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Review Article

India's efforts towards improving maternal healthcare: a narrative review of government maternal health schemes

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ABSTRACT

Maternal mortality is still a major public health concern. India stands second across the globe in absolute maternal deaths. Even though the country has reduced the maternal mortality ratio (MMR) from 570 in 1990 to 97 per 100,000 live births in 2020. The present narrative review traces the evolution of centrally sponsored Government of India maternal health schemes from 1952 to 2019, and examines their objectives, key interventions and outcomes against the national targets and sustainable development goal (SDG) 3. Literature was identified from PubMed/MEDLINE, Scopus, google scholar and the Cochrane library and supplemented by government policy documents, NFHS data and WHO/UNICEF reports and synthesized narratively in chronological order. From the family planning programme (1952) to the launch of SUMAN scheme in 2019, several schemes have strengthened the maternal health continuum of care in India. JSY and JSSK have significantly increased institutional delivery (41% in 2005 to 88.6%, NFHS-5) and reduced out of pocket expenditure. Continued persistence of socioeconomic inequities, disparities and urban–rural gaps limit universal coverage of maternal health schemes in India. India's estimated 2023 MMR of 116 which means it is off track to meet the SDG 3.1 target of below 70 by 2030. India's maternal health policy architecture is characterised by sustained government commitment. but equity-focused implementation, demand-side interventions and evidence-based programme refinement are crucial to achieving zero preventable maternal deaths.

Keywords: Maternal health schemes, Maternity benefit schemes, Maternal health programs, India, Sustainable development goals

INTRODUCTION

Pregnancy and childbirth are generally perceived as grand moments of joy. Safe childbirth and safe motherhood depend upon the care and attention given to the mothers and their newborns.[1] Improvement of maternal health is crucial for reducing pregnancy-related maternal deaths. Healthy women give birth to healthy babies and are better able to care for them.[2] Improved maternal health contributes to the nation's economic development by reducing maternal and child health problems.[3]

Maternal mortality remains a stubborn public health problem. It heavily impacts on low- and middle-income countries. Approximately 800 women die from complications of pregnancy and childbirth every day. This is close to roughly one maternal death worldwide every two minutes.[4] These deaths are overwhelmingly concentrated in developing nations. Whereby, they account for about 93% of the global burden. This necessitates targeted interventions to improve maternal healthcare in these regions. Africa and South Asia alone contribute a disproportionate 87% of maternal deaths worldwide.[5]

The United Nations Millennium Development Goals (MDGs) were 8 goals that united nation members committed to accomplishing by the year 2015. Target number six under MDG 5 sought to decrease the maternal mortality ratio (MMR) by 75 percent, from 1990 to 2015. Against this target, the global reduction in MMR was 43.9 percent (from 385 in 1990 to 216 in 2015). Whereas India reduced its MMR by 69.5 percent (from 570 in 1990 to 174 in 2015). Hence both global and national targets remained under-achieved.[6] Therefore, sustainable development goals (SDGs), also referred as the Global Goals, were instituted by the United Nations in 2015 to succeed the MDGs. Among the 17 SDGs, four are directly or indirectly associated with maternal health. These includes good health and well-being (SDG 3), quality education (SDG 4), gender equality (SDG 5), and reduced inequalities (SDG 10).[7]

SDG target 3.1 calls for bringing the MMR below 70 per 100,000 live births by 2030. India's MMR of 97 per 100,000 live births in 2020, against a global figure of 223, suggests steady progress toward this goal. But the picture is more complicated underneath. In 2000, India accounted for 1,49,000 maternal deaths. India's share was 27.3% of the global total, the highest of any country. By 2020, its count had fallen to 25,220 deaths (8.79% of the global total), second only to Nigeria.[3] Being the world's most populous country does not excuse this burden. The leading direct causes of maternal death remain haemorrhage (27%), hypertension (14%), sepsis (11%), complications of unsafe abortion (8%), and embolism (3%).[8]

Need for the review

India has invested heavily in policy and programmatic interventions to improve maternal health outcomes. This aligns with national development priorities and global commitments including the MDGs and SDGs. The Government of India (GoI) has recognised maternal mortality as a public health and social equity challenge. Therefore, GoI has launched a series of schemes and initiatives that cover the continuum of care from antenatal services to safe delivery and postnatal follow-up. The cumulative result of these efforts has been a reduction in the MMR gradually. But the challenge of further reductions, especially in high burden states and among marginalised populations continues. This calls for the continuous evaluation and evidence-based refinement of these programmes.

