimized.

IMMUNIZATION

Immunization status should be reviewed pre-pregnancy to ensure protection against vaccine-preventable infections that can cause serious maternal or fetal complications. Women lacking immunity should be vaccinated prior to conception, with attention to live vaccines which must be administered at least one month before attempting pregnancy.

Key immunizations include:

- **Rubella:** Non-immune women should receive the MMR vaccine. Congenital rubella syndrome can result in severe fetal abnormalities.
- **Varicella (Chickenpox):** Seronegative women should be vaccinated to prevent maternal varicella, which carries risks of congenital varicella syndrome.
- **Hepatitis B:** Recommended for those at risk or unvaccinated, to reduce maternal morbidity and vertical transmission.
- **Influenza:** Annual inactivated influenza vaccine is advised.
- **Tdap (Tetanus, Diphtheria, and Pertussis):** If not administered in the previous pregnancy Tdap should be updated to ensure maternal and neonatal protection.

HEALTH OPTIMIZATION

Pre-pregnancy and interpregnancy interval provide a critical opportunity to manage existing or residual health conditions and promote overall wellness.

- Chronic disease management is central conditions such as hypertension, diabetes, hypothyroidism, or autoimmune disorders should be stabilized before subsequent conception.
- Any unresolved issues from the previous pregnancy, such as anemia, gestational diabetes follow-up, or complications from surgical delivery, must be addressed.

Family Planning

Effective contraceptive care is a key component of interpregnancy care, aimed at promoting optimal birth spacing, which is associated with improved maternal and neonatal outcomes.

Nutrition and Supplement

Nutrition remains a vital part of pre-pregnancy and interpregnancy care, particularly if breastfeeding.

Folic acid and iron supplementation should be recommended, especially for women who are anemic, and before breastfeeding. Dietary care should address any ongoing nutritional deficiencies, and assess caloric and micronutrient needs, establishing a balanced diet particularly in lactating women.

Psychosocial Support

Psychosocial factors play a significant role in maternal health and must be actively addressed.

Mental health screening should be routinely performed especially for women who have experienced pregnancy loss to identify depression or anxiety, with appropriate referral to psychiatric or psychological services as needed.

Screening for intimate partner violence (IPV) must be incorporated into care, as IPV can have serious health consequences.

Special Considerations in Pre-pregnancy and Interpregnancy Care

Certain populations require tailored pre pregnancy and interpregnancy care to address their specific risks and needs. Adolescents, for instance, face heightened vulnerabilities due to biological immaturity and social factors. Early care focused on nutrition, contraception, education, and psychosocial support is essential to reduce the risks of preterm birth, low birth weight, and maternal morbidity.

Women with infertility affecting 8–12% of reproductive-aged couples globally—benefit significantly from preconception optimization before assisted reproductive technologies (ART). Management of underlying conditions such as obesity, PCOS, and thyroid dysfunction, along with nutritional support and mental health counseling, improves ART outcomes, and reduces miscarriage risk. Women with a high-risk obstetric history, such as prior preeclampsia, stillbirth, or preterm birth face elevated recurrence risks.

Engaging men in the process enhances shared decision-making, increases antenatal care participation, and supports healthier maternal outcomes.

Woman centered quality care

By shifting focus from reactive to preventive and promotive care, a woman-centered pre-pregnancy care is tailored to the individual's medical, cultural, and social context improving adherence and satisfaction. Establishing rapport and maintaining a non-judgmental, empathetic environment is essential to foster open communication and trust. Providers should promote shared decision-making by offering evidence-based information, supporting informed choices, and respecting patient autonomy.

Integrating pre-pregnancy care into quality improvement initiatives—such as Manyata will ensure continuity of care, enhance identification of at-risk women, and promote long-term reproductive health.

Thus, embedding pre-pregnancy and interpregnancy care within a quality-of-care framework will not only improve maternal and neonatal outcomes but also align with global health goals, including the Sustainable Development Goals (SDGs).

CONCLUSION

Pre-pregnancy and interpregnancy care represent evidence-based strategies for improving maternal and neonatal health outcomes. By identifying and addressing medical, nutritional, psychosocial, and environmental risk factors before conception or between pregnancies, healthcare providers

Pre-pregnancy and interpregnancy care are game-changers—addressing risks before conception can drastically reduce preventable maternal and neonatal complications, improve reproductive choices, and set the foundation for healthier generations.

can significantly reduce preventable morbidity and mortality, enabling women and couples to make informed reproductive decisions, optimize health status, and prepare physically and emotionally for future pregnancies.

The integration of pre-pregnancy care into routine reproductive healthcare guided by principles of quality, equity, and woman-centered care—has the potential to transform maternal and child health trajectories.

As India continues to advance maternal and child health agendas, strengthening the implementation of pre-pregnancy and interpregnancy care through multidisciplinary collaboration, community engagement, and policy support is critical. Ultimately, embedding these services into the continuum of care is not only a clinical imperative but also a public health priority to ensure healthier generations.

Preconception Care – Maximizing the Gains for Maternal and Child Heath

A new WHO report shows that preconception care has a positive impact on maternal and child health outcomes (1). Addressed primarily at health professionals responsible for developing national and local health policies, the report provides a foundation for implementing a package of promotive, preventive, and curative health interventions shown to have been effective in improving maternal and child health. A wide range of sectors and stakeholders needs to be engaged to ensure universal access to preconception care. The report also guides non-health sectors, foundations, and civil society organizations to collaborate with, and support, public health policymakers to maximize gains for maternal and child health through preconception care.

What is preconception care, and is its aim?

Preconception care is the provision of biomedical, behavioral, and social health interventions to women and couples before conception occurs. It aims at improving their health status, and reducing behaviors and individual and environmental factors that contribute to poor maternal and child health outcomes. Its ultimate aim is to improve maternal and child health, in both the short and long term (1). Opportunities to prevent and control diseases occur at multiple stages of life; strong public health programs that use a life-course perspective from infancy through childhood and adolescence to adulthood are needed. Preconception care contributes to these efforts. Even if preconception care aims primarily at improving maternal and child health, it brings health benefits to the adolescents, women and men, irrespective of their plans to become parents.

FACTS

- 4 out of 10 women report that their pregnancies are unplanned (2). As result, essential health interventions provided once a woman and her partner decide to have a child will be too late in 40% of pregnancies.
- Maternal undernutrition and iron-deficiency anemia increase the risk of maternal death, accounting for at least 20% of maternal mortality worldwide (1).
- In 2010, 58,000 newborn babies died from neonatal tetanus (3).
- Female genital mutilation increases the risk of neonatal death (including stillbirths) by 15% to 55% (4).
- Perinatal deaths are 50% higher among children born to mothers under 20 years of age compared to mothers aged 20–29 years (1).

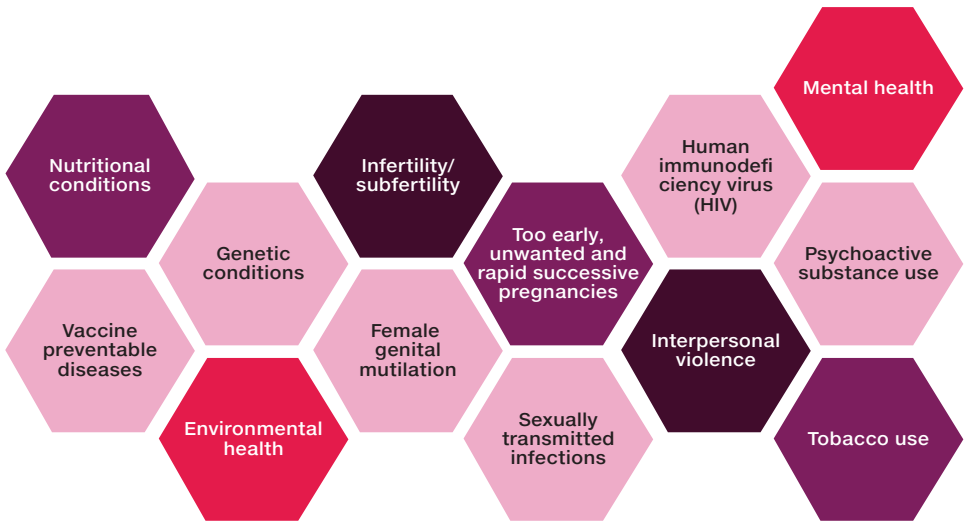
- Up to 35% of pregnancies among women with untreated gonococcal infections result in low-birth-weight infants and premature deliveries, and up to 10% result in perinatal death (1).
- In the absence of interventions, rates of HIV transmission from mother to child are between 15 and 45% (1).
- Violence against girls and women results in adverse physical, psychological, and reproductive consequences, as well as increased risk for premature delivery and low-birth-weight infants (5).
- Women with epilepsy are at increased risk of having babies with congenital anomalies (both epilepsy and the medications given for its control may have adverse effects on the baby) (1).
- Estimates indicate that eliminating smoking before or during pregnancy could avoid 5–7% of preterm related deaths and 23–24% of cases of sudden infant death syndrome (1).

Preconception care can make a difference:

Why invest in preconception care?

Preconception care has a positive effect on a range of health outcomes. Among others, preconception care can:	• Reduce maternal and child mortality • Prevent unintended pregnancies • Prevent complications during pregnancy and delivery • Prevent stillbirths, preterm birth and low birth weight • Prevent birth defects • Prevent neonatal infections • Prevent underweight and stunting • Prevent vertical transmission of HIV/STIs • Lower the risk of some forms of childhood cancers • Lower the risk of type
Gaps are substantial	Even where strong public health programs are in place across the life-course, they do not guarantee that women enter pregnancy in good health.
Examples of successful preconception care initiatives are available to inform policymakers	There is growing experience in implementing preconception care initiatives both in high-income countries, such as Italy, the Netherlands and the United States, and in low-and middle-income countries, such as Bangladesh, the Philippines and Sri Lanka (1)

Areas addressed by the preconception care package



Areas addressed by the preconception care package	Examples of evidence-based interventions[1]
Nutritional conditions	• Screening for anemia and diabetes • Supplementing iron and folic acid • Information, education, and counseling • Monitoring nutritional status • Supplementing energy-and nutrient-dense food • Management of diabetes, including counseling people with diabetes mellitus • Promoting exercise • Iodization of salt
Tobacco use	• Screening of women and girls for tobacco use (smoking and smokeless tobacco) at all clinical visits using "5 As" (ask, advise, assess, assist, arrange) • Providing brief tobacco cessation advice, pharmacotherapy (including nicotine replacement therapy, if available) and intensive behavioural counseling services • Screening of all non-smokers (men and women) and advising about harm of second-hand smoke and harmful effects on pregnant women and unborn children
Genetic conditions	• Taking a thorough family history to identify risk factors for genetic conditions • Family planning • Genetic counseling • Carrier screening and testing • Appropriate treatment of genetic conditions • Community-wide or national screening among populations at high risk
Environmental health	• Providing guidance and information on environmental hazards and prevention • Protecting from unnecessary radiation exposure in occupational, environmental, and medical settings • Avoiding unnecessary pesticide use/providing alternatives to pesticides • Protecting from lead exposure • Informing women of childbearing age about levels of methyl mercury in fish • Promoting use of improved stoves and cleaner liquid/gaseous fuels
Infertility/sub-fertility	• Creating awareness and understanding of fertility and infertility and their preventable and unpreventable causes • Defusing stigmatization of infertility and assumption of fate • Screening and diagnosis of couples following 6–12 months of attempting pregnancy, and management of underlying causes of infertility/sub-fertility, including past STIs • Counseling for individuals/couples diagnosed with unpreventable causes of infertility/sub-fertility
Interpersonal violence	• Health promotion to prevent dating violence • Providing age-appropriate comprehensive sexuality education that addresses gender equality, human rights, and sexual relations • Combining and linking economic empowerment, gender equality, and community mobilization activities • Recognizing signs of violence against women • Providing health care services (including post-rape care), referral, and psychosocial support to victims of violence • Changing individual and social norms regarding drinking, screening, and counseling of people who are

Too-early, unwanted and rapid successive pregnancies	• Keeping girls in school • Influencing cultural norms that support early marriage and coerced sex • Providing age-appropriate comprehensive sexuality education • Providing contraceptives and building community support for preventing early pregnancy and contraceptive provision to adolescents • Empowering girls to resist coerced sex • Engaging men and boys to critically assess norms and practices regarding gender-based violence and coerced sex • Educating women and couples about the dangers to the baby and mother of short birth intervals
Sexually transmitted infections (STIs)	• Providing age-appropriate comprehensive sexuality education and services • Promoting safe sex practices through individual, group, and community-level behavioral interventions • Promoting condom use for dual protection against STIs and unwanted pregnancies • Ensuring increased access to condoms • Screening for STIs • Increasing access to treatment and other relevant health services
HIV	• Family planning • Promoting safe sex practices and dual method for birth control (with condoms) and STI control • Provider-initiated HIV counseling and testing, including male partner testing • Providing antiretroviral therapy for prevention and pre-exposure prophylaxis • Providing male circumcision • Providing antiretroviral prophylaxis for women not eligible for, or not on, antiretroviral therapy to prevent mother-to-child transmission • Determining eligibility for lifelong antiretroviral therapy
Mental health	• Assessing psychosocial problems • Providing educational and psychosocial counseling before and during pregnancy • Counseling, treating, and managing depression in women planning pregnancy and other women of childbearing age • Strengthening community networks and promoting women's empowerment • Improving access to education for women of childbearing age • Reducing economic insecurity of women of childbearing age
Psychoactive substance use	• Screening for substance use • Providing brief interventions and treatment when needed • Treating substance use disorders, including pharmacological and psychological interventions • Providing family planning assistance for families with substance use disorders (including postpartum and between pregnancies) • Establishing prevention programs to reduce substance use in adolescents
Vaccine-preventable Diseases	• Vaccination against rubella • Vaccination against tetanus and diphtheria • Vaccination against Hepatitis B
Female genital mutilation (FGM)	• Discussing and discouraging the practice with the girl and her parents and/ or partner • Screening women and girls for FGM to detect complications • Informing women and couples about complications of FGM and about access to treatment • Carrying out defibulation of infibulated or sealed girls and women before or early in pregnancy • Removing cysts and treating other complications

1. Meeting to develop a global consensus on preconception care to reduce maternal and childhood mortality and morbidity. Geneva, World Health Organization, 2013.

AN AGENDA FOR ACTION: LEARNING FROM EXPERIENCE, SUPPORTING CHANGE

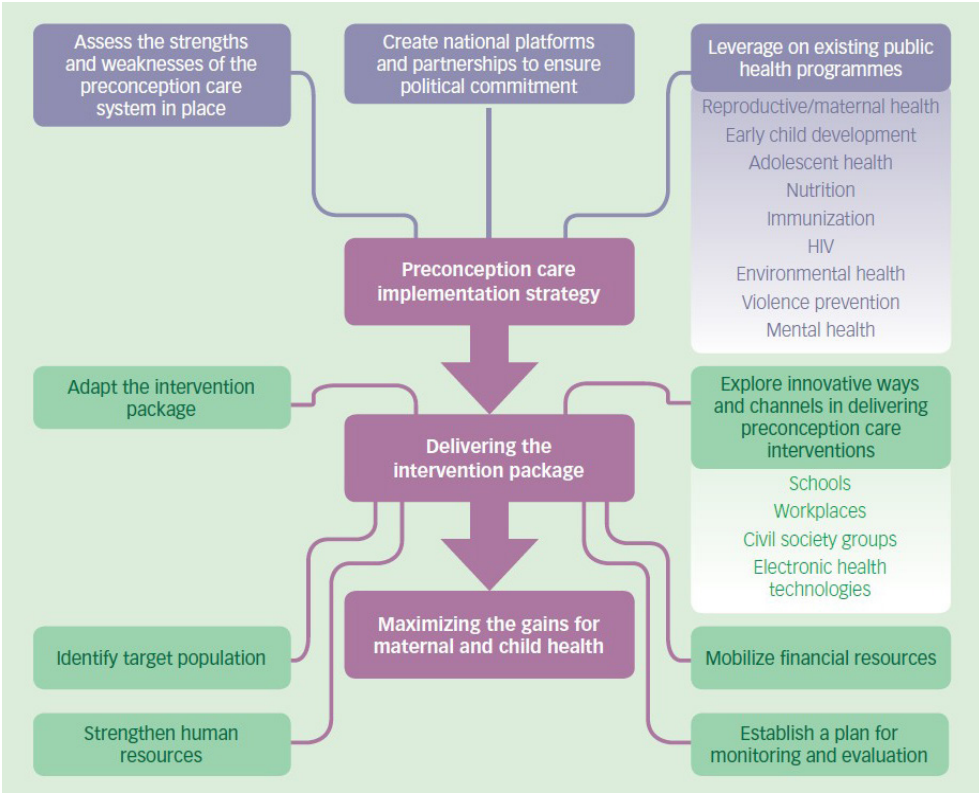
In February 2012, a World Health Organization (WHO) meeting brought together researchers, practitioners, and program managers with experience in preconception care, as well as United Nations agencies and partner organizations to achieve a global consensus on the place of preconception care as part of an overall strategy to prevent maternal and childhood mortality and morbidity (1).

An agenda for action was agreed upon at the meeting, including actions to:

- Build regional and national capacity to plan, implement, and monitor preconception care programs and services.
- Stimulate and support country action.
- Carry out demonstration projects in selected countries.
- Document and disseminate good preconception care practices.

The "Draft action plan for the prevention and control of noncommunicable diseases 2013–2020" which was discussed at the 66th World Health Assembly in May 2013, calls governments to reduce modifiable risk factors for noncommunicable diseases and underlying social determinants. Preconception care, as part of the national policy framework, is recognized as an important contributor to noncommunicable disease prevention and control (6).

A STRATEGY FOR COUNTRY ACTION



WHO support to countries

WHO supports regions and countries in implementing a step-by-step process to improve availability of and access to preconception care interventions:

- Create regional/national platforms and partnerships to advance preconception care interventions.
- Introduce professionals in countries to international experience, research, evidence, and good practices. Provide a methodology to analyze and understand the strengths and weaknesses of the preconception care system in place, and opportunities for improvement.
- Explore various delivery strategies for preconception care interventions, and their comparative advantages in terms of coverage, feasibility, acceptability and cost.
- Adapt the package of preconception care interventions to regional and country priorities, and health systems contexts.
- Explore and document innovative ways to deliver preconception care outside the traditional maternal and child health programmes, while recognizing the importance of integrated delivery mechanisms.
- Develop a roadmap to make changes over time.
- Monitor, evaluate, and document progress.

RISK SCREENING AND PREVENTIVE STRATEGIES

Dr. Niranjan Chavan, Dr. Chinmayee Ratha

Standard - Antenatal Care: Provider screens and documents data for key clinical conditions that may lead to complications during pregnancy

INTRODUCTION - CARE AREA OVERVIEW

ANC provides opportunities for health promotion, disease prevention, early diagnosis, and timely management. This standard underscores the importance of quality Antenatal care (ANC) for timely identification and appropriate management of high-risk conditions. The WHO 2020 ANC model recommends minimum eight contacts with the healthcare provider during the antenatal period to improve continuity and quality[1]. The shift from "contact-based" rather than "visit-based" care ensures care by the healthcare provider entails active, effective exchange of care, whether at the facility, in the community, or even through outreach. In addition to screening, issues relating to prevention of these conditions and current recommendations for vaccination in pregnancy are included.

BACKGROUND - RATIONALE AND OBJECTIVE

High-risk pregnancy is defined as one in which the likelihood of adverse maternal or perinatal outcomes is higher than in the general obstetric population[2]. High-risk pregnancies contribute significantly to maternal and perinatal morbidity and mortality. The screening and prevention strategies are included under this standard for selected high-risk conditions such as maternal anemia, gestational diabetes mellitus (GDM), hypertensive disorders of pregnancy, thyroid dysfunction, infections and blood group incompatibility. Screening for key clinical conditions is critical to reducing complications such preterm birth and intrauterine growth restriction (IUGR)

Most common cause of anemia in India is iron deficiency (>50%)
(NCEAR-A), AIIMS

Anemia affects over 50% of pregnant women in India[3]. Pregnant women with anemia are at higher risk of developing pregnancy-induced hypertension, cesarean section, premature rupture of membranes, preterm birth, postpartum hemorrhage, neonatal asphyxia and low birth weight neonates compared to non-anemic pregnant women. Thereby screening and prevention is crucial for favourable outcomes.

Hypertensive disorders of pregnancy affect one in ten pregnant women and are a leading cause of maternal mortality globally, second only to obstetric hemorrhage. Around 15% of pregnancies around the globe are affected by gestational diabetes mellitus. Mothers with GDM are at risk of developing gestational hypertension, preeclampsia, infections, preterm labour, termination of pregnancy

Anemia affects **52.2% pregnant women** in India (NFHS -5)

1 World Health Organization. (2016, November 7). *New guidelines on antenatal care for a positive pregnancy experience. World Health Organization.*
2 WHO. Recommendations on antenatal care for a positive pregnancy experience. 2020
3 National Family Health Survey (NFHS-5), GoI- 2019-21

via cesarean section and postpartum hemorrhage. Also, fetal complications include macrosomia, delayed lung maturity, intrauterine fetal demise or stillbirth is associated with gestational diabetes mellitus. In addition, GDM increases the risk of complications, including cardiovascular disease, obesity and impaired carbohydrate metabolism, leading to the development of type 2 diabetes (T2DM) in both the mother and infant.[4] The standard also includes newer areas for testing such as Asymptomatic bacteriuria (ASB). The prevalence of ASB globally is 2-15% of all pregnancies.

During pregnancy, the risk of developing pyelonephritis is likely to be 20–30 times higher in women with bacteriuria. This can further result in preterm birth, a major contributor to infant morbidity and mortality. Other fetal complications associated with ASB include increased perinatal mortality, increased risk of stillbirth, intrauterine growth restriction (IUGR), mental retardation, and development delays.[5]

High-risk pregnancy increases chances of adverse maternal and perinatal outcomes, making screening essential.

An effective, comprehensive screening during antenatal care has been included as the first standard in the Manyata initiative and is the first starting point for ensuring improved outcomes.

Clinical Components

Systematic screening for conditions that may complicate pregnancy and its outcomes is included under this standard.

ANEMIA IN PREGNANCY

Screening: Haemoglobin estimation in each trimester is recommended.

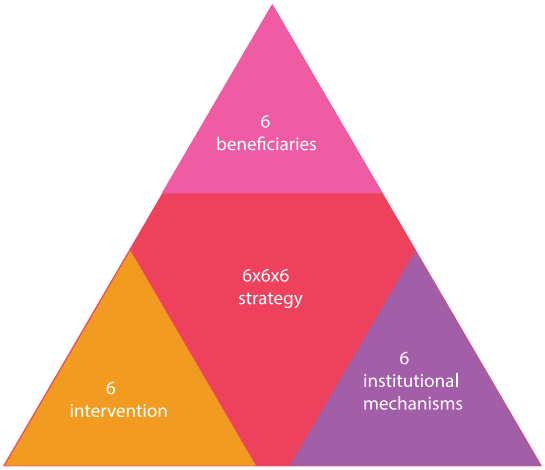
The standard ensures that the provider understands the classification of Anemia as per the WHO criteria: Mild: 10–10.9 g/dL; Moderate: 7–9.9 g/dL; Severe: <7 g/dL)

The standard ensures that the provider understands the causes of anemia and is aware that iron deficiency anemia is the most common cause of anemia.

The Government of India has launched a flagship program called ‘Anemia Mukt Bharat’ designed to reduce prevalence of anemia by 3 percentage points per year among children, adolescents and women in the reproductive age group. The program entails a 6×6×6 strategy (Fig 1 and 2) The Manyata standard aligns with the recommendations of the Anemia Mukt Bharat strategy and has incorporated the six interventions. The standard aims to address Anemia by adapting the three-pronged approach under the national program of ‘Test treat and talk’ (T3 approach for addressing Anemia)

4 Modzelewski R et al. Gestational Diabetes Mellitus-Recent Literature Review. J Clin Med. 2022 Sep 28;11(19):5736.

5 Khapre, Meenakshi Sharma et al., Prevalence of Asymptomatic Bacteriuria (ASB) in Pregnant Women in India: A Systematic Review and Meta-Analysis, Indian Journal of Community Medicine 48(6):p 879-887, Nov–Dec 2023.



Anemia Mukt Bharat (AMB): 6×6×6 Strategy

SIX INTERVENTIONS

1. Prophylactic IFA supplementation
2. Deworming
3. Behavior Change Communication (BCC)
4. Testing of Anemia using digital methods and point of care
5. Iron Folic Acid Rich Fortified Foods
6. Addressing non-nutritional causes of Anemia

PREVENTION

1. **Diet:** Balanced, nutritious, protein rich diet including sources of iron and multivitamins. Fortified food intake.
2. **Supplements:** Iron (60 mg elemental) + folic acid (500 mcg) (IFA) supplementation from second trimester (Prophylaxis)
3. **Deworming**: Tablet Albendazole 400mg after 1st trimester preferably in endemic regions and anemic pregnant women.

MANAGEMENT

The management of anemia is dependent on its severity and the gestational age. Parenteral iron formulations are used in cases not responding to oral iron therapy or in cases with non-compliance. FCM enables rapid correction with fewer visits, improving compliance in late pregnancy[6]. Blood transfusion is recommended in cases with severe anemia and in pregnancy in advanced gestation.

HYPERTENSIVE DISORDERS OF PREGNANCY

The spectrum of hypertensive disorders of pregnancy includes chronic hypertension, gestational hypertension, preeclampsia, and preeclampsia superimposed on chronic hypertension.[7]

Screening: BP monitoring at each ANC visit is included under the standard, with the understanding of the correct method of checking the blood pressure.

6 Qassim A, et al. Efficacy of ferric carboxymaltose versus iron sucrose in pregnancy. Int J Gynaecol Obstet. 2022

7 Bajpai D et al. Evaluation and Management of Hypertensive Disorders of Pregnancy. Kidney360. 2023 Oct 1;4(10):1512-1525.

Procedure for Recording of Blood Pressure Using Digital BP Apparatus

Tell the woman about the procedure and ask her to sit on a chair or lie down on a flat surface

Check that the tube is properly attached to the digital BP apparatus

Place the apparatus on a horizontal surface at woman's heart level

Tie the cuff 1 inch above the elbow, placing the tube in front

Press the START button

Wait for inflation and deflation of the cuff and display of BP reading on screen

Press the STOP button

Remove the cuff

Inform the woman of the findings

Record the reading on woman's MCP card

The standard ensures that the provider understands the various disorders as per the classification:

Chronic Hypertension	Hypertension presenting before 20 weeks of gestation in the absence of proteinuria
Gestational Hypertension	Hypertension presenting after 20 weeks of gestation in the absence of proteinuria
Preeclampsia (PE)	BP>=140/90 but <160/110 with presence of proteinuria trace, 1+ or 2+
Severe Preeclampsia (Severe PE)	**Presents with any of the following two scenarios:** 1. BP>=160/110 with proteinuria 3+ or 4+ 2. PE with presence of any of the danger signs/ symptoms: headache, blurring of vision, epigastric pain or oliguria and abnormal oedema over face, hands, abdomen and vulva
Eclampsia	Presence of convulsions/ seizures with BP>=140/190 and proteinuria more than trace

GESTATIONAL DIABETES MELLITUS (GDM) - HYPERGLYCAEMIA IN PREGNANCY [HIP]

Screening: The standard includes universal screening for GDM based on the Diabetes in Pregnancy Study Group India (DIPSI) GOI guidelines.[8] The first screening is done at first antenatal visit then repeated at 24-28 weeks of pregnancy, if the first screening is negative for HIP. Fasting is not needed. Irrespective of previous meals, 75 gm of glucose dissolved in water is given orally. Blood glucose levels are checked after 2 hours.

THYROID DISORDERS

Thyroid hormones play a critical role in fetal growth and neurocognitive development, necessitating precise interpretation of maternal thyroid function tests, which differ from non-pregnant states. Thyroid disorders are the second most common endocrine disorders in pregnancy. Proper management of thyroid dysfunction can significantly reduce morbidity in both mothers and their fetuses.[9]

Screening: Universal screening at first ANC visit is included under this standard.

RH NEGATIVE PREGNANCY

Screening: The standard includes all antenatal mothers being offered blood group testing on their first antenatal visit. In case of Rh-negative blood group, husband blood group analysis is done at the earliest.

Prompt evaluation prevents Rh alloimmunization of the current pregnancy.

In a Rh-negative female, Indirect Coomb's Test (ICT) should be performed on first visit and subsequently at 28 weeks of gestation.

Infections

Syphilis and HIV: The standard includes 'Universal Screening' of syphilis and HIV be ensured for all pregnant women.

If pregnant women are 'at-risk' of HIV/Syphilis, the screening should be repeated in the third trimester and at time of labour.

Risk of Mother-to-Child HIV Transmission With or Without ARV Intervention:

ARV Intervention	Infant Feeding Practice	Risk of Transmission
No ARV	Breastfeeding	30–45%
No ARV	No breastfeeding	20–25%
Triple ARV therapy (ART)	Breastfeeding	~2%
Triple ARV therapy (ART)	No breastfeeding	~1%

8 Diagnosis & Management of Gestational Diabetes Mellitus. Technical and Operational Guidelines, MoHFW,GoI, 2018

9 Puthiyachirakal MA et al. Overview of thyroid disorders in pregnancy. Matern Health Neonatol Perinatol. 2025 Apr 2;11(1):9.

ASYMPTOMATIC BACTERIURIA (ASB)

It is defined as a condition in which urine culture shows a significant growth of bacteria equal to or more than 105 colony-forming units (CFUs)/ml in the absence of any symptoms of acute urinary tract infections.

The standard recommends screening for ASB for all pregnant women at booking (preferably in the first trimester) and the screening be conducted preferably once in each trimester.

Screening Methods: [if feasible]

Urine multireagent dipstick for presence of nitrites and leucocyte esterase is used.

Urine routine microscopy and culture

Role of Point-of-Care (POC) Diagnostics in Maternal Healthcare: Enhancing Early Detection and Health System Efficiency

One of the persistent challenges in early identification of high-risk pregnancies is often inadequate diagnostic infrastructure at the primary level, uncalibrated testing tools, and gaps in data entry and reporting mechanisms within health management information systems (HMIS).

Point-of-Care (POC) diagnostics have emerged as a transformative solution, particularly in low-resource settings. The ability to obtain immediate results accelerates clinical decision-making, shortens the time to treatment, and ensures early initiation of care.

Point of care tests, when made available bring critical diagnostic capabilities closer to the last mile for conditions such as anemia, gestational diabetes, HIV, tuberculosis, and syphilis improving the overall quality and reliability of maternal health data. Investing in the scale-up of POC technologies at the last mile is both a strategic and essential step.

USE OF DIGITAL END-TO-END TRACKING

There are best practices in certain states such as the PICME Application (is used both in the private and public facilities) in Tamil Nadu and the ANMOL application in Madhya Pradesh (used in public facilities) that help in end-to-end tracking of the pregnant woman through her antenatal, intrapartum and postpartum period. The antenatal tests and details are readily available to the healthcare provider through the digital application at the time of admission into the labour room. The Manyata efforts align with point of care testing and digital tracking approaches and is slowly moving towards this direction to revolutionize private sector care through digitalization.

VACCINATION IN PREGNANCY

Vaccines such as the influenza and the Tdap (Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis) are strongly recommended in each pregnancy. Other vaccines can be offered based on risk factors and only when the benefits of receiving them outweigh the risks. There is no evidence of adverse fetal effects from vaccinating pregnant women with inactivated virus, bacterial vaccines, or toxoids. Live attenuated vaccines are contraindicated in pregnancy.[10]

10 FOGSI-ICOG Good Clinical Practice Recommendations (GCPR) Vaccination in Women 2024

Vaccination in pregnancy:

Vaccine	Type of Vaccine	Interval	Dose & Route
Td1 /TT1	Tetanus, diphtheria toxoid	Early in pregnancy	Single, 0.5 mL IM
Td2 /Tdap	Tetanus, diphtheria toxoid and acellular pertussis	27–36 weeks	Single, 0.5 mL IM
Influenza (IIV)	Inactivated vaccine	26 weeks onwards / Any time in pregnancy if risk of influenza is high	Single, 0.5 mL IM

CONCLUSION

Effective antenatal care (ANC) forms the cornerstone of risk screening and prevention in high-risk pregnancies.

Early detection matters: Timely screening for anemia, hypertensive disorders, GDM, thyroid dysfunction, infections, and asymptomatic bacteriuria reduce maternal and perinatal risks.

Timely identification of conditions such as anemia, hypertensive disorders, gestational diabetes, thyroid dysfunction, infections, and asymptomatic bacteriuria allows for evidence-based interventions that can significantly reduce maternal and perinatal morbidity and mortality. Integration of updated national and international guidelines, use of newer IV iron formulations, and universal GDM screening, into the Manyata Standard, ensures comprehensive care. Preventive approaches, combined with health promotion, patient education, and vaccination, places ANC as a life-saving platform for both mother and child.

IMPORTANCE OF EARLY ANC REGISTRATIONS AND ASSESSING ALL PREGNANT WOMEN AT ADMISSION

Dr. Jayam Kannan, Dr. Ritu Khanna, Dr. Abha Rani Sinha

Standard: Provider assesses all pregnant women at admission in labour

INTRODUCTION- CARE AREA OVERVIEW

This standard is a critical component of quality intrapartum and maternal care, ensuring that every pregnant woman admitted to a facility in labor receives a respectful, systematic, and comprehensive assessment at the point of entry. The process begins with welcoming the woman and her attendant, explaining the admission procedure, and documenting any referral information. A thorough review of obstetric, medical, and surgical history covering antenatal records, investigations, immunization status, previous pregnancy outcomes, chronic medical conditions, and relevant surgeries enables early identification of risks. Key clinical assessments at admission include determining gestational age, recording fetal heart rate, maternal vital and abdominal examination. This standard ensures timely detection of complications, guides appropriate management decisions helping with triaging and strengthens the continuum of respectful, woman-centered care from the moment of admission into the labor room. This chapter aims to detail "standard 3" named as "Assessment on Admission". This follows quality antenatal care[1] and preparedness for safe care during delivery by the Manyata accredited facility.

BACKGROUND – RATIONALE AND OBJECTIVE

Institutional deliveries have been key in reducing maternal mortality and notable progress has been made in recent years in India with the Maternal Mortality Ratio (MMR) reduction to 88 per 100,000 live births[2]. As per NFHS-5[3], India has achieved a high rate of institutional births with 88.6% births happening in healthcare facilities overall, and some states such as West Bengal showing a remarkable rise from 12.5% to 93.5%. As institutional births increase, assessment on admission to the labor room is a critical window for assessing maternal and fetal well-being. Hence, this standard for assessment of the pregnant woman on admission is critical.

This Manyata standard aims to ensure that every pregnant woman admitted to a health facility receives a respectful, comprehensive, and timely assessment to identify potential risks, triaging to guide appropriate clinical management and ultimately improve maternal and newborn outcomes. It emphasizes early risk detection through systematic history-taking, accurate measurement of vital signs, correct estimation of gestational age, and thorough assessment of maternal condition including assessment of uterine contractions, presence of any bleeding or rupture of membranes and fetal well-being. By standardizing admission assessment practices, the standard promotes consistency and completeness across facilities, enabling timely interventions and appropriate referrals that can prevent complications from progressing to life-threatening emergencies right from the first point of contact. The standard recommends accurate documentation to strengthen both immediate clinical decisions and monitoring.

1 World Health Organization. (2020). WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization. https://www.who.int/publications/i/item/9789240008120.

2 Sample Registration System (SRS). (2023). Maternal Mortality Ratio Bulletin 2021–23. Office of the Registrar General, India. https://censusindia.gov.in.

3 International Institute for Population Sciences (IIPS) & ICF. (2021). National Family Health Survey (NFHS-5), 2019–21: India. Mumbai: IIPS. https://dhsprogram.com/pubs/pdf/FR375/FR375.pdf.

CLINICAL COMPONENTS

As the pregnant woman progresses from outpatient care to inpatient care during labor, this standard encompasses structured protocols for history-taking, vital signs monitoring, gestational age evaluation, and fetal assessment for all admitted women in labor.

Standardized admission assessment saves lives—early risk detection, accurate documentation, and timely triage ensure every woman receives the right care at the right time.

This standard ensures that every woman and her attendant experience a respectful and supportive admission process. The healthcare providers welcome the patient and her attendant, introduce themselves, and provide a clear explanation of the admission procedures. In cases where the woman is referred, the referral slip is documented in the admission notes.

At the time of admission, by adhering to this standard, the healthcare provider documents the complaints including pain, bleeding, leaking and/or reduced fetal movements. Provider conducts a thorough review of the woman's obstetric, medical, and surgical history including perusal of the antenatal records, investigation reports, ultrasound findings, screening tests, immunization status, and identifying any high-risk factors. A detailed past obstetric history is recorded, covering events such as recurrent pregnancy loss, medical termination of pregnancy, preterm birth, stillbirth, prolonged or post-term pregnancy, and prior caesarean sections. The patient's medical history is reviewed for conditions such as hypertension, diabetes, bleeding disorders, infectious diseases or other significant illnesses. Surgical history relevant to reproductive and general health is also documented. This standard ensures comprehensive assessment to help in continuity, safety and triaging. Maintaining accurate records to support clinical decision-making, risk tracking and triaging is a part of this standard. Maternal assessment includes measuring blood pressure and temperature with functional instruments and performing an abdominal examination for gestational age assessment, fetal lie and uterine contractions while ensuring privacy and dignity.

ROLE OF MONITORING THE HEART RATE OF THE FETAL HEART RATE

Fetal well-being is checked by recording the fetal heart rate for one full minute using a functional Doppler, Pinard's fetoscope, or CTG, as available. The standard ensures assessing of the fetal heart rate at admission, followed by intermittent auscultation of the FHR throughout labor. This is aligned with the WHO, that does not recommend routine continuous FHR monitoring during labor[4].

CONCLUSION

Comprehensive assessment of all pregnant women at admission is a critical step in ensuring maternal and newborn safety. Integrating standardized clinical practices strengthens decision-making, promotes timely interventions, and supports a continuum of respectful, woman-centered care.

Every admission is an opportunity—assess thoroughly, act early, address complications before they escalate.

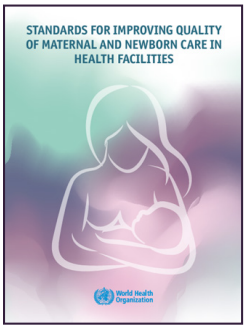
4 World Health Organization. (2018). WHO recommendations: Intrapartum care for a positive childbirth experience. Geneva: World Health Organization. https://www.who.int/publications/i/item/9789241550215.

SHIFT IN MINDSET: "READINESS FOR LABOR-BEGINS EARLY"

Dr. Shantakumari, Dr. Neharika Malhotra

Quality Care Standard: Provider prepares for safe care during delivery (to be checked every day)

INTRODUCTION – CARE AREA OVERVIEW



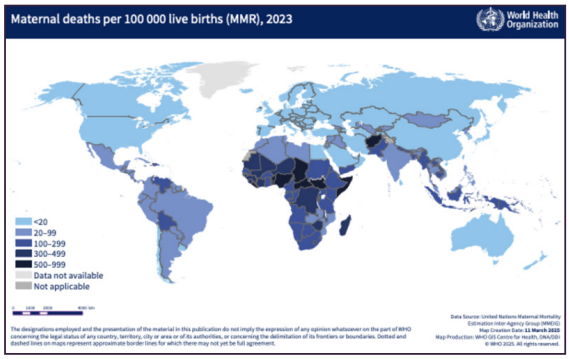
Readiness of the labor room plays a pivotal role in ensuring safe childbirth. An unprepared labor room can contribute to delays in critical care, leading to adverse outcomes for both mothers and newborns. Therefore, readiness is not an event, but a continuous state of being. The WHO 2016[1] standards emphasize that providers must prepare for safe childbirth by ensuring readiness of equipment, medications, and the care environment. This includes verifying emergency supplies, functional monitoring devices, and adherence to infection prevention and safety protocols before each delivery.

