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Review Article

Seven years of Surakshit Matritva Aashwasan: a narrative review of implementation and outcomes

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ABSTRACT

The Surakshit Matritva Aashwasan (SUMAN) initiative was launched by India's Ministry of Health and Family Welfare on 10 October 2019. The major objective was to convert maternal and newborn health entitlements into an assured, zero-cost service guarantee with zero tolerance for denial of care. Databases like PubMed/MEDLINE, Scopus, Web of Science, CINAHL, Embase, DOAJ and Google Scholar were searched to carry out this narrative review. This was futher supplemented by government guidelines, Sample Registration System bulletins, and National Family Health Survey rounds three to six. All relevant data and documents published between October 2019 and September 2026 were pooled together to synthesise evidence on SUMAN's design, implementation, and outcomes. SUMAN converges existing maternal health schemes under one charter, but facility notification has proceeded unevenly. India's Maternal Mortality Ratio, already declining before SUMAN's launch (327 in 1999-2001 to 130 in 2014-16). It fell further to 97 in the year 2018-20. Institutional deliveries rose from 78.9% to 90.6% (NFHS-4 to NFHS-6). Respectful maternity care remains inconsistent. Pooled prevalence of disrespect and abuse during childbirth has been estimated between 54.5% and 85% across studies, birth companionship is merely provided despite LaQshya guidelines. Also, beneficiary awareness of SUMAN itself remains low. SUMAN represents a coherent policy architecture for assured maternal and newborn care. However, impact evaluation remains scarce, and implementation and respectful-care gaps warrant sustained monitoring and targeted research.

Keywords: Health policy, India, Institutional delivery, Maternal mortality, Respectful maternity care, Surakshit Matritva Aashwasan yojana

INTRODUCTION

Maternal and newborn survival remain among the most closely watched indicators of health-system performance. This is because death during pregnancy or childbirth is preventable in most of the cases with timely and quality obstetric care. India has one of the largest annual birth cohorts in the world. It has historically carried a disproportionate share of the global maternal mortality burden. Successive governments have responded with an evolving sequence of maternal-health programmes.[1]

The Janani Suraksha Yojana (JSY) was launched in April 2005 to promote institutional delivery among pregnant women through conditional cash transfer.[2] This was followed by the Janani Shishu Suraksha Karyakram (JSSK). JSSK sought to eliminate out-of-pocket expenditure for pregnant women and sick infants by entitling them to free delivery, including caesarean section.[3] The Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) subsequently guaranteed fixed-day, quality antenatal check-ups.[4] And in 2017 the Ministry of Health and Family Welfare (MoHFW) launched 'LaQshya', the Labour Room Quality Improvement Initiative. LaQshya operational guidelines aimed at reducing preventable

maternal and newborn mortality, morbidity, and stillbirths around the time of delivery. It also ensures respectful maternity care (RMC) in the labour room.[5] At the time LaQshya was launched, India's Maternal Mortality Ratio (MMR) had already declined by 22% in a few years, from 167 per 100,000 live births in 2011-13 to 130 in 2014-16.[6]

Despite the cumulative effect of these programmes, policymakers recognised that entitlements set out on paper were not always translating into an assured, dignified experience of care at the facility level. This recognition underpinned the launch of the Surakshit Matritva Aashwasan (SUMAN) scheme. SUMAN was explicitly framed as a move beyond 'service delivery' to 'assured service delivery'. SUMAN is best understood as a convergence and accountability layer superimposed on India's existing maternal-health programme architecture, rather than a new scheme in the conventional sense. It adds a formal service-guarantee charter, a zero-tolerance policy for denial of services, and a dedicated grievance redressal mechanism.[7]

Seven years on from its launch, SUMAN has moved from a national announcement to a facility-by-facility notification exercise. This seven years period has also coincided with the release of two further rounds of the National Family Health Survey (NFHS-5 and NFHS-6).[8,9] Several rounds of the sample registration survey (SRS) special bulletin on Maternal Mortality have also been released. Together, these provide a substantive, if imperfect, evidence base against which SUMAN's implementation and associated outcome trends can now be examined. This review is timed to that seven-year mark. It draws on official government sources and records, along with peer-reviewed literature. It synthesises what is publicly documented about how SUMAN has been designed, rolled out, and experienced by beneficiaries and providers. It also examines the trajectory of India's key maternal and newborn health indicators over the same period.