Perinatal conditions are the seventh leading cause of mortality in India. Ever after the launch of several maternal health schemes India contributes substantially to the global share of maternal deaths.[9] This necessitates the importance of continuous assessment and improvement of maternal health programs.[3] The challenge remains and highlights the need for a holistic review of the maternal health schemes of the GoI and their effectiveness. The literature on maternal health schemes in India is present in abundance but in a disorganised way. In this narrative review we have tried to explore the need to implement several maternal health schemes in a sequence and their different objectives.

METHODS

Literature search and sources

We systematically searched the literature in several electronic databases. This included PubMed/MEDLINE, Scopus, Google scholar, and the Cochrane library, from January 1990 to June 2026. In addition, the search was supplemented by grey literature from authoritative sources. This included official Government of India policy documents and operational guidelines published by the Ministry of Health and Family Welfare (MoHFW), National Health Mission (NHM) and NITI aayog; reports from international organisations such as the World Health Organization (WHO), UNICEF and World Bank; and data from National Family Health Survey (NFHS) series and sample registration system (SRS).

Search terms

Search terms were used both individually and in combination using Boolean operators (AND, OR). Keywords used were: "maternal health", "maternal mortality", "maternal health schemes", "maternity benefit programmes", "safe motherhood", "antenatal care", "institutional delivery", "skilled birth attendance", "India", "National Health Mission", "Janani Suraksha Yojana", "Pradhan Mantri Matru Vandana Yojana", "Government health programmes India", and "sustainable development goals maternal health". Searches were limited to English language publications. Given the descriptive and policy-oriented nature of this review, there was no restriction on the study design.

Inclusion and exclusion criteria

Studies and documents were included if they: described or evaluated a centrally sponsored Government of India maternal health scheme or programme; reported on maternal health outcomes, coverage metrics, or programme implementation data relevant to India; or provided epidemiological data on maternal mortality trends at the national level. We excluded documents exclusively related to state-sponsored schemes, studies focusing solely on child health outcomes without a maternal health component, and publications unavailable in the English language.

Data extraction and synthesis

Two reviewers carried out data extraction independently. Discrepancies were resolved through discussion and consensus involving a senior reviewer. We extracted the following information for each scheme: name and year of launch, implementing ministry or agency, target beneficiaries, key interventions, financial provisions, and

reported outcomes or coverage data. A narrative synthesis approach was adopted. Data on the schemes was organized chronologically and thematically. Evolution of the schemes and its alignment with national and global health targets was assessed.

RESULTS

After extensive literature review, several national schemes were identified. Summary of national maternal health schemes launched by GoI between 1952 to 2019 is presented in Table 1. India versus global MMR trends is depicted in Figure 1.

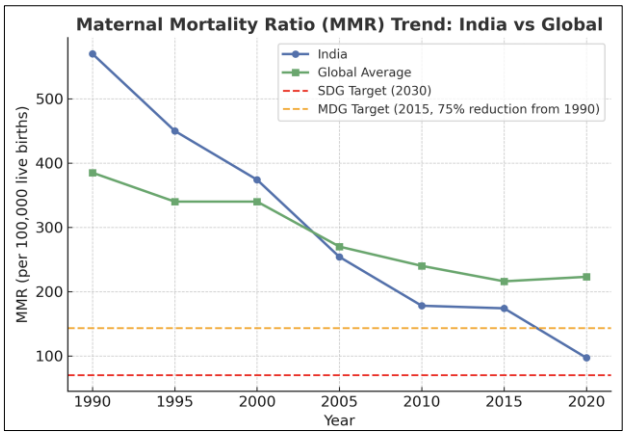

Figure 1: India versus global maternal mortality ratio trend.

Table 1: Summary of national maternal health schemes launched by government of India (1952-2019).

