WOMEN'S COLLECTIVE FORUM

Confederation of Indian Industry

INDIA'S WHITE PAPER ON

PROGRESS IN IMPROVING MATERNAL HEALTH OUTCOMES

POPULATION RESEARCH CENTRE
जनसंख्या अनुसंधान केंद्र
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Author

C M Lakshmana

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i) Confederation of Indian Industry (CII), The Mantosh Sondhi Centre; 23, Institutional Area, Lodi Road, New Delhi 110003, India, Tel: +91-11-45771000; Email: info@cii.in; Web: www.cii.in; and

ii) Women's Collective Forum, C/o Ugraya Agro Farm Pvt Ltd At Post Shrungartalital Guhagar Ratnagiri Maharashtra India 415703; ; Email: richa.sharma@womenscollectiveforum.com; Web: womenscollectivforum.org

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FOREWORD

India's Progress in Improving Maternal Health Outcomes

The progress of a nation is measured not only by its economic milestones but by the health, dignity, and empowerment of its mothers. India's achievements in improving maternal health outcomes reflect an enduring commitment to ensuring safe pregnancies, healthy deliveries, and thriving families.

This report, developed in collaboration by the Women's Collective Forum (WCF), Confederation of Indian Industry (CII), and the Population Research Centre, Bengaluru, presents a compelling synthesis of recent advancements, persistent challenges, and practical solutions to further reduce maternal mortality and transform the experiences of women across our country.

The last decade has seen remarkable progress, India's Maternal Mortality Ratio (MMR) has declined significantly, with many states surpassing national and global targets. These achievements are a testament to improved access to healthcare, robust public health programmes, and the tireless dedication of countless frontline workers and communities. Yet, challenges remain; regional disparities, resource gaps, and preventable complications still hinder our collective goals.

This report offers not only a thorough assessment of these issues, but also a blueprint for future action, driven by collaboration, capacity building, and innovative service delivery. I urge policymakers, healthcare professionals, industry partners and civil society to use these findings and recommendations to further build resilient health systems, foster inclusive care, and empower every woman to realize her full potential.

True progress in maternal health is measured by each mother whose life is saved, each family that thrives, and each community that advances through the strength of its women.

Smriti Z. Irani

Chairperson, Alliance for Global Good, Gender Equity and Equality

Advisor, Women's Collective Forum

FOREWORD

India's Progress in Improving Maternal Health Outcomes

Improving maternal health is fundamental to the wellbeing of families and the broader health of our nation. While India has achieved important milestones in reducing maternal mortality and increasing institutional deliveries, persistent gaps in healthcare access, quality of services, and social determinants continue to challenge the health of pregnant women and new mothers, especially among marginalized and vulnerable populations.

This report, developed in collaboration with the Women's Collective Forum (WCF), Population Research Centre, Bengaluru, and Confederation of Indian Industry (CII), provides a rigorous and forward-looking analysis of India's maternal health landscape. It highlights evidence-based strategies to strengthen service delivery, enhance nutrition and antenatal care, promote respectful maternity services, and address inequities through multisectoral approaches.

The comprehensive recommendations put forth emphasize the critical need for innovation, intersectoral coordination, and community empowerment. Improving maternal health is not merely a healthcare objective—it is an indispensable investment in human capital that underpins our demographic dividend, economic productivity, and social progress.

I commend the dedication that have shaped this work and trust that policymakers, practitioners, and stakeholders will leverage its insights to accelerate India's maternal health gains. Together, through strategic action and sustained commitment, we can ensure safer pregnancies, healthier mothers, and stronger future generations for India.

Dr Naresh Trehan

Chairman, CII Steering Group on Health and CII Healthcare Council

Chairman and Managing Director, Medanta – Medicity

FOREWORD

Population Research Centre (PRC) at the Institute for Social and Economic Change (ISEC) is an interdisciplinary community of scholars engaged in population research and training, established in the year 1972 the year in which Institute for Social and Economic Change foundation was laid down. The major objectives of the PRC are to conduct and promote research in population studies and to assist the Ministry of Health and Family Welfare (MoHFW), Government of India (GoI), as well as the Government of Karnataka, with policy inputs and feedback on population and health issues. Capacity building is an important contribution of the centre through the training of scholars in the doctoral programme and through the conduct of workshop and training programmes in population and health studies for mid-career professionals. The financial support for the centre comes from the Ministry of Health and Family Welfare (MoHFW), GoI.

The Population Research Centre (PRC) at ISEC has been actively engaged in research relating to contemporary issues of demography and health since its inception. Currently, the areas of research that the PRC staff are engaged in (1) population, development and the environment (2) population ageing (3) reproductive, maternal, child and adolescent health and (4) gender dynamics. In addition, the centre monitors and provides feedback on various health programmes and plans under the National Health Mission (NHM), as well as the quality of the Health Management Information Systems (HMIS) implemented by the Ministry of Health and Family Welfare (MoHFW).

Here, I am happy to write my Foreword to an important academic research paper on India's White paper on "Progress in Improving Maternal Health Outcomes" which has been written by my colleague Dr C M Lakshmana, Prof and Head, Population Research Centre. The paper is ably well drafted using data on maternal health outcomes in India which contributes to various policy making bodies. The author has collected relevant data, and the analysis has come out very well. I take this opportunity to thank Confederation of Indian Industry (CII) for giving an opportunity to PRC, ISEC to write an important research paper on maternal health outcomes in India. The National Whitepaper on India's Progress in Improving Maternal Health Outcomes has been highlighted through graphical representation, charts and boxes. Insightful analysis has been carried out to understand the overall progress of maternal outcomes in India. Finally, actionable policy recommendations have been drawn for the study to achieve sustainable goal of 3.1 in India by all the states using the study findings and recommendations. I congratulate Prof C M Lakshmana on this wonderful paper, which is certainly very useful for academia, researchers and policy makers.