BACKGROUND – RATIONALE AND OBJECTIVE

Safe childbirth is the cornerstone of maternal and neonatal healthcare. Globally, an estimated 260,000 women died from a maternal cause in 2023, equivalent to over 700 maternal deaths every day, and approximately one every two minutes[2]. Many of these deaths can be prevented with timely, quality intrapartum care. The shift in mindset toward early readiness for labor emphasizes preparedness of the labor room (LR), newborn care area (NBC), essential equipment, drugs, and protocols.

Daily checks and protocol adherence ensures preparedness and readiness for every delivery, vital for safe, high-quality maternal care.

Additionally, National Quality Assurance Standard (NQAS) 2019[3] guidelines by the Government of India outline standards for labor rooms and maternity OTs, emphasizing provider readiness, infection control, and availability of essential equipment and medicines. They ensure that daily checks and adherence to protocols maintain safe, high-quality maternal care during delivery.



Global MMR figures

1 WHO Standards for Improving Quality of Maternal and Newborn Care in Health Facilities, 2016

2 Trends in maternal mortality estimates 2000 to 2023 Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA / Population Division

3 National Quality Assurance Standards (NQAS) for Labor Rooms and Maternity OT, GOI, 2019

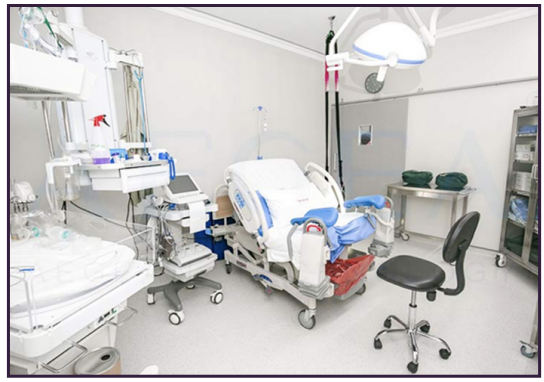
Manyata Standard 2 for safe care during delivery outlines daily checks and preparedness actions to ensure that every delivery occurs in a safe, respectful, and resource-ready environment

KEY COMPONENTS

Entry Protocols

Entry protocols are the first line of infection prevention in any clinical area. In the labor room, these protocols must be strictly implemented and monitored. This includes wearing gowns, masks, shoe covers, and using hand sanitizer or washing hands with soap and water before and after every patient contact. Signage with instructions should be displayed at the entrance. Staff must be trained regularly to follow these protocols to reduce the risk of hospital-acquired infections.

Readiness is Continuous



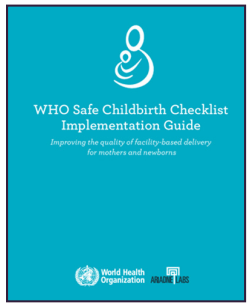
The standard of care practiced under the Manyata initiative for labor room readiness not only begins when a woman enters in active labor, but is a part of the daily routine, where every staff member contributes to maintaining a state of constant preparedness. Checklists are followed every morning, equipment tested, stock levels reviewed, and the environment assessed for cleanliness. Team-based readiness drills and surprise audits ensure vigilance. A well-prepared LR minimizes delays, facilitates smooth decision-making, and allows immediate response to emergencies. Cultivating this mindset builds accountability and confidence among staff, leading to better care outcomes at the Manyata-certified facilities.

Labor Room Layout and Protocols

A well-planned and functional labor room layout is the foundation of safe and efficient intrapartum care under this standard. The layout ensures smooth flow from triage and stabilization to delivery and newborn care, while also providing space for emergency interventions.

Adequate lighting is essential not only for visibility during procedures but also to create a welcoming environment. Proper ventilation helps in reducing airborne infections.

Initial Assessment and Triage and OT



Every labor room must have a designated triage area with a stabilization bed to enable rapid assessment of women on arrival. Triage is critical for ensuring that those with complications are prioritized for care to save lives by preventing delays in care. The assessment area should be equipped with basic tools such as a BP apparatus, fetal doppler, thermometers, pulse oximeters, and a stabilization bed. Staff are trained to promptly recognize maternal and fetal danger signs, including bleeding, high blood pressure, and abnormal fetal heart rates. In addition, a newborn care corner is integrated into the labor room layout, and the maternity operation theatre (OT) should

ideally be located nearby for rapid access in case of obstetric emergencies, accessible within minutes. Coordination between labor room and OT teams is essential for seamless care transitions.

Supportive Infrastructure

Essential supporting spaces include a changing room, doctors'/nurses' room with attached toilet, clearly demarcated for handwashing (elbow tap with running water and soap dispenser), clean and dirty utility sections, a functional nursing station equipped with a telephone, whiteboard for case updates, an alarm system for code activation, and an adult resuscitation kit for maternal emergencies, forming part of this standard.

Labor Room Setup

The labor room must maintain privacy through curtains or partitions and be equipped with a functional labor table, suction machine, and controlled oxygen supply. Ambient temperature should be regulated at 25–26°C with an AC and thermometer to ensure maternal and newborn comfort. Essential trays must be standardized and readily available, including Examination, Delivery, Episiotomy, Newborn Resuscitation, Baby, Emergency, and Medicine trays, along with dedicated PPH and Eclampsia boxes. A functional refrigerator is vital for storing temperature-sensitive medicines, especially oxytocin, and written care protocols should be prominently displayed in the labor room or nursing station for easy reference. Regular cleaning schedules must be adhered to and documented.

Essential Trays and Kits to be prepared and Kept in Labor Room[4] as in Dakshata guidelines recommended national protocols.

Cold Chain Management of Oxytocin

Oxytocin is critical in preventing postpartum hemorrhage. The effectiveness of oxytocin depends on maintaining the cold chain. From the point of manufacture to administration, oxytocin must be stored at temperatures between 2°C to 8°C.[5] Health facilities should have functional refrigerators, daily temperature logs, and contingency plans for power outages. Loss of potency due to poor storage can be life-threatening and must be prevented at all costs.

Newborn Care Area

The newborn care corner must be fully prepared before every delivery. It should be equipped with all essential resuscitation and thermal protection items, including a radiant warmer (switched on at least 30 minutes prior to delivery), shoulder roll, pre-warmed towels, head cap, mucus extractor, cord clamp, stopwatch, neonatal ambu bag and mask, weighing scale, and necessary resuscitation drugs. Immediately after birth, newborns must be assessed and stabilized following Essential Newborn Care (ENC) protocols, which emphasize thermal protection, early initiation of breastfeeding, and hygienic cord care. The area must be kept clean after every use, and all equipment should be checked daily for proper functionality to avoid delays during emergencies.

4 Dakshata Guidelines: Empowering Providers for Improved MNH Care during Institutional Deliveries, 2015

5 WHO/UNICEF/UNFPA JOINT STATEMENT: Appropriate Storage and Management of Oxytocin – a Key Commodity for Maternal Health

Essential Documentation

Accurate documentation is a hallmark of quality care. All registers (labor room, delivery, referral, and incident) should be updated in real-time. The partograph, a critical tool for monitoring labour progression, must be filled meticulously. Proper record-keeping not only ensures continuity of care but is also essential for audits, quality assurance, and medico-legal purposes. Digital record systems, where available, can enhance accuracy and efficiency.

Together, these elements ensure that the labor room functions as a safe, well-equipped, and responsive environment for mothers and newborns, enabling timely management of both routine deliveries and obstetric or neonatal emergencies.

CONCLUSION

Labor room readiness standard ensures that preparedness is not a one-time exercise but a continuous process. **Embedding this into routine practice at the Manyata-certified facilities ensures that essential equipment, drugs, and supplies are always functional and available**.

Labor room readiness improves timely, safe, and quality care for every mother and newborn.

By cultivating a culture of readiness, facilities can significantly reduce preventable maternal and newborn deaths. Continuous readiness thus transforms the labor room into a safe, reliable, and responsive environment for every mother and baby.

BIRTHING:
A POSITIVE EXPERIENCE

RESPECTFUL MATERNITY CARE

Dr. S Sampathkumari, Dr. Charmila Ayyavoo, Dr. Vinita Singh, Dr. Bela Bhatt

Manyata Standard: Provider ensures respectful and supportive care

INTRODUCTION – CLINICAL CARE AREA

Childbirth is an important event in a woman's life, and all women need and deserve to receive respectful care during labor and childbirth. Yet, for many women worldwide, these experiences are marred by neglect, mistreatment, and disrespect in health facilities. Disrespectful maternity care manifests as verbal or physical abuse, denial of privacy, discrimination, lack of consent for procedures, abandonment during labor, and other forms of mistreatment. Such practices compromise not only the woman's dignity but also her willingness to seek facility-based care in the future. The Manyata initiative has laid special emphasis on this important aspect of quality care by assigning a separate standard for this care area for private facilities across India. It recognizes Respectful Maternity Care (RMC) as a priority both a fundamental human right and a critical determinant of quality of care, as defined by WHO[1].

WHO: Respectful maternity care–refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth

Manyata positions RMC as a crosscutting theme across its standards. While technical excellence in managing pregnancy complications saves lives, respectful care ensures that women experience care with dignity, autonomy, and trust in the health system. RMC is therefore both a clinical care area—embedded in antenatal, intrapartum, and postnatal phases—and a moral imperative in maternal and newborn health programs. Under Manyata there have been targeted interventions towards establishing the practice of RMC across private healthcare settings.

BACKGROUND – RATIONALE AND OBJECTIVE

Recent evidence suggests that that the principles of compassionate and respectful care during childbirth are violated in maternity facilities.[2] In a systematic review of obstetric violence, it has been reported that in India women experience at least one instance of mistreatment during childbirth and

1 World Health Organization. WHO Recommendations: Intrapartum care for a positive childbirth experience.

2. Patabendige M, Agampodi SB, Jayawardane A, Wickramasooriya DJ, Agampodi TC. Perceptions on respectful maternity care in Sri Lanka: Study protocol for a mixed-methods study of patients and providers. PLoS One. 2021;16: e0250920

that women avoid seeking care in health facilities because of mistreatment[3]. In another systematic review, the pooled prevalence of disrespect and abuse during labor was 71.31% in India. Disrespectful treatment threatens women's rights to dignified life and health and deters them from seeking evidence-based institutional care[4]. On the other hand, respectful maternity care can contribute to the timely provision of care, improved patient–provider communication, and increased adherence to treatments and maternal health service utilization.[5] The standard of care provided to all women at a Manyata accredited facility maintains dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth.

The Manyata standard on RMC aligns with The Respectful Maternity Care (RMC) Charter, published in 2011 and updated in 2019 that articulates the fundamental rights of childbearing women and newborns based on widely accepted human rights instruments, and provides a framework for high-quality care that supports and upholds the dignity of all parties. The 12 Universal Rights of Women and Newborns outlined by the White Ribbon Alliance form the ethical backbone of the Manyata RMC standard. In collaboration with the Center for Catalyzing Change and based on the original research, the standard for RMC has been developed keeping in mind the country context. The Manyata standard on implementation of RMC practices within the facilities is also aligned to the global frameworks for implementation of RMC, the Laqshya Quality of Care guidelines (GoI, 2017), WHO recommendations on intrapartum care for positive childbirth experience, 2018, the International Childbirth Initiative, 2019 and the FIGO Medical Ethical Guidelines.

Universal Rights of Childbearing Women and Newborn, 2019

1	Right to freedom from harm and ill treatment.
2	Right to information and informed consent.
3	Right to a companion of their choice and preference during maternity care.
4	Right to privacy and confidentiality.
5	Right to be treated with dignity and respect.
6	Right to equality, freedom from discrimination and equitable care
7	Right to healthcare and highest attainable level of health.
8	Right to liberty, autonomy, self-determination, freedom from arbitrary detention, and refusal to informal payments
9	Right of every child to be with their parents or guardians.
10	Right to an identity and nationality from birth.
11	Right to adequate nutrition and clear water.
12	Right of women and newborn for timely and effective grievance redressal.

3. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Boston: USAID-TRAction Project, Harvard School of Public Health; 2010.

4. Shrivastava S, Sivakami M. Evidence of 'obstetric violence' in India: An integrative review. J Biosoc Sci. 2020; 52:610–28

5. Molina RL, Patel SJ, Scott J, Schantz-Dunn J, Nour NM. Striving for Respectful Maternity Care Everywhere. Matern Child Health J. 2016; 12(23):1–7. https://doi.org/10.1007/s10995-016-2004-2

KEY COMPONENTS

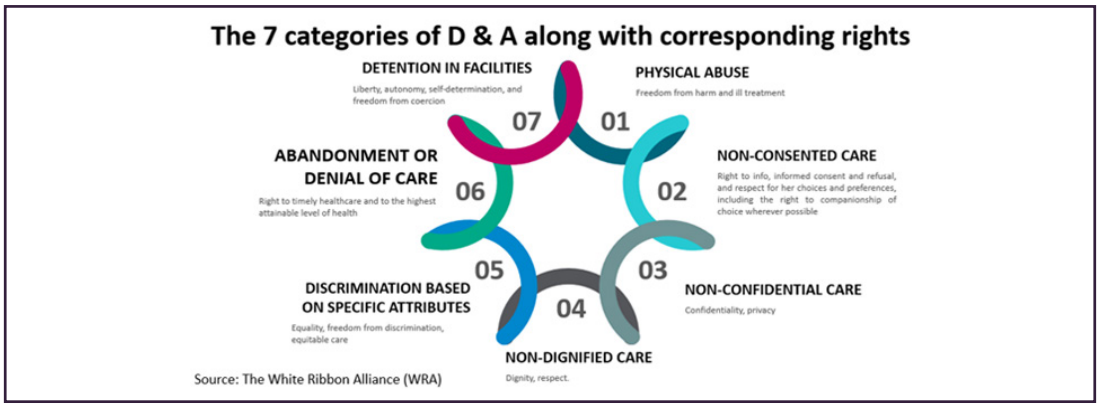
The key clinical components under this standard include:

Prevention of Disrespect and Abuse (D & A)

- The Manyata facilities work towards preventing D & A through training, accountability, and a culture of zero tolerance toward mistreatment.

Person-Centred Respectful Maternity Care

- Dignity and respect: Women are treated kindly, protected from abuse, and provided privacy.
- Communication and autonomy: Providers introduce themselves, address women by name, seek consent, explain procedures, and respond to questions.
- Supportive care: Continuous emotional and physical support, presence of a chosen birth companion, pain relief, and attention to comfort.



Clinical Communication and Consent

- Self-introduction by providers.
- Clear explanation of examinations, procedures, and medications.
- Informed consent for interventions like episiotomy, induction, or cesarean section.
- Shared decision-making that involves women and their families.

Labor Companionship

Evidence shows that continuous companionship during labor reduces the need for medical interventions, shortens labor, and improves maternal satisfaction. The RMC standard ensures that women can choose a birth companion, such as a spouse, family member, or friend.

Pain Relief and Comfort

Respectful care standard includes offering a comfortable birthing position and pain management options—non-pharmacological (breathing techniques, massage, mobility) and pharmacological (analgesics, epidural)—while respecting women's preferences.

Equity and Non-Discrimination

Women of all social, cultural, and economic backgrounds must receive equal treatment. This is especially important in India, where women from marginalized groups often report higher levels of mistreatment.

CONCLUSION

A high standard of respectful care during pregnancy and childbirth is the need of the hour and the Manyata initiative is catalyzing the private health systems to be organized and managed in a manner that protects the human rights of women and respects their sexual and reproductive health.

Respectful Maternity Care is a woman's right, a health system's duty.

RMC should be the standard, not the exception.

The Manyata initiative maintains that respectful maternity care is the right of all pregnant women and is the predictor of health seeking behavior of our future generations. RMC is today a non- negotiable part of healthcare. It should be in the DNA of all health systems and the Manyata initiative has shown that this can easily be provided without any burden of additional resources.

WOMAN-CENTERED CARE

Dr. Komal N. Chavan, Dr. Seetha Ramamurthy Pal

Standard: Provider conducts PV examination appropriately

INTRODUCTION – CLINICAL CARE AREA

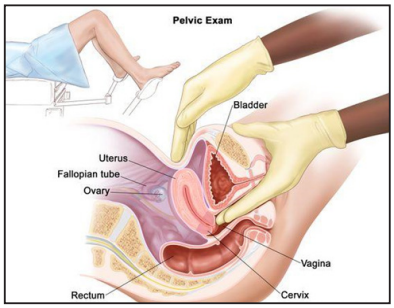
The per vaginal (PV) examination (Fig.1) is a fundamental clinical procedure in obstetric practice. It provides essential information about the progress of labor, the condition of the cervix, and the relationship between the fetus and the maternal pelvis. While its clinical value is unquestionable, the PV examination is also an intimate and potentially uncomfortable procedure that requires sensitivity, respect, and careful technique. This chapter presents the principles, indications, techniques, and ethical considerations for conducting a PV examination.

RATIONALE AND OBJECTIVE

Minimize Harm: Avoid inappropriate or repeated PV exams to reduce risk of infection, delays in care, and psychological distress.

Inappropriate or repeated examinations can increase the risk of ascending infection, delay labor management, and cause significant psychological distress. For this reason, the standard has been included to ensure that the provider always performs PV examination judiciously, with a clear clinical indication, with adherence to aseptic principles, and a strong emphasis on patient dignity and autonomy.

This Manyata standard highlights the dual responsibility of the healthcare provider: to obtain accurate clinical information while simultaneously protecting the safety, comfort, and rights of the pregnant woman.



PV Examination

KEY COMPONENTS – WHEN AND HOW

When?

Conduct PV examination as per indication

The Manyata standard recommends that the PV examination should never be performed routinely or indiscriminately. Each examination must be justified by a clinical question that will influence decision-making, and the examination is done only when indicated as per the standard. Avoid unnecessary or repeated examinations, as these increase the risk of maternal and neonatal infection.

Source: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/pelvic-exam

During Pregnancy

- **Confirm onset of labor –** To distinguish true labor from false labor by assessing cervical dilatation, effacement, and fetal station.
- **Assess presentation and position –** Particularly when abdominal palpation is inconclusive.
- **Confirm rupture of membranes –** In cases where the clinical history is unclear.
- **Evaluate antepartum hemorrhage –** Only after placenta previa has been excluded by ultrasound.

Indications for PV Examination

Stage	Clinical Indication	Purpose
During Pregnancy	Confirm onset of labor	Assess cervical dilation, effacement, and fetal station
	Assess presentation and position	When abdominal palpitation is inconclusive
	Confirm rupture of membranes	If history is unclear
	Evaluate antepartum hemmorrhage	After excluding placenta previa
During Labor	On admission in labor	Establish baseline (dilatation, effacement, presentation, membranes)
	To monitor progress	Usually every 4 hours in first stage
	Suspected rupture of membranes	When diagnosis is uncertain
	Abnormal labor	Delayed progress, obstruction, malpresentation
	To confirm full dilatation	Before encouraging pushing
	Assess presentation of part	Face, brow, or breech
	Before operative delivery	Confirm safety of forceps, vacuum, or cesarean
Postpartum/ Emergencies	Genital tract trauma	Assess source of bleeding
	Retained products	Confirm incomplete expulsion of placenta/ membranes

During Labor

- **On admission in labor –** To establish a baseline assessment of cervical dilatation, effacement, fetal presentation, and membrane status.
- **Monitor progress –** Usually at intervals of four hours during the first stage, provided there are no complications.
- **When rupture of membranes is suspected –** Especially if the diagnosis is uncertain.

- **In cases of abnormal labor –** Such as delayed progress, suspected obstruction, or malpresentation.
- **Confirm full dilatation –** Before the woman is encouraged to bear down.
- **Assess presentation of the part –** For example, face, brow, or breech presentations.
- **Prior to instrumental or operative delivery –** To confirm the safety of proceeding with forceps, vacuum, or cesarean section.

Postpartum and Emergencies

- **Assessment of genital tract trauma –** In women with postpartum hemorrhage or persistent bleeding.
- **Evaluation of retained products –** When incomplete expulsion of the placenta or membranes is suspected.

Contraindications

PV examination may be harmful in certain situations and should therefore be avoided or delayed.

Contraindications include:

- **Placenta previa –** Risk of severe hemorrhage.
- **Unexplained vaginal bleeding –** Until diagnosis is clarified.
- **Preterm premature rupture of membranes (PPROM) –** Risk of infection.
- **Vasa previa –** Risk of fetal vessel rupture.
- **Active genital infections –** Such as herpes simplex virus.

In such cases, alternative diagnostic methods (e.g., ultrasound, external palpation, sterile speculum exam) should be used.

How?

Infection Prevention and Patient Safety

Aseptic Technique

PV examination should be performed with meticulous aseptic precautions.

The PV examination, if performed without appropriate precautions, may introduce pathogens into the genital tract and amniotic cavity. This risk underscores the importance of strict adherence to infection prevention practices. The standard stresses the importance of asepsis.

KEY MEASURES

- **Hand hygiene –** Before and after every examination
- **Sterile gloves –** Always mandatory
- **Use of sterile lubricant –** To minimize trauma and ensure comfort
- **Clean environment –** Adequate lighting, sterile equipment, and minimal crowding
- **Limitation of frequency –** Restrict PV examinations to clinically indicated occasions

Infection prevention safeguards not only maternal health but also reduces the risk of neonatal sepsis, chorioamnionitis, and other complications.

Communication and Patient Preparation

The psychological aspects of PV examination are equally important as the clinical ones. Anxiety, embarrassment, or fear are common, particularly if the woman has not been adequately informed.

1. **Steps in Effective Communication:** Effective communication transforms the PV examination from a passive experience into a collaborative and respectful interaction.
2. **Introduction and Rapport:** Greet the woman respectfully, introduce yourself, and establish a supportive atmosphere.
3. **Explain the Purpose:** Clearly state why the examination is necessary, avoiding technical jargon.
4. **Describe the Procedure:** Inform the woman what to expect, including potential sensations of pressure or discomfort.
5. **Reassure Continuously:** Remind her she can request a pause or termination of the procedure at any time.
6. **Obtain Consent:** Ensure voluntary and informed agreement. Informed consent is a cornerstone of ethical practice. Respecting consent upholds autonomy and enhances trust between patient and provider. A woman's right to refuse or withdraw consent must always be honored.

Before proceeding, the provider must:

- Explain the reason, process, risks, and benefits of the examination
- Allow the woman to ask questions and express concerns
- Ensure that her decision is voluntary and free from coercion
- Document that consent has been obtained

Essential steps include:

- Positioning the woman comfortably, usually in the lithotomy or dorsal position
- Ensuring privacy with appropriate draping
- Performing hand hygiene and donning sterile gloves
- Using sterile lubricant
- Inserting fingers gently to minimize discomfort
- Explaining findings afterward in clear and respectful language

Step/Principle	Description	Purpose
Hand Hygiene	Wash or sanitize hands before and after procedures	Removes transient microorganisms and reduces infection risk
Personal Protective Equipment (PPE)	Wear sterile gloves, masks, gowns, caps, and eye protection as required	Provides a barrier between healthcare worker and patient
Sterile Field	Prepare and maintain a sterile area using sterile drapes and equipment	Prevents contamination of instruments and supplies
Sterile Equipment	Use only sterilized instruments, dressings, and solutions	Ensures no microorganisms are introduced
No Touch Technique	Avoid touching key parts (e.g., needle tips, sterile dressings)	Prevents transfer of organisms
Proper Disposal	Dispose of sharps in puncture-proof containers, and waste in appropriate bins	Reduces risk of cross-contamination and injury
Environmental Control	Keep doors closed, minimize movement, maintain clean work surfaces	Reduces airborne contamination
Patient Preparation	Clean skin with antiseptic solution before invasive procedures	Reduces skin flora and infection risk

RECORDING FINDINGS

Accurate documentation is an essential component of safe obstetric practice. Findings from the PV examination should be recorded immediately on the partograph, a tool designed to monitor labor progress systematically.

After recording, findings should be explained to the woman in clear terms. She should be made aware of her progress, potential risks, and the planned next steps in her care.

CONCLUSION

The per vaginal examination is a central element of obstetric care. The standard ensures that the providers keep the woman in the center of the care process, and ensures consent and reassurance, balancing the need for accurate clinical information with the duty to protect the woman's safety, comfort, and rights.

Woman-centered Care: Always explain, seek consent, and reassure to build trust and reduce anxiety.

When conducted appropriately, it provides vital clinical information, ensures timely interventions, and supports safe labor outcomes. However, its intimate nature also requires that providers exercise sensitivity, uphold ethical standards, and always respect the woman's dignity.

MONITORING OF LABOR

Dr. Madhuri Patel, Dr. Anju Soni

Standard: Provider monitors the progress of labor appropriately

INTRODUCTION – CLINICAL CARE AREA

Labor is the most critical and dynamic physiological process, however without timely and skilled monitoring, it can easily deviate into life-threatening complications for both mothers and newborns. Appropriate monitoring allows timely detection of complications, guides interventions, and optimizes outcomes, while minimizing unnecessary interventions. Monitoring can be clinical (observation, examination) and/or technological (cardiotocography, intrapartum ultrasound), and requires knowledge of normal labor patterns, warning signs, and the principles of intrapartum care. The Manyata initiative emphasizes quality of care during labor, with one of its central standards focusing on monitoring of labor using the partograph. This tool, and its next-generation successor—the WHO Labor Care Guide (LCG)—provides a structured, evidence-based framework for continuous intrapartum monitoring. By using these tools systematically, providers can recognize obstructed or prolonged labor, prevent unnecessary inductions or augmentations, and optimize maternal and newborn outcomes. This chapter builds on the Manyata standard for labor monitoring and integrates global best practices and national guidelines to provide a consolidated reference for health providers.

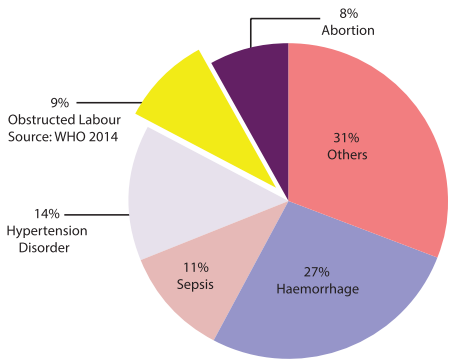
BACKGROUND – RATIONALE AND OBJECTIVE

The rationale for labor monitoring is rooted in its lifesaving potential. Globally, a considerable proportion of maternal and perinatal mortality occurs due to complications during labor—such as obstructed labor, uterine rupture, sepsis, and neonatal asphyxia.

Complications during labor, like obstructed labor and uterine rupture, are a major cause of maternal and perinatal deaths. Labor monitoring is crucial for saving lives.

In India, delays in recognizing and managing labor abnormalities continue to contribute to preventable maternal deaths and stillbirths.

The Manyata standard on labor monitoring encapsulates the objectives of evidence-based systematic monitoring of labor by making the partograph/LCG a mandatory tool and emphasizing on timely assessment, interpretation, and appropriate response to abnormal findings ensuring teamwork, communication, and documentation in labor rooms.



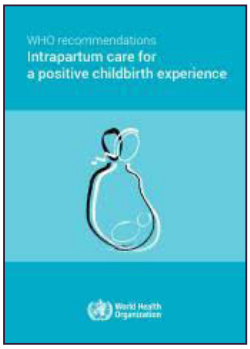
CLINICAL COMPONENTS

The Manyata Standard outlines the clinical care elements of labor monitoring, which are aligned with both WHO recommendations[1] and the national guidelines[2].

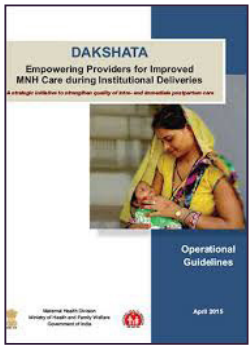
Stages of Labor and their Monitoring Needs:

First Stage

- Latent Phase: Early cervical changes (up to 4–5 cm dilatation).
- Active Phase: Rapid cervical dilatation until full dilatation (10 cm).



WHO recommendations on intrapartum care for a positive childbirth experience



Until full dilatation

Tools for Monitoring Labor

Partograph, a WHO-recommended chart for labor progress and maternal/fetal condition has been included as a tool for monitoring labor under the Manyata initiative. This tool enables the providers from the Manyata certified facilities for early detection of abnormal labor, standardises documentation, and aids clinical decision-making. Alternatively, the facilities may opt to use the Labor care guide as a monitoring tool.

Assessment and Documentation of Labor Progress:

- **Availability of Partograph/LCG:** As per Manyata, facilities must ensure partographs/ LCG tool are readily available in the labor room.
- **Initiation:** Recording should begin when the cervix is ≥4 cm as per earlier WHO guidance or ≥5 cm dilatation, if provider is following the Labor care Guide (LCG).
- **Cervical Dilatation and Descent:** Vaginal examinations should be done every 4 hours, and progress documented. Descent of the head should be assessed by abdominal palpation to avoid false impressions caused by moulding or caput.

Components Monitored Under the Partograph:

- Cervical dilatation- Vaginal examination every 4 hours, or sooner if indicated
- Descent of head
- Amniotic fluid- color, odor, presence of meconium or blood.
- Uterine contractions- Manual palpation: frequency, duration, intensity
- FHR monitoring- Intermittent auscultation or continuous electronic fetal monitoring.
- Maternal vitals (Pulse, BP, temperature, Respiratory rate) and urine output.

Interpretation and Clinical Decision-Making

- **Correct Use of Partograph/LCG:** The standard ensures that the providers interpret the graph holistically for the progress of labor, covering maternal vitals, fetal well-being, uterine contractions, and cervical dilatation.

1 World Health Organization. (2018). WHO recommendations: Intrapartum care for a positive childbirth experience. Geneva: WHO.

2 Dakshata Guidelines for intrapartum care, MoHFW, GoI, 2015

- **Deviations:** If parameters deviate from normal, providers can diagnose complications (e.g., prolonged labor, fetal distress) and escalate care as per protocol.
- **Adjustment of Birth Plan:** As per the standard, decisions should involve both the clinical team and the woman and or her family, with clear documentation.

Partograph

Parameter	Frequency (low risk)	Frequency (high risk)	Points to consider
BP, Pulse	4-hourly	1–2 hourly	More frequent in preeclampsia
Temperature	4-hourly	2-hourly	Watch for infection
Respiratory rate	4-hourly	Hourly	Especially if on opioids
Urine output	Every void	Hourly if catheterized	Check for ketones, protein, sugar
Pain assessment	Ongoing	Ongoing	Guide analgesia

Table 1: Guidance on use of the Partograph

OBSTRUCTED LABOR

The standard clearly outlines recognition and management of obstructed labor as a critical competency. The standard ensures correct interpretation of the partograph, diagnosis and immediate steps towards management of obstructed labor such as rehydration and stabilization (IV fluids), monitoring the vitals, administration of broad-spectrum antibiotics to reduce sepsis risk, bladder catheterization, blood grouping, and cross-matching in anticipation of surgical intervention. Prompt referral or surgical intervention (cesarean delivery) is followed as per protocols at all Manyata-certified facilities.

Rational Use of Induction and Augmentation- Always to be Done as per Clinician's Discretion

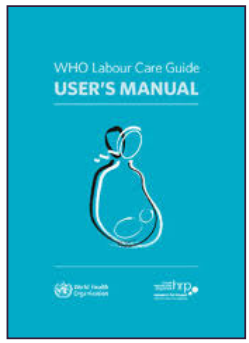
- **No routine uterotonic use:** The standard recommends that augmentation or induction with oxytocin or prostaglandins should only be done for clear medical or obstetric indications (e.g., preeclampsia, intrauterine growth restriction, post-term pregnancy).
- **Risks:** Inappropriate use increases the risk of uterine rupture, fetal hypoxia, and poor outcomes. This is highlighted to the providers through this standard, to ensure a rational use of uterotonics.
- **Monitoring:** When oxytocin is used, maternal and fetal monitoring is intensified, with careful titration of infusion rates, as per the standard.

WHO Labor Care Guide[3]

The WHO recommended modified partograph being used as a tool to monitor maternal and fetal wellbeing has the cut-off of 4 cm to define the onset of active labor and uses one cm/ hour rate of dilatation in the active phase as the minimum rate. This was found to be unrealistic and led to

3 WHO Labor care guide: user's manual. Geneva: World Health Organization; 2020.

unnecessary interventions. To overcome these shortcomings, an alternative novel tool in the form of Labor Care Guide (LCG) was developed by WHO and is also called “the next generation partograph.”



The Manyata standard in keeping with this latest evidence, has incorporated use of the LCG as an alternative tool for monitoring labor. LCG was primarily designed for women with low-risk pregnancies. Women at high risk of developing labor complications may require additional specialized monitoring and care. Monitoring on the LCG begins at 5 cm dilatation, it integrates supportive care and avoids rigid “1 cm per hour” thresholds. It covers both first and second stages of labor, emphasizes respectful maternity care, and provides evidence-based alert parameters rather than arbitrary lines. Additionally, the LCG includes assessment of presence of the labor companion, maternal hydration, maternal position and mobility, and pain management.

Structure of the LCG:

The LCG contains seven sections which contain a list of labor observations recorded by the health care provider as soon as a woman is admitted to the labor room and is in the active stage. Each observation has a horizontal time axis for recording the corresponding time of observation and a vertical value axis for recording any deviation from normal observation.

The seven sections are:

1. Information and Labor characteristics
2. Supportive care
3. Care of the baby
4. Care of the women
5. Labor progress
6. Medications
7. Shared decision making

The providers ensure correct and systematic implementation of LCG by systematically following ‘Assess-Record-Check and Plan’ approach Following this, the well-being of the mother and fetus is first assessed, along with labor progression. This is followed by documentation of labor progression and comparing observations, with reference values in the “alert” column. By recording and reviewing their observations against these references, action is taken on warning signs as needed. When there is a deviation from the expected observations, the decision for intervention is taken by the clinical team in consultation with women and is documented accordingly.

CONCLUSION

Effective monitoring of labor is the cornerstone of safe childbirth. It requires a balance of clinical observation, judicious use of technology, and supportive care. Emphasis should be on timely detection of deviations from normal, guided interventions, and respectful communication[4]. With skilled monitoring, most complications can be prevented or managed promptly, ensuring a safe outcome for mother and child.

Skilled monitoring: The key to a safe and respectful childbirth.

Both the partograph and the newer evidence-based LCG tools have been embedded into the standard, and the providers are encouraged to monitor labor judiciously using either of these tools. The standard helps in monitoring the mother and the fetus throughout labor and delivery towards a positive childbirth experience and a favorable outcome.

4 Downe S, Finlayson K, Oladapo OT, Bonet M, Gülmezoglu AM. (2018). What matters to women during childbirth: A systematic qualitative review. PLoS ONE, 13(4), e0194906.

SAFE CHILDBIRTH PRACTICES

Dr. Manoj Chellani

Standard: Provider assists the pregnant woman to have a safe and clean birth

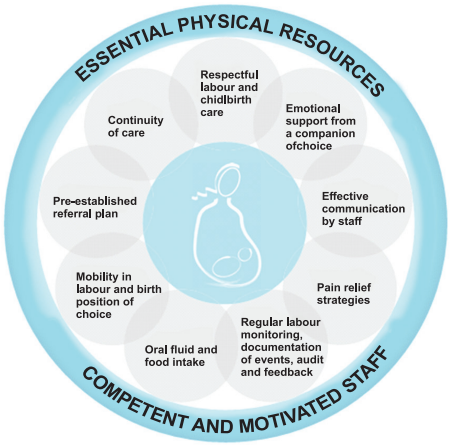
INTRODUCTION - CARE AREA OVERVIEW

Clean and safe childbirth is a cornerstone of maternal and newborn survival. These practices are the key clinical and non-clinical methods used to guarantee the health and safety of both the mother and the infant during childbirth. These procedures reduce difficulties, avoid infections, and improve delivery outcomes.

BACKGROUND AND OBJECTIVE

Ensuring every birth is clean and safe is not only a matter of reducing infection-related mortality but also of enhancing women's trust and satisfaction with institutional care. Infections remain a major contributor to maternal and neonatal morbidity and mortality, accounting for an estimated 10.7% of maternal deaths and 44% of neonatal deaths globally each year.[1] Respectful, hygienic, and protocol-driven practices form the foundation for safe deliveries and contribute directly to achieving SDG targets on maternal and neonatal mortality reduction.

Schematic representation of the WHO intrapartum care model



A safe and respectful delivery is fundamental to institutional care. When births are consistently clean and safe, it reduces mortality and builds women's trust in the healthcare system.

The Manyata standard has been adapted from the global (WHO)[2] and national guidelines[3] ensures that labor rooms are well-prepared with trained staff and sterile equipment. It emphasizes adherence to the 'Six Cleans,' promotes safe delivery practices such as allowing spontaneous delivery of the head with controlled flexion and perineal support, recommends episiotomy only when clinically indicated, and provides guidance for the appropriate management of complications. Through proper monitoring, aseptic practices, and safe bio-medical waste disposal, maternal and newborn health is always safeguarded.

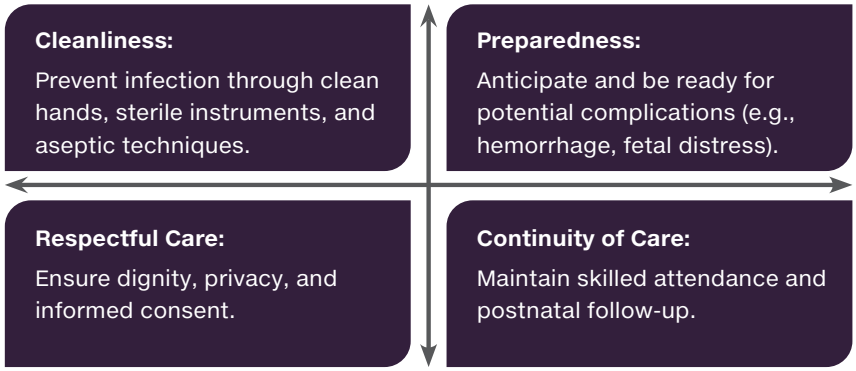
1 Gebeyehu, N.A., Atalay, Y., Tegegne, K.D. et al. clean delivery kit use in low-and middle-income countries: a systematic review and meta-analysis. *BMC Pregnancy Childbirth* **24**, 791 (2024).

2 WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018.

3 Dakshata Guidelines for intrapartum care, MoHFW, GoI, 2015

KEY COMPONENTS

Providing safe and respectful maternal care is essential to ensuring positive health outcomes for mothers and newborns. Key principles include:



LABOR ROOM READINESS

Ensuring that the labor room is consistently prepared is the foundation for safe and clean births. Key elements include:

- **Infrastructure & Supplies:** The standard ensures availability of handwashing stations with soap and running water, wall clock, autoclaved instruments, sterile drapes, antiseptics (Betadine/ Savlon), sterile gloves, sterile cord clamps, and cord-cutting instruments.
- **Monitoring Equipment:** Standardized clinical monitoring tools and equipment or functional monitors for vital signs (BP, pulse, temperature, fetal heart rate) should be available, as per the standard.
- **Staff Competency:** Labor and delivery areas should have competent, well-trained staff, and skilled birth attendants (SBAs) available 24 hours a day.
- **Quality Checks:** The standard recommends using readiness checklists to ensure supplies, equipment, and infection prevention standards are met before every shift.

ADHERENCE TO THE SIX CLEANS

To prevent maternal and neonatal infections, providers must strictly follow the Six Cleans during delivery:

The **WHO "Six Cleans":**

1. Clean hands of the attendant
2. Clean delivery surface
3. Clean perineum of the mother
4. Clean cutting instrument for the umbilical cord
5. Clean cord tie or clamp
6. Clean cord stump care after delivery

SAFE DELIVERY TECHNIQUES

Manyata standard emphasizes that providers must support safe birth while minimizing interventions unless clinically indicated. Labor and delivery should always be attended by skilled healthcare providers.