S. no.	Scheme name and year	Target beneficiaries	Key interventions	Documented outcomes/coverage
1	National programme for family planning 1952	General population; women of reproductive age	Contraceptive services; population stabilisation; family welfare counselling	TFR reduced from 6.0 (1960) to 3.9 (1988); renamed as national family welfare programme (1977)
2	Child survival and safe motherhood (CSSM) 1992	Pregnant women; newborns; under five children	TT immunisation for pregnant women; IFA supplementation; ANC and complication detection; skilled birth attendance; promotion of institutional delivery	TT immunisation: 55%→67% (+12%); IFA coverage: 51%→69% (+18%); negligible effect on other key interventions
3	Reproductive and child health programme phase I (RCH-I) 1997-2005	Pregnant and lactating women; children; couples of reproductive ages	Essential and emergency obstetric care; 24-hour delivery services; MTP Act 1971 services; STD control; training of dais	Birth rate: 24.26/1,000; IMR: 57/1,000 live births (target met); MMR: 286/100,000 (target met); institutional delivery: 41% (target 80% - unmet)
4	Reproductive and child health programme phase II (RCH-II) 2005-2012	Pregnant and lactating women; newborns; couples	EmOC training for MBBS doctors; Blood storage at FRUs; JSY and JSSK implementation; safe abortion services; maternal death review (MDR); village health and nutrition day (VHND)	MMR: 162/100,000 (target <100 - unmet); IMR: 43/1,000 (target <30 - unmet); TFR: 2.5 (target 2.1 - unmet)
5	Janani Suraksha Yojana (JSY) 2005	Pregnant women from BPL families; women in low performing states (LPS)	Cash incentives for institutional delivery (mother and ASHA); Enhanced benefits in LPS and rural areas; ASHA as birth companion and facilitator	Institutional delivery rate: 41% (2005) → 88.6% (NFHS-5, 2020); Significant reduction in home deliveries in LPS
6	Janani Shishu Suraksha Karyakram (JSSK) 2011	All pregnant women; sick newborns up to 30 days; extended to ANC/PNC complications (2014)	Free deliveries and C-sections; free medicines, diagnostics and diet; free blood supply; free transport (home→facility→home); zero user fees	Reduced out-of-pocket expenditure (OOPEs) at public facilities; improved uptake of institutional delivery alongside JSY
7	National Health Mission (NHM) 2013	All citizens; special focus: rural, urban poor, marginalised populations	Merger of NRHM (2005) and NUHM (2013); umbrella framework for all health programmes; strengthening health infrastructure; HR capacity building	Improved health infrastructure in rural and urban areas; provided platform for all subsequent maternal health schemes

Continued.