Objectives of the review

This narrative review has four objectives: to describe the design, objectives, and service architecture of the SUMAN initiative, to document its implementation across the health system, to examine trends in key maternal and newborn health outcome indicators before and after SUMAN's launch and to identify documented strengths and gaps in implementation of the scheme.

METHODS

SUMAN was launched relatively recently. There is a resulting scarcity of dedicated, peer-reviewed impact-evaluation literature that treats it as a standalone intervention. For this reason, a narrative review design was adopted.

Information sources and search yield

Peer-reviewed literature published in English between October 2019 and September 2026 was searched in PubMed/MEDLINE, Scopus, Web of Science, CINAHL, Embase, DOAJ and Google Scholar. Search terms included: Surakshit Matritva Aashwasan, SUMAN, maternal mortality ratio, institutional delivery, respectful maternity care, LaQshya, Janani Suraksha Yojana, and Janani Shishu Suraksha Karyakram. Additionally, primary government sources were systematically reviewed, including MoHFW, National Health Mission (NHM) guidelines on SUMAN, LaQshya, SRS Special Bulletins on Maternal Mortality and successive NFHS rounds.[7,9,11-13]

Inclusion and verification criteria

Sources were included only where they reported primary data, official statistics, or documented analysis. This analysis had to be relevant to SUMAN's design, implementation, or outcomes, or to the wider maternal-health programme ecosystem in which SUMAN operates. Each factual claim used in this review was cross-checked against an identifiable primary document. The source types used in this review are heterogeneous. They include policy documents, parliamentary answers, facility-based cross-sectional studies, and national household surveys. For this reason, findings were synthesised narratively.

SCHEME PROFILE: WHAT IS SUMAN?

Background and launch

SUMAN was launched by the MoHFW, Government of India (GoI) on 10th October 2019, at the 13th Conference of the Central Council of Health and Family Welfare. It is a multi-pronged, coordinated policy approach subsuming all existing maternal health schemes under a single umbrella. It moves beyond entitlement provision toward assured service delivery. The stated overarching goal is zero preventable maternal and newborn deaths.[14]

Vision and objectives

SUMAN's core objective is assured, dignified, respectful, and quality healthcare at no cost. This applies with zero tolerance for denial of services, for every woman and newborn visiting a public health facility. The aim is to end preventable maternal and newborn deaths and morbidities, and to provide a positive birthing experience. Two further stated objectives are set out. The first is to provide high-quality medical, surgical, and emergency care as per the SUMAN service package, at no cost to beneficiaries. The second is to leverage institutional and community-based platforms to build awareness of entitlements.[7]

Beneficiaries

The scheme identifies three beneficiary categories: pregnant women, mothers up to six months post-delivery, and sick newborns and infants visiting public health facilities.[7]

Service guarantee packages

Government facilities are categorised into three service packages under SUMAN: Basic, Basic Emergency Obstetric and Newborn Care (BEmONC), and Comprehensive Emergency Obstetric and Newborn Care (CEmONC). Each facility is notified by the state health department according to the level of obstetric and newborn care it is equipped to provide. Entitlements under these packages are extensive. A baseline set applies across all three packages, including a minimum of four antenatal check-ups, with at least one in the first trimester, and free and cashless normal delivery. Higher-acuity packages add caesarean section capacity and free management of pregnancy-related complications. Across all packages, beneficiaries are also entitled to free transport from home to the facility and back (with a minimum 48-hour post-delivery stay), free diagnostics, drugs and diet, and free care for sick newborns and infants.[7] The three packages and their associated facility types and core entitlements are presented in Table 1.

Table 1: SUMAN service guarantee package by facility level.