Episiotomy should be performed only when clinically indicated and must be done under appropriate local anaesthesia to minimize discomfort and prevent complications. During spontaneous delivery, support should focus on maintaining flexion of the fetal head, gently supporting the perineum, and managing any conditions such as the umbilical cord around the neck. The delivery of the shoulders and body should be assisted carefully to ensure a safe and controlled birth.

Active management of the third stage of labor (AMTSL) plays a critical role in preventing postpartum hemorrhage (PPH). Newborns should not be bathed immediately to preserve the vernix caseosa, a natural barrier against infection and for avoiding hypothermia. Breastfeeding should be initiated within the first hour of birth, and pre-lacteal feeds or artificial teats must be avoided. **Common complications must be promptly identified and managed.**

INFECTION PREVENTION PRACTICES

Aseptic practices must be strictly followed to prevent infection. Infection prevention protocols such as using sterile gloves and equipment, safe disposal of biomedical waste, and administering antibiotics, when necessary, are to be strictly followed. Maintaining a clean and hygienic environment in the labor and delivery area is essential for preventing infections and ensuring patient safety. Waste management plays a critical role and should involve the proper segregation and disposal of biomedical waste—including used gloves, placentas, and contaminated materials—into designated color-coded bins, following biomedical waste protocols. Instrument disinfection must be carried out diligently as per established guidelines, to ensure complete sterilization and to prevent cross-contamination.[4] In addition, environmental hygiene should be consistently upheld through routine cleaning of labor room surfaces, delivery beds, and all medical equipment with appropriate disinfectants. These measures collectively help reduce the risk of hospital-acquired infections and promote a safe birthing environment for mothers and newborns.

CONCLUSION

Safe delivery practices save lives and improve health outcomes.

Through Manyata, the adherence to evidence-based protocols including infection prevention and ensuring availability of essential supplies makes sure of safe and clean birth for every mother and her newborn.

Every birth deserves to be a clean and safe one

Continuous training of healthcare providers on these standards at Manyata-certified facilities is a key driver in reducing maternal and neonatal mortality.

4 National Guidelines for Infection Prevention and Control in Healthcare Facilities, National Centre for Disease Control, Directorate General of Health Services Ministry of Health and Family Welfare, Government of India, 2020

ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR (AMTSL)

Dr. Richa Sharma, Dr. Yashodhara Pradeep

INTRODUCTION – CLINICAL CARE AREA

Active Management of the Third Stage of Labor (AMTSL) is a set of evidence-based interventions designed to prevent postpartum hemorrhage (PPH), the leading cause of maternal morbidity and mortality globally. The Manyata standard clearly outlines AMTSL as a prophylactic intervention composed of a package of three components or steps: 1) administration of a uterotonic, preferably oxytocin, immediately after birth of the baby; 2) controlled cord traction (CCT) to deliver the placenta; and 3) massage of the uterine fundus after the placenta is delivered, if uterus is not contracted.[1]

BACKGROUND – RATIONALE AND OBJECTIVES

Globally, an estimated 260,000 women died from a maternal cause in 2023, equivalent to over 700 maternal deaths every day, and approximately one every two minutes[2]. Obstetric hemorrhage remains the leading cause, responsible for 27% of these deaths, most of which result from postpartum hemorrhage (PPH)[3]. Active Management of the Third Stage of Labor (AMTSL) is a globally endorsed strategy aimed at reducing the risk of postpartum hemorrhage (PPH), which remains the leading cause of maternal mortality worldwide. The studies have shown that AMTSL, when performed correctly, can reduce the risk of PPH by more than 60%.[4] In 2021, FIGO and ICM also released a joint statement stating the use of uterotonics during active management of third stage of labor to prevent PPH during vaginal birth or cesarean section.[5] The Manyata standard aims to ensure the effective and timely implementation of Active Management of the Third Stage of Labor (AMTSL) to prevent postpartum hemorrhage.

CLINICAL COMPONENTS

By administering uterotonics, preferably Oxytocin 10 IU IM or Heat Stable Carbetocin (HSC) 100 mcg IM/IV within one minute of the birth or using Misoprostol where injectables are unavailable, the aim is to promote uterine contraction and minimize blood loss.

Delayed cord clamping (1–3 minutes post-delivery) supports neonatal transition and improves iron stores. Controlled Cord Traction (CCT), performed by a skilled provider after uterine contraction, facilitates safe placental delivery, while uterine massage (to be done if the uterus is not contracted) ensures the uterus remains well-contracted.

Active Management of the Third Stage of Labor (AMTSL): Timely, Simple, Lifesaving

1 World Health Organization. WHO recommendations for the prevention and treatment of postpartum hemorrhage. 2012

2 Trends in maternal mortality estimates 2000 to 2023 Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA / Population Division

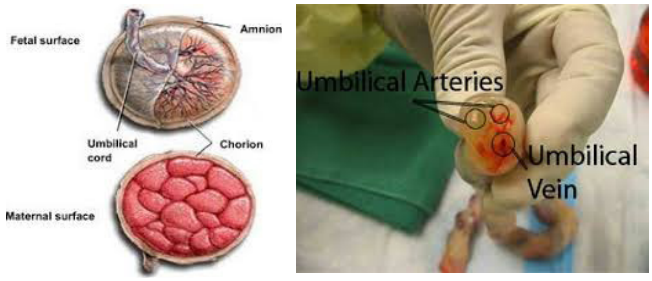
3 WHO recommendations on the assessment of postpartum blood loss and use of a treatment bundle for postpartum hemorrhage

4 Fissahaye B, et al Active management of the third stage of labor and associated factors among maternity care providers in public health facilities in Eastern Ethiopia: a multi-center study. BMC Pregnancy Childbirth. 2023 Sep 30;23(1):701.

5 FIGO – ICM Joint statement of recommendation for the use of tranexamic acid for the treatment of postpartum hemorrhage June 2021

Lastly, verifying the completeness of the placenta and membranes helps prevent retained products and associated complications. Collectively, these actions contribute to safer childbirth and improved maternal health outcomes.

Examination of placenta for completeness



Recommended agents and doses (WHO, 2023)[6]

Uterotonic	Recommended Dose & Route
Oxytocin	10 IU, IM/IV is the recommended uterotonic of choice for prevention of PPH for both vaginal and cesarean birth when multiple uterotonics are available and where quality of oxytocin can be guaranteed. Only if IV line is in place, the use of slow IV injection of 10IU of oxytocin is preferred (WHO 2020). If oxytocin is unavailable or the quality cannot be guaranteed, other uterotonics can be used.
Misoprostol	400 or 600 micrograms, orally, is recommended for prevention of PPH for all births especially where oxytocin is not available or quality cannot be assured. Misoprostol does not require cold storage that oxytocin and carbetocin require. In addition, it can be given by unskilled workers or by the woman herself during a birth outside of a health facility.
Carbetocin (heat-stable)	100 micrograms, IM/IV is recommended for the prevention of PPH for all births in contexts where its cost is comparable to other effective uterotonics. Unlike oxytocin, heat-stable carbetocin (HSC) does not require the same level of cold storage.
Ergometrine / Methylergometrine	200 µg, IM/IV OR fixed-dose combination of oxytocin and ergometrine (5 IU/500 µg, IM) is recommended for AMTSL oxytocin in contexts where hypertensive disorders can be safely excluded prior to its use.

Key point: Oxytocin remains the first-line drug for AMTSL

6 WHO recommendations on the assessment of postpartum blood loss and use of a treatment bundle for postpartum hemorrhage

CONCLUSION:

Active Management of the Third Stage of Labor (AMTSL) is a critical, evidence-based intervention proven to significantly reduce the risk of postpartum hemorrhage (PPH).

AMTSL: Every Birth, Every Time.

Implementing AMTSL consistently and correctly can save lives and improve maternal outcomes. With strong global endorsement from WHO, FIGO, and ICM, AMTSL represents a key component of quality intrapartum care and should be prioritized across all levels of healthcare to ensure safer childbirth experiences for women everywhere.

CESAREAN SECTION CARE

Dr. Hrishikesh Pai, Dr. Anupama Rao

Standard: Provider reviews clinical practices related to C-sections at regular intervals

INTRODUCTION – CLINICAL CARE AREA

Cesarean section (C-section) provides an effective, and often lifesaving, alternative to vaginal birth when maternal or fetal complications arise. Globally, C-sections have contributed to reducing maternal and neonatal mortality in high-risk cases. For women with obstructed labor, severe fetal distress, placenta previa, or pre-eclampsia, timely surgical intervention can be the difference between life and death. WHO states that C-sections are effective in saving maternal and infant lives, but only when they are required for medically indicated reasons.[1] The goal is to ensure that best practices are followed, delivering the most appropriate and beneficial obstetric care through shared decision-making.[2]

Every labor which is monitored and supervised, provides an opportunity to optimise interventions at the right time. The Manyata standard on C-sections promotes rational use of C-sections safeguarding maternal and newborn health, and embeds a culture of regular review, clinical accountability, and respectful care in the Manyata-certified facilities.

BACKGROUND – RATIONALE AND OBJECTIVE

In recent years, as per the National Family Health Survey (NFHS-5, 2019–21)[3] data, India has seen a sharp rise in C-section rates. The national C-section rate stands at nearly 21.5 %, with stark differences across states and between public and private sectors. In private facilities, the rate is 47.4%, while in public facilities it is around 14.3 %. The WHO has clarified that while there is no "ideal" rate for C-sections, however, population-level rates above 10–15% do not correspond with improved maternal or newborn survival.

There are clinical risks of both overuse and underuse of C-sections. As with any surgery, cesarean section is associated with short- and long-term risks. It is a major abdominal surgery, associated with complications such as infection, hemorrhage, anesthesia-related risks, delayed recovery, thromboembolism, and in the long term, increased risk of uterine rupture or abnormal placentation in future pregnancies. On the other hand, in resource-limited settings, some women in need of C-section (for obstructed labor, severe fetal compromise, or antepartum hemorrhage) may not get timely access, leading to maternal or perinatal deaths.

The Manyata initiative, recognizes that rational and safe use of C-section is critical to improving maternal and newborn outcomes.

1 WHO Statement on Cesarean Section Rates, World Health Organization, Geneva, 2015

2 ACOG Committee Opinion No. 761: Cesarean Delivery on Maternal Request. Obstet Gynecol. 2019 Jan;133(1): e73-e77

3 National Family Health Survey (NFHS-5), GoI- 2019-21

Every effort should be made to provide cesarean sections to women in need, rather than striving to achieve a specific rate

The Manyata standard on C-section care aims to ensure that every C-section performed in a facility is clinically justified, well-documented, safe, respectful, and followed by high-quality post-operative and newborn care. By embedding clinical governance practices—such as routine audits, Robson's classification, counseling, informed consent, adherence to infection prevention protocols, and postnatal recovery measures—the standard empowers providers to deliver surgical care that is both effective and accountable.

The rationale for including this standard under the Manyata initiative is twofold:

- **Clinical Justification –** ensuring that every C-section is performed for clear, documented, and evidence-based indications.
- **Quality and Safety –** ensuring adherence to surgical safety, infection prevention, maternal counseling, early recovery, and newborn care.

Thus, the Manyata standard is based on achieving a balance by ensuring timely and justified C-sections for those who need them, while preventing unnecessary procedures. This holistic approach safeguards women's health prevents misuse of surgical interventions and strengthens public trust in maternity care with evidence-based care. The Manyata C-section standard addresses this balance by establishing:

1. **Clinical appropriateness –** ensuring C-sections are done only when medically indicated.
2. **Safety and quality –** adherence to surgical safety protocols, infection prevention, and evidence-based intraoperative and post-operative care.
3. **Respectful care and communication –** involving women and families through counseling and informed consent.
4. **Accountability –** regular reviews of indications, classification using Robson's criteria, and clinical audits for quality improvement.

KEY COMPONENTS

The Manyata C-section care standard covers the entire care continuum—from indication and decision-making, through intraoperative safety, to postpartum recovery, and audit.

Indication for C-section

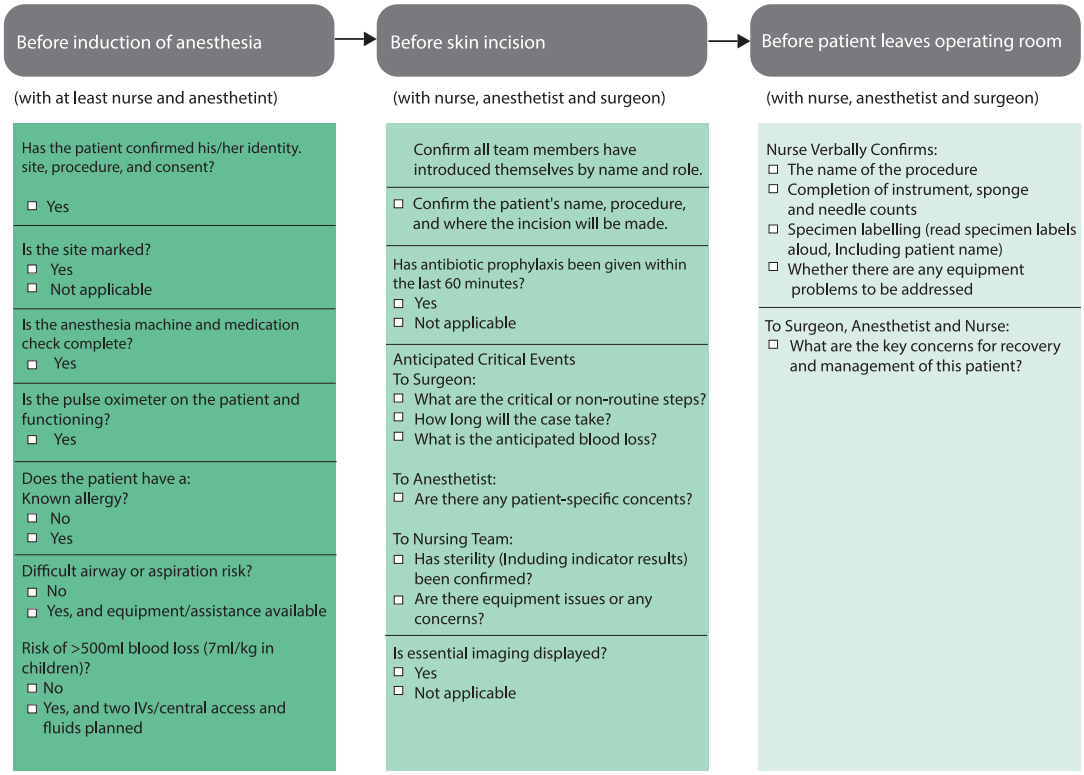
As per the standard, every C-section must be supported by a clear, documented clinical indication and placed into the Robsons classification for further audits.

Counseling of Mother & Family and Informed Consent

As per the standard, the providers are required to counsel both the woman and her family, explaining the indication for the C-section, benefits and potential risks, alternatives (if any) and the expected recovery process. Following this, it is mandatory that the consent form is signed and documented, as it protects patient rights and reinforces shared decision-making.

Safe Surgical Checklist

The WHO Safe Surgical Checklist[4] (modified for obstetrics) ensures safety at three stages: before anesthesia, before skin incision, and before leaving the operating room. Staff at the Manyata-certified facilities sign off on each case, and completed checklists are stored in patient records.



Antimicrobial Prophylaxis

A broad-spectrum IV antibiotic is administered 15–60 minutes before skin incision that significantly reduces surgical site infections.

Active Management of Third Stage of Labor (AMTSL)

Under the standard it is essential to practice AMTSL routinely in all C-section deliveries.

Early Breastfeeding

Breastfeeding is initiated within one hour of delivery, even after C-sections.

Early Ambulation

Mothers with low-risk C-sections should be mobilized early—within 12–24 hours post-surgery for faster recovery and reduced thromboembolism risk.

4 WHO Guidelines for Safe Surgery 2009

Classification and Audit using Robson Ten Group Classification System (TGCS)[5]:

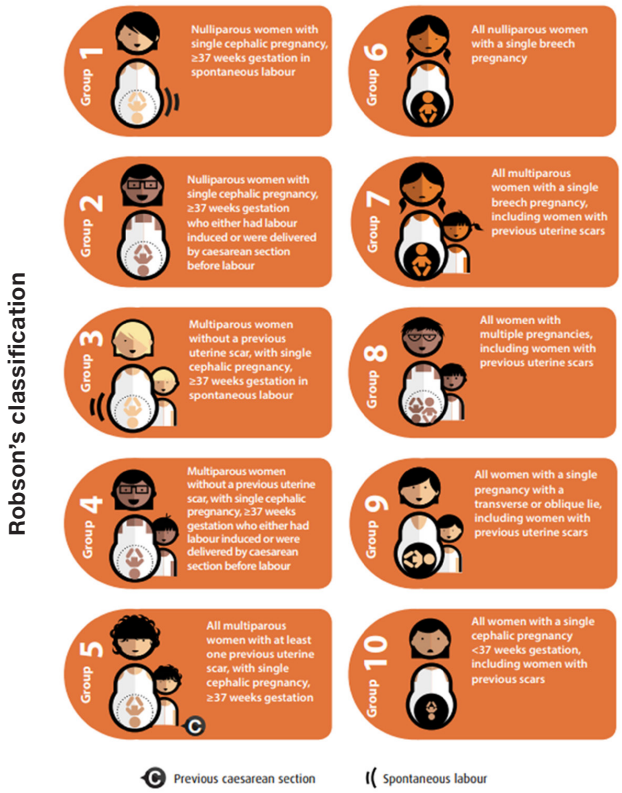
This standard is based on the WHO proposal that the Robson classification system is a global standard for assessing, monitoring, and comparing cesarean section rates within healthcare facilities.[6] The standard recommends that all C-sections must be classified using Modified Robson's Classification (TGCS) and ensure the rates of different categories are monitored in the facility. This standard has been adapted from the global WHO manual.[7]

ROBSON'S CLASSIFICATION SYSTEM – A DEEPER LOOK

The Robson Ten Group Classification System (TGCS) is the gold standard for analysing and comparing C-section rates across facilities. It categorizes all deliveries into 10 groups based on five obstetric characteristics:

1. Parity (nulliparous or multiparous)
2. Previous C-section
3. Onset of labor (spontaneous, induced, or pre-labor C-section)
4. Fetal presentation (cephalic, breech, transverse)
5. Number of fetuses (single or multiple) and gestational age

THE 10 ROBSON GROUPS



5 Robson M, Murphy M, Byrne F. Quality assurance: The 10- Group Classification System (Robson classification), induction of labor, and cesarean delivery. International Journal of Gynecology and Obstetrics.2015;131:S23–S27.

6 WHO Statement on Cesarean Section Rates, Geneva: World Health Organization; 2015

7 Robson Classification: Implementation Manual. Geneva: World Health Organization; 2017.

Why does Robson's Criteria Matter?

Universality: Applies to all deliveries, ensuring no case is excluded.

Comparability: Allows comparison of C-section rates across facilities, states, or countries.

Problem Identification: Facilities can identify which groups drive high C-section rates.

Action-Oriented: Facilities can set group-specific strategies

By mandating classification of all C-sections under Robson's system, the Manyata standard ensures facilities move beyond anecdotal reviews to structured, data-driven quality improvement.

REGULAR REVIEW AND AUDIT OF CLINICAL PRACTICES

Under this standard, providers conduct regular reviews of all C-sections performed that help identify common indications, adherence to guidelines, and trends in complications. Clinical audits help set improvement strategies. The standard aligns with the audits mandated under the national "LaQshya"- **LABOR ROOM QUALITY IMPROVEMENT INITIATIVE**, to ensure that cesarean sections are undertaken judiciously in only those cases requiring such surgical interventions. Regular meetings or morbidity and mortality reviews foster a culture of reflection and improvement.

CONCLUSION

The Manyata Quality Standard on C-section care represents a holistic approach to improving surgical obstetric care in India. It places equal emphasis on clinical justification, patient rights, safety protocols, and accountability through audits. By ensuring that C-sections are performed only when medically necessary, with appropriate counseling, informed consent, infection prevention, early recovery, and newborn care, the standard directly contributes to reducing maternal and neonatal morbidity and mortality. The integration of Robson's Classification System provides a robust, globally accepted framework for auditing and understanding C-section trends. Facilities can use it to identify the right indication for C-sections, improve labor management and ultimately, optimize outcomes for mothers and babies.

By adopting this standard, Manyata accredited facilities align themselves with global best practices, national guidelines, and the principles of respectful maternity care. Beyond being a technical checklist, it signifies a commitment to restoring trust in maternity services, ensuring accountability, and strengthening the continuum of maternal and newborn health care in India.

Safe, justified C-sections with counseling, consent, and care — guided by global standards, building trust and better outcomes for every mother and baby.

MANAGEMENT OF POSTPARTUM HEMORRHAGE

Dr. Priti Kumar, Dr. Meera Lakhtakia

Standard: Enables early identification and management of Postpartum Hemorrhage (PPH)

INTRODUCTION – CARE AREA OVERVIEW

This standard addresses the critical area of PPH prevention, detection, and response, which is vital for reducing maternal morbidity and mortality. It emphasizes facility preparedness, including availability of uterotonics, IV access, blood products, and emergency tools like UBT and NASG. Regular postpartum monitoring of bleeding, uterine tone, and vital signs ensures early detection. Management is guided by clinical signs, quantification of blood loss, and identification of shock, following the 4 Ts framework (Tone, Trauma, Tissue, Thrombin). The care process incorporates the E-MOTIVE bundle, which standardizes interventions such as uterine massage, oxytocin administration, tranexamic acid, IV fluids, and physical examination. Rapid escalation to advanced procedures or referrals is undertaken when initial measures fail. The standard ensures that all actions are timely, coordinated, and respectful supporting both clinical safety and woman-centered care in the immediate postpartum period.

BACKGROUND – RATIONALE AND OBJECTIVE

Despite advancements in care, Postpartum Hemorrhage (PPH) remains a major obstetric complication and a leading cause of maternal mortality and morbidity worldwide, affecting 2–11% of all deliveries. This highlights the need for early recognition and timely, effective management, particularly in the immediate postpartum period. Integrating the PPH care bundle is key to advancing maternal health and achieving global targets for reducing maternal mortality.

The standard is based on recent global evidence from the E-MOTIVE trial, emphasizing the value of a bundled approach to PPH care. The multi-country E-MOTIVE trial demonstrated that using a care bundle—including calibrated blood-collection drapes for early detection, uterine massage, oxytocin, tranexamic acid, IV fluids, and systematic examination reduced the risk of severe PPH, need for laparotomy, or PPH-related death by 60%.[1] The trial also showed a significant increase in early detection and protocol adherence, reinforcing the power of structured, team-based response.

Recognizing this, the Manyata standard is based on the updated recommendation on the assessment of PPH and on the use of a treatment bundle for the management of PPH by WHO in its 2023 updated guidelines[2] as the standard of care. These recommendations are further supported by the national guidelines[3],[4] Asia Oceania Federation of Obstetrics and

Integrating PPH bundles is essential to achieving maternal mortality reduction targets worldwide.

1 Ioannis Gallos et al, Randomized Trial of Early Detection and Treatment of Postpartum Hemorrhage, N Engl J Med 2023;389:11-21, 2023.

2 WHO recommendations on the assessment of postpartum blood loss and treatment bundles for postpartum hemorrhage. Geneva: World Health Organization; 2023.

3 Consensus Statement for Prevention of PPH, FOGSI, 2014

4 LaQshya Labour room quality improvement initiative, National Health Mission, MoHFW, GoI, 2017.

Gynecology recommendations (AOFOG)[5], and International Federation of Gynecology and Obstetrics (FIGO)[6] guidelines to improve outcomes.

CLINICAL COMPONENTS

The standard ensures a clear understanding of the definition & causes of PPH.

Postpartum Hemorrhage is blood loss over 500 mL after vaginal birth or 1000 mL after cesarean, with ACOG recognizing ≥1 liter loss or any loss with hypovolemia signs within 24 hours as PPH. It is classified as primary (within 24 hours) or secondary (24 hours to 6 weeks postpartum).

The causes of postpartum hemorrhage are usually attributed to the four "T's": 'Tone' with uterine atony accounting for 70% to 80% of all hemorrhage, 'Trauma' due to genital tract injuries, 'Tissue' related to retained placenta and 'Thrombin' as a failure of the coagulation system.

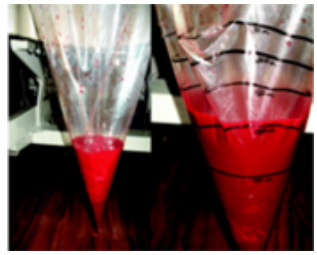
CLINICAL ASSESSMENT

The Manyata standard builds the competencies of the provider to diagnose PPH based on the patient's physical examination and clinical judgment. A quick assessment of the patient's condition and risk factors is a part of the initial evaluation.

Clinical findings	Probable diagnosis
Relaxed flabby uterus	Atonic PPH
Contracted uterus with bleeding	Traumatic PPH
Incomplete placental removal	Partial/total retained placental tissue
Non palpable uterine fundus	Uterine inversion
Contracted uterus in absence of trauma/retained tissue, failure of medical treatment	DIC

Measurement of blood loss:

Routine objective measurement of postpartum blood loss is recommended to improve the detection and prompt treatment of postpartum hemorrhage. Methods to objectively quantify blood loss, such as calibrated drapes for women having vaginal birth, can achieve this.



Management of PPH

The overarching challenges in PPH management have been:

1. PPH is often undetected or detected late and timely lifesaving treatment is not initiated.
2. Delayed or inconsistent use of interventions for the management of PPH.

5 AOFOG Recommendation on Postpartum Hemorrhage Care Bundle., Approach to improve Adherence to the WHO Guidelines, 2024

6 International Federation of Gynecology and Obstetrics, International Confederation of Midwives. Joint statement of recommendation for the use of uterotonics for the prevention of postpartum hemorrhage. 2021.

Immediate steps:

1. Team approach is emphasized. Call for help. Alert obstetrician, anesthesia team, and blood bank. Immediate steps enumerated in the standard aim is to manage airway, breathing & circulation.
2. Starting oxygen and continuous vitals monitoring.
3. Resuscitate immediately. Starting IV line with two wide bore cannulas 14G. IV fluids Ringer Lactate & Normal Saline are given up to 2L replacing the blood loss.
4. Initiation of blood transfusion therapy should be based on the estimated blood deficit and ongoing blood loss. In PPH, acute changes in hemoglobin or hematocrit do not accurately reflect the blood loss. Massive transfusion protocol to be initiated if required. Optimal blood replacement: Multicomponent therapy PRBC, FFP, and PLT are given in a 1:1:1 ratio.
5. Investigations: Complete blood count, bleeding & coagulation profile, renal profile, liver function test & electrolytes.
6. Catheterization.
7. If referral is planned, the non-pneumatic anti-shock garment (NASG) helps to keep her blood pressure and circulatory system stable.

Clinical signs-assessment of blood loss

	Stage 1	Stage 2	Stage 3	Stage 4
Blood loss (%)	<15	15-30	30-40	>40
Blood loss (cm3)	<750	750-1500	1500-2000	>2000
Pulse rate	<100	>100	>120	>140
Respiratory rate	14-20	20-30	30-40	>35
Blood pressure	Normal	Decreased	Decreased	Decreased
Mental state	Normal/ slightly anxious	Mild anxiety	Confusion and lethargy	Confusion

Figure 2: Clinical signs - assessment of blood loss

Medical management:

PPH is often treated in a sequential manner. Waiting to see if an intervention has had an effect before another intervention is administered delays the use of lifesaving interventions and can result in loss of life. In 2023, the World Health Organization (WHO) convened a Guideline Development Group to update an existing recommendation on assessing PPH and consider using a care bundle approach to treat PPH. The Manyata standard has adopted this guideline and recommends the bundle approach to PPH management.

Early diagnosis and first response bundle: "E-MOTIVE"

The standard recommends the E-MOTIVE intervention that consists of a calibrated drape for early detection of PPH and the WHO first response PPH treatment bundle, which includes uterine massage, oxytocic drugs, tranexamic acid, intravenous fluids, and a process for examination and escalation. Among patients having a vaginal birth, as per the study, use of the E-MOTIVE bundle leads to a lower risk of severe postpartum hemorrhage, laparotomy for bleeding, or maternal death from bleeding compared to usual care.

E	M	O	T	IV	E
Early detection	**Massage of uterus**	**Oxytocic drugs**	**Tranexamic acid**	**IV fluids**	**Examination and escalation**
Calibrated drape for collection of blood with trigger lines at 300 ml and 500 ml for the first hour after birth	Massage until uterus has contracted or for 1 minute	10 IU IV oxytocin injected diluted over 10 minutes plus a maintenance of 20 IU IV oxytocin in 1000 ml. Normal saline given over 4 hours (or Misoprostol 800 mcg)	1 Gm IV Tranexamic acid diluted and administered over 10 minutes	IV fluids through a second IV access if clinically indicated for resuscitation	Ensure bladder is empty, evacuate clots, check for tears and completion of placenta. Escalate if bleeding does not stop after first response

Figure 3: Interventions under E-MOTIVE

After identifying the cause of bleeding necessary intervention to be done. If the uterus is flabby start with uterine massage and proceed with bundle approach management. Simultaneous fluid replacement and blood transfusion should be done to compensate for hypovolemic status.

PPH care bundles	Components
First response PPH bundle	• Uterotonic drugs • Isotonic crystalloids • Tranexamic acid • Uterine massage • IV fluid resuscitation is performed together with intravenous (IV) administration of uterotonics. • If PPH is in the context of placental retention, the placenta should be extracted, and a single dose of antibiotics should be administered. If lacerations are encountered, they should be repaired
Response to refractory PPH bundle	• Compressive measures (aortic compression or bimanual uterine compression) • Intrauterine balloon tamponade • Non-pneumatic antishock garment • A continuing dose of uterotonics (e.g., oxytocin diluted in isotonic crystalloids), and a second dose of tranexamic acid should be administered during the application of this bundle

Figure 4: First response bundle and Response to refractory PPH bundle

Compressive measures:

In cases of refractory postpartum bleeding–where bleeding continues despite all interventions within the first response PPH bundle–prompt escalation to a higher-level healthcare facility providing further management is critical. Compressive measures aid in temporarily stabilizing and permit

time for resuscitation until higher care is reached. The standard recommends use of compression measures as follows:

- **Bimanual compression -** For bimanual compression, a gloved hand is inserted into the vagina, then formed into a fist at the anterior fornix to compress the anterior uterine wall and the other(abdominal) hand applies pressure on the fundus of the uterus (ensure the bladder is emptied by catheterization).
- **External aortic compression** is an emergency maneuver to control bleeding especially useful when transferring the patient to a higher care center where definitive measures can be taken. The concept is to maintain blood flow in the superior portion of the body, while reducing blood flow in the inferior portion, thus keeping the vital organs perfused. This is performed by pressing a closed fist down, just above and to the left of the umbilicus, with the intent to compress the aorta externally.
- **Intrauterine Balloon tamponade -** The intrauterine Balloon tamponade decreases uterine bleeding by compressing the placental sinuses, which are the source of bleeding in atonic PPH. The tamponade is created by inflating the balloon with up to 500 mL of saline and then left in place between 2 to 24 hours. Numerous devices are used such as the Bakri balloon or the Elavi free-flow uterine balloon tamponade system.

- **Non-pneumatic antishock garment (NASG) -** The NASG is a low-technology first-aid device designed for stabilizing cases with PPH until they receive definitive care. These are especially used for transferring PPH patients to higher care centers. Circumferential counter-pressure is applied to the lower body, reducing blood loss and increasing blood flow to vital organs.

Trigger for Transfer – escalation for surgical management

Provider understands and initiates timely actions for surgical management. Vascular ligation and uterine compression sutures must come before hysterectomy in the surgical treatment of PPH. Bilateral uterine artery blockage is the primary technique used in vascular ligation, while gradual devascularization approaches may improve the surgical strategy. The combination of vascular ligation and uterine compression sutures improves the efficacy of surgical PPH treatment.

Compression Sutures:

Used for uterine atony unresponsive to medical treatment, compression sutures mechanically compress the uterine walls to stop bleeding and promote thrombus formation, enhancing oxytocic effects.

Stepwise Uterine Devascularization:

Involves sequential ligation of pelvic vessels to reduce uterine blood flow.

Uterine Artery Embolization:

The arteries are catheterized and embolized with 150–300 micron-sized polyvinyl alcohol particles. The blood flow will be stopped, producing a result akin to a vascular ligation. In ten days, the polyvinyl alcohol particles are reabsorbed, and the vessels may be patent once again.

Obstetric Hysterectomy:

The last-resort surgery for severe, uncontrolled PPH when all medical and surgical measures fail.

Secondary PPH

Secondary PPH refers to bleeding that occurs between **24 hours and 6 weeks postpartum**. It is often caused by **retained placental tissue** or **infections** such as **endometritis**, **endomyometritis,** or **parametritis.**

The provider is made aware that bleeding can be abrupt and profound, leading to a rapid collapse of the cardiovascular system. Septic shock may also be present due to infection. The investigations in these cases are similar to those of atonic PPH, however, some additional investigations of septic foci to isolate organisms for culture and antibiotic sensitivity are mandatory. These cases may have early features of DIC, so a blood coagulation profile should be performed earlier.

The mainstay of management consists of:

- Resuscitation and fluid therapy.
- Broad spectrum intravenous antibiotic therapy (to cover gram positive, gram negative, and anaerobes). It can be changed according to the culture report and antibiotic sensitivity pattern.
- Evacuation of the uterus/surgical management for any septic foci.
- Individualized surgical procedures may be adopted. Depending on the case, uterotonics and tranexamic acid may be needed.
- Blood and blood products may be given depending on the hemoglobin and coagulation profile.

CONCLUSION

Hemorrhage impacts quickly and is often missed as it progresses from the compensated to the decompensated stage. Severe PPH-related deaths appear to mostly happen in the first 24 hours following birth.

Thus, the Manyata standard focuses on reducing the risk of severe PPH by enhancing its clinical management that includes prediction, early detection, and timely intervention through the Bundle Approach.

Early recognition and rapid response can reduce PPH deaths.

MANAGEMENT HYPERTENSIVE DISORDERS IN PREGNANCY

Dr. Mitra Saxena, Dr. Nivedita Dutta, Dr. Poonam Goyal

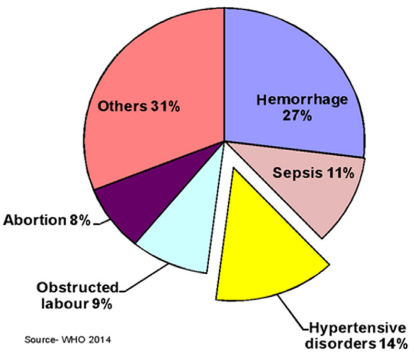
INTRODUCTION – CLINICAL CARE AREA

Hypertensive disorders of pregnancy (HDP) are the one of the most common causes of maternal and perinatal morbidity and mortality with significant adverse effects on maternal and newborn child health. The spectrum includes chronic hypertension, gestational hypertension, preeclampsia, and eclampsia.[1] Beyond pregnancy, HDP increases a woman's lifetime risk of cardiovascular disease and reduces life expectancy. They often present insidiously yet result in severe complications if undetected. With shifting demographics and lifestyles, more women are entering pregnancy with risk factors such as obesity, diabetes, and delayed childbearing, increasing their vulnerability to HDP. Addressing HDP is therefore a critical focus area under the Manyata initiative in reducing both maternal and perinatal risks and preventing long term non-communicable diseases (NCDs).

BACKGROUND – RATIONALE AND OBJECTIVE

HDP is one of the leading causes of maternal mortality, responsible for approximately 16% of maternal deaths globally[2] with similar numbers of maternal deaths seen in India (14%). It has been estimated that preeclampsia complicates 2–8% of pregnancies globally[3]. Preeclampsia with severe features can result in acute and long-term complications for the woman and her newborn. Maternal complications include pulmonary edema, myocardial infarction, stroke, acute respiratory distress syndrome, coagulopathy, renal failure, and retinal injury.

There are increased future health risks, including hypertension, cardiovascular and cerebrovascular morbidity and mortality, subsequent renal disease, thromboembolism, hypothyroidism, and type 2 diabetes mellitus[4]. Preeclampsia is associated with fetal complications of intrauterine growth restriction (IUGR), preterm birth, low birth weight (LBW), and perinatal death. It has been widely acknowledged after the pioneering work of Barker et al, that babies born to mothers with preeclampsia whether growth restricted or not, are at an increased risk of consequences of vascular dysfunction including hypertension and metabolic syndrome in later life.[5]



The Manyata standard on hypertensive disorders aims to improve timely identification, standardize diagnosis, strengthen evidence-based management, promote preventive strategies, and strengthen referral pathways and postpartum follow-up for HDP.

1 World Health Organization. WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia. Geneva: WHO; 2011.

2 Global and regional causes of maternal deaths 2009–20: a WHO systematic analysis Cresswell, Jenny A et al. The Lancet Global Health, Volume 13, Issue 4, e626 - e634

3 Steegers EA et al, Pre-eclampsia. Lancet 2010;376:631–44.

4 Magee LA, Pels A, Helewa M, et al. Diagnosis, evaluation, and management of the hypertensive disorders of pregnancy. Pregnancy Hypertens 2014 April;4(2):105e45.

5 Barker, D. J. The fetal and infant origins of adult disease. BMJ301, 1111 (1990).

CLINICAL COMPONENTS

The Manyata standard builds on global and national recommendations to ensure comprehensive HDP care, structured around the following components:

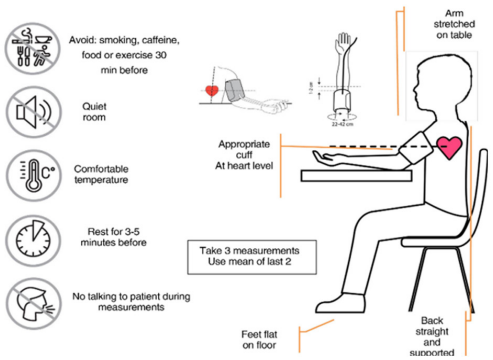
Identification and Screening:

The standard ensures:

*Correct blood pressure measurement technique (appropriate position, cuff size, repeated readings, measured using appropriate technique for the machine in use)

*Universal BP measurement at every ANC visit and during labor

*Proteinuria testing: dipstick, *protein/creatinine ratio, or *24-hour urine collection (Significant proteinuria is strongly suspected when urinary dipstick proteinuria is >or = 2+)



*Gestosis score for risk factor-based screening in the first trimester[6]

Preeclampsia is associated with adverse outcomes both for the mother and the newborn

Diagnosis and Classification

Chronic Hypertension	Hypertension presenting before 20 weeks of gestation in the absence of proteinuria
Gestational Hypertension	Hypertension presenting after 20 weeks of gestation in the absence of proteinuria
Preeclampsia (PE) Severe Preeclampsia (Severe PE)	Presents with any of the following two scenarios – 1. BP>=160/110 with proteinuria 3+ or 4+ 2. PE with presence of any of the danger signs/ symptoms: headache, blurring of vision, epigastric pain or oliguria, and abnormal oedema over face, hands, abdomen, and vulva
Eclampsia	Presence of convulsions/ seizures with BP>=140/190 and proteinuria more than trace

Intrapartum Management of severe preeclampsia/eclampsia

The standard outlines the key steps for management. Two main goals of management of women with severe preeclampsia/ eclampsia during labor and delivery are

1) Prevention of seizures
2) Control of hypertension

6 FOGSI-GESTOSIS-ICOG Hypertensive Disorders in Pregnancy (HDP) Good Clinical Practice Recommendations 2019

Severe preeclampsia/ eclampsia is managed by immediate hospitalization, initiation of $MgSO_4$ and anti-hypertensives, and supportive care. The clinical course of preeclampsia with severe features or in cases of eclampsia, is characterized by progressive deterioration of maternal and fetal condition. Delivery is recommended as per clinician's discretion, when preeclampsia with severe features is diagnosed at or beyond 34 0/ 7 weeks of gestation, after maternal stabilization.