S. no.	Scheme name and year	Target beneficiaries	Key interventions	Documented outcomes/coverage
8	RMNCH+A/ RMNCAH+N 2013 (renamed 2018)	Reproductive-age women; pregnant and lactating mothers; newborns, children, adolescents	Integrates JSY, JSSK, PMSMA; Universal screening (GDM, HIV, Syphilis); strengthening FRUs and delivery points; MCH wings and obstetric HDUs/ICUs; comprehensive Abortion Care (CAC); midwifery initiative; MPCDSR surveillance	Comprehensive continuum-of-care framework; unified monitoring through MPCDSR; expanded nutrition integration under POSHAN Abhiyaan
9	Dakshata 2015	Frontline health providers; MBBS doctors, nurses, ANMs at delivery points	Intrapartum and immediate postpartum quality care training; standardised training packages and materials for states	Improved quality of care at delivery points; competency-based skill enhancement of birth attendants
10	Beti Bachao Beti Padhao (BBBP) 2015	Girl child; women; communities with low child sex ratio	Addresses declining child sex ratio; promotes female empowerment and education; aims: institutional delivery >95%; 1% annual increase in 1st-trimester ANC registration	Expanded to all districts nationally; contributes to improved ANC registration and institutional delivery targets
11	Kilkari 2016	Pregnant women (from 2nd trimester); mothers up to child's 1st birthday	Free weekly IVR audio messages via mobile; timely information on newborn and maternal care; linked to RCH portal enrolment	Active in 20 states (as of Feb 2024); Improved health-seeking behaviour and awareness among beneficiaries
12	Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) 2016	All pregnant women	Fixed-day (9th of each month) ANC at public facilities; package: investigations, medications, counselling; specialist/OBGYN involvement	Improved quality and coverage of ANC; high-risk pregnancies identified and referred; complements routine ANC services
13	Mothers' absolute affection (MAA) programme 2016	Pregnant and lactating women; family members; community members	Breastfeeding promotion and protection; awareness generation; community-level and facility-level interventions; ongoing monitoring of breastfeeding rates	Improved early initiation and exclusive breastfeeding rates; strengthened health system support for lactating mothers
14	Pradhan Mantri Matru Vandana Yojana (PMMVY) 2017	Pregnant and lactating women (1st child); girl child (2nd child)	1st child: ₹5,000 in instalments (on ANC registration + child vaccination); 2nd child (girl): ₹6,000 as single instalment; partial wage-loss compensation	Incentivised health-seeking during pregnancy; promoted ANC registration and immunisation linkage; revised from Indira Gandhi Matritva Sahyog Yojana
15	Labour room quality improvement initiative (LaQshya) 2017	Women in labour; newborns; labour room and maternity OT staff	Standardisation of labour room layout and workflow; dedicated obstetric HDUs at district hospitals and medical colleges; respectful maternity care (RMC); clinical protocols for complication management pre-referral	Reduced preventable intrapartum and postpartum mortality; improved quality of care at highest-risk delivery moment; LaQshya certification of qualifying facilities
16	POSHAN Abhiyaan (National Nutrition Mission) 2018	Adolescent girls; pregnant and lactating women; children 0-6 years	Community-based events (8th and 22nd of month at AWCs); village health sanitation and nutrition day (15th of month); themes: Annaprasan Diwas, Suposhan Diwas	Improved nutritional status monitoring; integrated with RMNCAH+N for maternal nutrition; reduction in stunting and anaemia targets across life cycle
17	Anaemia Mukt Bharat (AMB) 2018	Pregnant and lactating women;	Weekly IFA (non-pregnant/non-lactating females); daily IFA from 2nd trimester to 6 months	Targeted reduction of anaemia prevalence in vulnerable groups; life-cycle

Continued.

S. no.	Scheme name and year	Target beneficiaries	Key interventions	Documented outcomes/coverage
		adolescent girls; children	postpartum; deworming: albendazole 400mg (2nd trimester)	approach to iron deficiency prevention
18	Surakshit Matritva Aashwasan (SUMAN) 2019	All pregnant women; mothers up to 6 months postpartum; all sick newborns	Consolidates all existing schemes into assured-service-delivery framework; 4 service packages: essential, basic, BEmONC, CEmONC; zero preventable maternal and infant mortality goal; dignity and respectful care mandate; behavioural change communication (BCC)	Aims to eliminate all preventable maternal and neonatal deaths; responsive grievance redressal mechanism; unified monitoring and reporting system

ANC: antenatal care; ASHA: accredited social health activist; AWC: anganwadi centre; BEmONC: basic emergency obstetric and newborn care; BPL: below poverty line; CAC: comprehensive abortion care; CEmONC: comprehensive emergency obstetric and newborn care; EmOC: emergency obstetric care; FRU: first referral unit; GDM: gestational diabetes mellitus; HDU: high dependency unit; IFA: iron and folic acid; IMR: infant mortality rate; IVR: interactive voice response; JSY: Janani Suraksha Yojana; JSSK: Janani Shishu Suraksha Karyakram; LPS: low performing states; MCH: maternal and child health; MMR: maternal mortality ratio; MPCDSR: maternal perinatal and child death surveillance and response; MTP: medical termination of pregnancy; NFHS: National Family Health Survey; NHM: National Health Mission; NRHM: National Rural Health Mission; NUHM: National Urban Health Mission; OOPEs: out-of-pocket expenditures; PNC: postnatal care; RCH: reproductive and child health; RMC: respectful maternity care; SDG: sustainable development goal; STD: sexually transmitted disease; TFR: total fertility rate; TT: tetanus toxoid; VHND: village health and nutrition day