Prof Parmod Kumar

Acting Director
ISEC, Bengaluru-72

ABBREVIATIONS

Abbreviation	Full Form
AB-HWCs	Ayushman Bharat - Health and Wellness Centres
AI	Artificial Intelligence
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
CII	Confederation of Indian Industry
EAG	Empowered Action Group
FOGSI	Federation of Obstetric and Gynaecological Societies of India
HMIS	Health Management Information System
ICDS	Integrated Child Development Services
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MCTS	Mother and Child Tracking System
MMR	Maternal Mortality Ratio
MNT	Maternal and Neonatal Tetanus
NFHS	National Family Health Survey
NHM	National Health Mission
NHP	National Health Policy
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission (now part of NHM)
PHC	Primary Health Centre
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PNC	Postnatal Care
PRCs	Population Research Centres
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
RCH	Reproductive and Child Health
RMNCAH+N	Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SNP	Supplementary Nutrition Programme
SOPs	Standard Operating Procedures
SRS	Sample Registration Survey/System
TT	Tetanus Toxoid
UHC	Universal Health Coverage
UT	Union Territory
VHSNDs	Village Health Sanitation and Nutrition Days

EXECUTIVE SUMMARY

India has sharply reduced maternal mortality over three decades. India has made remarkable strides in improving maternal health outcomes over the past three decades, with the Maternal Mortality Ratio (MMR) declining from 398 per 100,000 live births in 1997–98 to 93 per 100,000 in 2019–21. This progress is driven by a robust policy ecosystem, targeted programs under the National Health Mission (NHM), strategic flagship schemes, digital innovations, and community engagement. A growing emphasis on equitable access to quality maternal healthcare has further reinforced these gains. As a result, several Indian states have already achieved or are well nearing the Sustainable Development Goal (SDG) 3.1 target of reducing the Maternal Mortality Ratio (MMR) to less than 70 deaths per 100,000 live births by 2030.

Flagship schemes have expanded access and institutional deliveries. Flagship schemes such as the Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) have significantly enhanced maternal healthcare utilization by incentivizing institutional deliveries and providing comprehensive, free-of-cost maternal and newborn care services. Between 2018 and 2021 alone, over 3 crore women availed of JSSK's entitlements, which included free medicines, diagnostics, dietary support, and transport. Concurrently, under JSY, financial assistance was disbursed to more than 3 crore beneficiaries during the same period, contributing to a notable rise in institutional births, which reached 95.5% in 2021–22 (HMIS).

Maternal nutrition and social determinants are integral to progress. The integration of maternal nutrition and broader social determinants of health through schemes such as the Pradhan Mantri Matru Vandana Yojana (PMMVY) and POSHAN Abhiyaan has further strengthened health-seeking behaviour. These initiatives have been instrumental in addressing key contributors to maternal morbidity, including anemia, undernutrition, and micronutrient deficiencies. As a result, key maternal health indicators have shown significant improvement: antenatal care (ANC 4+) coverage increased from 52% in NFHS-3 to 82% in NFHS-5; TT2+ (Tetanus Injection) immunization coverage rose from 76% to 92%; and institutional deliveries improved from 38.7% to 95.5%. Simultaneously, the proportion of home births attended by skilled health personnel declined from 8.2% to 3.2%, indicating improved reliance on institutional care.

Digital innovations have strengthened tracking and service delivery. Platforms such as the Mother and Child Tracking System (MCTS), Reproductive and Child Health (RCH) portal, Anemia Mukt Bharat Dashboard, and community-based mechanisms like Village Health,

Sanitation, and Nutrition Days (VHSNDs) have enhanced real-time tracking, service coverage, and timely care-seeking behaviours. Furthermore, the Ayushman Bharat Health and Wellness Centres (AB-HWCs) have strengthened the continuum of care by integrating antenatal care (ANC), postnatal care (PNC), and high-risk pregnancy screening into the ambit of primary healthcare.

Persistent challenges remain, especially in high-burden states. Despite significant progress in maternal health, challenges persist, particularly in Empowered Action Group (EAG) and North-Eastern states, due to infrastructural deficits, workforce shortages, geographic barriers, financial burdens, adolescent pregnancies, and limited access to quality preconception and postnatal care. Anemia remains a critical concern, with prevalence among women of reproductive age still at 70%, highlighting the need for more intensive nutritional strategies (MoHFW, 2021).

Interstate disparities highlight inequities in maternal outcomes. Wide interstate disparities in antenatal care (ANC) coverage and maternal outcomes underscore inequities. While southern states such as Kerala and Tamil Nadu have achieved near-universal ANC coverage, states like Meghalaya report less than 60% coverage for four ANC visits (IIPS & MoHFW, 2021). Similarly, maternal mortality remains uneven, with Kerala reporting an MMR of 19 and Andhra Pradesh 45, compared to 195 in Assam and 167 in Uttar Pradesh (RGI, 2023).

Structural and socio-cultural barriers continue to constrain progress. Underlying determinants include gaps in rural health infrastructure, shortages of skilled providers (e.g., obstetricians, midwives, ASHAs), indirect costs, low female literacy, adolescent pregnancies, and entrenched cultural norms that delay timely care-seeking. Addressing these challenges requires targeted, equity-focused strategies that strengthen service delivery, improve social determinants, and prioritize high-burden regions.