Conditions Precluding Expectant Management

Maternal

1. Uncontrolled severe range blood pressures (persistent SBP 160 mm HG or more or DBP 110 mmHg or more not responsive to anti-hypertensive medication)
2. Persistent headache, refractory to treatment
3. Epigastric pain or right upper pain unresponsive to repeat analgesics
4. Visual disturbances, motor deficit, or altered sensorium
5. Stroke
6. Myocardial infarction
7. HELLP syndrome
8. New or worsening renal dysfunction (serum creatinine greater than 1.1 mg/dL or twice baseline)
9. Pulmonary Edema
10. Eclampsia
11. Suspected acute placental abruption or vaginal bleeding in the absence of placenta previa

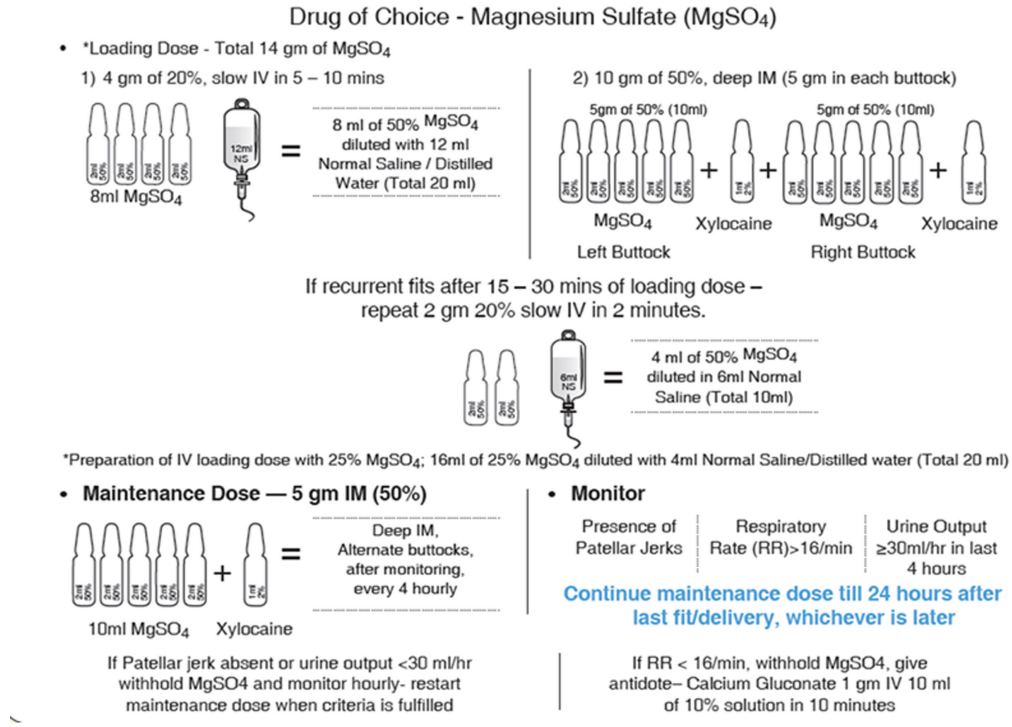
Fetal

1. Abnormal fetal testing
2. Fetal death
3. Fetus without expectation for survival at the time of maternal diagnosis (e.g., lethal anomaly, extreme prematurity)
4. Persistent reversed end diastolic flow in the umbilical artery

Ideal Investigations and Monitoring: Close monitoring of BP and urine output is conducted. In addition to basic testing such as CBC with peripheral smear, some additional evaluations need to be performed: platelet count, LFT, KFT, and fundus exam.

Nursing Care: Immediate basic supportive measures such as calling for help, prevention of maternal injury, placement in lateral decubitus position, prevention of aspiration, administration of oxygen, and monitoring vital signs including oxygen saturation, IV fluids, strict I/O charting. Continuous monitoring of maternal vitals and fetal well-being.

Seizure Prophylaxis: The Manyata standard guides the provider with the protocol for appropriate administration of Magnesium Sulfate along with proper monitoring of reflexes, respiratory rate, and urine output to prevent toxicity.

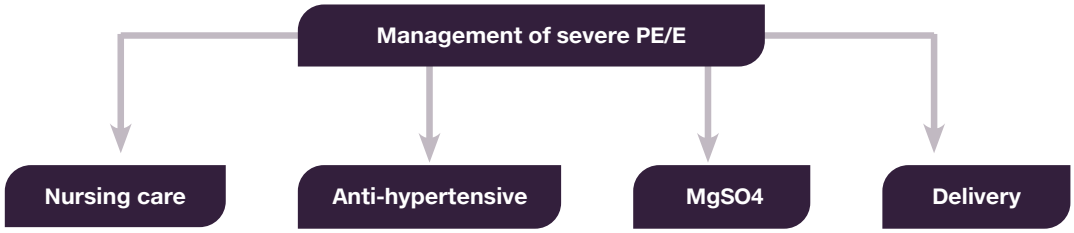


Anti-hypertensive Therapy: The standard gives clear recommendations for the use of anti-hypertensives. Anti-hypertensive treatment should be initiated expeditiously for acute-onset severe hypertension (SBP of 160 mm Hg or more or DBP of 110 mm Hg or more, or both) The provider at the Manyata-certified facilities is competent and confident to use the correct doses of anti-hypertensives such as Labetalol, Hydralazine, or Nifedipine for acute hypertensive crisis with BP ≥160/110 mmHg. The management is directed to achieve a target SBP between 130–150, and DBP 80–100 mmHg.

Anti-hypertensive Drugs:

Drug	Dose	Comments	Onset of Action
Labetalol	10-20 mg IV, then 20 - 80 mg every 10-30 minutes to a maximum cumulative dosage of 300 mg; or constant infusion 1-2 mg/ min IV	Tachycardia is less common with fewer adverse effects. Avoid in women with asthma, preexisting myocardial disease, decompensated cardiac function, heart block and bradycardia	1-2 minutes
Hydralazine	5mg IV/IM, then 5 - 10 mg IV every 20-40 mins to a maximum cumulative dosage of 20 mg or constant infusion of 0.5-10mg/hr	Higher or frequent dosages associated with maternal hypotension, headache and abnormal fetal heart rate tracing may be more common than other agents	10-20 minutes
Nifedipine (immediate release)	10-20 mg orally, repeat in 20 mins if needed, then 10-20 mg every 2-6 hrs, maximum daily dosage is 180 mg	May observe reflex tachycardia and heartache	5-10 minutes

Management of Severe Preeclampsia/Eclampsia:



Decision to Deliver:

- ≥34 weeks with severe features; stabilize and deliver
- <34 weeks with stable condition; expectant management with close monitoring
- Vaginal delivery preferred unless contraindicated

Termination of pregnancy: Deliver the baby irrespective of gestational age after stabilization and reviewing investigations. Convulsion-delivery interval should not be more than 12 hours. Opt for vaginal delivery if the patient goes into active labor within this time.

Future scope to include Prediction of Hypertensive Disorders of Pregnancy (HDP)

Early Prediction is Preventive: Early prediction is not merely diagnostic—it is preventive, offering an opportunity to alter the trajectory of pregnancy outcomes. Transitioning routine antenatal care to include first-trimester screening and preventive measures has the potential to address defective placentation, reduce prevalence, and transform outcomes.[7] Identifying high-risk women in the first trimester allows targeted surveillance and aspirin prophylaxis, reducing severe preeclampsia, preterm births, fetal growth restriction, and ICU admissions.

History-based screening: The Gestosis score, a history-based tool for maternal risk factors integrated with mean arterial pressure (MAP) is particularly valuable in resource-limited settings, Score ≥3 identifies women at risk.

Biophysical Markers:

Mean Arterial Pressure (MAP): Women likely to develop preeclampsia often exhibit elevated systolic BP and MAP prior to clinical onset.[8] When combined with maternal factors, MAP achieves ~74% detection for early PE and ~49% for late PE at a 10% false-positive rate.[9]

Uterine Artery Doppler (11–13 weeks): High pulsatility index and notching suggest defective placentation and increased risk. Persistent early diastolic notching and PI >95th percentile are strong predictors.[10]

Biochemical Markers such as PAPP-A (low levels) PlGF (low levels), sFlt-1 (elevated) and sFlt-1/PlGF ratio (high) are highly predictive of preeclampsia and adverse outcomes.[11]

7 FIGO Working Group on Good Clinical Practice in Maternal-Fetal Medicine. Int J Gynaecol Obstet. 2019;144(1):1–23.

8 Poon LC, et al. First-trimester maternal mean arterial pressure and prediction of preeclampsia. Ultrasound Obstet Gynecol. 2009;34(5):497–502.

9 Wright D, et al. Maternal factors with mean arterial pressure in screening for preeclampsia. Am J Obstet Gynecol. 2015;213(1):62.e1–62.e10.

10 Papageorghiou AT, et al. Uterine artery PI and prediction of preeclampsia. BJOG. 2011;118(9):1030–8.

11 Levine RJ, et al. Circulating angiogenic factors in preeclampsia. N Engl J Med. 2004;350(7):672–83

CONCLUSION

Hypertensive disorders of pregnancy remain a preventable but leading cause of maternal and perinatal morbidity and mortality.

The Manyata standard provides a comprehensive framework—spanning prevention, early detection, accurate diagnosis, timely management, and postpartum follow-up.

By aligning with WHO, FIGO, FOGSI, and ACOG guidance, and adapting to India's health system priorities, this standard ensures that women receive high-quality, respectful, and evidence-based care. Integration of hypertensive disorders in pregnancy into the Manyata initiative strengthens the continuum of maternal health services across public and private facilities, thereby safeguarding maternal and newborn lives.

Prevention, prediction, early detection, standardized diagnosis, evidence-based management, referral, and postpartum follow-ups improve outcomes for mothers and newborns.

ESSENTIAL NEWBORN CARE

Dr. Alka Pandey, Dr. Kiran Pandey

Standard: Provider conducts a rapid initial assessment and performs immediate newborn care (if the baby cries immediately)

INTRODUCTION – CLINICAL CARE AREA

Essential newborn care (ENBC) encompasses a set of evidence-based practices designed to ensure the survival, health, and well-being of newborns during the critical first day of life. These practices address immediate needs at birth, protect against environmental and biological risks, and promote early initiation of breastfeeding and bonding. The Manyata standard outlines the key components of essential newborn care, including immediate care at birth, thermal care, breastfeeding support, cord care and infection prevention, Vitamin K administration, assessment for congenital anomalies, recognition of danger signs, and timely referral.

BACKGROUND – RATIONAL AND OBJECTIVE

ENBC is critical to reduce neonatal mortality, with 2.3 million newborn deaths globally in 2023, many being preventable through simple interventions. Practices like delayed cord clamping, early breastfeeding, and thermal care stabilize newborns, boost immunity, and lower risks of anemia and infections.[1]

The Manyata standard on ENBC bridges care gaps, reducing newborn mortality rates via evidence-based and cost-effective measures. It also promotes bonding and long-term health, aligning with global health goals.

Essential newborn care (ENBC) ensures survival, health, and well-being during the critical first 24 hours of life.

CLINICAL COMPONENTS

Immediate care at birth involves a series of coordinated actions to stabilize the infant and promote early bonding. These include delayed cord clamping, thorough drying, assessment of breathing, skin-to-skin contact, and early initiation of breastfeeding.

Delayed Cord Clamping: Delaying umbilical cord clamping for 1-3 minutes after birth allows additional blood transfer from the placenta to the newborn, increasing iron stores and reducing the risk of anemia in the newborn. The World Health Organization (WHO) recommends delayed cord clamping for all births unless immediate resuscitation is required. This practice can improve hemoglobin levels and reduce the incidence of intraventricular hemorrhage in preterm infants. The cord should be clamped and cut using sterile instruments to prevent infection, with care taken to ensure the stump remains clean.[2]

1 UNICEF Neonatal Mortality: United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME), 2025

2 WHO. Guideline: Delayed umbilical cord clamping for improved maternal and infant health and nutrition outcomes. Geneva: World Health Organization; 2014

Thorough Drying: Newborns are wet from amniotic fluid at birth, making them susceptible to hypothermia. The Manyata standard recommends thorough drying with a clean, dry, and preferably warm towel immediately after birth to remove moisture, protect from cold, and stimulate breathing. This step should take place within the first 30 seconds and is critical in maintaining body temperature. The drying process also helps clear the baby's skin of amniotic fluid and blood, reducing the risk of irritation or infection.

Assessment of Newborn: Assessment of the newborn's health is necessary to identify and address potential issues early. Key parameters to monitor include weight, breathing, temperature, feeding patterns, and jaundice levels. Soon after birth the standard recommends for the healthcare providers to conduct a thorough physical examination to check for congenital anomalies, signs of infection, or breathing difficulty.

Providers following the Manyata standard assess the newborn's breathing immediately after birth as this is essential to ensure adequate oxygenation. Most newborns begin spontaneous breathing within seconds of birth. Healthcare providers or birth attendants should observe the baby's chest movements, listen to the cry, and check for signs of respiratory distress, such as grunting or cyanosis. If breathing is absent or inadequate, immediate intervention, such as stimulation or resuscitation, is necessary. This assessment should be completed within the first minute of life to guide further actions.

Weight monitoring is particularly important, as excessive weight loss (more than 7-10% of birth weight) may indicate feeding difficulties or dehydration. Jaundice, a common condition in newborns, should be assessed by checking the skin and eyes for yellowing. Severe jaundice requires prompt treatment, such as phototherapy, to prevent complications like kernicterus.

For preterm or low-birth-weight infants, additional assessments, such as monitoring for apnea or feeding intolerance, are critical. Parents should be trained to observe their baby's behavior and report concerns, such as poor feeding or lethargy.

Skin-to-Skin Contact: Placing the newborn on the mother's abdomen and bare chest immediately after drying is an important component of the Manyata standard, as it promotes thermoregulation, bonding, and breastfeeding initiation. Skin-to-skin contact stabilizes the baby's heart rate, breathing, and temperature while fostering the emotional connection. It also helps reduce stress for both mother and baby, as the mother's warmth and heartbeat create a familiar, reassuring environment. This practice should continue uninterrupted for at least an hour or until the first breastfeeding session is complete.

Early Initiation of Breastfeeding: Breastfeeding within the first hour of life provides the newborn with colostrum, a nutrient and antibody-rich milk that boosts immunity and supports early nutrition. The standard encourages providers to assist mothers in positioning the baby correctly to ensure a proper latch, which prevents nipple pain and feeding difficulties. Mothers should be counseled about the benefits of exclusive breastfeeding for the first six months.[3]

Thermal Care: Newborns, particularly preterm or low birth weight infants, have limited ability to regulate their body temperature due to a high surface area-to-body mass ratio, thin skin, and minimal fat stores. Thermal care is essential to prevent hypothermia, which can lead to complications such as hypoglycemia, respiratory distress, and increased mortality risk.

3 WHO and UNICEF recommendations on Breastfeeding, 2022

Maintaining a warm environment begins in the delivery room, which should be kept at a minimum temperature of 25°C (77°F) and free from drafts. After thorough drying, the baby should be wrapped in a clean, dry blanket or cloth, with the head covered by a cap to reduce heat loss. Skin-to-skin contact with the mother is one of the most effective ways to maintain warmth, as it leverages the mother's body heat. For preterm or sick infants, additional measures such as incubators, radiant warmers, or heated mattresses may be necessary in clinical settings.

Bathing should be delayed for at least 24 hours after birth, as it can disrupt thermoregulation and remove the vernix caseosa, a protective skin coating. In resource-limited settings, the "warm chain" concept—ensuring a continuous warm environment from birth through transport and home care—is critical. Caregivers should monitor the baby's temperature regularly, aiming to maintain it between 36.5°C and 37.5°C (97.7°F–99.5°F). Signs of hypothermia, such as cold extremities or lethargy, require immediate warming and medical evaluation.[4]

Administration of Vitamin K: The standard recommends administration of Vitamin K to the newborn to protect against hemorrhagic disease of the newborn. The recommended dose is 1 mg for babies weighing over 1000 g, and 0.5 mg for those under 1000 gms.[5,6]

Nurturing Care: Nurturing care refers to the provision of a supportive, responsive, and stimulating environment that promotes the newborn's physical, emotional, and cognitive development. It encompasses emotional bonding, responsive feeding, and early stimulation, which lay the foundation for long-term well-being.

Skin-to-skin contact is a cornerstone of nurturing care, fostering emotional security, and attachment.

Parents should be educated about developmental milestones and encouraged to create a safe, calm environment. For preterm or sick infants, kangaroo mother care (prolonged skin-to-skin contact combined with exclusive breastfeeding) has been shown to improve growth, reduce infections, and enhance bonding.

Infection Prevention: Newborns are highly susceptible to infections due to their immature immune systems. Infection prevention is a critical component of essential newborn care, particularly in the first month of life when sepsis, pneumonia, and meningitis pose significant risks.

Handwashing with soap and water before handling the newborn is the single most effective way to prevent infections. Caregivers should also maintain clean surfaces, bedding, and clothing. The umbilical cord stump should be kept clean and dry, with no substances applied unless recommended. In many regions, WHO advises against traditional practices like applying ash or herbs to the cord, as these can introduce pathogens.

Sterile equipment must be used for all procedures, including cord cutting and injections. In healthcare facilities, adherence to infection control protocols, such as sterilizing equipment and maintaining clean delivery rooms, is essential. Limiting visitors and avoiding contact with sick individuals further reduces infection risk. Vaccinations—such as Hepatitis B within the first 24 hours, and BCG in regions where tuberculosis is prevalent—offer crucial additional protection.

4 WHO Thermal Protection: Thermal Protection of the Newborn: a practical guide, Maternal and newborn health/Safe motherhood unit Division of reproductive health (technical support) World health organization, Geneva, 1997

5 Hand I, Noble L, Abrams SA; AAP Committee on Fetus and Newborn, Section on Breastfeeding, Committee on Nutrition. Policy statement: Vitamin K and the Newborn Infant. Pediatrics.2022;149(3):e2021056036

6 Operational guidelines injection Vitamin K Prophylaxis at Birth (in facilities) Child Health Division

Ministry of Health and Family Welfare, Government of India, 2014

Recognition and Response to Danger Signs: Early recognition of danger signs is vital for timely intervention and preventing newborn mortality. Common danger signs include difficulty in breathing (fast breathing, chest indrawing, or grunting), lethargy, poor feeding, fever (temperature >37.5°C), hypothermia (temperature <36.5°C), severe jaundice, hypoglycemia, convulsions, or persistent vomiting.

The Manyata standard helps to recognize these signs and provide immediate medical care if they occur. The providers use simple tools, such as checklists or visual guides, to teach families and the patient about danger signs. Providers assess newborns presenting with symptoms promptly and determine the need for antibiotics, oxygen, or other treatments.

TIMELY AND SAFE REFERRAL WHEN NEEDED

When danger signs or health problems are identified and cannot be managed at the facility, timely and safe referral to a higher level of care is critical. This is particularly important for pre-term infants, those with severe infections, or those requiring specialized interventions like surgery for congenital anomalies.

Referral systems are well-coordinated. The standard ensures that transport should be safe, with the baby kept warm and stable during transfer. Accompanying caregivers are informed about the baby's condition and the referral process to reduce anxiety and ensure compliance.

CONCLUSION

Essential newborn care is a comprehensive approach that addresses the immediate and ongoing needs of newborns to ensure their survival and healthy development. By implementing evidence-based practices—such as delayed cord clamping, thermal protection, breastfeeding support, and infection prevention, caregivers and healthcare providers can significantly reduce neonatal mortality and morbidity.

Essential newborn care saves lives, prevents complications, and builds a healthy start for every baby.

Nurturing care fosters emotional and cognitive growth, while timely recognition of danger signs and referral systems ensure that complications are addressed promptly. These practices, when consistently applied, create a strong foundation for a newborn's health and well-being, setting the stage for a healthy life.

NEWBORN RESUSCITATION

Dr. Asha Baxi, Dr. Kiranmai Devineni

Standard: The provider performs newborn resuscitation if the baby does not cry immediately after birth.

INTRODUCTION – CLINICAL CARE AREA

Newborn resuscitation is a critical intervention in maternal and newborn health, aimed at supporting infants who fail to establish effective breathing immediately after birth. Adhering to the Manyata standard on Newborn Resuscitation is very crucial to prevent birth asphyxia, a leading cause of neonatal mortality and long-term morbidity. This Manyata standard focuses on ensuring skilled, timely actions to revive asphyxiated newborns in private facilities in India. It is important to reduce preventable deaths, aligning with broader efforts to improve perinatal care and safeguard the health of mothers and infants during the vulnerable transition from intrauterine to extrauterine life.

BACKGROUND – RATIONALE AND OBJECTIVE

Birth asphyxia contributes significantly to global newborn mortality. It accounts for approximately 23% of neonatal deaths worldwide, with higher rates in low-and middle-income countries like India, where neonatal mortality stands at around 20 per 1,000 live births[1,2]. Effective resuscitation can reduce intrapartum-related neonatal deaths by up to 30%, preventing hypoxia-induced brain damage, cerebral palsy, and other morbidities[3]. Globally, evidence from the World Health Organization (WHO) indicates that about 10% of newborns require some form of assistance to initiate breathing, while less than 1% need advanced measures like chest compression or medications[4]. A systematic review in the International Consensus on Cardiopulmonary Resuscitation (CoSTR) underscores that timely interventions like positive-pressure ventilation can reduce asphyxia-related mortality by half[5].

Most babies just need help to breathe: Around 10% require assistance at birth, <1% need advanced measures.

The Manyata standard on newborn resuscitation is adapted from the global guidelines including the International Liaison Committee on Resuscitation (ILCOR), which recommend immediate resuscitation within the “golden minute” and the use of the ABC approach for newborns not breathing at birth. Nationally, in India this standard is aligned with the National Health Mission’s neonatal care protocols[6], ensuring compliance and reflecting updates from the Neonatal Resuscitation Program (NRP) adapted for Indian contexts. The Manyata standard also adapts from the FOGSI GCPR[7] and aims to prevent newborn mortality and morbidity by ensuring standardized, evidence based, and timely interventions to save newborns. Most interventions that are needed are simple and can easily be performed at the Manyata-certified facilities to save newborn lives.

1 Soni P, Nagalli MM. Enhancing neonatal resuscitation outcomes: bridging theory and practice. Eur J Pediatr. 2025 Mar 19;184(4):258.

2 Sample Registration System 2020 Report of Registrar General of India.

2 Anne CC Lee et al, Neonatal resuscitation and immediate newborn assessment and stimulation for the prevention of neonatal deaths: a systematic review, meta-analysis, and Delphi estimation of mortality effect., BMC Public Health 11 (Suppl 3), S12 (2011).

4 Neonatal Resuscitation: 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

5 2025 International Liaison Committee on Resuscitation Consensus on Science with Treatment Recommendations

6 NSSK Resource Manual MoHFW GOI page no: 32, 36, 39-40, 43

7 FOGSI-ICOG GCPR – Neonatal Resuscitation 2024.

CLINICAL COMPONENTS

The Newborn Resuscitation standard has structured protocols and is divided into assessment, initial steps, and advanced interventions. Providers must act within 1 minute (golden minute) if the baby does not cry, following a sequential algorithm.

Initial Assessment and Steps: The standard recommends immediate resuscitation within the first 30 seconds. This includes following steps as the baby is delivered on the mother's abdomen: immediately clamping and cutting the cord, shifting to a radiant warmer if baby is not breathing or crying, and performing steps under the radiant warmer (Positioning, Suctioning, Drying, Stimulation, Repositioning–PSDSR). Place under radiant warmer, position head with neck slightly extended, clear airway by suctioning mouth then nose, dry the baby, discard wet linen, stimulate by rubbing the back, and reposition the baby.

(Positioning of the baby with shoulder roll in place: To attain the correct posture, a shoulder roll is placed under the shoulder of the baby)

- **If Breathing Well:** If the baby is breathing well, observe with mother: place the baby prone between the mother's breasts, cover baby and mother together, initiate breastfeeding, monitor neonate (temperature, heart rate, breathing, and color) every 15 minutes in the first hour and then every 30 minutes in the next hour.

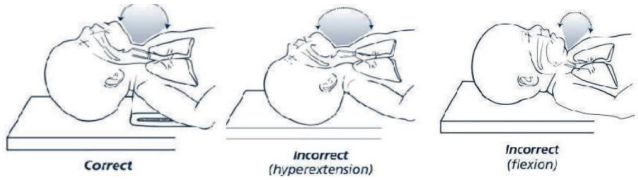


Figure 1: Correct and incorrect head positions for resuscitation

- **Provider Initiates Bag and Mask Ventilation (If Not breathing Well):** If the baby is not breathing **after the initial steps, an ambu bag with an appropriate mask is applied and 5 ventilatory breaths** is given. If there is an adequate chest rise, the ventilation is continued for further 30 seconds, and the baby is reassessed. During the initial stages of neonatal resuscitation, breaths should be delivered at a rate of **40 to 60 breaths per minute** (Figure 4).

Figure 2: Correct and incorrect mask sizes


Figure 3: Positioning the baby and mask

The mask usually is held on the face with the thumb and encircling the rim of the mask in shape of letter **C** while the middle, ring and little fingers bring the chin forward in shape of letter **E** to maintain a patent airway. Once the mask is positioned, using light downward pressure on the rim of the mask helps to achieve an airtight seal (Figure 3).

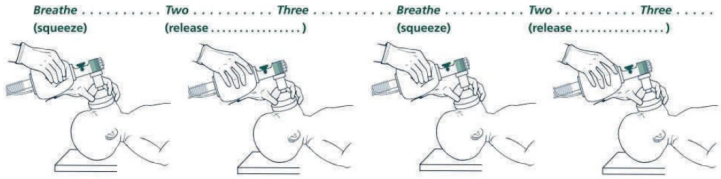


Figure 4:Counting out loud to maintain a rate of 40 to 60 breaths per minute

- **If still Not Breathing:** Breathing is assessed, if still not breathing, call for help, continue bag, and mask ventilation. Check heart rate/cord pulsation. If the heart rate is <100 / min and the baby is still not breathing, continue bag, mask ventilation, and connect oxygen. If the baby is not breathing and advance help is not available, then refer to a higher center, continuing bag, and mask ventilation with oxygen during transfer. If a specialist is available, proceed with intubation, chest compressions, and medications as needed.
- Quality measures for the standard include availability of equipment (e.g., ambu bag, oxygen), adherence to the "golden minute," and documentation using forms like resuscitation checklists. Algorithms emphasize the ABC approach (Airway, Breathing, Circulation), with tools like radiant warmers and pulse oximeters for monitoring .

CONCLUSION

Newborn resuscitation is a vital intervention that significantly reduces neonatal mortality and morbidity due to birth asphyxia, particularly in resource-constrained settings like private maternity facilities in India.

The "golden minute" matters – rapid assessment and immediate care are critical for survival.

By adhering to structured protocols, such as rapid initial assessment and immediate care within the "golden minute," healthcare providers at the Manyata-certified facilities can effectively support newborns. The systematic approach, encompassing initial steps, bag and mask ventilation, and advanced interventions, when necessary, ensure timely and skilled responses to prevent hypoxia-related complications. Effective resuscitation not only saves lives but also mitigates long-term morbidities, aligning with broader maternal and newborn health goals. Strengthening training, ensuring equipment availability, and fostering adherence to evidence-based algorithms are critical to sustaining progress in reducing preventable neonatal deaths and improving perinatal outcomes.

CARE OF SMALL AND VULNERABLE NEWBORNS

Dr. Geeta Balsarkar

Standard: Provider ensures care of small and vulnerable newborns at birth

INTRODUCTION – CLINICAL CARE AREA

Small and vulnerable newborns, typically defined as those with low birth weight (LBW, <2500 grams), preterm birth (<37 weeks gestation), or small for gestational age (SGA), require specialized care immediately after birth to mitigate risks of mortality and long-term morbidity. This care area encompasses interventions such as thermal regulation, assisted feeding, Kangaroo Mother Care (KMC), and early detection of respiratory distress or other danger signs. Its significance in maternal and newborn health lies in addressing the leading causes of neonatal deaths, which account for approximately 47% of under-five child mortality globally, with prematurity and low birth weight contributing to over 80% of these cases. The Manyata standard ensures that optimal care is given to the small and vulnerable newborns through various evidence-based interventions to improve survival and overall growth and development.

BACKGROUND – RATIONAL AND OBJECTIVE

Care for small and vulnerable newborns is essential due to their heightened susceptibility to complications like hypothermia, feeding difficulties, infections, and respiratory issues, which can lead to preventable deaths. Globally, an estimated 2.3 million newborns die annually, with the leading causes of death being premature birth, birth complications (birth asphyxia/trauma), and neonatal infections[1]. Preterm infants have a gestational age below 37 weeks at birth and low birth weight (LBW) infants have a birth weight below 2.5 kg. Approximately 45% of all children under the age of five who die are newborns, and 60–80% of those newborns who die are premature and/or small for gestational age. LBW infants face a 2- to 10-fold higher risk of mortality compared to those born at term with normal weight, and survivors often experience stunting, neurodevelopmental delays, and chronic health issues[2]. Evidence from the Lancet Small Vulnerable Newborns (SVN) series indicates that every fourth baby is born too soon or too small, and SVNs encompassing preterm, SGA and LBW affect over 35 million births yearly, contributing to 80% of neonatal deaths and significant morbidity.[3]

Nationally, in India, where neonatal mortality remains high at around 20 per 1,000 live births[4], and as per Cause of Death Statistics (2020-22), the major causes of newborn deaths in India, are prematurity and low birth weight, and have the highest share of 48 percent of total proportion of deaths.[5]

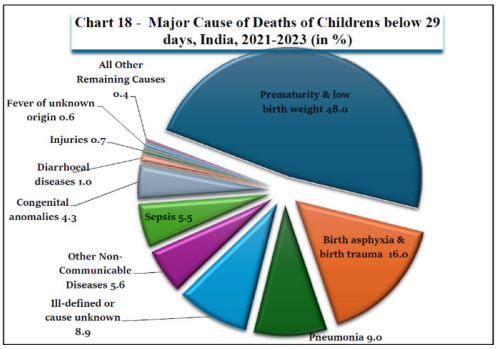


Figure 1: SRS Causes of Neonatal deaths statistics report, India

1 WHO Factsheet, Newborn mortality, 2024

2 WHO recommendations for care of the preterm or low birth weight infant. Geneva: World Health Organization; 2022

3 Lawn JE et al. small babies, big risks: global estimates of prevalence and mortality for vulnerable newborns to accelerate change and improve counting. Lancet 2023; published online May 8.

Simple interventions like Kangaroo Mother Care (KMC) can reduce mortality by up to 40%, while early feeding and thermal care can decrease morbidity such as necrotizing enterocolitis and hypothermia[6].

Every fourth baby is born too soon or too small and has a markedly increased risk of stillbirth, neonatal death, and later childhood mortality.

The Manyata standard on care for small and vulnerable newborns has been included to ensure effective management of these babies and not only improves survival rates but also supports maternal bonding, breastfeeding success, and family involvement–fostering a continuum of care from birth through early childhood. In resource-limited settings, where access to advanced facilities may be constrained, the practice of this standard is crucial for equity in neonatal health outcomes.

KEY CLINICAL COMPONENTS

Under this standard the essential clinical interventions for small and vulnerable newborns include assessments, procedures, and protocols tailored to their needs. The standard has adapted WHO's 2022 guidelines for preterm/LBW care outline protocols for assisted feeding, hypothermia prevention, and respiratory distress management, with clear referral pathways to specialized units.

Specialist Care for LBW Infants: The Standard emphasizes the need to refer newborns <2500g to pediatricians or facilities like Special Newborn Care Units (SNCUs). Gestational age is determined via first-trimester ultrasound or Last Menstrual Period (LMP) to classify as preterm or SGA. Protocols involve initial stabilization and referral pathways per WHO guidelines[7].

Feeding: The standard helps in supporting breastfeeding or expressed breast milk, identifying difficulties like poor latch and referring to lactation specialists. Tools include breastfeeding assessment forms; quality measures track exclusive breastfeeding rates. The standard builds the competencies and skills needed for assisted feeding, in cases where breast feeding is not initiated. The 2023 WHO recommendations advocate for family-centered care, including privacy for breast milk expression, and culturally sensitive IEC materials.

Figure 2: Breast Feeding

Figure 3: Expressed breast milk and spoon or Paladai Feeding

Hypothermia Prevention: The standard encourages rooming-in and skin-to-skin contact if the newborn is stable. The providers at the Manyata-certified facilities guide families on wrapping the baby, covering head and extremities, and for Kangaroo Mother Care (KMC). The standard has adapted the algorithms from the India Newborn Action Plan (INAP) that emphasize immediate drying and warm chain maintenance[8]. The Manyata standard is aligned with the World Health Organization (WHO) recommendation of immediate and continuous KMC for preterm and LBW infants, emphasizing at least 8-24 hours daily to reduce mortality and improve thermal regulation and breastfeeding outcomes.

4 Sample Registration System 2020 Report of Registrar General of India.

5 Sample Registration System, Causes of death Statistics, 2021-2023, Office of the Registrar General of India Ministry of Home Affairs Vital Statistics Division, Govt of India

6 World Health Organization. (2023). Kangaroo mother care: a transformative innovation in health care: global position paper. World Health Organization.

7 WHO recommendations for care of the preterm or low birth weight infant. Geneva: World Health Organization; 2022

8 India Newborn Action Plan (INAP) , MoHFW, GoI, 2014.

Kangaroo Mother Care (KMC) Infrastructure and Support: The Manyata facility provides dedicated spaces near SNCUs with reclining chairs for KMC, privacy for milk expression, and storage facilities. The standard ensures 24/7 trained staff, IEC materials in local languages, and family counseling. For mothers unable to provide KMC, family members are involved in kangaroo family care.

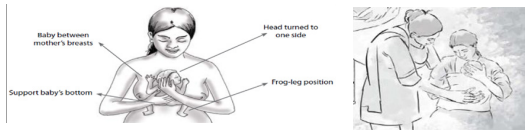


Figure 4: Kangaroo Mother Care

Respiratory Distress Management: Providers recognize signs like apnea or cyanosis, assess SpO2 and follow referral to SNCU as per the algorithms. The referral protocol enlisted under the standard aligns with India's Newborn Action Plan (INAP) mandating Facility-Based Newborn Care (FBNC) for LBW infants, with SNCUs equipped for advanced respiratory support like CPAP and trained staff for 24/7 KMC facilitation.

- **Routine Assessments and Counseling:** Evaluate newborns at every maternal visit for danger signs (e.g. lethargy, convulsions). Counsel families on support needs for feeding, thermoregulation, and breathing; refer for specialist counseling as needed.
- **Infection prevention:** Low birth weight and preterm babies are at high risk for infection and sepsis. Follow infection prevention practices and look for signs of sepsis.

Before Delivery	After Birth
▪ Appropriately manage maternal infections and use prophylaxis wherever needed ▪ Use of partograph ▪ Do not perform unnecessary Per Vaginal examination during labour ▪ Maintain "Six Cleans" during delivery	▪ Avoid unnecessary interventions for the baby such as routine suctioning at birth ▪ Perform hand hygiene every time before handling the baby. Avoid frequent handling ▪ Facilitate early and exclusive breastfeeding ▪ Ensure dry cord care ▪ Avoid KMC with infected person

CONCLUSION

The care of small and vulnerable newborns, including those with low birth weight, preterm birth, or small for gestational age, is a critical component of reducing neonatal mortality and improving long-term health outcomes.

By prioritizing evidence-based care and family-centered support, we can give our smallest and most vulnerable babies a chance to thrive.

By implementing evidence-based interventions such as Kangaroo Mother Care, assisted feeding, hypothermia prevention, and timely management of respiratory distress, healthcare providers can significantly mitigate the risks of complications and death. These practices, guided by global standards from the World Health Organization and national frameworks like India's Newborn Action Plan, emphasize the importance of specialized care, family involvement, and equitable access to resources, particularly in resource-limited settings.

Ensuring robust referral pathways, trained staff, and family-centered support systems is essential to address the high burden of neonatal mortality, which accounts for nearly half of under-five deaths globally. By prioritizing these interventions through the Manyata initiative, healthcare systems can enhance survival rates, promote maternal-infant bonding, and foster healthier developmental outcomes, contributing to sustainable improvements in maternal and newborn health equity.

CONTINUUM OF CARE: THE FOURTH TRIMESTER

POSTNATAL CARE: MATERNAL

Dr. Jaideep Malhotra, Dr. Jyoti Malik

Standard: The provider ensures adequate postpartum care package is offered to the mother and baby–at and after discharge.

INTRODUCTION AND CARE AREA OVERVIEW

The postpartum period, the first six weeks after birth and extending into the "fourth trimester" is a critical window for promoting recovery, establishing lactation, initiating contraception, addressing mental health, and supporting long-term health and preventing maternal morbidity. Recent guidance reframes postnatal care as a continuum of proactive, person-centered contacts rather than a single six-week visit. In India, the Manyata initiative that certifies quality standards in private facilities has adapted recommendations to close persistent gaps in postpartum quality of care. WHO's 2022 guideline defines a "positive postnatal experience" encompassing physical, mental, social, and relational well-being. Along with ensuring routine post-natal care, the Government of India has emphasized the need to systematically identify high-risk post-natal mothers and has laid out a clear guideline for postnatal care.[1] Together, the Manyata standard adapts these guidance documents to anchor a coherent standard of postpartum care that is contextual and actionable across settings[2].

BACKGROUND - RATIONALE AND OBJECTIVE

Globally, a substantial proportion of maternal deaths and severe morbidities occur after childbirth, often in the first days and weeks postpartum. As per WHO, close to 30% of maternal deaths happen in the postnatal period. Reframing the postnatal period as a "fourth trimester" emphasizes longitudinal care, anticipatory guidance, and early re-engagement with services. Manyata postnatal care standard for the mother ensures care across the continuum for the mother including postpartum period.

Care doesn't end at birth–the fourth trimester ensuring continuum of care for every mother, saves lives.

Manyata's core metrics emphasize childbirth safety and postnatal care as a continuum for every mother. Structured 48–72-hour follow-ups and standardized counseling and checklists at the time of discharge ensure that every healthcare provider is competent to identify and manage the postnatal complications for improved maternal outcomes.

1 NHM_GOI_Guidance Note on Optimizing Postnatal Care

2 WHO recommendations on maternal and newborn care for a positive postnatal experience, 2022

WHO-RECOMMENDED SCHEDULE FOR POSTNATAL CARE

- **48–72 hours** after birth
- **Before discharge** (minimum length of stay individualized to clinical and social context)
- **7–14 days** postpartum
- **6 weeks** postpartum (and beyond as needed)

KEY CLINICAL COMPONENTS

Care coordination includes a personalized postnatal care plan before discharge, counseling on danger-signs, and prompt management of complications (bleeding, headache, dyspnea, fever, wound issues, mood changes). Danger signs are explained to the attendants and the mother.

Excessive bleeding	Foul-smelling lochia
Yellowness of urine, skin or eyes	Inability to pass urine after delivery
Pale skin or eyes, giddiness or weakness	Abnormal behavior
Cracked and painful nipples	Urinary burning and frequency
Fever	Dribbling or leakage of urine
Easy fatiguability/not feeling well	Incontinence of stool
Swelling on face, hands, and legs	Difficulty in breathing
Severe abdominal pain	Convulsions

Table 1: Danger signs in the mother in the postnatal period

The broad areas of support are as follows:

Lactation and Breastfeeding support: Breastfeeding support forms the cornerstone in ensuring a healthy baby with adequate nutrition. Breastfeeding is initiated and maintained with skilled counseling on latch, positioning, demand feeding, milk sufficiency. The importance of exclusive breastfeeding and techniques of breastfeeding are stressed upon. Managing common problems (engorgement, cracked nipples, mastitis) associated with breastfeeding is ensured by having competent healthcare providers. Early treatment and lactation-compatible antibiotics are recommended in case of mastitis.