National Maternal Health Schemes in India

National programme for family planning (1952)

India is the first nation to implement a family planning program in the year 1952. The key objectives of this programme were to reduce growth rate and to stabilize the growing population. This program successfully reduced Total fertility rate (TFR) from 6.0 (1960) to 3.9 (1988). It was renamed as National Family welfare program in the year 1977.[10]

Currently, family planning services are offered through Mission Parivar Vikas (MPV). It was initiated in 2016 to enhance access to contraceptives and family planning services in 145 High Fertility Districts across seven priority states. These states have TFR ≥3 and include Bihar, Rajasthan, Jharkhand, Madhya Pradesh, Uttar Pradesh, Chhattisgarh, and Assam. The Extended Mission Parivar Vikas for the six North-Eastern states was inaugurated on November 3, 2021, encompassing all districts of Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, and Mizoram.[11]

Child survival and safe motherhood programme (CSSM-1992)

After the safe motherhood conference in Nairobi in 1987, issues of maternal mortality and safe motherhood were extensively focused. The World Bank, UNICEF, and other donors in supported India in launching CSSM program in the year 1992. Its central aim was to bring the maternal mortality rate down from 400 to below 200 per 100,000 live births by the year 2000.[12]

Several key interventions for safe motherhood were done within the CSSM program. This included vaccination for pregnant women, prevention and treatment of anaemia, antenatal care and early detection of maternal complications, skilled birth attendance, birth spacing, promotion of institutional delivery, and management of obstetric emergencies. After 3 years of CSSM, there was 12 percent rise in TT immunization (from 55 percent to 67 percent) and IFA coverage hiked by 18 percent (from 51 percent to 69 percent). But there was negligible effect imposed by other key interventions.[13]

Reproductive and child health programme (RCH)

Reproductive and child health programme phase I (15th October 1997 to 31st March 2005)

Under RCH phase I, major interventions were focused on essential and emergency obstetrical care, 24 hour delivery services, services under MTP act 1971, control of sexually transmitted diseases (STDs), drug and equipment kits and training of Dais.[14] Following RCH I, the achieved birth rate was 24.26 per 1,000 population (target <21/1,000 population), with an infant mortality rate (IMR) of 57 per 1,000 live births (target <60 per 1000 live birth), MMR of 286 per 100,000 live births (target <400/1,00,000 live births), an institutional delivery rate of 41 percent (target of 80 percent), antenatal care coverage of 74 percent (target of 100 percent), and a childhood immunisation rate of 44 percent (target of 100 percent). All of these fell short of their respective targets except for the targets for IMR and MMR.[15]

Reproductive and child health programme phase II (1st April 2005-2012)

Due to the underachievement of RCH I aims, RCH II was initiated. The principal initiatives under RCH II included the training of MBBS doctors for EmOC, establishment of blood storage facilities at first referral units (FRUs),

implementation of the JSY and JSSK, provision of safe abortion services, maternal death review (MDR), and observance of VHND.[14,18] After RCH II, the MMR was 162 per 100,000 live births (exceeding the aim of <100 per 100,000 live births), the IMR was 43 per 1,000 live births (surpassing the target of <30 per 1,000 live births), and the TFR was 2.5 (above the target of 2.1).[17,18]

Janani suraksha yojana (JSY) (12 April 2005)

JSY aimed at reducing maternal and newborn mortality by promoting institutional deliveries among impoverished pregnant women. The ASHA serves as the link between the government and pregnant women. ASHA accompanies pregnant women to the hospital for safe confinement. Under the JSY initiative, states exhibiting institutional delivery rates below the national average are classified as LPS, which included Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Assam, Rajasthan, Orissa, and Jammu and Kashmir. All other states are classified as high performing states (HPS). Both ASHA and the mother receive cash assistance for each institutional delivery, with amounts being greater in LPS and rural areas. JSY effectively improved institutional delivery rates from 41 percent (2005) to 88.6 percent (2020), according to NFHS-5.[19]

Janani-Shishu Suraksha Karyakram (JSSK) (01 June 2011)