Key Recommendations

India's maternal health progress is real but uneven, and the next phase requires sharper focus on equity, quality, and last-mile delivery. While policies and schemes are strong, targeted implementation, regional prioritisation, and inter-sectoral collaboration are critical to bridging persistent gaps. Strengthening referral systems, embedding preconception care, investing in human resources, and leveraging digital tools will be key to sustaining gains. At the same time, addressing high-risk pregnancies and tackling socio-cultural barriers will ensure no woman is left behind.

Key recommendations from the paper include:

A. **Enhance Referral & Transport Services:** Prioritizing ambulance availability and inter-facility transport in remote and tribal regions.

B. **Institutionalizing Preconception Care:** Integrate risk assessment, nutritional screening, and micronutrient supplementation into RMNCHA+N workflows.

C. **Leverage Digital Health:** Expand digital pregnancy cards, telemedicine, and interoperable health records to improve continuity of care, especially across public-private systems.

D. **Investment in Human Resources for Health:** Addressing specialist shortages in CHCs/SDHs and training frontline workers in emergency obstetric care.

E. **Target High-Risk Pregnancies:** Establish screening, tracking, and referral protocols for anemia, hypertension, gestational diabetes, and adolescent pregnancies.

F. **Cultural Sensitivity & Community Engagement:** Design IEC campaigns in local languages, focusing on early ANC registration and discouraging child marriage.

Focus Area	Partners	Proposed Actions
Optimize Referral and Transport Services	Local transport authorities; EMS providers (e.g., 108 services); district administrations; tribal development departments	Prioritise deployment of ambulances and mobile health units in hard-to-reach regions (forested, border, hilly areas).
		Strengthen referral protocols through digitalisation and standardisation across CHCs, SDHs, and district hospitals to ensure timely transport and escalation of high-risk pregnancies.
		Map and geo-tag maternal health risk zones and enable dynamic ambulance routing based on terrain and seasonal inaccessibility (e.g., monsoons, landslides).
Introduce Preconception Care Services at Scale	ICMR; FOGSI; nutrition programs; private diagnostic chains	Institutionalise preconception counselling and screening at sub-centres, PHCs, and Urban HWCs, focusing on anemia, BMI, thyroid function, and hereditary risk factors.
		Leverage RKSK, WIFS, and VHSNDs to reach newly married couples and adolescent girls with micronutrient supplementation, health education, and lifestyle support.
		Foster public–private collaborations for affordable lab testing and sustained nutritional support, especially in aspirational districts.

Upgrade Digital Health Infrastructure for Maternal Health	Private hospitals; digital health startups; Ayushman Bharat Digital Mission (ABDM)	Expand digital pregnancy cards to cover both public and private sectors for seamless ANC–PNC data sharing.
		Develop state-level maternal health dashboards to monitor coverage and quality indicators with disaggregated geographic and risk-level data.
		Train frontline workers and data operators on tools like ANMOL, TeCHO+, RCH portal, and mobile data capture systems.
		Leverage AI/ML analytics to flag at-risk pregnancies and guide timely facility- and district-level interventions.
Enhance Community Engagement and Culturally Responsive Communication	Local NGOs; self-help groups (SHGs); ASHAs; Anganwadi workers; youth networks	Roll out culturally sensitive IEC and behaviour change campaigns promoting early ANC registration and facility-based deliveries.
		Mobilise community leaders and youth to reduce adolescent pregnancy and child marriage through targeted drives in high-prevalence states.
		Use digital storytelling and gamification via WhatsApp, YouTube, and school platforms to build maternal health literacy and encourage delaying first pregnancy.
Prioritise Early Detection and Management of High-Risk Conditions	ICMR; endocrinologists' and cardiologists' associations; digital health innovators	Supplement PMSMA and ANC screening protocols to include gestational diabetes, hypertensive disorders, anemia, and preeclampsia.
		Integrate high-risk pregnancy flagging systems into the RCH portal with real-time alerts for frontline workers and referral facilities.
		Conduct refresher training for ANMs, nurses, and MOICs, supported by job aids, on early detection, triage, and referral.
		Drive timely care-seeking through localized IEC materials and digital nudges (SMS/IVR) for pregnant women and families.

In conclusion, India's maternal health architecture provides a strong foundation, but progress now hinges on execution. The path forward lies in equity-focused, regionally tailored implementation that reaches the last mile, backed by digital innovation and stronger accountability. By addressing systemic gaps and embedding maternal health firmly within the universal health coverage agenda, India can move decisively toward achieving universal maternal health coverage by 2030.

1 BACKGROUND

India has reduced maternal mortality significantly, but progress is uneven and the burden remains high. India's Maternal Mortality Ratio (MMR) has declined from 398 per 100,000 live births in 1997–98 to 93 per 100,000 in 2019–21, a reduction of nearly two-thirds and yet India still accounts for approximately 15% of global maternal deaths (MoHFW, 2021; WHO, 2022). This persistent burden, coupled with stark regional disparities, highlights that national gains in institutional deliveries have not uniformly translated into improved survival or equity (NITI Aayog, 2023; UN, 2024).

A strong policy framework has driven higher institutional deliveries. Under the National Health Mission (NHM) and its RMNCAH+N strategy, supplemented by Ayushman Bharat, the government has consolidated Janani Suraksha Yojana, Janani Shishu Suraksha Karyakram, and Pradhan Mantri Surakshit Matritva Abhiyan into an integrated framework that offers free maternity services, strengthens facility infrastructure, and provides conditional cash incentives for pregnant women (MoHFW, 2021). This is also supported by expanded primary-care networks and community health workers, institutional delivery rates have exceeded 80% nationwide (WHO, 2022), marking a substantial service-delivery achievement.