Infection Prevention and Recognition: Mother is screened for vitals, uterine tenderness, malodorous lochia, and any incontinence of stool and urine. Perineum is evaluated for wound healing of perineal tears or episiotomy and for presence of any infection. Hand hygiene, perineal care instructions, and importance of a clean and healthy environment is reinforced. Mother is encouraged to practice early pelvic-floor exercises. Correct regimen of antibiotics is administered in cases with postpartum infection.

Assessment for PPH: Bleeding volume, uterine involution, tenderness is checked and secondary PPH is excluded (often 1–2 weeks postpartum) due to subinvolution, retained tissue, or infection. Counseling is provided on normal lochia vs. danger signs (sudden heavy bleeding, clots, dizziness), iron therapy for anemia, follow-up Hb, and contraception that does not exacerbate anemia when relevant is ensured.

Assessment of Venous Thromboembolism (VTE) Risk: Calf tenderness, redness, dyspnea and swelling in lower limbs are assessed. Early mobilization and hydration are prioritized.

Mental Health and Psychosocial Support: Mood and anxiety related screenings are done using validated tools; adequate sleep and social support are promoted. Stepped-care pathways (self-help, counseling, pharmacotherapy safe during lactation) and immediate referral for suicidality or psychosis have been included.

Contraception and Birth Spacing: Counselling on healthy timing and spacing of pregnancy and access to a full range of contraceptive methods, including immediate postpartum long-acting reversible contraception (LARC) is provided as per eligibility criteria. Method safety with specific comorbidities (e.g., hypertension, thrombosis), shared decision-making and documented plan with follow-up is ensured.

Immunization and Nutrition: The provision of postpartum immunization like HPV & MMR (if not received before) is encouraged. The mother is counseled on the importance of a healthy and nutritious diet.

CONCLUSION

Strong postnatal care safeguards maternal health beyond birth.

Postnatal care must be timely, longitudinal, comprehensive, and respectful. Globally aligned guidance now recommends multiple early contacts, integrated mental health and lactation support, nutrition counseling, and shared decision-making for contraception among others. The Manyata initiative provides a powerful lever to operationalize these postnatal standards in private facilities. With these strategies, postnatal care can fulfill its promise to safeguard maternal health and well-being in the fourth trimester and beyond.

POSTNATAL CARE: NEWBORN

Dr. Supriya Jaiswal, Dr. Richa Gupta

Standard: The provider ensures adequate postpartum care package is offered to the mother and baby – at and after discharge.

INTRODUCTION – CARE AREA OVERVIEW

Postnatal care (PNC) of the newborn aims to mitigate risks and promote well-being for the newborn laying the foundation for long-term health, growth, and mother-infant bonding[1]. The first six weeks following birth is a critical window for newborn survival, healthy development, and mother–infant bonding. According to the World Health Organization (WHO), this period is most susceptible to neonatal mortality and morbidity[2].

BACKGROUND – RATIONALE & OBJECTIVE

Most newborn deaths are preventable with quality postnatal care through simple, evidence-based practices. Systematic reviews confirm that postnatal care within the first 48 hours significantly improve breastfeeding outcomes, reduce infection rates, and enable early referral of sick newborns[3]. In India, neonatal mortality accounts for almost 70% of infant deaths, with the majority occurring soon after birth[4].

The Manyata standard for newborn care in the immediate postnatal period has demonstrated measurable impact in reducing newborn morbidity and mortality by ensuring structured assessment and counseling at the time of discharge. By ensuring these important interventions the standard directly contributes to reducing preventable neonatal mortality and morbidity, while laying the foundation for healthy growth, neurodevelopment, and long-term well-being.

Most newborn deaths are preventable — quality postnatal care ensures early detection & management, timely referral, and a healthy start to life.

CLINICAL COMPONENTS

Newborns are vulnerable to hypothermia, hypoglycemia, and sepsis due to immature systems and environmental exposures. These risks can lead to severe complications. Postnatal care ensures early detection and management through monitoring and interventions of the newborn.

- **Hypothermia:** Caused by immature thermoregulation, low fat stores, and environmental factors (e.g. low temperatures in winters) with risks of metabolic acidosis, hypoglycemia, and infection. Prevention includes immediate drying, skin-to-skin contact, and Kangaroo Mother Care.

1 National Institute for Health and Care Excellence (NICE). Postnatal care up to 8 weeks after birth (NICE guideline NG194)

2 World Health Organization. WHO recommendations on postnatal care of the mother and newborn. Geneva: WHO; 2014

3 Lassi ZS, et al Interventions to Improve Neonatal Health and Later Survival: An Overview of Systematic Reviews. EBioMedicine. 2015 May 31;2(8):985-1000.

4 Debnath, Aninda et al Burden, Differential and Causes of Child Mortality in India (2010–2020): A Review. Preventive Medicine Research & Reviews 2(Suppl 1):p S14-S20, July 2025

- **Hypoglycemia:** Results from low glucose levels, especially in babies of GDM mothers or due to delayed /difficulty in breastfeeding. Risks include seizures and brain injury. Early initiation of breastfeeding and glucose monitoring are important.
- **Sepsis:** Early or late-onset bacterial infections from maternal or environmental sources can cause neonatal sepsis, shock, or mortality. Key interventions include monitoring vital signs, administering timely antibiotics, and referring patients to higher centers when required.

Timing and Frequency of Postnatal Contacts

WHO recommends:

- Minimum 24-hour hospital stay post-delivery.
- Routine contacts at Day 3 (48–72 hours), Days 7–14, and six weeks postpartum. These visits, whether clinic-based or via home visits, provide opportunities to assess newborn health, reinforce practices, and intervene early if neonatal complications emerge.

Immediate Management (First 24 Hours):

Clinical Examination: Vital signs (temperature, heart rate, respiratory rate), general appearance, and detection of birth injuries, congenital anomalies, or infection signs are evaluated.

Immediate, continuous 'Skin-to-Skin Contact' is initiated that supports thermal regulation, breastfeeding initiation, physiological stability, and enhances attachment/bonding[5].

Feeding support is initiated with early breastfeeding, observing latch, milk let-down, newborn position, and maternal comfort[6].

Cord Care is recommended to ensure clean and dry cord.

Immunization: Vaccination is administered as per national schedule, beginning within 24 hours.

Subsequent Visits (Day 3, at discharge):

- Monitoring weight, growth, feeding, jaundice, hydration, and overall well-being.
- Checking for infection signs, cord issues, and developmental concerns.
- Counseling on immunizations to be done at the six-week visit.

Small or Sick Newborns (For preterm, low-birthweight, or ill infants):

Thermal protection (including kangaroo care), respiratory support, feeding support, infection management, phototherapy for jaundice, neurodevelopmental follow-up, and level-appropriate interventions are vital[7]. Ensure hand hygiene to protect the newborn from infectious sources[8].

5 Lawn JE, Blencowe H, Oza S, You D, Lee AC, Waiswa P, et al. Every Newborn: progress, priorities, and potential beyond survival. Lancet. 2014;384(9938):189–205.

6 World Health Organization. Recommendations on newborn health: guidelines approved by the WHO Guidelines Review Committee. Geneva: WHO; 2022

7 Bhutta ZA, Das JK, Bahl R, Lawn JE, Salam RA, Paul VK, et al. Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost? Lancet. 2014;384(9940):347–70.

8 United Nations Children's Fund (UNICEF). Care for the newborn. UNICEF; 2020

SUMMARY TABLE (KEY RECOMMENDATIONS)

Phase	Timeline	Newborn Focus	Additional Notes
Initial	First 24 h	Skin to Skin Contact, vital signs, feeding, cord care, immunizations, exam	Facility stays or early home visit
1st Visit	Day 3 (48–72 h)	Feeding, weight, jaundice, cord, infection, breastfeeding	N/A
2nd Visit	Days 7–14	Growth, feeding, illness signs, developmental screening	Continuing support and early detection
3rd Visit	Six Weeks	Full exam, immunization, developmental milestones, environment review	In-depth assessment and anticipatory guidance
Ongoing	Postnatal weeks	Safe sleep, warmth, feeding, bonding, safety	Family support and maternal–infant integration

(Extended follow-up at 3, 6, and 12 months is emerging as a best practice).

CONCLUSION

Providing high-quality postnatal care by following the Manyata standard for newborn care lays the foundation for lifelong health. It encompasses skin-to skin contact, thermal regulation, safe sleep practices, breastfeeding support, developmental nurturing through mother-infant bonding, and health assessments.

Integration with maternal care-physical recovery, mental health, nutrition, and culturally sensitive support ensures both mother and baby thrive beyond the early weeks. As global evidence evolves, extended postpartum monitoring may improve outcomes further for families worldwide.

Postnatal Care Ensures Safety, Growth, and Thriving Beyond Birth."

PERINATAL MENTAL HEALTH

Dr. Parikshit Tank, Dr. Pratibha Singh

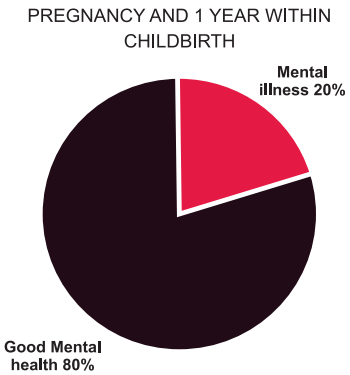
Standard - Provider ensures screening and timely referral of mothers with mental ill health.

INTRODUCTION – CLINICAL CARE AREA

Mental health, as defined by WHO, is a state of well-being where an individual realizes their abilities, manages life stresses, and contributes productively to society. Mental health and well-being during pregnancy and after childbirth is essential for the emotional well-being of the mother and to nurture a healthy child. Being in a state of mental well-being allows the woman to ensure good nutrition, adequate rest, and avail the necessary antenatal care. It improves the mother-fetal bonding and provides a foundation for normal fetal growth and development, leading further to a healthy infant. Overall, there is an improved quality of life with experiences of good relationships with the partner and family.

RATIONALE AND OBJECTIVE

Perinatal mental well-being is critical not only for mothers but for fetal development, newborn health, and family dynamics. With significant reduction in maternal mortality in the country, the focus is now shifting towards addressing morbidities, including maternal mental health.



The perinatal period (conception to one year postpartum) poses heightened psychological risks due to physiological, hormonal, and social changes. Globally, 1 in 5 women experience perinatal mental health disorders (PMHDs), anxiety, and depression. According to a recent systematic review and meta-analysis, the prevalence of postpartum depression in India was reported to be 22%[1]. Prevalence of generalized anxiety disorder was estimated to be 23% among perinatal women in a tertiary care hospital in the southern region of India.[2] Additionally, an estimated 7.6% of women in India experience suicidal ideation in pregnancy, a key contributor to maternal mortality.[3]

Identifying and supporting mothers with mental health concerns is as important as managing physical complications – both save lives and improve outcomes.

1 Upadhyay RP, Chowdhury R, Salehi A et al. Postpartum depression in India: a systematic review and meta-analysis. Bull WHO 2017;95(10):706–17

2 Jyothi Kantipudi S, Kannan GK, Viswanathan S et al. Antenatal depression and generalized anxiety disorder in a tertiary Hospital in South India. Indian J Psychol Med 2020;42(6):513–8.

3 Supraja TA, Thennarasu K, Satyanarayana VA et al. Suicidality in early pregnancy among antepartum mothers in urban India. Arch Women's Ment Health 2016;19(6):1101–8.

Mental health disorders can have a severe impact on the health of the woman and the newborn and adversely affects the child's future growth and development.

ON PREGNANCY

- Poor Antenatal care
- Risks of preterm delivery low birth weight stillbirth

ON MOTHER

- Impaired parenting skills and bonding
- Fail to care for self
- Increased risk for suicide /infanticide

ON CHILD

- Lower IQs
- Behavioural problems
- Delayed milestones
- Academic issues
- Sleep problems

The Manyata standard focuses on identifying and supporting women experiencing Perinatal Mental Health (PMH) issues by equipping providers to screen for risk factors and identify signs and symptoms during antenatal and postnatal care, and to facilitate timely management, referral, and appropriate follow-up.

CLINICAL COMPONENTS

History, psychosocial risk factors, and screening:

The Manyata standard integrates the past history of difficult childbirths, complications, perinatal losses, or any past history of mental illness as a key component to identify women at risk to develop a mental disorder in the index pregnancy. In addition, the standard includes assessing psychosocial risk factors that go beyond medical conditions and play a significant role in contributing to the risk of a mental illness. These are factors such as financial difficulties and domestic violence.

The standard builds the capacity of the provider to screen for common mental health disorders namely–anxiety and depression, to integrate the same into the antenatal and postnatal care routine. The provider screens using a standardized checklist at least once in the antenatal period and at least once in the postnatal period.

SIGNS AND SYMPTOMS

The standard ensures the competency of the provider to recognize and identify the signs and symptoms associated with common perinatal mental disorders (anxiety and depression) and severe perinatal mental disorders (postpartum psychosis).

Anxiety is a common mental disorder characterized by feelings of worry, nervousness, or fear that interferes with one's daily activities, whereas, depression is identified when the woman is in an unusually sad mood that does not go away and lasts for at least two weeks and beyond. The standard also enables the provider to differentiate between the various presentations and manage accordingly.

Baby Blues	Postpartum Depression	Postpartum Psychosis
UP TO 80% OF NEW MOTHERS	**UP TO 15 -22% OF NEW MOTHERS**	**1 - 2 PER 1000 OF NEW MOTHERS**
• Begins one to three days and lasts no more than 2 weeks after childbirth • Tearfulness and mood swings	• Onset usually within 4 weeks or any time in the 1st year after birth • Persistent sadness • Lack of attachment • Inability to care for self / infant • Loss of identity	• Begins rapidly usually within 2 weeks, often within 48-72 hours • Often is labile with agitation, restlessness, disorganization, confusion • Accompanied by delusion and/or auditory hallucinations

Management of common mental health disorders (Anxiety and Depression):

The Manyata standard is aligned with the WHO stepped care model, for managing conditions based on the severity of the mental health disorder.[4] First-line treatment for a mild mental disorder is counseling and psycho-social therapy. For women with moderate to severe disorders timely referrals are made for psychological interventions (cognitive behavioral therapy and interpersonal therapy) or pharmacotherapy as needed. The standard ensures that providers are equipped to identify risk factors, detect mental health disorders, manage mild cases, and facilitate referrals to specialists (psychiatrists) when required.

Assessment for Risk factors and PMH Screening		Yes	No
1.	Do you feel there is lack of emotional support?	☐	☐
2.	Are you facing serious financial difficulty?	☐	☐
3.	Are you facing any kind of domestic violence?	☐	☐
4.	Have you faced any loss of a loved one recently?	☐	☐
5.	Is there lack of support for doing household chores?	☐	☐
6.	In the last 2 weeks, have you been feeling excessively nervous or anxious?	☐	☐
7.	In the last 2 weeks, have you not been able to stop worrying?	☐	☐
8.	In the last 2 weeks, have you had no interest or pleasure in doing things?	☐	☐
9.	In the last 2 weeks, have you been feeling down, depressed or hopeless?	☐	☐
10.	Do you feel like running away or have any thoughts of harming yourself?	☐	☐
***Please tick ☑ the appropriate response** **Need further evaluation, if the response is Yes to any of the above**			

Table 1: *Checklist for Risk Assessment and Screening of Perinatal Mental Health Disorders*

4 Guide for integration of perinatal mental health in maternal and child health services" by WHO, 2022

CONCLUSION

Integrating Perinatal Mental health services into antenatal and postnatal care will improve outcomes for mothers and their babies.

Overall, perinatal mental health is a vital aspect of comprehensive maternal care. By adopting a proactive approach and addressing mental health concerns during the perinatal period, healthcare professionals can contribute significantly to the well-being of mothers and their children. Integrating routine screening and comprehensive risk assessment into antenatal and postnatal care can aid in the early detection and timely management of maternal mental health disorders. Improving the understanding, detection and management of common mental disorders among women is key to improving women's health and promoting gender equality.[5]

Ensuring perinatal mental health of women supports and guides them towards a positive pregnancy experience and for children to be healthy and grow with optimal emotional and psychological parental bonding and well-being.

5 Perinatal mental health in India: protocol for a validation and cohort study

G. Fellmeth, M.T. Kishore, A. Verma, G. Desai, O. Bharti, P. Kanwar, S. Singh, H. Thippeswamy, P.S. Chandra, J.J. Kurinczuk, M. Nair, F. Alderdice. Journal of Public Health | Vol. 43, Supp 2, pp. ii35–ii42

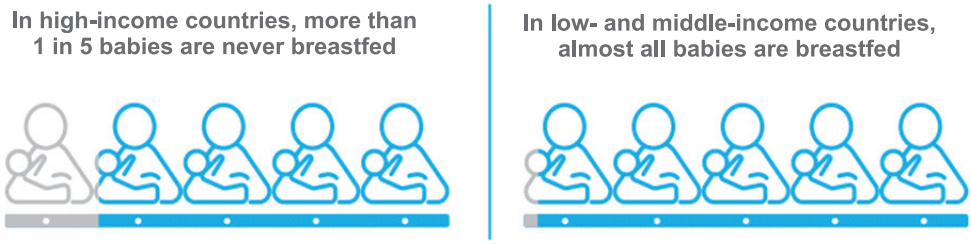
BREASTFEEDING

Dr. Charulata Bapaye

Standard: Provider counsels on the importance of exclusive breastfeeding and assists on the techniques of breastfeeding.

INTRODUCTION – CLINICAL CARE AREA

Breastfeeding is a fundamental component of newborn care, playing a crucial role in reducing infant morbidity and mortality while promoting healthy growth and development. It is more than just a source of nutrition, it provides immunological protection, fosters mother-infant bonding, and supports neurodevelopment[1]. Breastfeeding women experience fewer respiratory, cardiovascular, gastrointestinal, and emotional health issues, and require less medical care compared to non-breastfeeding women[2]. The Manyata standard emphasizes the timely initiation of breastfeeding, correct technique, and continued support, all of which are vital to achieving better health outcomes.



Share of babies that are breastfed in high, low- and middle-income countries[3]

BACKGROUND – RATIONALE AND OBJECTIVE

Breastfeeding is one of the simplest, cost effective, and high impact interventions for ensuring child survival, optimal nutrition, and healthy development. As per the WHO early initiation of breastfeeding, within one hour of birth is recommended[4]. Additionally, the *Lancet* Neonatal Survival Series highlights breastfeeding as a highly effective intervention, capable of reducing all-cause neonatal mortality and morbidity by 55–87%.[5] Despite the well-established advantages, many newborns are not breastfed within the recommended timeframe, and exclusive breastfeeding rates remain below optimal levels in many regions. Globally, it is estimated that less than half (42%) of all newborns are put to the breast within the first hour of birth[6]. In India, NFHS-5 reports that only 41.8% of newborns were breastfed within the first hour of birth[7].

1 Vakilian K, Farahani OCT, Heidari T. Enhancing Breastfeeding - Home-Based Education on Self-Efficacy: A Preventive Strategy. Int J Prev Med. 2020 Jun 3;11:63.

2 Del Ciampo LA, Del Ciampo IRL. Breastfeeding and the Benefits of Lactation for Women's Health. Rev Bras Ginecol Obstet. 2018 Jun;40(6):354-359.

3 BREASTFEEDING A Mother's Gift, for Every Child. UNICEF 2018

4 WHO/UNICEF. Global strategy on infant and young child feeding. Geneva: World Health Organization; 2003.

5 Darmstadt GL, Bhutta ZA, Cousens S, Adam T, Walker N, De Bernis L, et al. Evidence-based, cost-effective interventions: how many newborn babies can we save? Lancet. 2005;365(9463):977–88. 10.1016/S0140-6736(05)71088-6

6 Health in 2015: from MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals. Geneva: World Health Organization; 2015

7 National Family Health Survey -5 , GoI, (NFHS 5) – 2019-21

Thus, the Manyata standard underscores the importance of timely initiation of breastfeeding, supports exclusive breastfeeding for the first six months, and equips healthcare providers to deliver skilled lactation support both immediately after birth and throughout the postnatal period. Strengthening clinical practices around breastfeeding particularly in the critical hours after birth can lead to significant improvements in maternal and child health outcomes.

Breastfeeding Within the First Hour – Gives Life a Healthy Start.

KEY CLINICAL COMPONENTS

Breastfeeding technique: Using the correct breastfeeding technique is essential for effective milk transfer, prevention of nipple pain or engorgement, and fostering maternal confidence. Proper latch and positioning not only ensures the baby receives adequate nutrition but also supports sustained and comfortable breastfeeding for the mother.

A. Positioning:

The mother and baby should be c**omfortable and well-aligned:**

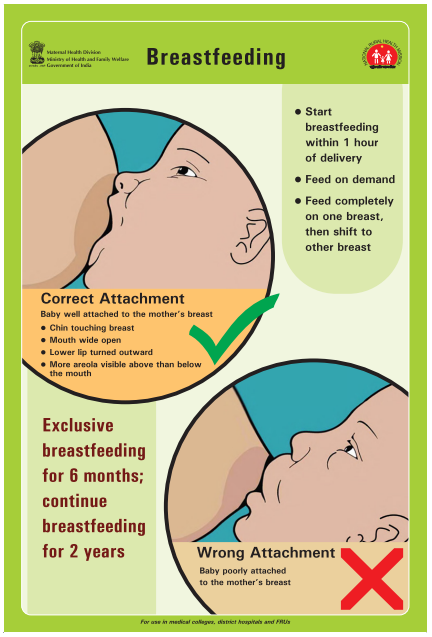
- Baby's head and body in a straight line.
- Facing the breast, nose opposite the nipple.
- Held close to mother's body.

B. Attachment (Latch): A deep, effective latch is critical.

- Baby's mouth wide open.
- Chin touches the breast.
- More areola visible above than below.
- No clicking or smacking sounds.

Signs of effective feeding:

- Suck–swallow–pause pattern.
- Baby appears relaxed and content post-feed.
- Mother does not feel pain; breasts soften after feeding.
- Baby gains weight steadily.



Benefits of Breastfeeding:

Benefits to mother	Benefits to baby
■ Improves emotional bonding ■ Readily available and affordable ■ Exclusive breastfeeding is associated with a natural (though not safe) method of birth control (98% protection in the first six months after birth) ■ It reduces risks of breast and ovarian cancer ■ Helps women return to their pre-pregnancy weight faster and lowers rates of obesity.	■ Ideal food for newborns and infants ■ Safe and contains antibodies ■ Prevents hypothermia in newborns ■ Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. ■ They are less likely to have type-2 diabetes and perform better in intelligence tests.

CONCLUSION

Breastfeeding is a critical, evidence-based intervention that offers lifelong benefits for both mothers and babies. Despite its proven advantages in improving child survival, maternal health, and long-term development outcomes, early initiation and exclusive breastfeeding rates remain suboptimal in many settings.

Strong Systems, Strong Start – Makes Breastfeeding the Norm.

Strengthening clinical practices through the Manyata initiative, particularly in the immediate postpartum period and providing skilled, compassionate lactation support are essential for closing this gap. Sustained efforts through community engagement, provider training, and supportive health systems are key to ensuring every newborn gets the best start to life through breastfeeding.

POSTPARTUM FAMILY PLANNING (PPFP)

Dr. Ashish Kale

Standard: Provider counsels on the return of fertility, healthy timing and spacing of pregnancies, and postpartum family planning options to the mother at the time of discharge.

INTRODUCTION

Postpartum Family Planning (PPFP) refers to the prevention of unintended pregnancies and the promotion of healthy birth spacing during the first 12 months after childbirth. The PPFP ensures that every woman leaving a facility after delivery is aware of her fertility return, risks associated with short interpregnancy intervals, and available contraceptive choices. Counseling at the time of discharge is a critical opportunity because it coincides with high unmet contraceptive needs and maximum contact with the health system.

BACKGROUND, RATIONALE AND OBJECTIVE

Return of fertility after childbirth is often variable and unpredictable. Ovulation can occur before the first postpartum menses, and the woman may become pregnant without ever experiencing a period. The unmet need for contraception is particularly high during the postpartum period, with nearly 60% of women worldwide wishing to delay or avoid pregnancy after childbirth, yet many still lacking access to effective methods. Short Interpregnancy Intervals (<18 months) are associated with increased risks of maternal anemia, maternal mortality, low birth weight, preterm birth, and neonatal death. On the other hand, adequate spacing (18–24 months) improves maternal recovery, optimizes infant nutrition, and reduces Risks of Short Interpregnancy Intervals.

Risks of Short Interpregnancy Intervals (<18 months)

Maternal Risks	Newborn Risks
Maternal anemia	Low birth weight
Maternal mortality	Preterm birth
Increased risk of cesarean delivery	Small for gestational age
Nutritional depletion	Neonatal mortality

The rationale for PPFP is therefore rooted in both rights and health outcomes—women should have the right to make informed reproductive choices and access contraception when they need it most.

The Manyata standard explicitly ensures that providers counsel mothers on the return of fertility, healthy timing and spacing of pregnancy, and postpartum family planning (PPFP) options before discharge. The objective of the standard is to ensure that every postpartum woman and her family receive comprehensive, respectful, and unbiased counseling and the full range of contraceptive options. This

Every woman has the right to informed, voluntary reproductive choices and timely access to contraception after childbirth.

empowers women to make voluntary, informed decisions that align with their reproductive goals. The purpose of the standard is for the provider to offer comprehensive PPFP service to help women to choose the contraceptive method they want to use, to start that method, and to continue to use it for 2 years or longer, depending on their reproductive plans.

KEY COMPONENTS OF PPFP

Through this standard, integration of family planning services into postpartum care ensures continuity of care and improved access. This includes:

Timing Windows:

- **Immediate postpartum:** within 10 minutes of placental delivery (e.g., post-placental IUD)
- **Early postpartum:** within 48 hours of delivery
- **Delayed/interval:** from 4–6 weeks postpartum
- **Extended postpartum:** up to 12 months after childbirth

Counseling and shared decision-making:

The standard aligns with the World Health Organization (WHO) recommendation on counseling on contraception in the postnatal period, and supports immediate postpartum initiation of contraception.[1] The Manyata standard ensures that the counseling is client-centered, begins during antenatal care, and continues at delivery, discharge, and postnatal contacts including immunization clinics, and covers method mix, breastfeeding compatibility, partner involvement, and addresses myths. The counseling component under the standard covers Healthy Timing and Spacing of Pregnancy (HTSP), emphasizing the practice of spacing pregnancies to improve health outcomes for both mother and child.

HTSP entails three components depending on the reproductive history

a. Waiting at least 24 months before attempting another pregnancy after childbirth (applicable to postpartum women)
b. Waiting for at least 6 months before attempting another pregnancy after an abortion (applicable post-abortion)
c. Waiting at least until a girl is at age 18 before attempting the first pregnancy (applicable to Nullipara)

Contraceptive Method Mix:

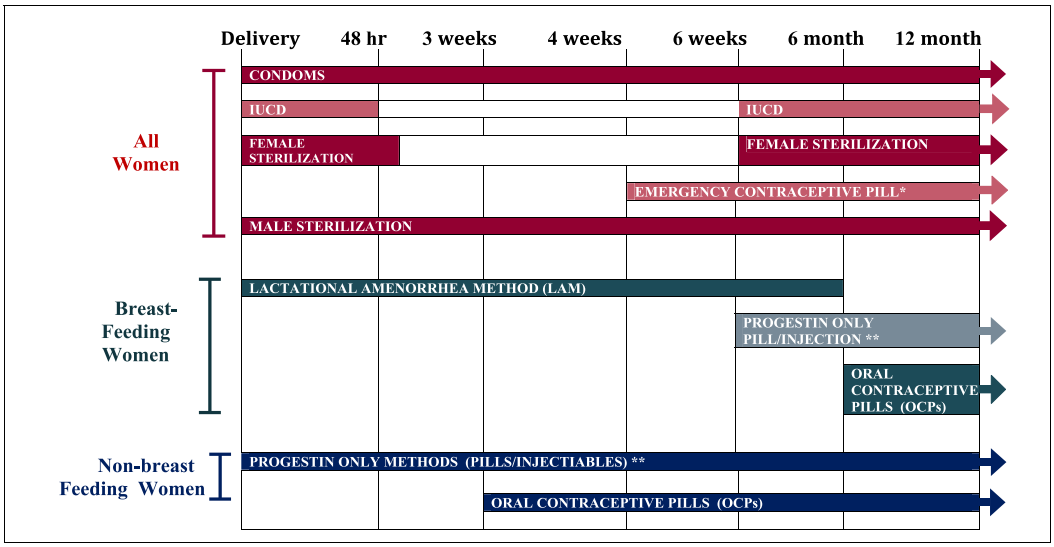
Choice of method should depend on individual needs, reproductive intentions, breastfeeding status, and medical eligibility.[2] Aligning with national and the updated MEC guidance[3] Progestin-only contraception may be initiated in the immediate postpartum period, as estrogen-containing methods are generally not recommended in the early post-partum period. The standard complements the FIGO position statement to include postpartum IUDs (PPIUD) as part of routine maternity care, with emphasis on provider training, informed choice, and follow-up.[4]

- Lactational Amenorrhea Method (LAM)
- Intrauterine devices (copper IUD, LNG-IUS)
- Implants (etonogestrel)

1 World Health Organization. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: WHO; 2022
2 World Health Organization. Medical eligibility criteria for contraceptive use. 5th ed. Geneva: WHO; 2015. (Use with national adaptations and SPR updates.)
3 Centers for Disease Control and Prevention (CDC). U.S. Medical Eligibility Criteria for Contraceptive Use, 2024. MMWR Recomm Rep 2024;73(RR-4):1–127
4 FIGO. Position statement on postpartum intrauterine devices (PPIUD), 2025. Int J Gynecol Obstet.

- Injectables (DMPA, NET-EN)
- Progestin-only pills (POPs)
- Combined hormonal methods (pills, patches, rings)
- Barrier methods (condoms, diaphragm)
- Permanent methods (tubal ligation, vasectomy)
- Emergency contraception (pills, copper IUD)

SAFE TIMES FOR POSTPARTUM INITIATION OF VARIOUS METHODS OF FAMILY PLANNING



* This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.
** This is available in private sector.

Table 1: Contraceptive options in postpartum period

Equity, Rights, and Quality: The standard enables the provision of services that are rights-based, voluntary, equitable.

CONCLUSION

Postpartum Family Planning is a cornerstone of maternal and newborn health initiatives. Counseling women at discharge, as mandated by the Manyata standard, ensures they understand their return of fertility and the importance of healthy timing and spacing of pregnancies that can dramatically reduce maternal and neonatal morbidity and mortality.

Better Health Outcomes: Healthy birth spacing reduces maternal and newborn risks, improving survival and long-term well-being.

The Manyata initiative integrates PPFP into routine maternity care and is aligned with WHO, FIGO, CDC, and national guidelines. The Manyata-certified facilities prioritize availability of long-acting reversible contraceptives, strengthen provider skills, and ensure respectful, rights-based counseling. When PPFP is systematically offered, it empowers women to make informed reproductive choices that safeguard their health and that of their children.

OVERARCHING DOMAINS

INFECTION PREVENTION

Dr. Laxmi Shrikhande, Dr. Priyankur Roy

Standard: The facility adheres to universal infection prevention protocols

INTRODUCTION

Infection prevention in maternal and newborn healthcare is a critical component of ensuring safe and effective care during pregnancy, childbirth, and the postpartum period. Healthcare-associated infections (HAIs) pose significant risks to mothers and newborns, particularly in labor rooms (LR) and operating theaters (OT), where invasive procedures and high-risk interventions occur. Effective infection prevention protocols safeguard maternal and newborn health, reduce morbidity and mortality, and enhance the quality of care. This chapter outlines the Manyata standard and the importance of infection prevention and the key clinical practices that align with global and national health priorities. The standard aligns with the WHO's Guidelines on Core Components of Infection Prevention and Control Programs (2016) emphasizing multimodal strategies, including hand hygiene, environmental cleaning, and staff training.

BACKGROUND – RATIONAL AND OBJECTIVE

Infection prevention is a cornerstone of maternal and newborn health due to the vulnerability of mothers and neonates to infections during childbirth. Globally, HAIs contribute significantly to maternal and neonatal morbidity and mortality. According to the World Health Organization (WHO), approximately 10% of hospitalized patients in low-and middle-income countries (LMICs) acquire HAIs, with higher rates in obstetric and neonatal units[1]. In India, studies indicate that puerperal sepsis accounts for 10–15% of maternal deaths, and neonatal sepsis is a leading cause of neonatal mortality[2].

Infections such as puerperal sepsis, surgical site infections (SSIs), and neonatal sepsis are often preventable through adherence to standardized infection prevention protocols[3].

Most infections (puerperal sepsis, surgical site infections, neonatal sepsis) are preventable through standardized protocols.

These infections not only increase mortality but also lead to prolonged hospital stays, higher healthcare costs, and long-term complications. By following the Manyata standard and implementing robust infection prevention measures, healthcare facilities can significantly improve maternal and newborn outcomes.

1 *WHO Guidelines on Core Components of Infection Prevention and Control Programmes 2016*

2 *Indian Council of Medical Research. (2019)*

3 Liu, L., et al. (2015). *Global, Regional, and National Causes of Child Mortality in 2000–13.* The Lancet Global Health.

KEY CLINICAL COMPONENTS

The following clinical practices are highlighted as essential components of the standard for infection prevention in maternal and newborn healthcare settings:

Sterilization and Instrument Process:

Sterilization Facilities: Facilities must have autoclaves and designated areas for sterilizing small and large instruments. A unidirectional flow for soiled and sterile items prevents cross-contamination (WHO, 2016).

Post-Use Processing: All reusable instruments must be cleaned, disinfected, and sterilized after each use to eliminate pathogens.

Maintenance Schedules: Labor rooms and OTs must follow strict cleaning schedules, with regular swabbing to detect microbial contamination.

Spillage Management: Protocols for managing blood and body fluid spills must be displayed and followed, with spill management kits readily available. Labor rooms must be equipped with spill management kits to handle biohazardous spills promptly.

Biomedical Waste Management:

Segregation and Disposal: The standard recommends biomedical waste to be segregated into color-coded, covered bins and disposed of as per the Biomedical Waste Management Rules, 2016 (India), Ministry of Environment, Forest and Climate Change, 2016.

Protocol Display: Guidelines for waste segregation and disposal should be prominently displayed in the biomedical waste (BMW) area.

Color Codes for BMW:

Yellow	Human tissues, organs, soiled waste, expired medicines	Placenta, blood-soaked dressings, body parts
Red	Contaminated plastics	Gloves, syringes without needles, IV tubing
White/Translucent	Sharps in puncture-proof containers	Needles, blades, scalpels
Blue	Glassware and metallic implants	Broken glass, ampoules, implants

Hand Hygiene:

Hand Washing Protocols: Healthcare providers must perform hand hygiene before and after procedures, and this standard is aligned to WHO's "5 Moments for Hand Hygiene" WHO, 2009. Posters illustrating these moments should be displayed in labor rooms and OTs at Manyata-certified facilities.

Sterile Gloves: Sterile gloves must be worn during deliveries and internal examinations to prevent contamination.

The Manyata standard is based on the national guidelines[4] that provide protocols for sterilization, PPE use, and microbial surveillance

Moments for Hand Hygiene

Steps of Hand washing

Personal Protective Equipment (PPE):

Availability: Masks, caps, protective eye covers, sterile gloves, elbow-length gloves, disposable gowns/aprons, and utility gloves for housekeeping staff must be available at all Manyata-certified facilities.

Usage: PPE must be used consistently during procedures to protect both patients and healthcare workers.

Infection Control Protocols:

Separation of Routes: Clean and dirty items must follow separate pathways to prevent cross-contamination.

Disinfectants and Cleaning: Standard mopping and scrubbing practices, along with the availability of disinfectants, are mandatory.

4 'National Guidelines for Infection Prevention and Control in Healthcare Facilities, National Centre for Disease Control, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, January 2020 (MoHFW)

Labor Table Spacing: The distance between labor tables must comply with the Maternal and Newborn Health (MNH) Toolkit to reduce infection risk.

Microbiological Surveillance:

Surgical Site Infection (SSI) Monitoring: Regular audits and records of SSIs must be maintained to identify and address infection trends.

Swabbing: Routine swabbing of high-risk surfaces (e.g., delivery tables, door handles) is essential for microbial surveillance.

Prevention of Mother-to-Child Transmission (PMTCT) of HIV:

The standard outlines protocols for preventing mother-to-child transmission of HIV. The Manyata-certified facilities must adhere to national guidelines for managing HIV in pregnant women and newborns to prevent vertical transmission.

Protection of Healthcare Workers:

Immunization: All staff should be immunized against Hepatitis B.

Post-Exposure Prophylaxis (PEP): PEP kits must be available, and staff should be trained in managing needle-stick injuries.

Sharps Handling: Providers must follow protocols for safe handling and disposal of sharps

Documentation:

Registers: Facilities must maintain registers for PEP, autoclave use, microbial surveillance, SSIs, and staff health records to ensure accountability and track compliance.

The Manyata standard provides the framework for standardizing practices across healthcare facilities, ensuring alignment with global and national health priorities for infection prevention.

CONCLUSION

Infection prevention is a non-negotiable aspect of maternal and newborn healthcare, directly impacting mortality and morbidity outcomes. By adhering to standardized protocols for sterilization, waste management, hand hygiene, and staff protection, Manyata-certified facilities create a safe environment for mothers, newborns, and healthcare workers. Continuous monitoring of practices, and alignment with national and global guidelines ensure sustained progress in reducing HAIs and achieving health equity.

SAFE SURGERY

Dr. Suvarna Khadilkar, Dr. Shyjus P

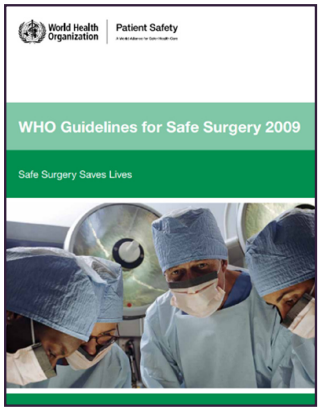
Standard: Provider ensures safe surgery in the facility

INTRODUCTION

Safe surgery is an essential part of providing quality maternal and newborn healthcare. Within the context of the Manyata initiative, this standard ensures that surgical care, especially cesarean sections, is conducted in a safe, efficient, and well-coordinated manner. The Manyata standard ensures that proper systems are in place to support safe practices in the operation theater (OT), including the availability of necessary equipment, trained personnel, protection of patient privacy, seamless transitions between departments, and complete documentation of surgical procedures. This comprehensive approach helps minimize risks and improves outcomes for both mothers and newborns at the Manyata-certified facilities.