JSY markedly improved institutional delivery rates; yet mothers were reluctant to choose for institutional delivery due to OOPEs. In response to this, JSSK was initiated. The JSSK offers numerous free benefits for pregnant women, including free and cashless deliveries, caesarean sections, medications and consumables, diagnostic services, dietary provisions during hospitalisation, blood supply, waivers on user fees, transportation from home to healthcare facilities, inter-facility transport for referrals, and return transport to home after a 48-hour stay. All antenatal and post-natal complications were also covered since the year 2014.[20]

National health mission (NHM) (2013)

NRHM was initiated in the year 2005 and with launch of NUHM in 2013, these two were merged under the name of NHM. Thereafter, every health program including maternal health programs comes under NHM.[21]

Reproductive, maternal, newborn, child, and adolescent health program (RMNCH+A) (2013)

RMNCH+A program was launched in 2013. With the launch of POSHAN Abhiyaan in 2018 RMNCH+A was renamed as RMNCAH+N (reproductive, maternal, newborn, child, adolescent health, and nutrition). Key interventions for 'Maternal Health' under RMNCAH+N include benefits of schemes like: SUMAN, JSY, JSSK, PMSMA, LaQshya, universal screening for GDM, HIV and Syphilis, strengthening FRUs and delivery points (DP), MCH wings and obstetric HDUs/ICUs, capacity building of human resource [Dakshata, comprehensive emergency obstetric and newborn care (CEmONC), MBBS doctors were trained for life saving anaesthetic skills (LSAS), skilled attendance at birth (SBA)], midwifery initiative, CAC, MPCDSR.[22] Key Interventions for 'Nutrition' under RMNCAH+N were provided through mother's absolute affection (MAA) program, POSHAN Abhiyan and Anemia Mukt Bharat (AMB) schemes which are discussed further.

Dakshata (30 April 2015)

Dakshata was initiated to promptly enhance the quality of treatment throughout the intrapartum and immediate postpartum periods at delivery points. The Dakshata package offers a comprehensive array of materials to aid states in the planning and execution of training programs aimed at enhancing the quality of care.[23]

Kilkari (15 January 2016)

The Kilkari program is a mobile service designed for new and pregnant mothers to promote healthier decisions about newborn care. Kilkari provides free of charge, weekly, timely audio messages through IVR to women enrolled in the RCH portal. Communication commences in the second trimester and persists till the child turns one year of age. As of 07 February 2024, the Kilkari Project is active in 20 states.[24]

Pradhan mantri surakshit matritva abhiyan (PMSMA) (31 July 2016)

It aimed at enhancing the quality and accessibility of antenatal care (ANC), encompassing diagnostic and counselling services. Under PMSMA, a basic package of antenatal care services (comprising investigations and medications) is given to beneficiaries on the 9th day of each month at designated public health facilities in both urban and rural areas, supplementing standard antenatal care.[25]

Mothers absolute affection (MAA) programme (05 August 2016)

This is the only program aiming for the promotion, protection, and support of breastfeeding practices to attain higher breastfeeding rates. The beneficiaries include pregnant and lactating women, family members, and community members. The MAA program emphasizes upon creating awareness, community-level interventions, health facility enhancement, and ongoing monitoring to promote breastfeeding.[26]

Beti Bachao Beti Padhao (BBBP) Scheme (22 January 2015)

This initiative was started in Panipat district of Haryana state but now it covers all districts of the country. The initiative primarily sought to tackle the reduction in the

child gender ratio in the country, alongside associated concerns of female empowerment. But its objectives also include improving institutional delivery rates >95 percent and increasing 1st trimester antenatal care registration by 1 percent per year.[27]

Pradhan Mantri Matru Vandana Yojana (PMMVY) (0t January 2017)

PMMVY is the renamed and revised Indira Gandhi Matritva Sahyog Yojana. The major objectives were to partially compensation for wage loss due to pregnancy and childbirth through monetary incentives. And, to enhance health-seeking behaviours among pregnant women and lactating mothers. Under PMMVY Rs. 5000 is given for the first child. In that, 1st instalment of Rs. 3000 is given upon the registration of pregnancy and completion of at least one antenatal checkup within six months from the last menstrual period at the AWC or an accredited health facility. The second instalment is disbursed following the registration of childbirth and the administration of the 14-week vaccines as per the Universal Immunization Program (UIP). If the 2nd child is a girl, a single instalment of Rs. 6000 is given upon the fulfilment of all the conditions of 1st childbirth.[28]

Labour room quality improvement initiative (LaQshya) (11 December 2017)

LaQshya aims to reduce unnecessary maternal and infant mortality, morbidity, and stillbirths related to care in and around childbirth, and ensure respectful maternity care (RMC). The major strategies under LaQshya includes the following.