Quality, continuity, and equity remain uneven across states. Despite these advances, quality and continuity of care remain inconsistent. Emergency obstetric readiness is variable across states, and respectful postpartum follow-up is often lacking, especially in socio-economically marginalized and tribal regions (Kruk et al., 2018). Moreover, although southern states have already achieved the SDG 3.1 target of an MMR ≤ 70 per 100 000 live births, several high-burden states continue to lag, underscoring the need for targeted quality-improvement measures and equity-focused strategies (UN, 2024; NITI Aayog, 2023).

Policy must now shift from expanding facility births to ensuring safer deliveries. To accelerate progress toward the 2030 SDG 3.1 goal, policy emphasis must shift from expanding facility births to ensuring "safer deliveries." Recommended actions include the implementation of routine clinical audits, competency-based emergency obstetric training, data-driven performance incentives, and enhanced public–private collaboration on tele-triage and mobile health monitoring. Such measures—coupled with community engagement and continuous evaluation—are essential to closing the remaining gaps in maternal health outcomes (Campbell & Graham, 2006; Kruk et al., 2018).

2 RATIONALE OF THE PAPER

Maternal health is a critical indicator of India's health system and social development. Maternal health serves as a vital barometer of India's overall health-system performance, gender equity, and socio-economic development (Campbell & Graham, 2006). Although India's Maternal Mortality Ratio (MMR) has declined, India still contributes roughly 15% of global maternal deaths, with pronounced disparities across states and socio-economic groups (Ministry of Health & Family Welfare [MoHFW], 2021; World Health Organization [WHO], 2022). As institutional deliveries exceed 80% nationally under the National Health Mission's integrated framework (including JSY, JSSK, and PMSMA), outcome gains have plateaued in many regions, revealing persistent gaps in emergency obstetric readiness, respectful care, and continuum of services (Kruk et al., 2018; United Nations, 2024)

Achieving the SDG 3.1 target requires a shift from more births in facilities to safer births everywhere. Achieving SDG 3.1 with MMR ≤ 70 per 100 000 live births by 2030, demands that India pivot from simply expanding facility births to ensuring "safer deliveries" through quality-and-equity-centered interventions. Clinical audits, competency-based emergency obstetric training, data-driven performance incentives, and robust postpartum follow-up are essential to close the remaining mortality and morbidity gaps, particularly in under-served rural and tribal areas (Kruk et al., 2018; United Nations, 2024).

This white paper brings together diverse strengths for action. The Confederation of Indian Industry (CII), the Women's Collective Forum, and the Population Research Centre (PRC) Bengaluru constitute a complementary alliance uniquely positioned to drive this shift. CII through evidence-driven advocacy and industry-wide quality benchmarks, aligns commercial incentives with public-health goals to ensure recommended interventions are both viable and uniformly implemented. The Women's Collective Forum brings gender-transformative leadership and community advocacy, ensuring that policy recommendations reflect the lived experiences of women and address demand-side barriers to care uptake. PRC Bangalore contributes rigorous, disaggregated analyses of state- and demographic-level data, enabling precise identification of systemic bottlenecks and modeling of intervention impacts.

By integrating CII's leverage of engaging with private sector in complementing the existing health system, the Women's Collective Forum's grassroots insights, and PRC Bangalore's analytical rigor, this joint white paper will offer evidence-based, context-sensitive strategies to fast-track India's achievement of SDG 3.1, ensuring that every institutional delivery is truly a safe delivery.

3 OBJECTIVES

This white paper aims to evaluate India's progress on maternal health and chart a roadmap for the future.

A. Provide a comprehensive, data-driven overview of India's maternal mortality ratio (MMR) trends over the past two decades, with a comparison of pre- and post-NRHM periods.

B. Assess the measurable impact of targeted public-health interventions under the National Health Mission, grouping Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), and Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) on maternal-health outcomes.

C. Identify and analyze key systemic drivers of change, including service-delivery reforms and incentive structures that have shaped maternal-health improvements.

D. Outline actionable insights to inform future strategies for maternal-health equity and health-system strengthening, ensuring alignment with national and global health goals.

4 REVIEW OF LITERATURE

There are several research scholars and health professionals who have addressed the issue of maternal health relating to India using National Family Health Survey (NFHS) and data from Sample Registration Surveys. Bhatia M. et.al.2021, examined maternal mortality trends in India using data from the Sample Registration Systems and the National Family Health Surveys (NFHS-4, 2015–16), which included the information on maternal and pregnancy-related deaths from over 6,00,000 households. By employing logistic regression, the study explored the influence of various socio-economic factors on maternal deaths across states. The findings indicated that household wealth status does not have a statistically significant association with maternal mortality, suggesting that financial barriers to accessing maternal health services have been minimized.

However, disaggregated analysis revealed persistent regional disparities, with Empowered Action Group (EAG) states such as Bihar, Odisha, Assam, and Rajasthan experiencing maternal mortality ratio above the national average despite reductions in the rich-poor gap. These states also face significant supply-side challenges, including shortages of primary healthcare facilities, doctors, and specialists. The study attributed India's progress in maternal health outcomes to pro-poor policies, cash incentive schemes, and strong community-level involvement, particularly through various health workers. The authors emphasized the need for policymakers to address underperforming states and socio-economic groups by simultaneously targeting both demand- and supply-side measures, considering contextual factors to achieve equitable improvements in maternal health outcomes.