BACKGROUND – RATIONALE AND OBJECTIVES

According to the World Health Organization, Surgical Site Infections (SSIs) complicate 11.8 out of every 100 surgical procedures in low- and middle-income countries, highlighting a significant burden on patient recovery and healthcare systems.[1]



In 2009, WHO released WHO's *Safe Surgery Saves Lives* [2], initiative to reduce surgical complications and deaths by promoting essential safety practices. It emphasizes the use of the Surgical Safety Checklist to improve team communication and ensure critical steps are followed before, during, and after surgery. Evidence shows that the use of the WHO Surgical Safety Checklist leads to a significant decline in both complications and mortality. A study found that post-operative complication rates fell by 36% on average, with a similar reduction in death rates.[3]

In response to these challenges, the Manyata standard on Safe Surgery aims to ensure that private healthcare facilities implement evidence-based, respectful, and patient-centered surgical practices. The standard focuses on the consistent availability and functionality of surgical and anesthesia equipment, protection of women's privacy and dignity throughout the surgical journey, and the establishment of clear protocols for continuity of care during transfers between departments. It also mandates thorough surgical documentation and emphasizes staff training in emergency

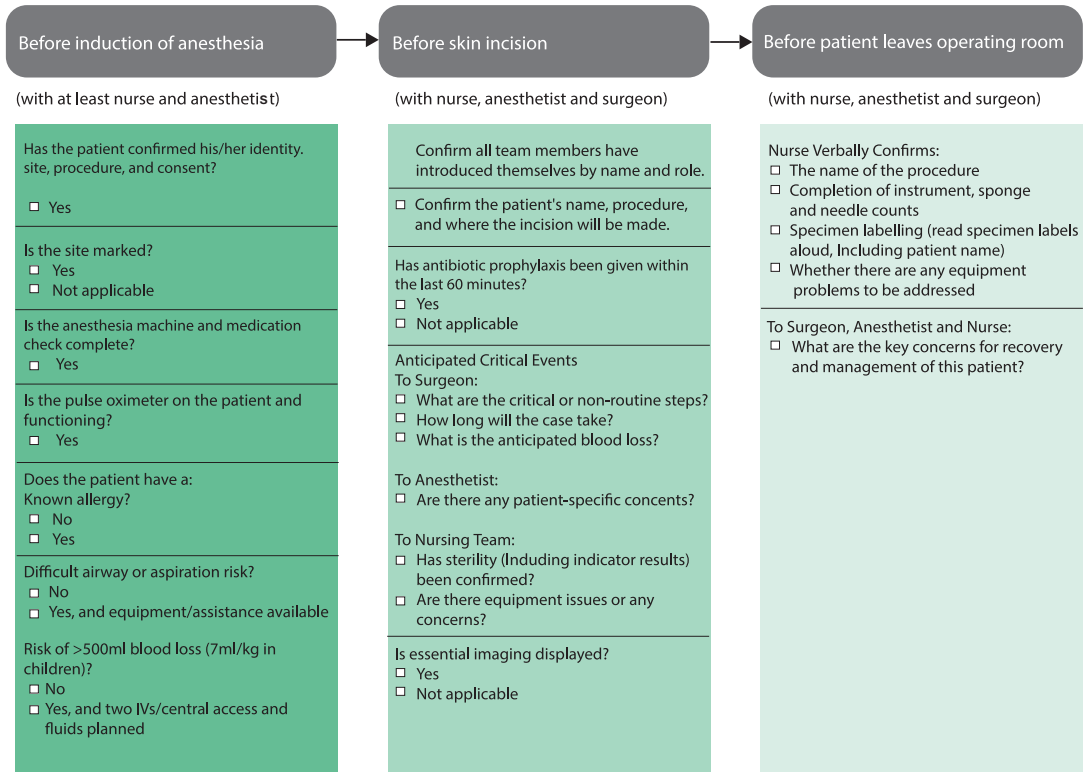
1 Singh, Saddam & Singh, et al (2022) Prevalence of operative complications in obstetric and gynecological surgeries requiring interventions by a general surgeon and their associated risk factors: A retrospective study in a tertiary care hospital in Vindhya region. Asian Journal of Medical Sciences. 13. 178-182. 10.3126/ajms.v13i9.44060.

2 WHO Guidelines for Safe Surgery 2009

3 Haynes AB, et al. (2009). *A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population.* New England Journal of Medicine, 360(5), 491–499.

management, including Advanced Life Support (ALS). Aligned with global and national initiatives such as WHO's quality standards, India's LaQshya program, and NABH guidelines, this standard is designed to improve surgical safety, reduce avoidable complications, and enhance maternal and newborn outcomes across private health facilities.

Surgical procedures, particularly cesarean sections, are among the most common and life-saving interventions in obstetric care, yet they carry significant risks when safety protocols are not consistently followed. Complications such as surgical site infections, hemorrhage, anesthesia-related issues, and even maternal or neonatal mortality often arise due to non-functional equipment, untrained staff, poor documentation, and communication gaps during departmental handovers. Post-operative complications can occur any time after surgery, with SSIs, urinary tract infections, respiratory infections, abdominal distension, and fever being the most common. In India, SSIs are the leading complication, accounting for 0.5% to 15% of post-operative cases[4].



KEY CLINICAL COMPONENTS

The Manyata standard mandates that healthcare providers deliver surgical care within private facilities that are unequivocally safe, effective, and respectful. Central to this standard is the assurance that all necessary surgical and anesthesia equipment is always not only available but fully functional. This is supported by rigorous training of all staff in equipment management, including meticulous record keeping and adherence to a proactive maintenance schedule, which together guarantee operational readiness and minimize the risk of equipment failure during critical procedures.

4 Bangal VB et al.,Study of surgical site infections following gynaecological surgery at tertiary care teaching hospital in rural India. Int J Biomed Res. 2014,5(2):113-116

Respect for patient dignity is paramount, with the standard requiring adequate visual privacy at every stage of care. This means that patients must be properly draped or covered before, during, and after surgical procedures, ensuring their comfort and preserving their modesty. Furthermore, privacy must be maintained between surgical tables or workstations through physical barriers or spatial separation, thereby safeguarding patient confidentiality and fostering a respectful environment in the operation theatre.

A critical pillar of safe surgical care under this standard is the establishment of clear, documented protocols for continuity of care, particularly during the transfer of patients between departments. Pregnant women undergoing surgery must never be left unattended or ignored, reflecting a commitment to vigilant, continuous monitoring during vulnerable periods. Defined procedures must be in place for the handover of mothers and newborns from the operating theatre to maternity wards, High Dependency Units (HDU), or Special Newborn Care Units (SNCU). This process must be comprehensive and well-coordinated to ensure seamless clinical management and reduce risks associated with transitional care. Additionally, the maintenance of a transfer register is compulsory, enabling accurate tracking of patient movements and facilitating accountability and communication among care teams.

Integral to high-quality surgical care is the complete and accurate documentation of all surgical procedures. The operative notes should comprehensively record the names of all personnel present, pre- and post-operative diagnoses, details of the procedures performed, including the length of surgery, estimated blood loss, fluids administered, specimens removed, and any intraoperative or post-operative complications encountered. These detailed records are vital for ensuring continuity of care, enabling audit and quality improvement, and supporting medico-legal accountability.

By rigorously implementing these components, Manyata ensures that surgical interventions are conducted with the highest levels of safety, clinical excellence, and respect for the woman's dignity. This comprehensive approach minimizes preventable complications, strengthens clinical outcomes for mothers and newborns, and upholds the trust and confidence of women seeking surgical care.

CONCLUSION

In conclusion, safe surgery is a critical component of quality maternal and newborn healthcare. Ensuring that surgical procedures are performed with the right equipment, skilled personnel, effective communication, and respect for patient privacy not only reduces complications and mortality but also enhances the overall childbirth experience. Adopting standardized safety protocols and fostering a culture of vigilance and accountability are essential to protecting the health and dignity of mothers and newborns during surgical care.

The 'Provider Ensures Safe Surgery' standard is vital in guiding healthcare facilities to implement these best practices consistently, ensuring that every surgical intervention is safe, respectful, and leads to better health outcomes. Upholding this standard is fundamental to building trust, improving clinical excellence, and saving lives.

Adherence to standardized protocols, use of surgical safety checklists, and ensuring functional equipment help prevent complications, reduce mortality, and promote respectful, patient-centered care.

HIGH DEPENDENCY UNIT (HDU) CARE

Dr. Alpesh Gandhi, Dr. J B Sharma, Dr. Rahul Wani

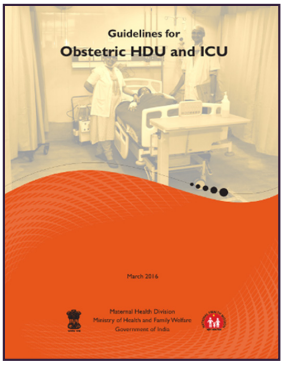
Manyata Standard: Provider delivers HDU care to obstetric patients with advanced care needs

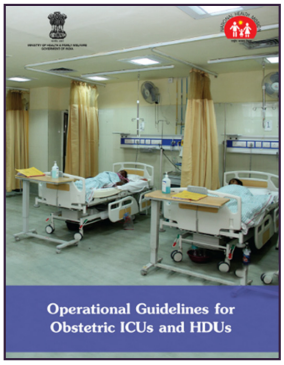
INTRODUCTION – CARE AREA OVERVIEW

The majority of maternal deaths are linked to complications such as hemorrhage, eclampsia, sepsis, and underlying medical comorbidities. However, maternity wards often lack the capacity for continuous monitoring, and referrals to intensive care units tend to happen too late. Even when referrals are made, ICUs are frequently overburdened and remain difficult for many women to access. All these conditions may benefit from an increased short-term level of monitoring and care, as provided by High Dependency Units (HDUs). HDUs play a vital role in saving the lives of women with severe obstetric and medical complications who require advanced monitoring and treatment, but not always full intensive care. An HDU can meet the critical care needs of at least half of the obstetric population and can also help reduce costs, as ICU care tends to be more expensive[1].

BACKGROUND – RATIONALE & OBJECTIVE

In 2020, about 800 women died each day from preventable pregnancy and childbirth causes one every two minutes.[2] Studies have shown that a dedicated obstetric HDU/ICU reduces maternal mortality by ensuring rapid, high-quality critical care. Timely management through a trained multidisciplinary team is essential for continuous skilled obstetric and critical care, making such units indispensable in tertiary and high-volume public hospitals serving high-risk pregnancies.[3] A major limitation in low-resource countries is the limited availability of ICUs and non-availability of spaces for obstetric patients since most of the ICUs admit patients from all medical specialties. By establishing dedicated HDUs within maternity facilities, health systems can create a critical bridge that ensures timely stabilization, vigilant monitoring, and life-saving interventions in a cost-effective manner thereby improving outcomes for both mothers and newborns.





The Government of India issued the Guidelines for Obstetric HDU and ICU[4] in 2016 and the Operational Guidelines for Obstetric ICUs and HDUs in 2017[5] to strengthen critical maternal care. These guidelines aim to enhance maternal

1 Adeniran A, et al The High Dependency Unit in the Management of Critically Ill Obstetric Patients in Low Resource Countries. Sierra Leone J Biomed Res. 2015;7(2):57-63.

2 Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division

3 Tayade S, Gangane N, Shivkumar P, Baswal D, Ratnu A, et al. (2018) Role of Obstetric High Dependency and Intensive Care Unit in Improving Pregnancy Outcome and Reducing Maternal Mortality-A Study in Rural Central India. Int J Crit Care Emerg Med 4:055.

4 GOI Guidelines for Obstetric HDU and ICU, 2016

and newborn outcomes by establishing dedicated units for high-risk pregnant women, standardizing infrastructure and equipment requirements, and ensuring the availability of trained obstetricians, anesthesiologists, and nursing staff.

The standard aims to ensure that obstetric patients with advanced care needs receive timely and high-quality HDU care. It establishes provisions for appropriate infrastructure, monitoring, and life-saving equipment in accessible locations. It emphasizes availability of trained multidisciplinary staff and regular skill updates, including emergency drills and use of critical care protocols. The standard also mandates accurate documentation, structured step-up/step-down care, and seamless referral to optimize maternal and newborn outcomes.

KEY COMPONENTS OF HDU CARE STANDARDS

Integration of HDU care into the Manyata standards reinforces the continuum of care for high-risk cases by ensuring that women are not only identified early but also managed in an environment equipped for advanced monitoring and interventions. By embedding HDU readiness within quality standards, Manyata bridges routine maternity services with advanced critical care, aligning clinical excellence with system preparedness, and ultimately contributing to the reduction of preventable maternal and newborn deaths.

An effective 8-bedded HDU is preferably suited for a healthcare facility that caters to over 250 childbirths per month. It is a purposefully designed unit, located close to the labor room, operating theatre, emergency, and neonatal care areas, so that women can be transferred quickly during emergencies. The unit must be equipped with all essential infrastructure and technological equipment such as cardiac and respiratory monitors, facilities for blood component therapy, fetal monitoring with continuous cardiotocography (CTG), ultrasound with Doppler or Echo, and ventilator support for transport to ensure that complications are promptly identified and managed.

Equally important is the presence of skilled and adequately staffed teams. Round-the-clock availability of medical officers trained in emergency obstetric care and preferably in critical care obstetrics, along with obstetric nurses trained in SBA and advanced critical care, ensures that every woman admitted to the HDU receives close and competent attention. Maintaining an optimal nurse-to-patient ratio allows continuous observation, timely interventions, and a culture of safety.

The strength of an HDU lies in the capacity of its providers. Regular training in advanced resuscitation, intubation, blood transfusion, use of monitoring equipment, and participation in quarterly emergency drills keeps the team prepared for unpredictable and life-threatening events. Competency in documentation is equally essential. Clear admission and discharge criteria, systematic recording of vitals, investigations, progress, newborn details, and use of structured tools such as the Modified Obstetrics SOFA score (a pregnancy-specific version of the Sequential Organ Failure Assessment (SOFA) score, which is a system to evaluate and predict organ dysfunction and mortality in critically ill patients) not only guide clinical care but also enable timely decisions about stepping down to ward care or escalating to ICU when needed. This ensures that patient movement is safe, appropriate, and guided by evidence-based protocols.

5 GOI Operational Guidelines for Obstetric HDU and ICU, 2017

Integration of HDU care into the Manyata standards reinforces the continuum of care for high-risk cases by ensuring that women are not only identified early but also managed in an environment equipped for advanced monitoring and interventions. This linkage strengthens the referral and care pathway from antenatal risk detection to emergency management during labor and delivery, to postnatal stabilization ensuring no woman falls through the cracks. By embedding HDU readiness within quality standards, Manyata bridges routine maternity services with advanced critical care, aligning clinical excellence with system preparedness, and ultimately contributing to the reduction of preventable maternal and newborn deaths.

CONCLUSION

High Dependency Units (HDUs) are a critical bridge between routine maternity care and intensive care, providing prompt, advanced monitoring and interventions for high-risk obstetric patients. By combining dedicated infrastructure, essential equipment, and a skilled multidisciplinary team, HDUs enables continuous observation, and evidence-based escalation of care, reducing maternal and neonatal morbidity and mortality. Integration of HDU standards into quality frameworks like Manyata strengthens the continuum of care from antenatal risk detection to emergency management and postnatal stabilization ensuring no woman or newborn falls through the cracks. Ultimately, establishing and operationalizing well-equipped HDUs in tertiary and high-volume facilities is essential for improving maternal and newborn outcomes, optimizing resource utilization, and advancing India's maternal and neonatal health goals.

MEDICOLEGAL DOCUMENTATION

Dr. Geetendra Sharma

Standard: Provider ensures complete medicolegal documentation

INTRODUCTION – CARE AREA OVERVIEW

Medicolegal documentation is a vital part of clinical practice, ensuring patient safety, protecting provider accountability, and establishing transparency in healthcare delivery. The Manyata standard ensures proper record-keeping and safeguards the rights of patients, supports continuity of care, and provides credible evidence in case of any legal proceedings. At the same time, it protects healthcare professionals and facilities from complaints, claims, or litigation. The standard has been adopted from various national and international guidelines.[1,2,3]

BACKGROUND – RATIONALE AND OBJECTIVE

The objective of complete medicolegal documentation is to ensure high-quality care while minimizing risks for both patients and providers. From a legal perspective, comprehensive records establish a clear sequence of events, determine liability when disputes arise, and serve as strong evidence in court. From a clinical perspective, they improve communication among healthcare teams, guide decision-making, and prevent misunderstandings with patients and families.

The rationale for this standard lies in embedding systematic documentation, consent processes, and communication practices into routine care to uphold ethical standards, patient rights, and institutional credibility.

Systematic documentation and consent safeguard rights, guide care, and uphold institutional credibility.

KEY COMPONENTS

1. Clinical Records

Standardized templates and registers must be maintained across all Manyata-certified facilities, including:

- Case sheets and labor room registers
- Surgical Safety Checklist and Safe Childbirth Checklist
- Partograph for monitoring labor progress
- Consent forms (procedure-specific and high-risk)
- Delivery notes, baby notes, anesthesia notes, operation notes
- Specialized registers: OT, stillbirth, MTP, autoclave, referral, blood transfusion, inventory management register

1 Ministry of Health & Family Welfare, Government of India. Guidelines & Protocols for Medico-Legal Care for Survivors/Victims of Sexual Violence. New Delhi: MoHFW; 2014.

2 National Health Systems Resource Centre (NHSRC). Emergency Care for MOs: Medico-Legal Issues and Documentation. Government of India; 2022.

3 Naidu RK, Momin SI. Medico-Legal Records and Indian Laws and Regulations: A Guide for Indian Hospitals & Physicians. Pravara Institute of Medical Research (PIMR); 2024.

2. Consent

Consent is a very vital component of the Manyata standard, and it is a document that confirms permission or agreement by a patient to allow a medical examination or a procedure. It can be expressed (written/verbal) or implied. The written forms should be preferably bilingual (English and local language understandable by the client).

Informed consent ensures respect for patient autonomy, beneficence, and justice, reducing provider–patient conflict.

Types of Consent Forms to be maintained by the facilities:

- Blood transfusion consent
- High-risk consent
- Cesarean consent
- Anesthesia consent (separate for surgery and anesthesia)

3. Communication

Sensitization of staff on complete, timely, and respectful communication is at the core of the Manyata standard. Families and the client are always informed in simple, understandable language about maternal and fetal conditions.

The staff are trained on ensuring availability of resources and continuous supportive supervision is done.

4. Facility-Level Documentation

Availability of valid NOCs and operational approvals is ensured at the Manyata-certified facilities. The key requirements are completed and always kept updated.

- Fire NOC, Biomedical Waste (BMW) NOC, Pollution Control Board certificate
- Facility registration with relevant authorities

There are display boards that are mandated to ensure transparency and equity to all clients visiting the Manyata facility:

- Display of citizen charter including patient rights and responsibilities
- Display of service costs and emergency contact numbers at prominent places
- Use of clear signage for patient guidance

5. Implementation Strategies

The Manyata standard clearly outlines the following:

- Assigning responsibility for documentation at facility and department levels
- Capacity building and regular staff training
- Ensuring completeness of all records and forms
- Conducting monthly, quarterly, and annual audits with a focus on documentation and communication quality

CONCLUSION

Complete medicolegal documentation is a cornerstone of quality and ethical practice. This Manyata standard ensures legal compliance, strengthens communication, and protects both patients and providers.

Good documentation protects patients, supports providers, and strengthens clinical and legal accountability.

By standardizing record-keeping, embedding informed consent, and ensuring transparent facility practices, healthcare institutions can safeguard patient rights, improve satisfaction, and enhance trust in the health system.

HEALTH SYSTEM RESPONSIVENESS AND SURVEILLANCE IN MATERNAL AND NEWBORN HEALTH

Dr. Palaniappan, Dr. Girija Wagh

INTRODUCTION

Maternal health is considered as one of the key and critical indicators of health systems and the capacity to deliver essential, equitable, and timely care across multiple levels to women as well as their newborns. Improving maternal and newborn health is central to the achievement of SDG of Maternal Mortality Ratio (MMR) to less than 70 per 100,000 live births. *Every day, 800 women die from preventable causes related to pregnancy and childbirth globally, and 94% of these deaths occur in low-and middle-income countries.*

Responsiveness is a key objective of national health systems. Responsive health systems anticipate and adapt to existing and future health needs, thus contributing to better health outcomes. With innovative approaches and evidence-based practices India has significantly reduced the MMR to 88 per 100,000 live births in India[1] (SRS 21-22). Responsiveness goes beyond service delivery; it encompasses the ability to adapt services based on emerging needs, feedback, and evidence, thereby fostering trust between communities and the health system. Surveillance complements responsiveness by providing the data and insights needed to early detection of high risks, monitor trends, and evaluate interventions. Manyata, a flagship initiative led by the professional association FOGSI, forms the backbone which helps the clinicians understand and contribute to a health system that continually improves to save lives.

Within the network of private providers under Manyata, surveillance mechanisms such as High-Risk Pregnancy (HRP) tracking and Maternal and Perinatal Death Surveillance and Response (MPDSR) are critical for accountability and system improvement. HRP tracking enables early identification and management with reduced chances of complications later and helps in identifying service delivery gaps and prioritizing interventions.

A. Health System Responsiveness

When health system responsiveness and surveillance are well-integrated, inclusive of public and private providers, they create a virtuous cycle: data drives action, improved outcomes that reinforce trust and utilization (Figure 1). *Digital health innovations, community engagement, and real-time data analytics are emerging as game changers in accelerating progress toward SDG targets*. This synergy is essential to accelerating progress toward national priorities and global commitments in maternal and newborn health.

Recent evidence suggests that responsiveness strongly correlates with increased service utilization and improved maternal satisfaction scores, particularly in intrapartum care settings[2]. WHO defines responsiveness as a performance goal encompassing two categories—respect for patients and patient orientation—across eight domains: dignity, confidentiality, autonomy, prompt attention, quality of amenities, choice of provider, provider-patient communication, and social support networks

1 Sample Registration System (SRS). (2023). Maternal Mortality Ratio Bulletin 2021–23. Office of the Registrar General, India. https://censusindia.gov.in.

2 Atnafu A, Dellie E, Kebede A, et al Health system responsiveness and its associated factors for intrapartum care in conflict affected areas in Amhara region, Ethiopia: a cross-sectional studyBMJ Open 2024;14:e082507.

(for inpatients). This framework highlights responsiveness to non-medical expectations as essential alongside health outcomes and equitable financing. The Manyata initiative is built on ensuring these components are met across all private facilities.

Digital health innovations, community engagement, and real-time data analytics are emerging as key drivers of surveillance and responsiveness of the health systems.

Patient experience and satisfaction serve as key indicators of health system responsiveness. In intrapartum care through Manyata standards, responsiveness is assessed through factors such as waiting time, respectful treatment, clear communication, involvement in decision-making, privacy, and choice of healthcare providers.

- Facility readiness ensures that essential staff, equipment, and supplies are consistently available to provide quality health services.
- Emergency referral systems must have functioning transport and communication pathways to manage obstetric and newborn emergencies promptly.
- Provider behavior focuses on professional conduct, empathetic communication, and clinical competence to deliver high-quality care.
- Respectful Maternity Care (RMC) promotes birth environments where women feel safe, supported, and free from abuse or neglect.

A responsive Manyata-certified MNH system thus combines clinical excellence with human-centered care, strengthening trust, encouraging service utilization, and improving health outcomes.

B. Surveillance Systems

In **Maternal and Newborn Health (MNH)**, surveillance is not merely a data-collection exercise, it is a proactive tool to protect lives and improve quality of care. When integrated into routine health system functions, it serves in early identification of high-risk pregnancies and tracking adverse outcomes.

This aids in informing service delivery and policy to provide evidence to guide resource allocation, refine clinical protocols, improve workforce deployment, and shape national strategies. By converting raw data collected through Manyata-certified centers, into **timely, actionable intelligence,** surveillance systems help close the gap between evidence and practice. They ensure that service delivery is informed by real-world realities and that policy decisions are grounded in current, reliable information critical for meeting **Sustainable Development Goals** and reducing preventable maternal and newborn deaths.

The integration of AI-driven predictive models into surveillance systems has shown promise in identifying high-risk clusters and enabling preemptive interventions in states like Tamil Nadu and Kerala.

Cycle: Timely high quality data drives action; Action improves outcomes; Builds trust and increases utilization; Generates richer data

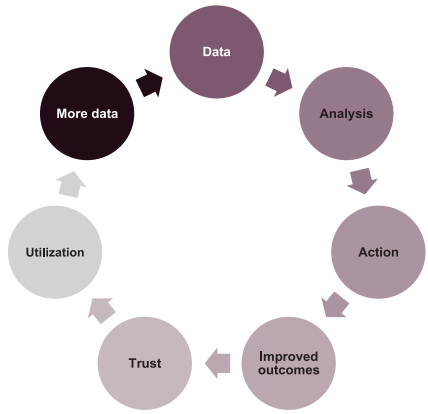


Figure 1: Virtuous cycle of Responsiveness and Surveillance

MECHANISMS OF SURVEILLANCE IN MATERNAL AND NEWBORN HEALTH

High-Risk Pregnancy (HRP) tracking:

HRP tracking is a critical surveillance and care-management function aimed at the early identification and continuous monitoring of women at increased risk of adverse maternal or perinatal outcomes. By flagging and following these cases, the health system can prioritize resources, strengthen referral pathways, and ensure timely, appropriate interventions.

The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)[3], launched by the Government of India, emphasizes universal screening, early identification, and appropriate management of high-risk pregnancies, with a focus on reducing preventable maternal and neonatal morbidity and mortality. **A unique strength of PMSMA lies in its public–private partnership model**, where private sector obstetricians and gynecologists volunteer their services at government health facilities. This collaboration bridges the gap in specialist availability in public facilities, particularly in underserved and rural areas.

Private providers from Manyata facilities play a critical role in screening and identifying high-risk pregnancies, advising appropriate management and referral pathways to ensure timely interventions, enhancing capacity of public health teams by mentoring and guiding medical officers and nurses, and lastly improving community trust and utilization of government health services through visible specialist involvement.

Digital dashboards and mobile-based reporting under PMSMA have improved HRP detection rates by up to 20% in pilot districts (NHM data, 2023).

By bringing together the expertise of private practitioners and the reach of the public health system, PMSMA demonstrates the potential of sustainable partnerships in strengthening maternal health services and accelerating progress toward safer pregnancies and healthier mothers. By linking early detection with proactive case management, HRP tracking strengthens maternal and newborn survival efforts and supports progress toward national and global health targets.

Maternal and Perinatal Death Surveillance and Response (MPDSR):

The Maternal and Perinatal Death Surveillance and Response (MPDSR) is a structured system to identify, notify, review, and act on maternal and perinatal deaths. The primary goal of MPDSR is reducing future preventable maternal mortality through a continuous action and surveillance cycle followed by the interpretation of the aggregated information on the findings which is used for recommended actions that will prevent future deaths. The national and global MPDSR guidelines[4] provide a structured approach to identifying, notifying, reviewing, and responding to maternal deaths, ensuring that lessons learned translate into corrective actions (Figure 2). These mechanisms

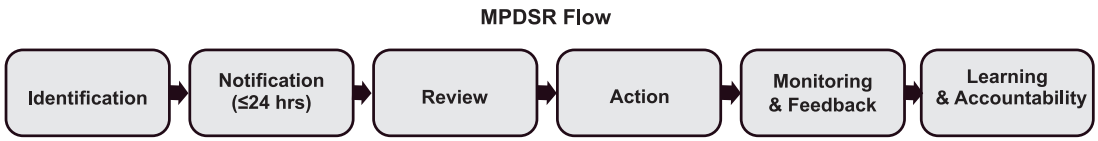


Figure 2: Maternal and Perinatal Death Surveillance and Response FLOW

3 Pradhan Mantri Surakshit Matritva Abhiyan, MoHFW, GoI, 2016

4 WHO guidelines on MPDSR: WHO Implementation Tools for Maternal and Perinatal Death Surveillance and Response, 2021

transform individual cases into opportunities for systemic learning, preventing recurrence of similar events, and making the system more ready to handle the cases in future.

An integrated approach—reviewing both maternal and perinatal deaths—helps detect shared risks such as delays in seeking, reaching, or receiving care, enabling comprehensive interventions that improve outcomes for women and newborns. MPDSR operates at three levels: **community** (verbal autopsies for deaths outside facilities), **facility** (clinical audits in hospitals and health centers), and **district/state** (aggregated analysis, oversight, and policy guidance). The providers at Manyata centers recognise the value of surveillance at their own facility. MPDSR highlights medical and systemic causes, implements corrective measures, and prevents recurrence—fostering a culture of learning over blame, and serving as a key accountability and quality improvement tool.

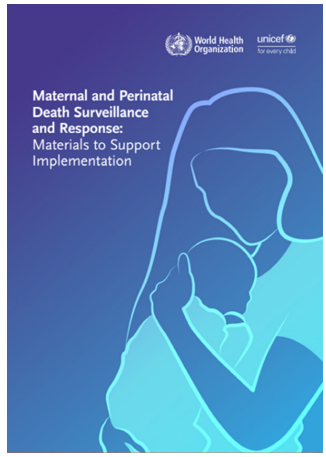
Capacity Building:

Under Manyata, 'Centers of Skill enhancement' have been set up across the country. These centers are led by eminent experts from FOGSI and run structured quality improvement sessions for facilities that enroll for the quality certification. A responsive system relies on competent and confident health providers at Manyata-certified facilities. Investments in CSE skill labs, simulation-based training, structured mentorship, and Simulation-based Instructional Modules (SIMs) strengthen provider competencies, improve clinical decision-making, and promote respectful care practices. Such continuous professional development ensures that frontline workers can respond promptly and empathetically to diverse maternal health needs.

Collectively, these interventions foster a health system that not only saves lives but also honors the dignity, preferences, and rights of women and families bringing India closer to achieving the Sustainable Development Goals for maternal and newborn health.

RECOMMENDATIONS AND WAY FORWARD:

- **Strengthen interoperability –** Integrate HMIS, HRP tracking, and MPDSR platforms for seamless data sharing and coordinated response, both in the private and public healthcare facilities.
- **Use data for action –** Shift from reporting to real-time, local-level problem-solving; institutionalize death review action plans with dedicated budgets to ensure implementation.
- **Enhance respectful care –** Scale up RMC training and expand midwifery-led care models to improve clinical quality, patient experience, trust, and service utilization.
- **Foster learning health systems –** Build feedback-driven, people-centered systems that embed continuous monitoring, reflection, and adaptation into routine practice.
- **Leverage advanced analytics –** Apply AI, ML, and big data for predictive surveillance to detect high-risk clusters early and enable preemptive interventions. *Expand telemedicine and community-based digital reporting to bridge geographic gaps and ensure timely escalation of high-risk cases.*



CONCLUSION:

Health system responsiveness and surveillance are twin pillars of a resilient maternal and newborn health system. Their integration ensures not only timely, quality respectful care but also continuous learning and accountability.

Achieving Sustainable Development Goals in MNH demands systemic change rooted in high-quality data, equity, and commitment to respectful, people-centered services. *Future strategies must prioritize digital transformation, community engagement, and continuous quality improvement to sustain gains and achieve equity in maternal and newborn health.* Strengthening these foundations through Manyata-certified facilities, will ensure quality care for every mother and newborn and optimize outcomes.

Health system Responsiveness and Surveillance build Resilient MNH Systems and together, they drive timely, respectful care and foster learning & accountability.

COLLABORATION MATTERS

LEADING THE WAY TOWARDS QUALITY CARE THROUGH MANYATA

Dr. Amit Shah

INTRODUCTION - THE IMPERATIVE OF QUALITY IN MATERNAL HEALTH

At Jhpiego, we have always believed that reducing maternal and newborn mortality is about more than simply increasing the number of women giving birth in health facilities. The past two decades have shown remarkable progress: institutional births in India increased from 78.9% to 88.6% between 2015–2016 and 2019–2021[1], and the Maternal Mortality Ratio (MMR) declined from 130 to 97 per 100,000 live births by 2018–2020[2]. These achievements reflect government leadership, financing schemes, and strong civil society action. Yet they also underscore a critical truth: access without quality will not deliver the health outcomes we seek.

Globally, Sustainable Development Goal (SDG) 3.1 commits to reducing MMR to below 70 by 2030[3]. The WHO's Quality of Care Network emphasizes that survival and well-being depend as much on the quality of care as on access. Indeed, poor-quality care is now estimated to cause more preventable maternal and newborn deaths than lack of access[4].

In India, this reality is sharpened by the structure of the health system. Approximately 60% of hospital beds and 80% of doctors are in the private sector, including most practicing obstetricians[5]. Nearly one in three births takes place in private facilities[6]. Yet historically, quality improvement initiatives largely focused on the public sector, leaving a gap in private maternity care–a gap marked by underprepared staff, absent protocols, and uneven accountability. For Jhpiego, this presented both a challenge and an opportunity: if we could find a way to engage the private sector meaningfully in quality improvement, the impact on maternal and newborn outcomes would be transformative.

It was against this backdrop that Manyata was born–a collaboration between the Federation of Obstetric and Gynaecological Societies of India (FOGSI) and Jhpiego, supported by forward-thinking funding partners. Today, we are proud to look back on over a decade of partnership that has made Manyata a model of professional-led, private sector quality improvement–and to look ahead at its potential as a regional and global exemplar.

MANYATA - BUILDING A CULTURE OF QUALITY

Launched in 2017, Manyata–meaning "recognition" – is India's first large-scale quality improvement and certification program tailored for private maternity facilities and led by a professional association, FOGSI. Manyata was born from a simple conviction: every woman deserves safe, respectful, evidence-based care, regardless of where she gives birth. Jhpiego's role was to provide the technical foundation, ensuring that the program was rooted in evidence-based clinical standards.

1 Press Release:Press Information Bureau [Internet]. [cited 2025 Sep 1]. Available from: https://www.pib.gov.in/PressReleasePage.aspx?PRID=1847431

2 Press Release:Press Information Bureau [Internet]. [cited 2025 Sep 1]. Available from: https://www.pib.gov.in/PressReleasePage.aspx?PRID=2119577

3 Maternal and reproductive health [Internet]. [cited 2025 Sep 1]. Available from: https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality

4 Quality of care | UNICEF [Internet]. [cited 2025 Sep 1]. Available from: https://www.unicef.org/health/quality-care

5 View of Health workforce in India: opportunities and challenges [Internet]. [cited 2025 Sep 1]. Available from: https://www.ijcmph.com/index.php/ijcmph/article/view/5326/3473

Together with FOGSI, we translated global and national guidelines into 20 practical, measurable standards for maternity homes. These covered the most common and dangerous complications–postpartum hemorrhage, preeclampsia, obstructed labor, and neonatal resuscitation–as well as respectful care practices such as informed consent and allowing birth companionship.

Beyond drafting standards, Jhpiego helped design the implementation framework, training curricula, and digital tools that translated guidelines into practice. We embedded a low-dose, high-frequency mentoring model–short, repeated coaching visits–to reinforce provider skills and confidence. Assessment checklists and monitoring systems enabled facilities to track progress.

Importantly, we supported FOGSI in shaping Manyata as voluntary and peer-driven. By positioning FOGSI as the certifying body, Manyata encouraged private providers to engage as professionals seeking to improve, rather than as facilities under regulation. Jhpiego's role was to backstop this peer-led process with rigorous technical design, capacity-building, and systems support.

FROM PROOF OF CONCEPT TO NATIONWIDE SCALE

Proof of Concept:

The origins of Manyata can be traced back to 2013–2015, when Jhpiego piloted structured mentoring approaches in small maternity facilities of Uttar Pradesh and Jharkhand[7]. These pilots demonstrated that with the right support, even resource-constrained private clinics could adopt lifesaving practices. Encouraged by these results, FOGSI formally launched Manyata in 2017, beginning with Uttar Pradesh, Maharashtra, and Jharkhand[7]. Jhpiego provided the technical scaffolding: training master mentors, conducting baseline gap assessments, and documenting results that validated the model.

Scale-Up:

From 2018 onward, Manyata rapidly expanded. Today, it spans 25 states and union territories, with more than 3,000 facilities engaged in quality improvement[8]. Its strongest presence lies in Uttar Pradesh, Maharashtra, Rajasthan, Jharkhand, Bihar, Karnataka, and Tamil Nadu. In Rajasthan, Manyata was embedded in the Utkrisht Development Impact Bond, while in Maharashtra, the LaQshya-Manyata collaboration with the state government aligned private facilities with national quality guidelines[9].

Partnerships and Ecosystem:

Scaling Manyata has been possible only through strong partnerships. Each partner brought unique contributions:

- **FOGSI –** professional legitimacy and certification leadership
- **Jhpiego –** technical backbone, training, mentoring, and digital tools
- **Donors (MSD for Mothers, MacArthur Foundation) –** catalytic financial support
- **Implementation partners (PSI, Palladium, Swasti, HLFPPT) –** on-ground expansion
- **Ariadne Labs –** research and evidence generation

This ecosystem approach was critical to scaling Manyata while maintaining technical fidelity.

6 Kumar GA, George S, Majumder M, Dora SSP, Akbar M, Mahapatra T, et al. Private sector delivery of care for maternal and newborn health: trends over a decade in the Indian state of Bihar. BMC Med [Internet]. 2025 Dec 1 [cited 2025 Sep 1];23(1):1–12. Available from: https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-025-03894-6

7 Pradesh U. Mission Build a sustainable model to improve and assure excellent maternity care at private healthcare facilities in India. SCALING AND SUSTAINING QUALITY PRIVATE MATERNITY CARE IN INDIA Overview PLACE: Five states. 2019;

8 Delaney MM, Usmanova G, Nair TS, Neergheen VL, Miller K, Fishman E, et al. Does Quality Certification Work? An Assessment of Manyata, a Childbirth Quality Program in India's Private Sector. Glob Health Sci Pract [Internet]. 2022 Dec 1 [cited 2025 Sep 1];10(6):e2200093. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC9771457/

9 How can LaQshya-Manyata benefit you? Regulatory Perspective Join Our Quality Care Community! [cited 2025 Sep 1]; Available from: www.maharashtralaqshayamanyata.org

Institutionalization:

Perhaps the most significant milestone was integration with NABH. Jhpiego provided technical inputs to align Manyata's standards with NABH's entry-level accreditation framework. In 2022, FOGSI and NABH signed an MoU, and by 2024, NABH had formally subsumed Manyata's standards into its certification process[10]. This institutionalization ensures longevity, embeds maternal health quality into national accreditation, and signals that private maternity care must meet the same expectations of safety and accountability as any other health service.

Challenges and Innovations - Lessons in Adaptation:

The journey was not without hurdles. Many small facilities struggled with:

- Documentation gaps
- Resistance to external evaluation
- Severe time constraints for training

Jhpiego and FOGSI responded with pragmatic innovations: simplified templates, peer-led mentoring, and simulation-based modular training. As one Jhpiego program officer reflected:

At first, many doctors said, "We don't have time for paperwork." When we showed them that good documentation was not bureaucracy but a safety tool, attitudes shifted.

These adaptive solutions nurtured a culture of continuous improvement.

Impact and Achievements:

Evidence from Manyata is robust and inspiring. In an evaluation of 466 private facilities, average knowledge scores increased from 6.3 to 13.2 out of 20, practical skill scores from 8.0 to 34.3 out of 40, and facility-level adherence to standards rose from 29% at baseline to 93% at endline[8].

Beyond numbers, Manyata empowered thousands of nurses and doctors with structured upskilling–often their first since graduation. Respectful maternity care practices such as informed consent and birth companionship were reinforced. By 2023, over 2,000 facilities were certified or in process, collectively serving hundreds of thousands of women[11,12].

Recognition followed: The AVPN Constellation Award in 2022, features in peer-reviewed journals, and global forums. For Jhpiego, perhaps the most profound shift has been cultural–quality has become part of the vocabulary of private maternity care, and certification is increasingly seen as a badge of distinction.

Voices from the Frontlines:

Ultimately, the success of quality initiatives rests not only on policies but on the people who live them daily. These voices bring the story of Manyata to life:

"I've noticed a remarkable trait among my staff during emergencies. They remain composed and focused on what needs to be done. This calm and collected approach instills confidence and ensures efficient management." – *Dr. Kumar Saurav, R D Memorial Hospital, Allahabad*

10 Elevating Maternal Care through the NABH–FOGSI Manyata Collaboration - National Accreditation Board for Hospitals and Healthcare Providers (NABH) [Internet]. [cited 2025 Sep 1]. Available from: https://nabh.co/project-partnership/elevating-maternal-care-through-the-nabh-fogsi-manyata-collaboration/

11 Evidence for Impact [Internet]. [cited 2025 Sep 1]. Available from: https://www.msdformothers.com/docs/MSD-for-Mothers-Evidence-for-Impact-2022.pdf

12 Transformational Impact: Scaling and Sustaining Maternal Health Solutions [Internet]. [cited 2025 Sep 1]. Available from: https://www.msdformothers.com/docs/transformational_impact.pdf

"Thorough documentation practices introduced under Manyata have been a game changer. Records are now cohesive, clear, and invaluable for quick decisions." – *Dr. James Elangbam, Acme Fertility & Healthcare Centre, Manipur*

"As a first-time mother, I was scared, but the staff at Deshmukh Hospital explained everything clearly and treated me with kindness and respect. I felt safe and cared for." – *Mishqat, New Mother, Ujjain*

These voices remind us that Manyata is not just about standards on paper; it is about equipping real people with lifesaving skills and creating trust between providers and communities.