Facility package	Facility types typically notified	Core assured services
Basic package	Sub-centres/health and wellness centres, Primary Health Centres (PHCs), smaller facilities conducting routine deliveries	Minimum 4 antenatal check-ups (at least 1 in first trimester), normal delivery, postnatal care, referral for complications, free transport (scheme-wide baseline)
BEmONC package (Basic emergency obstetric and newborn care)	Community Health Centres (CHCs), First Referral Units (FRUs), higher-caseload facilities	Additional to basic package: management of common obstetric emergencies, newborn resuscitation, blood transfusion linkage, referral transport
CEmONC package (Comprehensive emergency obstetric and newborn care)	District hospitals, medical college hospitals	Additional to BEmONC package: Caesarean section, obstetric ICU/HDU care, Sick Newborn Care Units (SNCU), comprehensive complication management

Convergence architecture

SUMAN is explicitly designed to integrate with existing maternal-health programmes. This convergence logic folds cash-transfer, free-entitlement, outreach, and quality-improvement programmes into a single service-guarantee framework. It most clearly differentiates SUMAN from its predecessor schemes. It is also the reason that isolating SUMAN's independent causal contribution to outcome trends is not straightforward.[15]

IMPLEMENTATION ARCHITECTURE

Institutional roles

As with other NHM components, responsibility for SUMAN is shared across two levels. The MoHFW issues policy and technical guidelines. State and Union Territory health departments and State Health Societies are responsible for facility notification, quality assurance committees, and monitoring.[14]

Facility notification and scale

Operationalising SUMAN requires each state to formally notify individual facilities under one of the three service packages, and this has proceeded unevenly. Punjab's Directorate of Health Services notified 3,449 facilities under the Basic package, further facilities under BEmONC, and 122 under CEmONC.[16] Meghalaya's first phase of notification, formalised through a State Gazette notification in August 2023.[17] District-level rollout reports from Nagaland as recently as 2024 describe individual district launches occurring on a phased basis years after the national announcement, only four SUMAN-certified and 33 SUMAN-notified health units were reported for Mokokchung district as of early 2024.[18] This pattern, a national launch in 2019 followed by staggered, multi-year state- and district-level notification still under way in 2023 to 2024, is one of the most consistently documented features of SUMAN's rollout.

Quality assurance and integration with LaQshya

SUMAN's quality assurance architecture draws directly on institutional structures created for LaQshya, including State and District Quality Assurance Committees and facility-level quality teams. It uses the National Quality Assurance Standards (NQAS) as its certification framework.[19] A 2024 peer-reviewed appraisal found that LaQshya addresses roughly three-quarters of the World Health Organization's (WHO) quality-of-care measures for

maternal and newborn care. But it does not comprehensively capture harmful labour-room practices, mistreatment of mothers or newborns, or clinical leadership and supervision. However, these all are central to SUMAN's respectful-care objectives.[5]

Grievance redressal

A defining feature distinguishing SUMAN from earlier entitlement schemes is its formal grievance redressal mechanism. This is intended to give beneficiaries a channel to report denial of services or breaches of the zero-tolerance policy. It is operationalised through a dedicated helpline and facility-level help desks, referenced on the official SUMAN portal maintained by MoHFW.[20]

Human resource and capacity building

Facility-level rollout of SUMAN has been accompanied by orientation and training activities for frontline staff. These staff include medical officers, staff nurses, ANMs, and district programme officers. Training topics include the scheme's vision, service packages, entitlements, facility-notification criteria, quality assurance requirements, grievance redressal procedures, maternal death reporting, and community engagement.[20]

State-level variation

SUMAN was announced as a national initiative in October 2019. However, its facility-level operationalisation has proceeded state-by-state and, within states, district-by-district. This process has extended over several years beyond the national launch date. There is also variation both in the pace of notification and in whether notified facilities go on to achieve formal certification. Continued legislative attention to this rollout is reflected in a Lok Sabha question that specifically addressed the SUMAN Initiative as recently as December 2025.[20]

OUTCOMES AND IMPACT

Maternal mortality ratio trend

India's MMR, measured by the Registrar General of India's (RGI) Sample Registration System (SRS), was already on a steep decline well before SUMAN's launch. It showed MMR decline from 327 per 100,000 live births in 1999-2001, to 301 in 2001-03, 254 in 2004-06, 212 in 2007-09, 178 in 2010-12, and 167 in 2011-13.[21] The decline continued through 130 in 2014-16, 122 in 2015-17, 113 in 2016-18, and 103 in 2017-19.[6] As per the Sample Registration System (SRS) released by the Registrar General of India (RGI), the Maternal Mortality Ratio (MMR) of the country has significantly declined by 33 points from 130 in 2014-16 to 97 in 2018-20 per lakh live births.