Ghosh et al. (2020) conducted a comprehensive evaluation of the National Health Mission's (NHM) impact on maternal health outcomes in India by using a pre–post comparison of key indicators such as institutional deliveries, antenatal care (ANC) utilization, and disparities in accessing at least four ANC visits. Using data from successive rounds of the National Family Health Survey 1 to 4. The study revealed a modest increase of 12.6 percentage points in institutional deliveries during the pre-NHM period, followed by a significant rise of 40.2 percentage points in the post-NHM phase. Despite these improvements, the findings highlighted inter- and intra-state disparities particularly in maternal healthcare access. Nationally, only 51.2 percent of pregnant women received at least four ANC visits, with women from the richest households being four times more likely to achieve this benchmark compared to those from the poorest households. The study emphasized the need for targeted public health strategies to reduce regional inequities and ensure equitable access to institutional deliveries and comprehensive antenatal care in alignment with the maternal and child health goals under the Sustainable Development Goals (SDGs).

Srivastava et al. (2014) traced the trajectory of maternal health care quality in India from 1947 to 2012, examining health system development and identifying areas for improvement to enhance maternal and infant survival outcomes. The review of 174 documents highlighted that, in the first four decades of post-independence, the focus was on infrastructure expansion and disease eradication, neglecting the quality of maternal healthcare. However, with the launch of NRHM in 2005, strategies to improve quality, including public health standards and quality assurance systems in reproductive and child health services, were introduced. While these measures have contributed to notable improvements in maternal and neonatal health indicators, the authors argue that sustained progress

requires increased public investment, improved responsiveness to growing healthcare demands, and further strengthening of quality assurance systems across all levels of care.

Singh A et.al. 2021, summarized the literature, published during 2000–2019, for investigating the impacts of public health programs on both the uptake of maternal and child health services and the related-health outcomes in India. The study followed Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines of systematic review and conducted a narrative synthesis of the study findings. The study found that most studies assessed the impact on the short-term and intermediate outcome of the uptake of various maternal and child health services on the long-term outcome of improvement in health.

Malik et.al. 2024 conducted comprehensive literature search from 2000 to 2023, utilizing PubMed, Google Scholar, and government databases, highlights critical barriers to maternal healthcare, including limited access in rural areas, cultural beliefs, low female literacy, and weaknesses in health systems. The study found that institutional delivery rates have increased, however, the quality of care remains inconsistent. Evidence from literature suggested that community-based interventions, health worker training, cash transfer programs, and health system strengthening hold promise for improving outcomes. Based on the result, the study suggested critical strategies for improving the quality of care, enhancing the capacity of frontline health workers, expanding community mobilization efforts, and promoting culturally sensitive practices. A renewed focus on equity and reaching vulnerable populations were suggested to ensure safe motherhood and achieve universal health coverage and to achieve the Sustainable Development Goal of reducing maternal mortality ratio to below 70 per 100,000 live births by 2030 in all the States/UTs in India.

5 DATA AND METHODOLOGY

This study employed a mixed-methods approach, combining secondary data analysis with structured stakeholder consultations to generate a comprehensive, evidence-informed assessment of India's progress in improving maternal health outcomes and to develop targeted, actionable policy recommendations.

A. Stakeholder Consultation

We conducted structured dialogues with a broad spectrum of maternal-health stakeholders, including government health officials, public-sector administrators, and NGO representatives to capture diverse perspectives on India's progress in reducing maternal mortality. Feedback from these consultations has been incorporated throughout the white paper to (a) showcase successful government efforts and private sector initiatives, and (b) generate targeted policy recommendations for accelerating improvements.

B. Data Sources and Study Period

Quantitative analysis draws on three nationally representative secondary data systems:

- **Sample Registration System (SRS):** State-level MMR estimates for 1997–98, 2007–09, and 2018–20
- **Health Management Information System (HMIS):** Facility-based service coverage and outcome metrics
- **National Family Health Survey (NFHS):** Household-level indicators of antenatal care, immunization, and delivery settings

The analysis distinguishes two phases: pre-NRHM (before 2005) and post-NRHM (2005 onward), enabling a clear comparison of maternal-health trends both before and after implementation of the National Rural Health Mission.

C. Analytical Framework

- **Trend Analysis:** We plotted time-series diagrams to visualize changes in MMR alongside key programme roll-outs.
- **Coverage Indicators:** We computed state and national percentages for:
  - ≥ 4 antenatal care (ANC) visits per registered pregnancy
  - ≥ 2 tetanus toxoid (TT) injections during ANC
  - Institutional delivery rates (public and private)
  - Proportion of births in public facilities
  - Home deliveries attended by a skilled birth attendant (SBA)

- **Programme Linkage:** We overlaid the timelines of flagship NHM schemes—JSY, JSSK, and PMMVY—to assess their temporal association with shifts in service coverage and MMR.
- **Qualitative Synthesis:** Key themes from stakeholder feedback were mapped to quantitative findings to elucidate systemic drivers of change (e.g., incentive structures, supply-side capacity, community engagement).