Aligning labour room and maternity operation theatre arrangement and workflow according to 'labour room standardisation guidelines' and 'maternal and newborn health toolkit'.

Ensuring functional dedicated obstetric HDUs in all government medical college hospitals and high case-load district hospitals.

Following clinical guidelines to manage and stabilise complications before referral.[29]

Poshan Abhiyan/National Nutrition Mission (08 March 2018)

POSHAN Abhiyaan was launched to lay emphasis on nutritional status. The beneficiaries include adolescent girls, pregnant women, lactating mothers and children from 0-6 years of age. Under POSHAN Abhiyaan, community-based events (CBE) are being celebrated on 8th and 22nd of every month in all AWCs. The themes include Annaprasan Diwas, Suposhan Diwas etc. Along with that, Village Health Sanitation Nutrition Day (VHSND) is conducted regularly on 15th of the month.[30]

Anaemia mukt bharat (AMB-2018)

AMB aims to reduce anaemia in the vulnerable age groups. This includes women, children and adolescents. Life cycle approach is followed to provide preventive and curative mechanisms. The major interventions for women's health under AMB includes IFA supplementation and deworming. For IFA supplementation, one IFA tablet (60 mg elemental Iron + 500 mcg folic Acid) is given weekly to non-pregnant/non lactating females and daily to pregnant women and lactating mothers from 2nd trimester to six months post-partum. For deworming, single dose of 400mg Albendazole tablet is given in the 2nd trimester.[31]

Ayushman Bharat (23 September 2018)

This is a premier initiative of the Government of India aimed at achieving the vision of Universal Health Coverage (UHC) and fulfilling SDGs. Ayushman Bharat comprises two components: health and wellness centres (HWCs) and Pradhan Mantri Jan Arogya Yojana (PM-JAY).

Health and Wellness Centres (HWCs)

In February 2018, the GoI announced the establishment of 150,000 HWCs by converting existing sub centres (SCs) and PHCs to provide comprehensive primary health care (CPHC). This has brought healthcare close to individuals' residences. The services encompass both MCH care as well as non-communicable diseases (NCDs) and providing complimentary medications and diagnostic services.

Pradhan Mantri Jan Arogya Yojana (PM-JAY)

It was launched on 23rd September 2018. It offers a health coverage of Rs. 5 lakhs per family every year for secondary and tertiary care hospitalisation. It may be utilised by an individual family member or collectively by all members, as required.[32]

Surakshit Matritva Aashwasan (SUMAN) (10 October 2019)

To attain SDG targets, the rigorous execution of current schemes is vital. It is essential to progress from 'service delivery' to 'assured service delivery.' To achieve this objective, the GoI has initiated "SUMAN" which consolidates all existing schemes into one. It simultaneously emphasises the government's commitment to resolve the existing disparities in maternal and neonatal healthcare services. SUMAN aims to attain zero maternal and infant mortality via the provision of quality treatment that includes dignity and respect. The objective is to eliminate all avoidable maternal and neonatal deaths. The beneficiaries of SUMAN encompass all pregnant women, mothers up to six months postpartum, and all sick infants.