India had thereby achieved the National Health Policy 2017 target of MMR 100 by 2020, with the trajectory aligned toward the SDG 3.1 target of MMR 70 by 2030.[22] India's overall MMR decline of 83% has outpaced the global average decline of 42% over the comparable period (Figure 1).[23] Independent compiled analyses drawing on subsequent SRS releases report a continued decline to 93 in 2019-21, followed by a plateau at 88 for two consecutive rounds, 2020-22 and 2021-23.[6] As per the SRS special bulletin on maternal mortality in India (2022-24) published in may 2026, India's MMR has declined to 87. The empowered action group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand) including assam has MMR of 116, Subtotal of south Indian states (Andhra Pradesh, Telangana, Karnataka, Kerala) is as low as 41. This depicts a regional disparity in MMR in the country.[24]

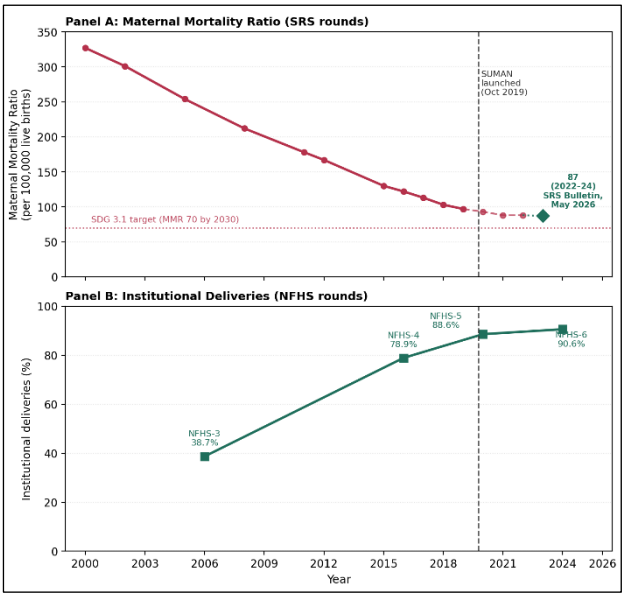


Figure 1: Maternal mortality ratio and Institutional deliveries in India, 2000-2026 (Shown as two separate panels on a shared time axis, not a claim of association).

Institutional delivery

Institutional delivery is a key proximal determinant of maternal and newborn survival. It rose sharply over the period spanning SUMAN's launch. According to NFHS rounds conducted by the International Institute for Population Sciences (IIPS), institutional deliveries increased from 38.7% in NFHS-3 (2005-06) to 78.9% in NFHS-4 (2015-16) and further to 88.6% in NFHS-5 (2019-21).[28,29] NFHS-6 (2023-24, released in 2026) reported institutional deliveries at 90.6%, antenatal care coverage of 95.9%, and 65.2% of mothers receiving four or more antenatal visits, up from 58.5% in NFHS-5. The share of institutional deliveries in public, as opposed to private, facilities also rose, from 52.1% in NFHS-4 to 61.9% in NFHS-5.[25] However, NFHS-6 reported institutional deliveries in public facility of 58.6% which shows slight decline.[9,26] Complementary Health management information system (HMIS) administrative data showed a

parallel trend, from 86.87% in 2014-15 to 93.41% in 2018-19.[27] The higher absolute levels relative to NFHS reflect differences between facility-based administrative reporting and household-survey estimation, and the two series are comparable in direction only. These national trends are further corroborated by independent peer-reviewed analyses of maternal mortality decline and health-service utilisation over the same period.[6,28]

Newborn and stillbirth indicators

In India, stillbirth is still a major public health issue. As part of the Global Every Newborn Action Plan (ENAP), which aims to lower the ≥28 weeks gestation period stillbirth rate to less than 12 per 1000 newborns by 2030, India has committed to a single-digit stillbirth rate. According to the Global Burden of Disease (GBD) research, India's anticipated stillbirth rate at ≥28 weeks gestation was 17.4 per 1000 births in 2021.[28-30] As per the SRS bulletin 2024, released in May 2026 India's stillbirth rate is 7 and the NMR stands at 18 per 1000 live births.[31]

Quality of care and respectful maternity care

SUMAN's central innovation is the addition of a zero-tolerance, RMC commitment on top of pre-existing entitlement schemes. Facility-based evidence on the lived experience of care is therefore particularly relevant to assessing what SUMAN has achieved beyond its predecessors. A meta-analysis published in 2020 estimated pooled prevalence of disrespectful maternity care in India as high as 71.31%.[32] But this was published closely after the launch of SUMAN and could not define SUMAN's contribution. A 2025 published meta-analysis estimated global pooled prevalence of mistreatment and disrespect during childbirth at 54.5%.[33]