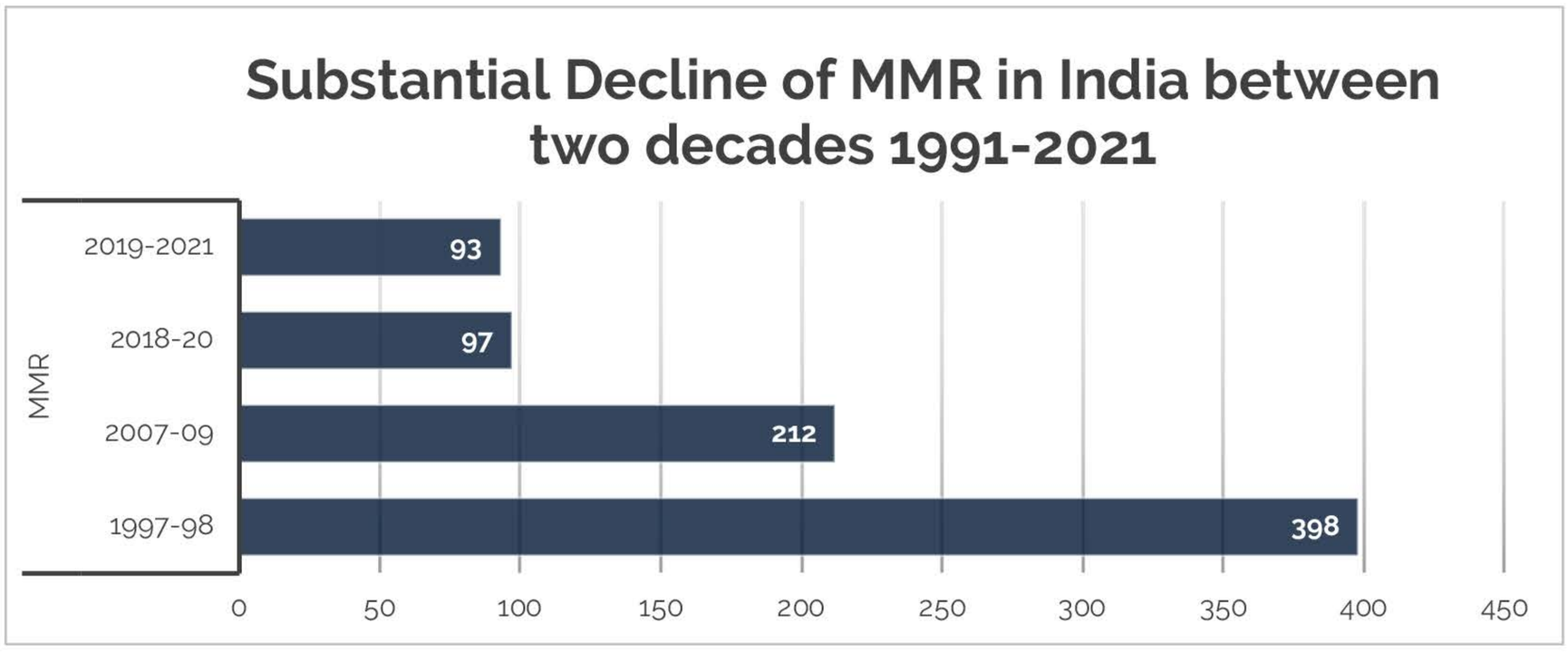
D. Policy Recommendation Development

By triangulating empirical trends with practitioner insights, we have identified scalable best practices and persistent gaps. These informed a set of actionable policy recommendations, tailored for national and state governments to optimise resource allocation, strengthen service delivery, and advance equity in maternal-health outcomes across all regions of India.

6 PROGRESS OF MATERNAL HEALTH OUTCOMES IN INDIA

Maternal health improvements have been substantial, but disparities persist. Maternal health is a core development priority in public health, with direct implications for equity and poverty reduction (World Health Organization [WHO], 2019). Despite substantial national gains in lowering the maternal mortality ratio (MMR), pronounced regional disparities persist between southern states and central/northeastern states, underscoring the need for targeted strategies to ensure equitable progress.

MMR has fallen sharply since NRHM, but gaps remain across regions. Against this backdrop, Sample Registration System (SRS) data demonstrate a marked decline in India's MMR following implementation of the National Rural Health Mission (NRHM) in 2005. Table 1 summarizes the national trends in MMR per 100,000 live births:



National averages mask stark state-level differences. Table 1 shows that India's MMR declined by over 75% between 1997–1998 and 2019–2021, reflecting an average annual reduction rate of approximately 4.1% (ORGI, 2021). These gains coincide with enhanced institutional deliveries, skilled birth attendance, and expanded antenatal and postnatal care under the National Health Mission (NHM) (Ministry of Health and Family Welfare [MoHFW], 2020).

However, national averages mask significant state-level variation. Southern states—Kerala (19), Telangana (43), Andhra Pradesh (45), Tamil Nadu (54), and Karnataka (69)—have reached or surpassed the Sustainable Development Goal target of fewer than 70 maternal deaths per 100,000 live births well before 2030 (IIPS & ICF, 2022). In contrast, several central and northeastern states continue to report MMRs above three digits - Assam: 195; Madhya Pradesh: 173; Rajasthan: 167; Uttar Pradesh: 103; Haryana: 110. These disparities reflect differing socio-economic contexts, health infrastructure, and program implementation intensity (Baru et al., 2020).

Public health programs have been pivotal, complemented by private sector contributions. The achievements of improvements in maternal health indicators is largely attributed to effective public health programs, enhanced institutional deliveries, skilled birth attendance, and improved access to antenatal and postnatal care under NHM. However, private healthcare providers have also played a crucial, and often under-acknowledged, role in complementing government efforts — especially in urban and peri-urban regions. Approximately one-fourth of institutional deliveries in India are conducted in private facilities (NFHS-5, 2019–21), showcasing the sector's significant footprint in maternity care. Moreover, private players have introduced innovations in quality of care, emergency obstetric services, and patient-centered models which have contributed to improvement in maternal health outcomes.