The Road Ahead - Towards a Replicable Exemplar:

With NABH integration, Manyata standards are now nationally recognized. Jhpiego is helping design financing models such as subscription-based mentoring, blended financing, and results-based mechanisms to ensure that quality improvement becomes routine practice.

Manyata's influence is now extending beyond India, spreading through the AOFOG-led *Uniting for Quality* initiative[13]. Professional associations in Bangladesh, the Philippines, Nepal, Pakistan, Indonesia, and Mongolia are adapting Manyata's principles–professional association leadership, peer mentoring, and practical standards–to local contexts with Jhpiego's support.

These early steps underscore the potential of Manyata as a replicable model of system reform in mixed health systems. With sustained partner support, replication can demonstrate how professional bodies, governments, and accreditation agencies across Asia can work together to raise maternal health quality.

CONCLUSION - LEADING THE WAY TOGETHER

For Jhpiego, Manyata represents more than a program. It is a testament to the power of partnership between a professional body and a global technical agency, supported by a broad coalition of funders, implementers, and governments. From modest beginnings in 2013 to nationwide recognition and NABH integration in 2024, Manyata has shown that quality of care is achievable, scalable, and lifesaving.

Key Takeaways:

- Quality is as critical as access.
- Private sector engagement is essential.
- Peer-led, evidence-based models can scale.
- Partnerships drive sustainability and replication.

We are proud to have provided the technical backbone and operational support that helped transform Manyata into what it is today. And we remain committed, now more than ever, to ensuring that Manyata continues to lead the way–in India and beyond – towards a future where quality care is every woman's right and every newborn's start in life.

13 AOFOG NEWS [Internet]. [cited 2025 Sep 1]. Available from: https://www.fogsi.org/wp-content/uploads/2024/07/AOFOG-Newsletter-April-2024.pdf

BUILDING THE MANYATA BRAND

Sonika Bakshi, Sanjana Jain, Titash Basu

COMMUNICATION AS A CATALYST FOR CHANGE

For Manyata, communication was never about promoting the program itself. It was about promoting **conversations on quality maternal care**, bringing maternal health to the forefront of public discourse, and positioning respectful, safe, and consistent care as a non-negotiable. This is where communication becomes transformative. It can elevate neglected issues, influence decision-makers, and shift societal attitudes.

Maternal health continues to be one of India's most pressing public health challenges. Despite advances in healthcare access, thousands of women still lose their lives each year due to preventable complications during childbirth. In such a context, saving lives requires more than clinical interventions alone. It also demands awareness, trust, and a supportive ecosystem that places women at the center of care.

As the integrated communications and ecosystem engagement partner, Weber Shandwick built a strategy rooted in **sustainable, simple, and scalable communication**. This strategy blended branding, media, advocacy, digital storytelling, and partnerships. Its levers were clear:

- Nudge the ecosystem towards recognizing quality maternal care as a priority
- Keep mothers visible in public conversations
- Demonstrate the role of the private sector and professional associations in advancing public health goals

At the core was a philosophy we call **"slow-burn advocacy."** Unlike campaigns that chase short bursts of visibility, this approach emphasizes steady, deliberate narrative building over time. It is about creating sustained conversations that move beyond headlines to influence mindsets, behaviors, and policies. By consistently amplifying women's voices and reinforcing the message of quality maternal care across multiple platforms, the strategy embedded the issue into the psyche of stakeholders—from policymakers to providers. This gradual, persistent effort cultivated collective ownership and ensured that maternal health quality was not just acknowledged but mainstreamed and acted upon.

MANYATA – THE BRAND VISION AND IDENTITY

From the outset, Manyata was envisioned not just as a program, but as a trustmark that providers, women, and communities could trust. Its purpose was clear: ensuring that every woman in India receives respectful, quality care during and after childbirth by empowering small healthcare facilities and providers to adopt and sustain high standards in maternity care.

The visual identity reinforced this mission. The name *Manyata* translates "recognition" in Hindi, underscoring reliability and assurance. Its embedded syllable "Ma"—meaning mother—kept women at the heart of the brand and carried symbolic weight, reflecting the central figure—the program exists to serve. A warm pink palette was chosen to symbolize tenderness, compassion, and safety, while also reflecting the idea that mothers should be in the pink of their health. The logo, depicting a mother and child, visually reinforced this bond of care and protection.

What truly set Manyata apart was its **everyday resonance.** The phrase *"Iss clinic ko Manyata praapt hai"* (this facility is Manyata-certified), became a simple, **easy-to-sustain communication device**, offering reassurance to families even in small, resource-constrained settings. By embedding this identity consistently across partner dialogues, digital platforms, community outreach, and media stories, Manyata built **trust that was both sustainable and accessible.**

The **#DontForgetMoms campaign** further reinforced this philosophy. In a culture where celebrations around childbirth often overshadow the mother's well-being, the campaign shifted focus back to women, reminding audiences that quality care for women is foundational to maternal and child health. Conceptualized and executed by Weber Shandwick, the campaign became the overarching communication umbrella under which all subsequent efforts were anchored. Through sharp messaging, compelling visuals, digital storytelling, and media outreach, #DontForgetMoms repositioned the conversation—bringing women back into the center of attention. This comprehensive campaign not only strengthened Manyata's identity but also reframed the maternal health discourse—making the mother visible again.

FROM CONVERSATIONS TO MOVEMENT – ADVOCACY IN ACTION

When we began our work with Manyata, the subject of Quality of Care in maternal health was marginal. Public health conversations in India largely focused on access and infrastructure, with little visibility of the private sector's role and limited attention to the Quality of Care women received in private facilities.

Changing this required **patient narrative seeding**, where communication was not about a single message but about steadily shaping mindsets. By consistently spotlighting gynecologists, facility leaders, and policymakers at FOGSI forums, roundtables, and other convenings, the idea of quality care was framed as a collective responsibility rather than an external mandate.

These platforms created engaging spaces for dialogue, peer learning, and recognition of best practices, which helped normalize the conversation. Over time, champions emerged—leaders who internalized the narrative and carried it into their own networks—ensuring the idea gained acceptance, traction, and a place within professional and policy agendas.

This was **not event-led advocacy, but slow, persistent cultivation**. From peripheral discussions, quality moved to the center of policy dialogues and media narratives. Thought leadership in the media—via opinion articles, interviews, and stories—brought forward the role of private facilities, the leadership of FOGSI, respectful maternity care, and models of public–private collaboration. This **positioned FOGSI not just as a medical society, but as a professional association actively complementing public health goals—setting an example for other healthcare challenges**.

Over time, what was once a fringe conversation became a mainstream priority, and this strategic visibility gave maternal health the spotlight it had long lacked, while building Manyata's standing as a movement aligned with both government priorities and societal needs.

PLATFORMS, PARTNERSHIPS, AND STORYTELLING

For advocacy to stick, the story needed to be heard at the **right platforms**. Manyata was positioned on both global platforms such as Partnership for Maternal, Newborn & Child Health (PMNCH), United Nations General Assembly (UNGA), Women Deliver, International Society for Quality in Health Care (ISQua), International Federation of Gynecology and Obstetrics (FIGO), Asian Venture Philanthropy Network (AVPN) and national stages like Federation of Indian Chambers of Commerce and Industry (FICCI), Confederation of Indian Industry (CII), NATHEALTH, National Quality of Care Network (NQOCN). These forums validated it as a pioneering **private sector led model complementing government priorities**. These opportunities validated the programand positioned it as an example of innovative collaboration in India.

Storytelling was central to this positioning. We created a diverse content suite including short films, newsletters, testimonials, social media engagement, WhatsApp communities, and YouTube videos. Each piece highlighted real stories of women, providers, and nurses whose lives or practices had been transformed through Manyata. These narratives cut through abstract data and statistics, personalizing the impact and making the brand relatable to multiple audiences—from policymakers to expectant mothers.

How Compassionate Practices at Manyata Centers Boost Pati...

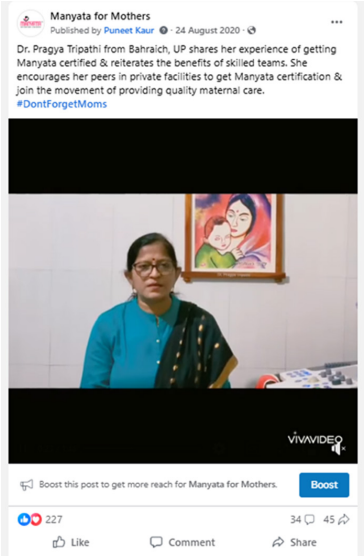
500 views • 1 year ago

Discover how @OmegaHospital, a Manyata Center in Nagpur is setting a new standard for maternal care with its compassionate approach. This video explores the impactful practices that prioritize patient well-being, leading to high levels of satisfaction among mothers. Watch to see how empathy and excellence in care are making a difference in the lives of patients....

READ MORE

Showcasing women's voices from Manyata-certified facilities sharing their lived experiences

Engaging with key stakeholders across the maternal health ecosystem and amplifying milestone



Deepening engagement across the FOGSI community and strengthening outreach to private providers

Equally important were the ecosystem convenings and roundtables that nurtured collaboration—creating neutral spaces for dialogue where stakeholders could exchange ideas, share challenges, and co-own the maternal health agenda. By serving as the 'glue' of the ecosystem, Manyata fostered collective solutions, catalyzed new partnerships, and amplified partner voices without overshadowing them.

RECOGNITION AND IMPACT – THE MANYATA BRAND TODAY

Years of consistent communication and ecosystem engagement have borne visible results. Manyata is today recognized as far more than a program—it is acknowledged as a **movement for quality maternal care.**

The initiative has received multiple awards and honors, including recognition at the Federation of Indian Chambers of Commerce and Industry (FICCI), Confederation of Indian Industry (CII), Asian Venture Philanthropy Network (AVPN), Healthcare Federation of India (NATHEALTH), Financial Express (FE) Healthcare Summit, and CSR Impact Awards. Each award has reinforced the reputation of Manyata as an **innovative, collaborative model** that delivers both social impact and systemic change.

Equally significant is the intangible impact of the brand. Within the healthcare community, Manyata has become synonymous with credibility and quality. Among partners, it is seen as a unifying platform that aligns diverse interests toward a common goal. And for women and their families, it is emerging as a **trusted symbol** that reassures them of safe, respectful, and quality care.

This transformation is directly linked to the integrated communication efforts led by the team at Weber Shandwick. The **slow-burn advocacy model**—anchored in consistency, layered storytelling, and ecosystem alignment—has not only created visibility but also fostered trust and sustainability. The value earned over years of deliberate communication has positioned Manyata as a blueprint for how maternal health programs can evolve into movements.

CONCLUSION – LESSONS IN BUILDING A MOVEMENT

The journey of Manyata demonstrates that public health communication, when strategically deployed, is not about amplifying programs but about amplifying issues. By elevating conversations on quality maternal care rather than the initiative itself, Weber Shandwick helped nurture ownership, align diverse stakeholders, and embed the discourse within national and global health agendas.

Through campaigns like *#DontForgetMoms,* the cultivation of ecosystem champions, and sustained presence across platforms, communication moved beyond visibility to foster partnerships, showcase the private sector's role in advancing public goals, and position associations like FOGSI as credible voices in public health.

The result is a blueprint for social impact: communication that is simple, consistent, and sustainable can catalyze systemic change, build trusted brands, and leave behind legacies. Manyata's story testifies when women's voices are elevated and ecosystems are aligned, communication does more than tell a story—it builds movements.

MANYATA GOES DIGITAL

Dr. Tarun Sodha

INTRODUCTION

The Manyata program, led by the **Federation of Obstetric and Gynaecological Societies of India (FOGSI)**, has been at the forefront of improving maternal and newborn care in India's private healthcare sector. With its vast network of obstetricians and gynecologists, FOGSI envisioned a program that would empower healthcare facilities to deliver safe, respectful, and evidence-based care to every woman.

From the start, Manyata's intent was clear, to make quality care a universal approach across all levels of healthcare facilities; small or large; rural or urban. Over the years, this model has reached 3000 plus healthcare facilities impacting around 24000 healthcare providers and more than one million pregnant women, making a measurable difference in maternal health outcomes across the country. But as the program expanded across the, it became clear that the next phase of impact would depend on one thing, **Digitalization**.

THE EARLY JOURNEY

From the very beginning, **Manyata has been a pioneer in bringing change to how quality in maternal care is measured and improved**, in India's private healthcare sector. It was among the first programs to set quality standards specifically for enhancing maternal and newborn care, train facility teams, and introduce certification that recognized compliance to these standards while delivering care provision.

The National Program Management Unit (NPMU) leads and anchors Manyata's quality assurance. They train assessors, who upon empanelment evaluate private facilities against Manyata standards and recommend for the certification. Even in its early, paper-based years, the program made remarkable strides. Assessors travelled across states to conduct in-person evaluations, capture observations, and share them with the National Program Management Unit (NPMU).

As the program grew, Manyata continued to innovate. **During the COVID-19 pandemic, when in-person visits became impossible, Manyata was pioneer to adapt and introduced virtual assessments**, ensuring that quality journeys did not stall even in the most challenging circumstances. This shift not only kept facilities engaged striving for quality of care during lockdowns but also demonstrated that remote quality evaluation was both possible and effective.

However, these pioneering efforts also revealed opportunities to further strengthen the model especially as the number of facilities enrolling for Manyata were increasing at the faster pace. Earlier, many facilities began their journey without a self-assessed baseline score or identified gaps, making it harder to measure progress from the outset. Mentoring required significant onsite effort by the Centers for Skill Enhancements (CSE), often without the benefit of real-time digital feedback, and facilities had limited access to required material for gap closure, sometimes slowing facility's improvement process. These were not shortcomings, but natural milestones in the evolution of a fast-growing, ambitious program, each becoming a stepping stone toward the next phase of innovation: the full digital transformation of the Manyata journey.

DIGITALIZATION – THE GAME-CHANGER

The decision to take Manyata digital marked a turning point, not just in operational efficiency, but in how facilities experienced and owned their quality journey. With digitalization of the entire process, the Manyata journey can now be clearly broken into three streamlined phases, (1) onboarding and self-assessment, (2) clinical trainings and quality improvement guided by CSEs, and (3) final assessments and certification. All three stages are completely digital, eliminating paper-based processes and delays, making the system more efficient and transparent, by significantly reducing manual effort and time.

Digitalization introduced a suite of features designed to empower facilities:

- **Self-assessment tools:** Facilities can now assess themselves against Manyata quality standards at their convenience on Manyata's Quality Assessment platform, immediately identifying strengths and gaps.
- **Instant baseline scores:** The system generates a baseline score on the spot, giving facilities a clear starting point and enabling them to track progress over time.
- **Platform to support quality improvement:** Facilities can take up their improvement journey supported by clear tasks, required resources on the platform and they can also upload the evidence of the improvement.
- **Targeted training, mentoring and evidence-based decisions:** With data available at their fingertips on Manyata's Quality Analytical Platform (QAP), CSEs can now tailor training sessions to the exact needs of each facility.

This isn't just about replacing paper with a platform; it's about creating a **living, dynamic quality improvement system** that guides facilities step-by-step, adapting to their progress in real time. All these changes from self-assessment and digital mentoring to transparent progress tracking and faster certification have been developed and anchored in the philosophy of continuous quality improvement brought by **PharmAccess's SafeCare framework of institutionalizing quality in healthcare facilities**. SafeCare ensures that the digital journey is not just about efficiency, but about guiding facilities step by step toward sustainable, long-term quality.

EMPOWERING STAKEHOLDERS THROUGH DATA

One of the most transformative aspects of the digital journey is how it empowers every stakeholder with access to timely, actionable data. Facilities no longer need to wait for external reports; they can instantly view their scores, identify gaps and produce /share evidence of improvement, giving them ownership of their quality journey from day one.

For **CSEs**, digitalization has been a game-changer. With facility-specific data at their fingertips, CSEs can deliver highly targeted training and mentoring, ensuring that every session addresses actual, identified gaps rather than relying on generic approaches. Their mentoring support is now more focused, efficient, and impactful.

Assessors also benefit from the digital system, which standardizes assessments by providing clear scoring guidelines, no paperwork, and generates instant results. This not only saves time but also ensures transparency and consistency across the system.

For **National Management Programme Unit and Partners**, aggregated data provides a strategic lens: they can identify gaps to be closed, evidence to strengthen the systems and policies, monitor regional trends, and allocate resources where challenges are most persistent.

In short, digitalization has created a shared ecosystem of accountability and collaboration where every stakeholder, from frontline staff to program leaders, is better equipped to drive quality improvements.

Dr. Shikha Maurya, Shikha Hospital, Prayagraj, Uttar Pradesh

"Self-assessment is an important step if undertaken sincerely by the hospital in-charge. We get to know our shortcomings. The digital tool and library section extensively supported us."

EARLY IMPACT AND POSITIVE OUTCOMES

Since the introduction of digital platforms for the complete journey, Manyata has observed:

- **Wider reach:** Facilities in remote or hard-to-reach areas are now actively participating, as distance is no longer a barrier to assessments and mentoring.
- **Faster turnaround:** The time from enrolment to certification has been significantly reduced.
- **More engaged training:** CSEs report that data-driven training is more impactful, with facilities able to act on specific feedback immediately.
- **Sustained improvement:** Digital tracking encourages ongoing quality efforts, even after certification.

THE ROAD AHEAD

The goal remains the same **to ensure that every woman, everywhere, receives the highest quality care possible** but now, with the digital tool, the aim is to achieve it faster, smarter, and in the wider regions.

CONCLUSION

The shift to digital is more than an operational change for Manyata; it is a statement of intent. It says that quality is not a one-time achievement but a continuous journey, and that every facility, no matter its size or location, can be part of that journey.

With the combined strength of FOGSI's leadership, technical know-how, and PharmAccess SafeCare's digital framework, Manyata is proving that scaling quality is possible.

BACKING MANYATA THROUGH EVIDENCE

Megan Marx Delaney, Erin Lawler, Danielle Tuller, Katherine Semrau

The goal was to build Manyata into a self-sustaining national initiative that could effectively bring together all groups with a stake in the quality of care in India's private sector. Reaching this goal would require a comprehensive evaluation of how well the initiative was working and what strategies could be used to boost participation and implementation. As Manyata entered its third phase in 2020, its leaders saw a need to begin building an evidence base that would inform a path forward for continued implementation and spread.

Manyata leaders sought to partner with an external research group to help evaluate the initiative and develop a learning agenda to guide its future. It was important that any partner coming into this work could be sensitive to the unique needs and challenges of the project while also bringing a global perspective to help prioritize areas for research and funding. Additionally, it would be important for the partner to be equipped to rapidly translate the evidence base into actionable recommendations to improve programming and practices.

Ariadne Labs was selected as a learning and evaluation partner and joined the Manyata collaboration in 2020. Ariadne Labs is a joint center for health systems innovation at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health. Co-founded by Atul Gawande, MD, MPH, Ariadne has more than a decade of experience designing, testing, and spreading solutions to some of the most pressing challenges in health care. From developing checklists and conversation guides to fostering international collaborations and establishing global standards of measurement, their work has been accessed in more than 185 countries, touching hundreds of millions of lives.

Starting in February 2020, Ariadne Labs partnered with MSD for Mothers, FOGSI, Jhpiego, and other partners to collaboratively build an evidence base to inform Manyata's future spread. Each partner brought unique perspectives and areas of expertise to create a highly practical approach to evaluation. Ariadne Labs brought expertise in evaluation and implementation science; Jhpiego brought extensive experience in large-scale implementation, quality improvement, and relationship building in India; FOGSI brought an immense network of obstetricians and gynecologists with clinical expertise; and MSD for Mothers centered the work with their vision for how quality programming within health systems drives better health outcomes. Together, the partners set the stage for effective evaluation.

MORE ABOUT ARIADNE LABS – A PROVEN LEADER IN MATERNAL HEALTH INNOVATION AND EVALUATION

Ariadne Labs' BetterBirth team came into the Manyata collaboration with a proven track record of designing, testing, and implementing solutions to improve global maternal and newborn health. Their work began in 2010 with an initial mandate to evaluate the WHO's Safe Childbirth Checklist, a 29-item tool intended to increase adherence to evidence-based practices in global birth facilities.

From 2012-2017, the team led the world's largest maternal and child health cluster randomized trial, the BetterBirth trial. Over five years the team followed more than 300,000 mothers and babies to

test whether use of the Safe Childbirth Checklist combined with a peer coaching program affected maternal and perinatal mortality and maternal morbidity in Uttar Pradesh, India. The study produced more than 204 million quantitative data points and a wealth of qualitative data. The BetterBirth trial earned recognition from Oxford Academic Press as one of the "50 studies every global health practitioner should know."

As of 2025, at least 35 countries have implemented the Checklist worldwide, and it has impacted an estimated 6.8 million births to date. The Checklist has been incorporated into national policy of several countries. In India, for example, the Checklist's incorporation into quality of care training and implementation packages for frontline facilities through Manyata in the private sector and LaQshya in the public sector will impact a potential 27 million births per year once fully scaled.

The team continues to identify new opportunities to adapt and implement the Checklist globally, while also turning to tackle new challenges in infant feeding and postpartum care, with the goal of designing and evaluating innovations to improve care across the entire maternal and child health ecosystem.

ROLE IN BUILDING AN EVIDENCE BASE FOR MANYATA

The Ariadne Labs team worked closely with implementation colleagues at Jhpiego India to co-develop an evaluation strategy, applying their decade-long learnings in evaluating maternal health interventions to understand the impact of Manyata and how to improve future implementation efforts. The Ariadne team brought both the rigorous methodological expertise and the practical implementation knowledge to effectively evaluate the impact of the Manyata initiative and translate findings in real time to inform its growth.

The evaluation used a mixed-methods approach to analyze existing program data for key trends while also conducting qualitative stakeholder interviews.

PRIMARY RESEARCH GOALS INCLUDED

- Analyzing Manyata's impact on health care providers' knowledge and skills, adherence to key childbirth-related clinical practices, and health outcomes for women and newborns
- Assessing how different iterations of the program (i.e., in-person versus virtual presentation of Manyata) affected the quality of care, providers' adherence to standards, and ultimate achievement of certification
- Understanding what facilities saw as the perceived value of the program that motivated them to join and achieve certification

For the rigorous **qualitative study**[1], Ariadne collaborated with Outline India to conduct and analyze more than 180 interviews across four states and nine stakeholder groups. Interviewees included physicians, nurses, FOGSI assessors, program implementers, and program leadership. For the quantitative component, the team used existing program data to evaluate the impact on staff knowledge and skills, adherence to evidence-based practices, health outcomes, and patient-reported experiences.

1 Spigel L, Pallipamula S, Chabba R, et al. Perceived effectiveness and recommendations from a childbirth quality assurance and improvement programme in India's private sector: a qualitative evaluation using the RE-AIM framework: BMJ Public Health 2025;3:e001054.

KEY FINDINGS

From their analyses, the team developed a set of key findings and recommendations to support the program's continued scale in India.

Findings were organized along three primary themes:

Factors that initially motivated facilities to **join** the Manyata program, how the program supported facilities to **succeed** in improving outcomes, and how facilities **sustain** quality improvement efforts in the long-term.

- **Join:** The team found that access to staff training, strategies to improve care, and the program's affiliation with FOGSI were the primary motivators for facilities to join Manyata.

  Recommendation: To further boost motivation to join, the team recommended expanding existing recruitment strategies that relied heavily on word-of-mouth, emphasizing program attributes (noted above) and communicating a clear process for facilities to follow from recruitment through certification.

- **Succeed:** Findings from the quantitative analysis showed the Manyata program had a positive impact on improving clinicians' **knowledge scores, skill scores, and adherence to evidence-based clinical standards**.[2] Data from 410 facilities showed adherence to Manyata quality standards was low at baseline, averaging 25% adherence across standards. Following Manyata implementation, standards on routine newborn care and management of postpartum hemorrhage showed the biggest increases in adherence (70 percentage point increase and 69 percentage point increase, respectively). Adherence to other complication management-related standards, such as cesarean deliveries, neonatal resuscitation, and eclampsia management, improved during Manyata, but continued to have the overall lowest adherence by the final measurement point.

  Recommendation: To further improve success, the team recommended developing additional strategies to improve complication management and adherence to standards for Cesarean deliveries, which did not significantly improve following program implementation. They also recommend using hybrid training models and a tiered approach to offer different levels of training and mentoring support depending on the needs of each facility.

- **Sustain and scale:** The team found that stakeholders felt that the improved standards were sustainable at the facility level, and that it was feasible to scale the program nationally and internationally.

  Recommendation: To further support the need for ongoing training and recertification, the team recommended developing post-certification support, options for refresher training, and training for facilities and staff on building a culture of quality.

Evidence that emerged from the study was quickly integrated to continually refine and improve program content and implementation approaches. Through the evaluation, Manyata was shown to offer a promising model for private sector engagement for governments, implementation agencies, and other professional societies as they collectively work to improve the quality of care for all women and newborns. The Manyata initiative continues to expand and evolve, as it seeks to build a feasible and sustainable model at scale. To this end, Manyata was incorporated into the National Accreditation Board of Hospitals and Healthcare Providers in India, the premier organization for healthcare accreditation in India.

2 Delaney, Megan Marx et al. "Does Quality Certification Work? An Assessment of Manyata, a Childbirth Quality Program in India's Private Sector." Global health, science and practice vol. 10,6 e2200093. 21 Dec. 2022, doi:10.9745/GHSP-D-22-00093

By building an evidence base for the initiative, the team was able to showcase Manyata's value for stakeholders, while highlighting its positive impact on improving quality of care in private facilities. The evidence developed informed creation of a learning agenda for the initiative to continue to improve and develop strategies for effective implementation and continued growth.

RESPECTFUL CARE - EVERY MOTHER'S RIGHT

Dr. Aparajita Gogoi, Tina Ravi

The labor room was quiet except for the sound of deep, steady breathing. Meena, a young woman from a small village in Maharashtra, gripped the edge of the bed as another contraction swept through her. She had heard stories from other women, stories of being scolded, strangers walking in without warning, women left alone in pain. She expected the same.

But today felt different. A nurse leaned close and said, "You're doing well. Would you like your mother to come in and be with you?" Curtains were drawn for privacy, and every procedure was explained before it began. Meena felt something she had not expected: she felt like she mattered.

That is the heart of Respectful Maternity Care, or RMC. It is not about advanced technology or expensive equipment. It is about dignity, kindness, and the right of every woman to feel safe and respected at one of the most important moments of her life–Childbirth.

THE ISSUE

Respectful Maternity Care (RMC) is a cornerstone of quality, rights-based maternal health services, yet institutionalizing it within health systems remains a global challenge. Supported by MSD for Mothers, our role within the Manyata network focuses on embedding RMC into the private sector services. Despite policy commitments, many countries struggle to translate principles into consistent practice at the facility level. Barriers to RMC exist at every level. In health facilities, entrenched norms and habits can overshadow women's right to RMC. Accountability mechanisms are often weak or absent. Many providers have not been trained to see empathy and communication as an essential part of care, and harmful behaviours may be normalized as "just the way things are done." Within communities, expectations are often so low that disrespect and abuse during childbirth are accepted as inevitable. Women may feel powerless to speak up or fear retaliation if they do.

India has taken important steps to institutionalize RMC. National programs have embedded RMC into guidelines, and initiatives like LaQshya and SUMAN have explicitly recognized that dignity and respect are central to quality care. Yet, policies on paper do not always guarantee change on the ground. Real transformation requires multi-level interventions–working with women to build agency, with providers to shift attitudes and skills, with health systems to create accountability, and with policymakers to ensure that respectful care is a standard of care.

C3'S WORK

For us, the journey toward RMC began with a question: *What do women want during childbirth?* Through our **What Women Want campaign,** that we conceptualized in India and which later became a global campaign directly hearing from over 2 million women, we learnt the one key thing that women wanted—**respectful maternity care**. They wanted to be treated kindly. They wanted to be free from shouting or scolding. They wanted to understand what was happening to their bodies. They wanted to have a birth companion by their side.

C3 chose to respond to women's expressed aspirations, with an **integrated approach**–one that does not focus solely on providers, or solely on women, but on the entire system in which maternity care takes place. This approach combines the capacity building of healthcare providers with efforts to strengthen women's agency, engage communities, and support health system improvements. It means working with decision-makers to design and implement RMC policies and programs. It means fostering partnerships with professional associations to shift institutional norms. And it means enabling women themselves to demand respectful care, while also addressing the attitudes, biases, and systemic barriers that providers face.

Our challenging role within the Manyata network focuses on embedding RMC into the private sector services. This meant generating insights into women's experiences within private facilities, strengthening provider capacity to deliver dignified care and working with leading professional associations of healthcare providers such as FOGSI, TNAI, and SOMI. At the same time, we worked to create public awareness and demand for respectful care in the private sector, ensuring that women's voices shape how maternity services are delivered.

We Created an Evidence Base:

From the beginning, our work was grounded in **research**. We partnered with many prominent Indian organizations, one among them being the Indian Council of Medical Research, to examine the typology and prevalence of disrespect and abuse in maternity care in India. An online survey we conducted with women using private sector facilities revealed that even those paying for services in modern, well-resourced hospitals often faced mistreatment during childbirth. This meant that the problem was not confined to one sector–it was present in facilities of all sizes and types, from overcrowded **public hospitals to modern, well-staffed private institutions**.

Across both settings, the most common forms of ill-treatment were strikingly similar–care provided without consent, verbal abuse, lack of privacy, threats, physical abuse, and discrimination. Non-consented care was especially common for procedures like episiotomy and vaginal examinations, often carried out without explanation or permission. Socio-economic status was a key factor with women from low-income backgrounds more likely to experience mistreatment.

One finding stood out across all our research. Disrespect and abuse were not always tied to how busy a hospital was. Even in quiet moments, mistreatment occurred. This showed us that the problem was not only about workload or resources but it was also about deep-rooted attitudes, systemic blind spots, and the absence of accountability mechanisms.

We Supported the Policymakers:

Policies shape priorities, and priorities shape practice. From the earliest stages of our work, C3 recognized that without embedding Respectful Maternity Care into national health strategies, progress would be slow, and fragmented.

We, therefore, supported policymakers to ensure that national programs recognized RMC as a key component of quality care. We contributed to the **LaQshya program**, India's flagship quality improvement initiative for labor rooms and maternity operation theatres, making sure that RMC was reflected as one of the guiding principles. We supported the formulation of the Surakshit Matritva Aashwasan **(SUMAN) initiative**, where we served on key committees that developed program components. We collaborated on the branding and positioning of the **Nurse Practitioner in Midwifery (NPM)**, a new cadre of midwives, as providers of women-centric respectful care.

At the state level, our partnerships have been deep and varied. In Telangana, Chhattisgarh, Odisha, Maharashtra, and beyond, we have worked with governments to integrate RMC into mainstream health service delivery.

We Built Capacities of Healthcare Providers:

Too often, healthcare providers enter the system without ever having been trained in empathy, communication, or the rights of women in childbirth. Without deliberate learning and ongoing mentorship, the culture of "business as usual" persists, and respectful care remains an exception rather than the rule.

To break this cycle, we designed a **blended training curriculum** that could reach providers wherever they were. The approach combined **in-person workshops and a flexible e-learning platform that** was grounded in the realities of the labor room. By blending technical skills with respectful care, the curriculum equipped providers with both the competence and the mindset to transform maternity care.

Collaboration with Manyata Master trainers to help build an objective and structured approach to the standard on RMC was a game changer.

We Engaged with Women and Communities:

For respectful care to truly become a reality, women and communities themselves needed to understand that it was their right and to expect and demand it. Through **public campaigns**, we carried the message of RMC as a right, from television screens and newspaper columns to online platforms and village squares. Our films, both documentary and animated, explained the rights of women in maternity care in ways that were accessible, relatable, and memorable. **Theater** became another powerful medium. Plays brought to life the struggles of women seeking dignity in childbirth. Our **social media** campaigns like **#IDemandRespectfulCare and #barahaqhamara** encouraged women to speak out about their experiences, while others, like **'Doctor Wonderful,'** celebrated providers who pledged to be champions of respectful care, showing that change was possible and already happening.

We Built a Regional Movement on RMC:

Our work did not stop at India's borders. As **the National Secretariat for White Ribbon Alliance India**, C3 recognized that the call for respectful maternity care was not just an Indian priority, it was a regional and global one. To bring voices, expertise, and experiences together, we established the **Asia Regional RMC Council.** This council is more than a forum. It is a fast-growing collective of health professionals, researchers, and community leaders from across Asia, united by a shared commitment to dignity in childbirth.

Publications and Global Dissemination:

Our work has been recognized not only within India but also in the global health community. Our research has been published in respected **peer-reviewed journals and books**. We have shared our findings at **international conferences and global forums**. Presenting alongside researchers, practitioners, and policymakers from across the world has allowed us to demonstrate that respectful maternity care is a measurable, actionable component of quality healthcare.

CONCLUSION

From listening to women's voices in remote villages to making their aspirations a reality, C3's journey in promoting RMC has been one of persistence, partnership, and profound belief in women's rights. We have seen that change is possible when empathy is treated as a skill, when dignity is made a measurable standard, and when communities know they can demand better. Our vision is clear–that every woman, everywhere, every time gets maternity care with compassion, respect, and dignity.

MISSION MANYATA: SUSTAIN AND SCALE

MANYATA PLAYS A LARGER ROLE NATIONALLY

Dr. Parvez Memon, Dr. Parag Bhamare

INTRODUCTION - WHY NABH INTEGRATION MATTERS

India has entered a critical phase in its maternal health journey. After years of efforts to expand access, the central question is no longer whether women reach facilities but whether the care they receive is safe, evidence-based, and accountable. This is particularly urgent both in the private and public sector, where nearly half of institutional deliveries take place. But where, until recently, the quality assurance remained largely unaudited.

"Quality in maternity care has moved from aspiration to accreditation."

The integration of Manyata—FOGSI's flagship maternal health quality certification for private providers—with the National Accreditation Board for Hospitals & Healthcare Providers (NABH) represents a systemic turning point. This collaboration not only elevates private maternity care from a voluntary certification regime to an accredited quality system but also redefines clinical governance, creates pathways for financial sustainability, and positions India as a leader in specialty-driven accreditation reform. For the first time, maternal health-specific clinical standards have been embedded into India's national accreditation framework.

FROM VOLUNTARY CERTIFICATION TO NATIONAL ACCREDITATION

Manyata began as a professional movement: a voluntary certification program designed by FOGSI, supported technically by Jhpiego, and scaled with funding partners. It introduced 16, later 20, evidence-based clinical standards aligned with national guidelines, global recommendations, and the WHO Safe Childbirth Checklist[1] [2]. The program demonstrated that even small maternity homes with limited resources could implement and sustain quality practices through structured mentoring and peer-led certification[3].

"What began as a voluntary professional movement is now a global exemplar of specialty-driven accreditation."

Manyata's early impact was confined to professional recognition. While it created a culture of quality within the obstetric community, it lacked the regulatory and financial levers needed for systemic transformation. NABH, by contrast, carried national legitimacy. Established under the Quality Council of India, NABH accreditation is increasingly linked to insurance empanelment, government schemes such as PM-JAY, and broader patient trust[4].

The 2022 MoU between FOGSI Manyata and NABH bridged these two spheres. It aligned Manyata's clinical standards with NABH's entry-level certification, enabling maternity homes to pursue dual certification in a single streamlined process[5]. For providers, this integration elevated Manyata from a voluntary marker of excellence to an accreditation pathway with tangible regulatory and financial benefits.

1 Jhpiego. Improving Quality of Maternal and Newborn Health in India: Fact Sheet – April 2017. Jhpiego; 2017.

2 World Health Organization. Standards for improving the quality of maternal and newborn care in health facilities. WHO, 2016.

3 Delaney MM, Marx M, Phogat A, et al. Does quality certification work? An assessment of Manyata, a childbirth quality program in India's private sector. Glob Health Sci Pract. 2022;10(6):e2200093.

4 NABH. About NABH. Quality Council of India; 2021.

5 NABH. Press Release: Integration of Manyata Standards into Entry-Level Certification. NABH; 2022.

TRANSFORMING CLINICAL GOVERNANCE IN MATERNITY CARE

The significance of the FOGSI Manyata–NABH collaboration lies not only in its certification mechanics but in its impact on clinical governance. Traditionally, accreditation frameworks in India emphasized infrastructure, safety protocols, and administrative systems. Maternal health rarely featured as a defined domain within these standards.

Integrating Manyata into NABH has introduced:

1. **Uniform Clinical Standards:** Maternal care protocols, including partograph use, active management of the third stage of labor, management of hypertensive disorders, and neonatal resuscitation, are now nationally standardized within accreditation.
2. **Parity Across Sectors:** Programs such as LaQshya–Manyata in Maharashtra demonstrated that aligning private facilities with government standards reduces disparities between public and private maternity care[6]. NABH integration now ensures parity nationwide.
3. **Continuous Improvement Cycles:** Accreditation mandates regular assessments, re-certification, and data reporting. This embeds continuous improvement into private maternity practice, moving beyond one-time recognition.

Through this integration, maternal health quality is no longer treated as an optional extension of accreditation but as a core component of system-wide accountability.

Accreditation and Financing – Aligning Market Incentives:

Accreditation has financial consequences. Under PM-JAY, facilities accredited by NABH at entry-level receive 10% higher reimbursement, and those with full accreditation receive 15% higher rates[7]. Private insurers also favour NABH-accredited hospitals for empanelment[8].

"Parity between private and public facilities is now a national reality, not an exception."

By aligning Manyata with NABH, small maternity homes, previously excluded from such systems, gain new access to financial incentives. This transforms quality improvement from a cost centre into a revenue enabler.

The collaboration also strengthens sustainability models. Donor-funded subsidies for training and certification are being gradually replaced with market mechanisms: subscription-based mentorship, results-based financing pilots, and insurance-linked reimbursement structures. Accreditation becomes both a quality imperative and a business case.

"NABH accreditation opens the door for small maternity homes to insurance, PM-JAY, and financial sustainability."

WORKFORCE AND INSTITUTIONAL CAPACITY

Human resources for health (HRH) remain a critical bottleneck in maternal care. Manyata has demonstrated that structured, simulation-based training can significantly improve knowledge and skills. Evaluations showed facility-level adherence to standards rising from 29% to 93%, while nurses' knowledge and emergency skills improved more than twofold[3].

6 Government of Maharashtra & FOGSI. LaQshya–Manyata Implementation Report. Government of Maharashtra, 2022.

7 National Health Authority. PM-JAY Operational Guidelines. Government of India, 2022

8 Insurance empanelment trends and quality accreditation. ETHealthworld; 2022

The NABH integration institutionalizes these gains. Accreditation requires documented protocols, regular emergency drills, and credentialed staff competencies. Partnerships with the Healthcare Sector Skill Council (HSSC) have further introduced credentialed maternal and perinatal life support training[9]. This creates a pipeline for professionalized, skilled, and certified maternity care workers—an important contribution to India's broader HRH agenda.

CHALLENGES AND ADAPTIVE STRATEGIES

The path to integration was not without obstacles.

- **Documentation Burden:** NABH places significant emphasis on documentation. Manyata facilities initially struggled, with baseline NABH compliance under 10%[10]. Adaptive tools, including simplified templates for partographs, registers, and infection control protocols, addressed this gap.
- **Assessor Preparedness:** NABH assessors lacked obstetric-specific expertise. A cadre of obstetricians from FOGSI was trained and empanelled as NABH assessors, ensuring contextual assessments.
- **Financial Barriers:** Smaller facilities were hesitant to invest in upgrades or certification fees. Pilots of blended financing models, CSR support, and state partnerships (as in Maharashtra) demonstrated feasible pathways[11].