Birth companion is an important part of ensuring RMC. However Mandal et al reposted that despite LaQshya guidelines, only 33.3% of women had a birth companion, and nearly all (99.3%) were unaware of the policy.[34] Gowda et al estimated the overall prevalence of RMC as low as 4.42% among 407 women studied from a thar desert district in India.[35] Dasari et al reported prevalence of disrespect and abuse as high as 85% as compared with the RMC standards.[36]

Attribution caveat

SUMAN operates as a convergence platform layered on top of JSY, JSSK, PMSMA, and LaQshya, rather than as a free-standing intervention. Because of this, none of the outcome trends reported above can be attributed to SUMAN in isolation using an before/after comparison. The MMR decline substantially predates SUMAN's 2019 launch. The institutional-delivery rise likewise began under JSY and accelerated under JSSK, well before SUMAN existed. SUMAN's launch coincides with a period in which the pace of MMR decline has appeared to slow even as institutional delivery has continued to rise. Dedicated facility-level evidence on the specific respectful-care and zero-tolerance objectives that distinguish SUMAN from its predecessors is also available. This evidence continues to show a meaningful number of women experiencing some form of disrespect or abuse during childbirth.[32,34-36] This review treats one distinction as a central, rather than incidental, finding. Aggregate national trends reflect the cumulative effect of the entire scheme ecosystem. SUMAN-specific quality-of-care objectives, by contrast, remain thinly evaluated.

STRENGTHS OF THE SCHEME

Several design features of SUMAN represent genuine additions to India's maternal-health policy architecture, rather than mere rebranding. First, the shift from entitlement to assurance, formalised through a published service guarantee charter, gives beneficiaries a more explicit basis on which to expect specific services at specific facility types.[7] Second, the dedicated grievance redressal mechanism creates, an accountability channel that predecessor schemes largely lacked.[7] Third, SUMAN builds on LaQshya's already-established quality-assurance infrastructure. It is an efficient use of existing institutional capacity rather than creating parallel structures.[20] Fourth, the explicit convergence of existing schemes under one framework has the potential to reduce the fragmentation across schemes.[7]

CHALLENGES AND GAPS

Awareness gaps

Dedicated, multi-site evidence on community-level awareness of SUMAN specifically remains scarce. Yadav et al reported low overall awareness about SUMAN scheme among beneficiaries from Uttarakhand state. And noted huge gaps in entitlements, respectful care and free support services.[37] Analogous evidence from other Indian flagship health schemes, such as the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana, suggests that general scheme awareness can substantially exceed awareness of specific entitlements or grievance mechanisms.

Staggered facility notification

Several states completed the first phase of SUMAN facility notification only in 2023 or 2024. This was three to five years after the scheme's national launch. This has an important implication that facility-level guarantee that gives SUMAN its name was not yet formally in force across large parts of the country. This was true even though the scheme had been nationally announced.[20]

Persistent quality-of-care and respectful-care gaps

SUMAN's zero-tolerance, dignity-centred objectives have not yet been uniformly realised at the facility level. There were varying degrees of disrespect or abuse during childbirth reported in few studies.[32,34-36] The 2024

appraisal of LaQshya, the quality-assurance backbone that SUMAN relies upon, similarly found a limitation.[5] The underlying NQAS-based certification framework does not comprehensively capture mistreatment of mothers or newborns, or clinical leadership and supervision failures. This means that a facility could, in principle, be certified without full assurance against the very behaviours SUMAN's zero-tolerance policy targets.[5]

State and interstate equity gaps

Large disparities in MMR persist. Some states have already met the SDG 3.1 targets while others remain well above the national average. Some states are showing stagnation or reversal in recent rounds after initial improvement.[13,31] SUMAN's implementation is administered by state health departments and NHM state units. Because of this, the pace and quality of its rollout is itself subject to the same interstate capacity variation that drives these underlying outcome disparities.[20]