Future progress depends on targeting lagging regions. Despite the remarkable decline of MMR in the country, it is imperative to leverage the collective strength of government initiatives, private sector innovation, and community engagement to sustain and build upon these gains, ensuring that no mother is left behind (IIPS & ICF, 2022). The data suggest that while progress has been achieved nationally, sustaining and accelerating declines in maternal mortality requires a concerted focus on lagging regions. Integrating community engagement, strengthening public-private partnerships, and addressing socio-economic determinants in central and northeastern states will be critical to ensure that no mother is left behind.

7 MAJOR INITIATIVES AND KEY DRIVERS OF INDIA'S PROGRESS IN MATERNAL HEALTH OUTCOMES

Policy reforms and service innovations have been central to India's maternal health progress. India's progress in maternal health has been driven by a combination of policy reforms, targeted service-delivery innovations, and integrated social-sector interventions. The key enablers include:

A. **Strengthened Maternal Health Service Coverage under NRHM/NHM.** Since the launch of the National Rural Health Mission (NRHM) in 2005, access to antenatal care (ANC) and institutional delivery has expanded significantly. ANC registration at public facilities has steadily increased, while institutional deliveries in public facilities rose from 70.6% in 2008–09 to 95.5% in 2021–22 (HMIS, 2009; 2022).

B. **Flagship schemes strengthened safe motherhood interventions.** The Janani Shishu Suraksha Karyakram (JSSK) ensures free deliveries—including C-sections—at public facilities, covering drugs, diagnostics, blood, diet, and transport. The Janani Suraksha Yojana (JSY) provides conditional cash transfers to promote institutional deliveries among low-income women, directly contributing to reduced maternal and neonatal mortality.

C. **Social determinants improved maternal outcomes.** Improvements in female literacy, reduction in child marriage, and increased reproductive autonomy have had a measurable impact on maternal outcomes by enabling women to seek timely ANC, adopt birth-spacing practices, and make informed reproductive health decisions.

D. **Community networks expanded reach at the grassroots.** Accredited Social Health Activists (ASHAs), Anganwadi Workers, and Auxiliary Nurse Midwives (ANMs) have played a pivotal role in community outreach—facilitating early pregnancy registration, creating awareness, and providing essential maternal health services at the primary-care level.

E. **Public–private collaboration expanded specialist access.** Initiatives like the Pradhan Mantri Surakshit Matritva Abhiyan provide free monthly ANC check-ups by specialists, enhancing high-risk pregnancy detection and expanding access to obstetricians and gynaecologists, especially in underserved districts.

F. **Ayushman Bharat–HWCs transformed primary healthcare delivery.** Health and Wellness Centres (HWCs) now integrate preventive, promotive, and maternal health services at the community level, offering comprehensive ANC, PNC, immunization, nutrition counselling, and high-risk screening. This continuum-of-care approach has strengthened early detection and referral systems.

G. **PM-JAY improved affordability through financial protection.** The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) reduces out-of-pocket expenditure by covering secondary and tertiary hospitalizations, including C-sections and neonatal care, thereby improving affordability and utilization of quality maternal care.

H. **PMMVY offered maternity benefits to offset wage loss.** The Pradhan Mantri Matru Vandana Yojana provides conditional cash transfers to partially offset wage loss and incentivize early ANC registration, institutional delivery, and exclusive breastfeeding—showing positive uptake among low-income groups.

I. **POSHAN Abhiyaan addressed maternal nutrition.** The National Nutrition Mission addresses anemia, low birth weight, and maternal malnutrition through nutrition counselling, supplementation, and growth monitoring, with strong convergence between Anganwadi Services and health services.

J. **Digital tools enhanced governance and accountability.** Platforms such as MCTS, the RCH portal, and the Anemia Mukt Bharat Dashboard enable real-time monitoring, service tracking, and targeted interventions. Concurrently, Village Health Sanitation and Nutrition Days (VHSNDs) have boosted awareness, care-seeking, and community engagement.

Table 1: India's Progress in Maternal Mortality Rates (MMR per 100,000 live births)
(In Major States)

	1997-98	2007-09	2018-20
Assam	568	390	195
Bihar	531	261	118
Jharkhand			56
Madhya Pradesh	441	269	173
Chhattisgarh			137
Odisha	346	258	119
Rajasthan	508	318	113

Uttar Pradesh	606	359	167
Uttarakhand			103
Andhra Pradesh	197	134	45
Telangana			43
Karnataka	245	178	69
Kerala	150	81	19
Tamil Nadu	131	97	54
Gujarat	46	148	57
Haryana	136	153	110
Maharashtra	166	104	33
Punjab	280	172	105
West Bengal	303	145	103
India Total	**398**	**212**	**97**