These challenges underscore the importance of adaptive management, technical support, and continuous mentorship in embedding quality into diverse private facilities.

IMPLICATIONS BEYOND OBSTETRICS – A TEMPLATE FOR SPECIALTY ACCREDITATION

The collaboration offers a template for other specialties. It demonstrates that professional associations can design evidence-based clinical standards and, through collaboration with NABH, integrate them into the national accreditation ecosystem.

This model could be extended to pediatrics (newborn care standards), emergency medicine (trauma protocols), or dialysis centers (infection control and patient safety benchmarks). The key lesson is that specialty-led, NABH-integrated accreditation creates a credible, scalable, and inclusive pathway for quality improvement across diverse sectors.

POLICY AND SYSTEMIC IMPLICATIONS

The collaboration aligns directly with national policy priorities. India's "One Nation, One Standard" initiative seeks to harmonize quality frameworks across sectors. Integrating Manyata into NABH operationalizes this vision in maternal health. It also supports India's commitments under SDG 3.1 by embedding quality into private-sector maternity care, which serves millions of women annually[12].

For state governments, the model provides a mechanism to engage private providers. For payers and insurers, it creates a trusted signal of quality. For communities, it offers assurance that maternity facilities meet nationally recognized standards.

9 Healthcare Sector Skill Council. Maternal and Perinatal Life Support Training Program. HSSC; 2023.

10 Sharma S, Khanna R, Sodhi R, Luthra A. Implementing a quality improvement initiative for private healthcare facilities to achieve accreditation: experience from India. BMC Health Serv Res. 2023;23:1026.

11 Swasti Health Catalyst. Financing quality improvement: Manyata sustainability models. Swasti, 2023.

FUTURE OUTLOOK – REGIONAL REPLICATION AND GLOBAL LEADERSHIP

Manyata is no longer confined to India. Through the AOFOG-led Uniting for Quality initiative, replication pathways are underway in Bangladesh, the Philippines, and Indonesia[13]. The NABH integration strengthens Manyata's positioning as a global exemplar, showing how voluntary certification can evolve into national accreditation.

In countries with similar mixed health systems, this model offers a roadmap: professional bodies lead, governments and accreditors institutionalize, and funders catalyze. India's leadership in this domain is setting the stage for regional consensus on maternal health quality standards.

"India's maternal accreditation model is already inspiring replication in Bangladesh, Indonesia, and the Philippines."

CONCLUSION – REDEFINING QUALITY AS A NATIONAL EXPECTATION

The FOGSI Manyata–NABH collaboration is a watershed in India's healthcare journey. It elevates maternal health quality from a professional aspiration to a national expectation, embedding it within the country's accreditation framework. It unifies fragmented initiatives, creates financial incentives for providers, strengthens HRH development, and establishes a model for specialty-driven accreditation reform.

For India, it signals that quality in maternity care is no longer optional or peripheral but central to system performance. For the region, it provides a replicable pathway to align professional, governmental, and market forces around safe motherhood. And for the world, it stands as evidence that accreditation can be inclusive, specialty-specific, and transformative.

In the years ahead, the success of this collaboration will be measured not only in certifications granted but in the consistency, accountability, and trust it builds across India's health system—and in the lives it saves.

12 Registrar General of India. Special Bulletin on Maternal Mortality in India 2018–20. Office of the Registrar General, Ministry of Home Affairs; 2022.

13 AOFOG & Jhpiego. Uniting for Quality: Regional Replication Pathways. AOFOG; 2023.

UNITING FOR QUALITY: A REGIONAL CALL TO TRANSFORM MATERNAL AND NEWBORN HEALTH IN ASIA-PACIFIC

Dr. Parvez Memon

Across Asia, countries have achieved substantial gains in service coverage and access to care over the past two decades, driven by investments in health infrastructure, social health insurance, and community outreach programs[1]. Maternal health indicators, such as facility-based deliveries and skilled birth attendance, have improved in most low-and middle-income countries (LMICs), reflecting this expansion in access[2].

Despite notable progress in past decades, maternal and newborn mortality remain pressing challenges across the Asia Oceania Federation of Obstetrics and Gynecology (AOFOG) member countries. Since 2000, the region's Maternal Mortality Ratio (MMR) declined by about one-third, but progress has stalled after 2015. In 2020, the regional MMR was approximately 113 per 100,000 live births–translating to over 66,000 women dying from pregnancy-related causes each year. Most of these deaths occur in South Asia and among disadvantaged populations, underscoring vast inequities. Within AOFOG, many countries still have high MMRs in the 100–300 range. A few countries continue to see increases in maternal deaths in recent years, indicating that current efforts need acceleration to reach the SDG target of <70 per 100,000 by 2030[3].

Global evidence underscores that improving the quality of care is now an urgent priority. According to WHO, UNICEF, the World Bank, and partners, poor quality care has overtaken non-utilization as the leading cause of preventable deaths in low-and middle-income countries, contributing to an estimated 5 million of 8.6 million amenable deaths annually[4]. Even where access is ensured, large disparities in the quality of maternal health services persist, especially in rural and peri-urban areas, resulting in care that is often not timely, evidence-based, or respectful. Simply put, increasing access without ensuring quality yields limited gains in maternal and newborn survival. High-profile initiatives like the WHO's Quality, Equity and Dignity (QED) network[5] (World Health Organization, 2018) and recent UNICEF/World Bank analyses[6] (World Health Organization, 2023) have all called for institutionalizing Quality of Care (QoC) within health systems as a next step to reduce maternal and neonatal mortality.

Across the Asia Oceania region, countries are not starting from the same place on QoC. Some have a robust policy and financing backbone for quality, while others are still assembling core building blocks. For example, the Philippines has a mature backbone under Universal Health Care with PhilHealth accreditation and defined quality signals; the challenge there is to consolidate and consistently operationalize standards through routine coaching, data-driven reviews, and incentivize alignment across public and private facilities. By contrast, Bangladesh reflects a fragmented, nascent system, where multiple initiatives are underway but dashboards, coaching pools, and private-sector

1 Kruk ME, Gage AD, Arsenault C, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *Lancet Glob Health. 2018;6(11):e1196-e1252*

2 Boatin, A. A., et al. "Quality of Care in Maternal and Newborn Health: The Role of the Obstetrician-Gynecologist." *International Journal of Gynecology & Obstetrics,* vol. 159, S1, 2022, pp. 37–44. https://doi.org/10.1002/ijgo.14194.

3 Nations, United. *Sustainable Development Goals Report 2025*. United Nations, 2025.

4 UNICEF. *Quality of Care*. UNICEF, https://www.unicef.org/health/quality-care. Accessed 29 Aug. 2025.

5 World Health Organization. *Quality, Equity, Dignity: The Network to Improve Quality of Care for Maternal, Newborn and Child Health – Strategic Objectives*. WHO, 2018, https://www.who.int/publications/i/item/9789241513951. Accessed 29 Aug. 2025.

6 World Health Organization. *Improving Maternal and Newborn Health and Survival and Reducing Stillbirth: Progress Report 2023*. WHO, 2023, https://data.unicef.org/wp-content/uploads/2023/05/Improving-Maternal_and_Newborn_Health_and_Survival_and_Reducing_Stillbirth_EN.pdf. Accessed 29 Aug. 2025.

engagement are not yet knit into a single, institutionalized QoC pathway. This variation means a one-size-fits-all model will underperform. Countries like the Philippines require consolidation and incentive alignment, while countries like Bangladesh need systemic investment and integration.

UNITING FOR QUALITY (U4Q) – A REGIONAL INITIATIVE BY AOFOG

In response to persistent gaps in maternal and newborn quality of care across Asia–Oceania, AOFOG, launched the Uniting for Quality (U4Q), a regional effort that mobilizes professional societies and partners to share proven practices and align behind common quality goals. In early 2024, AOFOG proposed a model inspired by Federation of Obstetric and Gynecological Societies of India–FOGSI's successful Manyata initiative in India. With support from MSD for Mothers and technical collaboration from Jhpiego, AOFOG invited member societies to participate; Mongolia, Nepal, Bangladesh, the Philippines, and Pakistan were selected as initial focus countries based on demonstrated need and readiness.

In March 2024, AOFOG, in collaboration with national societies convened a Joint Consultative Workshop in Bangkok under the theme, "**Uniting for Quality:** Landscaping Quality of Care in Maternal and Newborn Health across Asia-Pacific." This gathering brought together AOFOG officers, national OBGYN leaders, and technical experts to take an honest and comprehensive look at the region's maternal and newborn health systems through a Quality of Care lens. During the two-day dialogue, country delegates presented their existing QoC landscapes, engaged in SWOT analyses, and collaboratively developed context-specific roadmaps to accelerate progress. One of the most significant outputs was a cross-country mapping of current programs and systemic gaps, providing a clear evidence base for action. Additionally, each country outlined preliminary action plans anchored in national priorities and realities.

What became abundantly clear is that fragmented and uneven quality standards are limiting the overall impact of our maternal health investments. While access has expanded, survival and dignity will only improve if quality becomes non-negotiable. Drawing inspiration from proven models such as India's Manyata initiative, participants strongly advocated for adaptable, context-driven quality frameworks that can be scaled sustainably across diverse health systems.

The workshop was designed with around five core objectives, each critical to the collective mission:

- **Discuss Progress, Identify Challenges, and Seek Solutions:** A frank appraisal of where we stand and what barriers persist.
- **Co-create a Unified Regional Vision:** Aligning around a shared "North Star" for quality in maternal and newborn health.
- **Conceptualize and Socialize the AQRC (AOFOG Quality of Care Resource Center):** Introducing a dedicated platform for technical assistance, knowledge sharing, and capacity-building.
- **Forge Collaborative Pathways for Advocacy and Financing:** Building strategies that engage governments, donors, and the private sector for sustainable investment.
- **Develop Contextualized Country-Specific Roadmaps:** Translating vision into actionable steps tailored to each country's unique context.

This consultation marked the beginning of a regional movement to institutionalize quality of care as a central pillar of maternal and newborn health.

Momentum accelerated in 2025. Under the U4Q banner, the Obstetrical and Gynecological Society of Bangladesh (OGSB) and the Philippine Obstetrical and Gynecological Society (POGS) hosted stakeholder workshops in January (Dhaka) and March (Manila), deepening knowledge exchange and refining strategies. OGSB also launched a pilot with 12 facilities. In April 2025, in collaboration with AOFOG, Jhpiego convened a strategic workshop in Phuket, Thailand, to review progress, intensify cross-country learning, and co-create detailed national action plans. The meeting also explored establishing an AOFOG Virtual Resource Center (VRC) to sustain regional support.

U4Q has demonstrated the power of regional collaboration: AOFOG's convening authority, Jhpiego's technical stewardship, and MSD for Mothers' catalytic support have created a credible platform for shared learning, policy alignment, and early implementation. By combining Manyata's proven quality-improvement model with AOFOG's reach, U4Q now offers a ready pathway to translate country roadmaps into coordinated, multi-country action—positioning the region to achieve measurable gains in maternal and new-born survival and well-being.

Progress and Key Achievements across Asia

The Uniting for Quality platform has already established a foundation for regional replication through targeted engagements and country-led initiatives:

Bangladesh: Initiated a Quality of Care engagement process in collaboration with the Obstetrical and Gynecological Society of Bangladesh (OGSB), aligning with national maternal and newborn health strategies. Stakeholder consultations have laid the groundwork for integrating the Manyata quality-plus model within professional society-led accreditation and training frameworks. So far, 10 national QoC standards for maternal and newborn care have been developed, and a pilot is undergoing in 12 facilities.

Philippines: Completed the Uniting for Quality convening in partnership with the Philippine Obstetrical and Gynecological Society (POGS) and AOFOG. Received an in-principle interest for collaboration from the Unilab Foundation, with joint development underway for the Uniting for Quality 2030 initiative—an aligned national platform for quality improvement in maternal health.

Indonesia: Engaged the Indonesian Society of Obstetrics and Gynecology (POGI) and the Ministry of Health to co-design a national convening on maternal care quality. Completed a quick landscape assessment of QoC initiatives, stakeholders and opportunities for leveraging the existing MNH QI collaborative platform supported by Jhpiego. Discussions are in progress to host a multi-stakeholder national convening around for the quality of care in Indonesia.

Regional Evidence Base: AOFOG-led multi-country assessment across Bangladesh, the Philippines, Mongolia, Nepal, Pakistan, and India has generated a shared understanding of systemic quality gaps and opportunities for harmonization. This directly informs the prioritization of interventions for the next phase of work.

A**lignment of professional associations:** Two high-level AOFOG-led consultations have been completed with a joint consensus on a regional replication pathway across each of the countries.

STRATEGIC VISION AND APPROACH

In response to persistent gaps in maternal and new-born quality of care across Asia–Oceania, Jhpiego and AOFOG launched Uniting for Quality (U4Q), a regional effort that mobilizes professional societies and partners to share proven practices and align behind common quality goals. Uniting for Quality is envisioned as a regional stewardship platform aims to establish permanent governance, technical, and financing architectures to ensure sustained replication, policy integration, and system-wide adoption of the quality plus model across AOFOG member states.

The strategic objective is to enable member countries to adopt, adapt, share, and sustain proven quality-improvement interventions—drawing on the demonstrated Manyata model—with speed, fidelity, and scale. Specifically, the platform will help AOFOG member associations to:

- Adopt proven, evidence-based quality improvement standards, protocols, and training assets by consolidating them into a standardized, open-access regional repository accessible to all AOFOG member countries.
- Adapt modular, ready-to-implement intervention packages to each country's regulatory, epidemiological, and health system context in alignment with the core quality-of-care principles.
- Share operational innovations, implementation data, and lessons learned through structured regional exchange mechanisms—ensuring peer validation, rapid diffusion of best practices, and continuous refinement of the regional knowledge base.
- Sustain quality-improvement interventions by embedding them into national accreditation systems, financing mechanisms, and institutional capacities, securing long-term quality assurance beyond the project cycle.

QUALITY IS NOT OPTIONAL—IT IS FUNDAMENTAL

These consultations and conversations represent the beginning of a regional movement to embed quality of care in every corner of our maternal and newborn health systems. The message could not be clearer: quality is not optional; it is fundamental. For governments, this means moving beyond building more infrastructure to invest in robust, accountable systems that deliver consistent, respectful, and evidence-based care. For doctors, it means aligning their clinical work towards a larger public health goal, for development partners like Jhpiego, it means championing scalable, context-driven quality improvement strategies that can adapt to the diverse realities of our region. For citizens, it means expecting and demanding care that safeguards their dignity and their lives. Because every woman regardless of where she lives deserves nothing less than a safe, respectful, and healthy motherhood.

AOFOG members are now collectively shaping a clear, compelling vision for maternal and newborn care in Asia-Oceania, by mapping the critical enablers essential for success, and by sketching the initial framework for the AOFOG Quality of Care Resource Center (AQRC), This is just the beginning. Together, we will build a future where quality is the standard, not the exception, and where mothers and newborns everywhere can thrive.

VOICES FROM THE GROUND

CSE LEADS

...we attribute our success in clearing NABH certification to the foundational work done through Manyata's capacity-building approach...

The SMRITI Center for Skill Enhancement (CSE) in Agra has been among the first centers established under the Manyata initiative, and it has been a privilege to play a role in advancing quality maternal healthcare in our region. Our journey began from firsthand experience–a journey that made us realize the critical need for structured training, consistent skill-building, and sustained mentorship to improve maternal care outcomes.

Before becoming Manyata-certified, our hospital aspired to achieve NABH accreditation. Despite engaging consultants and investing effort, we struggled to meet the standards required. The breakthrough came with Manyata's structured training, which equipped our staff with the necessary competencies, confidence, and systems to meet accreditation requirements. The program's focus on practical, hands-on capacity building helped us overcome challenges that external consultants alone could not address. It is with gratitude that we attribute our success in clearing NABH certification to the foundational work done through Manyata's capacity-building approach.

The decision to establish the Agra CSE also stemmed from recognizing the urgent and growing need in maternal health. Inconsistencies in skill sets among providers were not just numbers on a report—they were experiences we encountered daily. When Dr. Jaideep, during her tenure as FOGSI President, endorsed Manyata's structured methodology and promoted it widely, we saw a real opportunity to contribute beyond conventional support. We believed that setting up a local hub would allow us to extend training to more facilities, provide mentorship, and create a community of practice where maternal health quality standards could be embedded into routine care.

Over the years, we have worked tirelessly to sensitize hundreds of facility owners to the importance of becoming quality-compliant through Manyata. It is one thing to raise awareness about quality as a critical need, and quite another to motivate facility providers to commit to structured training programs. Often, they feel a sense of accomplishment in their existing practices, and that pride can become a barrier to adopting new frameworks. Our approach has been to persistently engage with them, share evidence-based practices, and demonstrate the long-term value of standardization—so that they eventually approach us to enroll and train their staff.

We have left no stone unturned in advocating for Manyata's value. Every conference, seminar, or discussion on women's health has been an opportunity to highlight the importance of structured quality improvement. We view it not as an obligation but as a deep commitment to transforming maternal health outcomes across our community.

Our work at the Agra CSE is driven by the belief that true change happens when awareness is paired with action. As we move forward, we remain dedicated to building this culture of quality care—one facility, one provider, and one patient at a time.

Dr. Narendra Malhotra, Lead, Agra Center for Skill Enhancement (CSE)

...quality improvement is not a destination—it is a continuous journey, one that we are proud to walk every day...

My association with Manyata began not as a trainer or assessor, but as a provider. When I first enrolled my facility in the program, I was curious to see how much of a difference structured quality standards could make in an already busy maternity practice. What unfolded in the months that followed left me deeply convinced of the program's value.

The most visible impact was in the labor room. With systematic training and guidance, I saw my staff transform—not only in their clinical competency but also into their confidence and attitude toward patients. Complicated situations that would once cause panic were now managed with calm, stepwise interventions. Just as importantly, there was a palpable shift in behavior: respect, empathy, and attentiveness toward mothers became ingrained in everyday practice.

Beyond clinical outcomes, Manyata helped us streamline the often overlooked but critical aspects of running a facility. Documentation improved, protocols became clearer, and systems started to fall into place. I could see how these changes not only safeguarded patients but also made our practice stronger and more resilient. It was in this moment that a thought struck me: if one hospital could benefit so tangibly, why not many more in our community?

That thought led me, along with my colleagues at the Navi Mumbai OBGYN Society (NMOGS), to establish a Center for Skill Enhancement (CSE). Our vision was simple yet ambitious—to replicate the improvements we had witnessed, and to create a space where consistent, high-quality training could be delivered to providers and nurses across Navi Mumbai.

From the outset, my focus has always been on training. I know from experience that upholding quality is never a one-time effort. It requires persistence, refreshers, and constant reinforcement. Skills can fade, attitudes can lapse, and systems can weaken if they are not nurtured regularly. That is why our CSE places such emphasis on continuous sessions—engaging nurses in repeated hands-on trainings, drills, and discussions. These are not one-off workshops but ongoing conversations about what quality care looks like in practice.

Over time, this approach has paid off. The Navi Mumbai CSE has grown into a vibrant hub where nurses, doctors, and staff not only learn but also exchange their experiences and challenges. It has fostered a sense of collective ownership—because when everyone is aligned on the importance of quality, the responsibility doesn't fall on one person's shoulders alone.

Looking back, I feel a sense of pride in the journey we have undertaken. From being a Manyata provider who experienced change firsthand, to now leading a CSE that is helping spread that change across facilities, it has been both humbling and fulfilling. Manyata gave us the framework, but it is the commitment of our society, our trainers, and most importantly, our nurses that has made the CSE thrive.

For me, the success of the Navi Mumbai CSE is proof that quality improvement is not a destination—it is a continuous journey, one that we are proud to walk every day.

Dr. Sucheta Kinjawadekar, Lead, Navi Mumbai Center for Skill Enhancement (CSE)

...what began as a professional opportunity has turned into something that feels closer to a calling...

Some journeys change the way you see your work and yourself. My journey with Manyata has been one of those. What began as a professional opportunity has turned into something that feels closer to a calling.

Over the years, I have had the opportunity to don multiple roles. Starting as a passionate champion when the program first began, later serving as a trainer and assessor, and today leading the Krishna Medical Center (KMC) and Center for Skill Enhancement (CSE) in Lucknow under the guidance of Dr. Chandrawati. Each role has shaped my understanding in a unique way, but the most fulfilling experience has undoubtedly been leading the CSE. It has been equal parts exhilarating and daunting, because the responsibility rests squarely on your shoulders. It has given me and my team a true flavor of entrepreneurship, as we navigated the challenges and demands of managing such an important initiative.

Perhaps the hardest part of this work has been bringing facilities on board. You would think the importance of quality in maternal care is self-evident, yet awareness remains uneven. This challenge, however, has become our driving force. Each moment of hesitation from a provider only strengthens our resolve because our mission will remain incomplete until quality is recognized not as an option, but as a necessity.

What keeps me moving forward is the energy of the CSE team. Their tireless efforts in preparing facilities for certification have been inspiring. Two milestones I hold close is our expansion into new states Uttarakhand and Gujarat. In Gujarat, we recently brought 50 facilities on board in a very short span with the support of local leaders and the motivated team at KMC, we not only onboarded these facilities but are also close to completing their Manyata training. Watching them progress steadily toward certification was overwhelming in the best way—it proved what collective determination can achieve.

Yet, statistics and milestones are not what stay with you at the end of the day. It is the human stories that linger. A nurse who, after training, confidently managed an obstetric emergency that once would have shaken her. A doctor who shared how his approach to women's care changed after internalizing principles of dignity and respect. These are the moments that remind us why we do what we do.

For me, Manyata has never been just a program. It is a mission—a collective effort that reaffirms that improving maternal health is not the work of one individual or one organisation, but of many hands and hearts working together. The journey so far has been challenging, yes, but also deeply fulfilling. And I know the road ahead will continue to test and inspire us in equal measure.

Dr. Priti Kumar, Lead, Lucknow Center for Skill Enhancement (CSE)

PROVIDERS

...there is a noticeable difference in the way my nurses diagnose and document cases...

"There is a noticeable difference in the way my nurses diagnose and document cases. Initially, assessing a partograph was always a doctor's job. I often had to ensure it was attached myself. Today, our nurses attach the partograph with every case file and are well-versed with it. The training has expanded their knowledge and helped them manage records systematically, from analysis and diagnosis to documentation. Thanks to the Manyata team!"

Dr. Riddhi Kathuria, Vijay Nursing Home, New Delhi

...our journey with Manyata has been transformative, from chaos to order...

"Our journey with Manyata has been transformative, from chaos to order. Since the trainings, my staff has become extremely efficient in their daily practices. During deliveries, the labor room is always prepped in advance, kits are kept ready at hand, and all steps are taken to prevent infection, ensuring smooth functioning. In case of emergencies, I am confident that everyone present in the room is capable of handling the situation, which also makes my work easier."

Dr. Gautam Kapoor, Krishna Hospital, Jaipur

...I can now embrace responsibilities beyond practice...

"Having a competent and confident staff is a true blessing. Balancing personal and professional engagements becomes easier when you trust your team to expertly manage cases in your absence. With Manyata training enabling decentralization, I can now embrace responsibilities beyond practice. This has eased my burden, improved work-life balance, and streamlined operations, ultimately strengthening healthcare delivery in our hospital."

Dr. T. Ramani Devi, Ramakrishna Medical Center, Tiruchirappalli

ASSESSOR

...moments like these remind me why this work is so meaningful...

"I've been with Manyata since the very beginning. I've conducted done almost 200 assessments so far, both in person and online. I've truly enjoyed every session; the bright, eager faces of young staff, so excited at the prospect of learning something new. During COVID-19, I had the chance to conduct assessments in small, remote hospitals with just 5-6 deliveries a month. Sometimes, if they didn't have saline, someone had to be sent personally to fetch it. I still remember three remarkable young staff members who completed an assessment in just 25 minutes—so eager, with everything at their fingertips, their excitement to answer and score was infectious. Moments like these remind me why this work is so meaningful."

Dr. Jayam Kannan, Chennai

NURSES

...Manyata training equipped me with vital skills to take care...

"Manyata training equipped me with vital skills to take care of low birth weight babies, emphasizing practices like kangaroo mother care, skin-to-skin contact and regular check-ins to ensure their well-being. The training also empowered me to counsel families effectively, passing on knowledge for the baby's health."

Nasreen Bano, Kasih Hospital, Varanasi

...thanks to Manyata, we feel confident and prepared...

"After we underwent Manyata training, it completely changed the way we approach delivery care. We learned to guide a patient through all three stages—admission and labour, delivery, and post-delivery care. Manyata taught us the essential practices that shape our work ethic: how to check the placenta, follow up after delivery, keep the baby warm, and ensure the newborn is healthy and safe. Our concerns about PPH were fully addressed during the training. Thanks to Manyata, we feel confident and prepared; we haven't encountered any PPH cases yet because we are now well-versed in AMTSL."

Nurse Anita, MKW Hospital, Delhi

BENEFICIARIES

...the kindness, care, and respect I received here will always stay with me....

"I arrived at Deshmukh Hospital as an emergency patient, feeling quite scared as a first-time mother, but the staff took the time to review all necessary reports, explained everything clearly, and made sure I felt safe and informed. Their commitment to both my health and my baby's well-being was genuinely comforting. The kindness, care, and respect I received here will always stay with me."

Mishqat, New Mother, Deshmukh Hospital and Research Centre, Ujjain

....their attentive and reassuring care gave me great confidence...

"I recently had my baby girl delivered at Anuja Nursing Home, and I couldn't be more grateful for the care I received. I had come in for a routine checkup when the doctor noticed I was already dilated. I stayed overnight, and as the pain increased, the nurses came to check on me, carefully monitoring both me and my baby's health, including blood pressure, sugar, baby's heartbeat and contractions. The delivery was normal and went smoothly, without any complications. After the delivery, the nurses ensured proper administration of medicines and meals. Their attentive and reassuring care gave me great confidence throughout the process."

Premlatha, New Mother, Anuja Nursing Home, Navi Mumbai

*Image for reference use only

From Crisis to Care: Nurse-Led Triumph in High-Risk Pregnancy

Tiruchirappalli district, commonly called Trichy, in Tamil Nadu, has recorded zero maternal deaths in recent months.[1] This achievement is the result of strategic initiatives, rigorous monitoring, and the adoption of standardized healthcare practices. These measures have led to outcomes surpassing the targets set in Goal 3.1 of the Sustainable Development Goals (SDGs), which aims to reduce the global Maternal Mortality Ratio (MMR) to less than 70 per 100,000 live births by 2030. One notable initiative contributing to this success is Manyata, which focuses on improving maternal care by building the capacity of nurses to manage high-risk pregnancies and complications effectively. A shining example of this initiative's impact can be seen in the story of Kavitha from the Ramakrishna Medical Center in Trichy.

Kavitha (24 yrs), a first-time mother, experienced a smooth pregnancy until late-onset preeclampsia developed at 32 weeks. This critical condition made her labor high-risk, endangering both her and her unborn child. Despite the primary attending doctor's unavailability, a skilled team led by Nurse Chitra intervened, managing complications and ensuring a safe delivery.

Kavitha was eagerly anticipating the birth of her first child, meticulously attending all her antenatal check-ups (ANCs) at Ramakrishna Medical Center. As a primigravida she had many questions, which the nurses addressed with patience and compassion. This supportive environment fostered a strong bond between Kavitha and the nursing staff, setting a positive tone for her pregnancy journey.

The first 32 weeks of pregnancy progressed smoothly. However, as she approached her due date, complications arose in the form of late-onset pre-eclampsia, characterized by high blood pressure and hyperglycemia, characterized by high blood sugar. She had glucose intolerance which caused the baby to grow large. This transformed her pregnancy into a high-risk scenario, necessitating vigilant monitoring to safeguard both her and her fetus' well-being.

> *The sudden turn in my pregnancy was terrifying, and I was deeply worried for my baby's safety. I had countless questions, and so did my family. But Dr. Ramani and her team were a true rock for us. They counselled us with patience, offering transparent communication and mental support at every step of the way. I am grateful for their dedicated care during this challenging time- shares Kavitha.*

HYPERTENSIVE DISORDERS AND GESTATIONAL DIABETES DURING PREGNANCY ARE SIGNIFICANT CONTRIBUTORS TO MATERNAL AND PERINATAL DEATHS. AMONG THEM, LATE-ONSET PREECLAMPSIA, **WHICH ACCOUNTS FOR OVER 80% OF CASES GLOBALLY** [2], TYPICALLY OCCURS AFTER 32 WEEKS IN WOMEN PREVIOUSLY WITHOUT HYPERTENSION. WHILE CHALLENGES EXIST IN PREDICTING LATE-ONSET CASES, IT CAN BE MANAGED EFFECTIVELY WITH QUICK THINKING AND PROMPT MEDICAL TREATMENT.

[1] https://www.thehindu.com/news/cities/Tiruchirapalli/tiruchi-district-did-not-record-any-maternal-death-in-three-months/article68181951.ece
[2] https://www.ahajournals.org/doi/10.1161/hypertensionaha.107.107607

Critical Intervention

Dr. T. Ramani Devi, her primary attending obstetrician and gynae, had been overseeing Kavitha's care. Unfortunately, during her labor, she was engaged in a professional commitment that couldn't be avoided. Despite her absence, Kavitha remained in capable hands as the labor room team, led by Nurse Chitra under the supervision of a junior MBBS doctor, took charge with confidence. The nursing team spurred into action and meticulously checked her vitals, including blood pressure, heart rate, blood sugars, and oxygen levels, while administering necessary drips.

"The Manyata training has been invaluable to us as nurses," Nurse Chitra reflected. "It has given us the confidence to recognize and manage complications effectively. It not only builds our knowledge but also prepares us to act decisively while administering medication. It is incredibly fulfilling to witness firsthand how our enhanced skills save precious lives."

Overcoming Challenges

Kavitha's newborn was larger than average, posing additional complexities during delivery. The team leveraged digital connectivity to stay in contact with Dr. Ramani, who provided remote guidance and supervision throughout the labor process via videocall. During the labor process, the nursing team performed episiotomy due to large size of the fetus and to prevent any tears during delivery. Episiotomy involves a surgical incision to enlarge the vaginal opening. The team performed the procedure taking all precautions to prevent any tears.

Following the delivery, she experienced a mild postpartum hemorrhage (PPH). The nursing team swiftly assessed the situation and administered appropriate medications such as oxytocin, prostaglandin, and misoprostol to control the bleeding effectively. Their quick intervention arrested the bleeding, limiting blood loss to no more than 500ml. Additionally, the baby showed signs of mild asphyxia, prompting the team to perform neonatal resuscitation to stabilize his respiratory status.

> ***Having a competent and confident staff is a true blessing. Balancing personal and professional engagements becomes easier when you trust your team to expertly manage cases in your absence. With Manyata training enabling decentralization, I can now embrace responsibilities beyond practice. This has eased my burden, improved work-life balance, and streamlined operations, ultimately strengthening healthcare delivery in our hospital- remarks Dr Ramani.***

Successful Outcome

The collaborative efforts of the medical staff at Ramakrishna Medical Center culminated in the successful delivery of a healthy baby boy weighing 3.5 kilograms. Prior to discharge, the nursing team provided her with thorough instructions to prevent any post-natal complications.

Key Takeaways

Manyata training helps churn out competent professionals capable of handling high-risk complications with confidence

- ☑ Emphasizing critical thinking and evidence-based practices, Manyata prepares nurses to swiftly identify, manage, and respond to complications. This not only enhances their clinical skills but also fosters a safer care environment for mothers.

Effective teamwork in emergencies hinges on robust trust between doctors and nurses.

- ☑ The Manyata program fosters this trust, enabling doctors to delegate responsibilities, knowing nurses can manage situations independently. It streamlines operations and establishes decorum in the hospitals. Utilizing digital connectivity for remote supervision further safeguards both maternal and fetal health.

A decentralized approach with support from well-trained nursing staff reduces the doctors' workload and helps them achieve a better work-life balance.

- ☑ This not only enhances job satisfaction but also reduces burnout, allowing doctors to sustain high-quality healthcare delivery while committing to personal well-being and engagements. It also facilitates doctors to focus on critical tasks without being overwhelmed by administrative or routine responsibilities.

Manyata Initiative Overview

Manyata aims to improve the quality of care for mothers and newborns by strengthening the competencies among healthcare providers working in private maternity care facilities. The initiative ensures adherence to 16 clinical standards focused on antenatal, intra-partum and immediate postpartum care, in line with WHO (World Health Organization) standards of care. Developed by FOGSI (Federation of Obstetric and Gynaecological Societies of India) and supported by MSD for Mothers, the initiative works on a dual approach addressing both quality improvement and quality assurance. The Manyata training is delivered through both in-person and digital platforms, making it accessible to healthcare workers in even the most remote areas. Once the training is completed, the facility is assessed by trained and qualified assessors from FOGSI and rewarded 'Manyata Certification' upon successful completion.

*Image for reference use only

Tiruchirappalli Achieves Healthcare Excellence Through Targeted Approach

> ***Over the years, maternal health outcomes in Trichy have significantly improved, with FOGSI's Manyata initiative playing an important role. ARTIST For Her CSE has successfully trained 246 maternity facilities in Tamil Nadu. Through ARTIST's targeted approach, 31 hospitals have achieved Manyata certification in Trichy alone, including Ramakrishna Medical Center, covering a significant portion of the region's maternity hospitals. This case story highlights how building competencies among healthcare providers can lead to meaningful improvements in maternal health. We are excited to continue expanding our efforts to ensure the best possible care for mothers and newborns.***
>
> ***-Dr. Hema Divakar, National Convenor, FOGSI-Manyata Initiative & ARTIST For Her CSE Lead***

Specialized gynecological centers, monitoring and awareness cells, maternal and child health helpline, and comprehensive trainings for healthcare staff have been key players in driving timely assistance, prompt medical intervention and quality care in the Trichy district. This success is particularly significant given the common challenges faced by tier II cities in India, including limited healthcare infrastructure and overburdened medical workforces. These constraints typically lead to prolonged wait times and compromised quality of care, contributing to high levels of stress and burnout among healthcare providers. According to the Medscape Physician Burnout and Depression Survey, obstetricians and gynecologists reported one of the highest burnout rates, reaching 53% [3]. By emulating Tiruchirappalli's model and leveraging best practices, tier II cities can enhance healthcare accessibility, improve maternal health outcomes, and ensure equitable healthcare for all.

[3] https://www.chiefhealthcareexecutive.com/view/nearly-half-of-doctors-report-burnout-but-there-is-some-progress-survey-finds

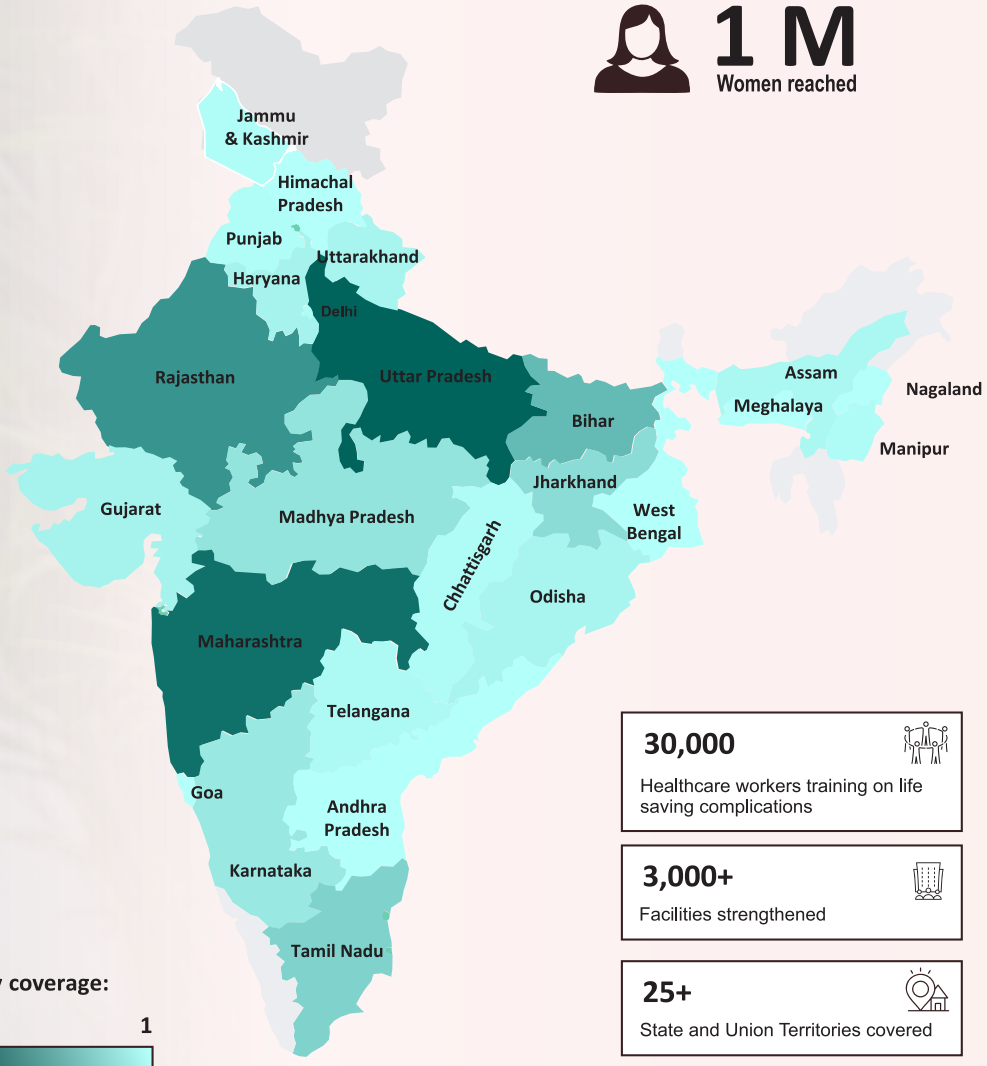
ANNEXURES

ANNEXURE

Standard No.	Manyata Clinical Standard
1.	Provider screens for key clinical conditions that may lead to complications during pregnancy (To be verified only among booked cases)
2.	Provider prepares for safe care during delivery (to be checked every day)
3.	Provider assesses all pregnant women at admission
4.	Provider conducts PV examination appropriately
5.	Provider monitors the progress of labor appropriately
6.	Provider ensures respectful and supportive care
7.	Provider assists the pregnant woman to have a safe and clean birth
8.	Provider conducts a rapid initial assessment and performs immediate newborn care (if the baby cries immediately)
9.	Provider performs Active Management of the Third Stage of Labor (AMTSL)
10.	Provider identifies and manages Postpartum Hemorrhage (PPH)
11.	Provider identifies and manages severe Preeclampsia/Eclampsia (PE/E)
12.	The provider performs newborn resuscitation if the baby does not cry immediately after birth
13.	The provider ensures the care of small and vulnerable newborns at birth
14.	The facility adheres to universal infection prevention protocols
15.	The provider ensures adequate postpartum care package is offered to the mother and baby – at and after discharge
16.	Provider reviews clinical practices related to C-sections at regular intervals
17.	Provider ensures screening and timely referral of mothers with mental ill health
18.	Provider ensures safe surgery in the facility
19.	Provider ensures complete medicolegal documentation
20.	Provider delivers HDU care to obstetric patients with advanced care needs

IMPACT AND REACH

1 M
Women reached



**Data reflects cumulative totals for the Manyata program as on end of Q2 FY25.*

30,000
Healthcare workers training on life saving complications

3,000+
Facilities strengthened

25+
State and Union Territories covered

18
Centers for Skill Enhancement (CSEs)

MANYATA™

DON'T FORGET MOMS – A FOGSI INITIATIVE

FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA

FOGSI

#DontForgetMoms

www.manyataformothers.org