The comprehensive framework of SUMAN encompasses service assurance, strengthening of health systems,

monitoring and reporting, community awareness, incentives and awards for SUMAN champions, and initiatives for behavioural change communication (BCC). The SUMAN service guarantee encompasses four categories of packages: the essential package (available at all levels), the basic package (offered at HWC-SC/HWC-PHC/PHC/UPHC), BEmONC package (provided at Non-FRU CHC/UCHC/HWC-PHC/Other Hospitals), and the CEmONC Package (accessible at Medical College/DH/SDH/CHC-FRU/UCHC).[33]

DISCUSSION

India has significantly progressed in maternal healthcare through its sequenced, demand-side schemes. JSY (2005) catalysed a rise in institutional delivery rates from 41% to 88.6% (NFHS-5). This was achieved through conditional cash transfers to mothers and ASHAs.[40] Gupta et al reported a 42.6% post-JSY rise in institutional deliveries, with gains extending to rural and lower socioeconomic groups.[41] Bhushan et al demonstrated that NHM accelerated decline in maternal and neonatal mortality in India.[42] JSSK (2011) complemented JSY by eliminating out-of-pocket expenditure for deliveries, diagnostics, and transport. However, Manna et al. found that OOPEs at institutional deliveries remained substantial even post-JSSK in private facilities. This pinpoints gap between policy entitlement and practice.[43]

The NHM provided the overarching infrastructure to operationalize various maternal health schemes. Thereafter, PMSMA (2016) extended quality antenatal care to underserved women on the 9th of every month. Singh M. et al. described it as a critical step in systematic identification of high-risk mothers.[44] Dandona et al, found gaps in service delivery at community health centres. They further emphasized the need for sustained quality monitoring to realise the scheme's potential.[45]

An estimated 46% of maternal deaths happens on delivery day. It highlights the importance of quality of intrapartum care. LaQshya (2017) addressed this by standardising labour room processes. Obstetric HDUs were established and respectful maternity care (RMC) was promoted under LaQshya. Singh et al, in a systematic review of LaQshya, found early evidence of reduced adverse events in Tamil Nadu.[46] After the launch of several maternal health schemes, SUMAN consolidated all existing schemes into one in the year 2019. SUMAN focuses on an assured-service-delivery framework targeting zero preventable deaths. Tolani et al confirmed that ANC coverage, skilled attendance, and facility quality under NHM were among the strongest state-level predictors of MMR reduction.[47]

India has progressed considerably in terms of maternal health. But if we look closely, deep structural inequities persist. After inspecting four rounds of NFHS data, Bango and Ghosh showed that while socioeconomic inequity in institutional delivery declined post-NHM, caste and class disparities in full ANC coverage remained pronounced. This was more prominent in EAG states such as Bihar.[48]

Sk et al applied the three delays model to 317 maternal deaths in West Bengal. They found delays in seeking care (48.6%) and reaching facilities (33.8%) as dominant contributors. Poor danger-sign awareness, cultural barriers, and transport constraints were the main contributors of these delays which resulted in maternal deaths.[49] These findings underscore that service coverage should be tailored to the specific needs of the locality to achieve equity in maternal healthcare.

India has made significant progress but still lags behinds multiple neighbouring countries. Raina et al found that Sri Lanka, Bhutan, Malaysia, and Thailand had already met the SDG 3.1 target of MMR below 70 per 100,000 live births. Particularly, Sri Lanka has reduced its' maternal mortality by 79.4%.[50] The Global Burden of Disease (GBD) 2023 study revealed India's MMR at 116 per 100,000 live births with 24,700 deaths in 2023. This places India off track to meet the 2030 SDG target.[51]

CONCLUSION

India's maternal health policy architecture reflects sustained governmental commitment. There was a substantial decline in India's MMR from 570 (1990) to 97 per 100,000 live births (2020). The progression from JSY through NHM, PMSMA, LaQshya, and SUMAN represents a maturing, quality-focused policy response.[42,47] However, persistent inequities, implementation gaps, and the 2030 deadline demand accelerated, evidence-driven action in EAG states and among marginalised communities.[48]

Recommendations

Future research should use quasi-experimental designs to isolate scheme-specific impacts and qualitative methods to capture women lived experiences. Sustained intersectoral coordination and health equity commitments remain essential. Priority actions should include strengthening implementation and quality monitoring in EAG and other high-burden states with equity-disaggregated tracking. Scaling up LaQshya and Dakshata-based quality-of-care training and strengthening intersectoral coordination will further accelerate India's goals towards the 2030 SDG deadline.

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