DISCUSSION

The evidence assembled in this review supports a more nuanced assessment of SUMAN scheme. On the positive side, SUMAN consolidates a genuinely useful set of design innovations. This includes, a published service guarantee, a grievance mechanism, and integration with an already-functioning quality-assurance infrastructure. It addresses real limitations of the predecessor maternal health schemes. On the more cautionary side, the aggregate national indicators most often cited in support of India's maternal-health progress were substantially under way well before SUMAN existed. The specific behavioural and quality-of-care objectives that distinguish SUMAN from its predecessors are dignity, respect, and zero tolerance for denial of service.[15] These are the areas whereby independent facility-level research continues to document persistent gaps.[32,34-36]

This pattern is broadly consistent with global evidence on respectful maternity care. Globally, policy commitments to dignity and respect have often outpaced measurable change in provider behaviour at the facility level.[33] This challenge is documented across low- and middle-income health systems along with India.[33]

Two further gaps documented in this review deserve to be read alongside each other, though the evidence does not establish a direct link between them. First, India's national MMR remains above the SDG 3.1 target, and progress remains most incomplete in a specific set of large states, including Haryana, Uttarakhand, West Bengal, Assam, Uttar Pradesh, and Madhya Pradesh.[13] Second, SUMAN's own facility notification has proceeded unevenly, with delays documented specifically in Meghalaya and Nagaland.[20] Further national progress is therefore likely to depend increasingly on differentiated, state-specific acceleration rather than uniform national policy announcements alone.

The apparent plateau in national MMR described in Section 5.1 merits particular attention in future research. The evidence reviewed here cannot distinguish between three possibilities. First is, a genuine slowing in the rate of preventable-mortality reduction as India approaches a harder-to-reach residual caseload. Secondly, a statistical or reporting artefact associated with the SRS bulletin release lag. And the third one is early evidence that the marginal returns to further scheme convergence, as opposed to more fundamental health-system strengthening, are diminishing. Resolving this question is precisely the kind of SUMAN-specific, methodologically rigorous evaluation that this review finds to be currently lacking.

Implications for nursing and obstetric practice

These findings carry direct implications for nursing and obstetric practice, not only for policy. The respectful-care gaps documented are gaps in the behaviour of frontline healthcare workers, at the time of birth, not gaps in policy. The facility-level training already under way in several states offers a practical entry point. That is, incorporating the specific disrespect-and-abuse domains and denial of birth companionship into SUMAN and LaQshya orientation curricula. This would translate SUMAN's key aim directly into frontline practice.

Limitations

This review has several limitations to be acknowledged. Selecting a narrative rather than systematic review is the first limitation. However, inclusion of government published data made systematic review difficult. Second limitation is inclusion of more official government data rather than peer reviewed literature limits understanding the real world implementation of the scheme. This happened because of limited peer reviewed evidence about SUMAN in the existing literature. Lastly, the scarcity of dedicated, SUMAN-specific primary research constrains how much of this review's findings can be attributed to SUMAN specifically, as opposed to the wider scheme ecosystem in which it operates.

Recommendations and way forward

Based on the gaps identified in this review, several directions are proposed for policymakers, programme managers, and researchers. For policymakers, priorities include establishing a publicly accessible dashboard tracking facility notification and certification status under SUMAN, strengthening the respectful-maternity-care and mistreatment-detection components of the NQAS/LaQshya certification checklist. For future research, priorities include commissioning an independent, SUMAN-specific impact evaluation using a quasi-experimental design to move beyond ecological before/after comparisons. Programme managers should focus on extending beneficiary-level awareness and sustaining differentiated, needs-based investment in the states that remain furthest from the SDG 3.1 target.

Because since uniform national policy announcements alone are unlikely to close a gap now concentrated in specific states.

CONCLUSION

Seven years after its launch, Surakshit Matritva Aashwasan represents a coherent and genuinely innovative attempt to convert India's maternal and newborn health entitlements into an assured, accountable service guarantee. It has been rolled out against a backdrop of continued, improvement in national maternal mortality and institutional delivery indicators. Though these aggregate trends substantially predate SUMAN and cannot be attributed to it in isolation. SUMAN's specific contribution is most visible in the dignity and zero-tolerance dimensions of care. As SUMAN's facility notification exercise approaches national completion and a fuller evidence base accumulates, the priority for both policymakers and researchers should shift from further programme announcements to rigorous, SUMAN-specific evaluation of whether the scheme's promises are being delivered where it matters the most.

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