Source: SRS Bulletin

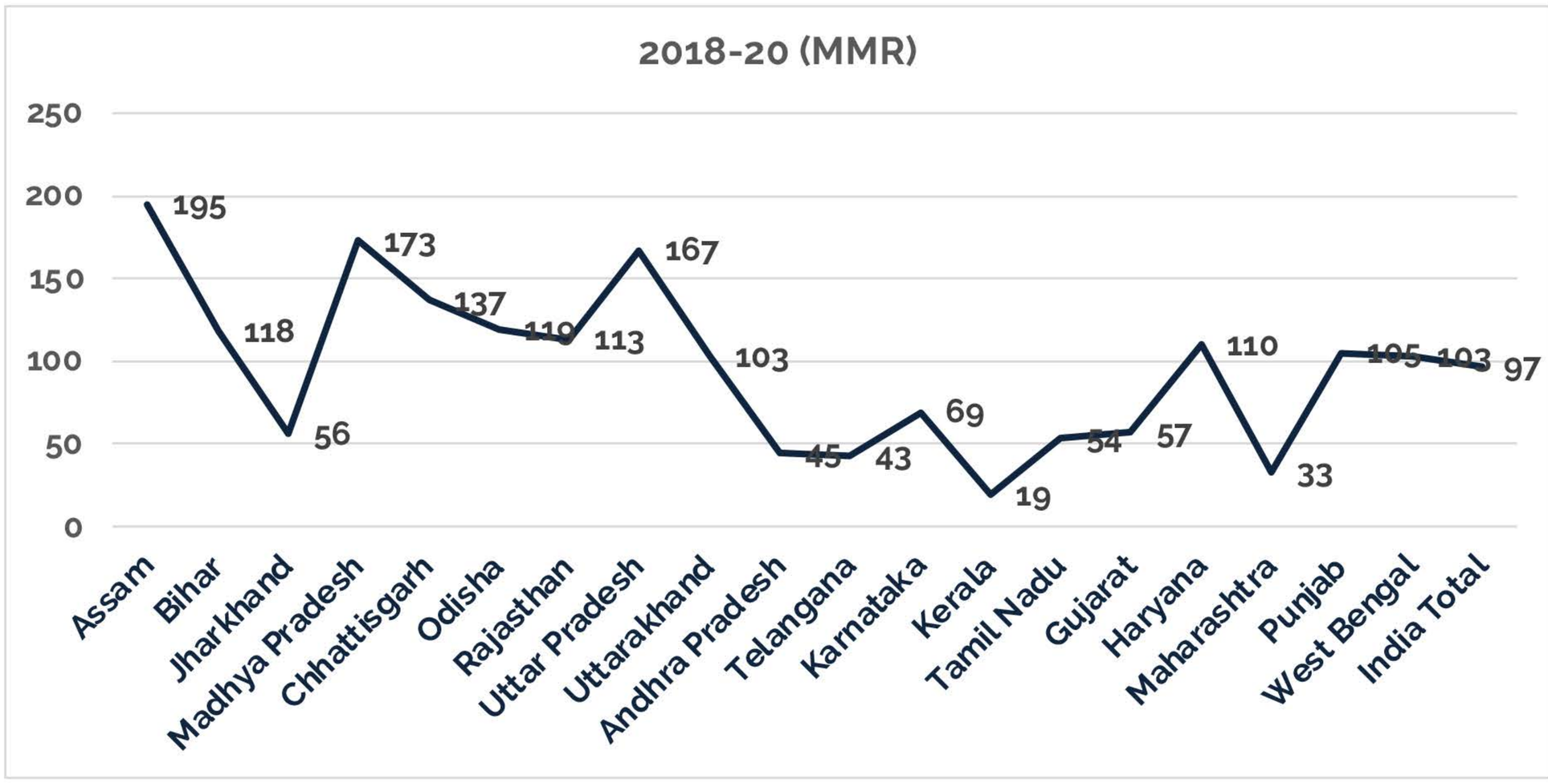


Fig 1: Status of MMR in the major States of India (2018-2020)

7.1. Progress in the ANC Coverage by Pregnant Women

ANC is a proven determinant of maternal mortality. There is a close association between maternal mortality and the access of ANC check up by pregnant women in India by State. Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women and adolescent girls to ensure the best health conditions for both mother and baby during pregnancy. In view of this an effort is made to reveal pregnant women received 4 or more ANC check-ups at the health facility.

ANC 4+ is globally tracked as a benchmark for progress. The proportion of pregnant women receiving 4 or more antenatal care visits (ANC 4+) is used prominently as a global benchmark indicator to track maternal health program performance. Annexure 1 provides the information regarding State wise distribution of percentage of pregnant women receiving 3 or 4 or more ANC check-ups at the health facility to the total ANC registration.

In the year 2005-06 (NFHS-3) i.e. in the beginning of NRHM, the percentage of women receiving 3/ 4 or more ANC check up to the total ANC registration was 52 per cent which has increased to 82 per cent as per NFHS-5 (2019-20).

Regional inequities remain sharp, with the northeast lagging. If we look at the increase of the same across States and Union Territories during the same time, it is confirmed that the northeastern States of Meghalaya recorded lowest checkups with only 53 per cent, EAG states of Bihar, Rajasthan, Andaman and Nicobar, Mizoram and even Delhi, percentage of 3/ 4 or more ANC checkup is from 60 to 70 per cent. On the other hand, in most of the southern States and Uttar Pradesh, Assam, Gujarat, Jammu and Kashmir, Odisha, Puducherry and Uttarakhand, the percentage is 80 to 100 per cent. The rest of all the States had the percentage from 71 per cent to 80 per cent. Increased ANC checkup across States and UTs in various rounds of NFHS could be seen from Fig 2.

7.2. Percentage of Pregnant women received two or more TT injections in the ANC

Tetanus protection is a cornerstone of safe pregnancy. Tetanus is a disease that can be prevented by vaccines containing tetanus-toxoids. Antibodies produced by maternal immunization that pass to the fetus via the placenta protect the baby in terms of tetanus during the neonatal period.

India achieved MNT elimination in 2015, but vigilance is needed. Elimination of Maternal New-born Tetanus (MNT) has been defined as less than 1 NT case per 1000 live births in a specific region by the World Health Organization (WHO). MNT elimination strategies include vaccination, hygienic practices at delivery, and surveillance. India was declared free of maternal and neonatal tetanus on 15th May 2015. Unlike polio or smallpox, tetanus can't be fully eradicated as the tenacious spores of bacteria causing tetanus, clostridium tetani, are widespread in the environment. The journey towards its elimination from India has not been easy, and sustained efforts will be required to maintain this status.

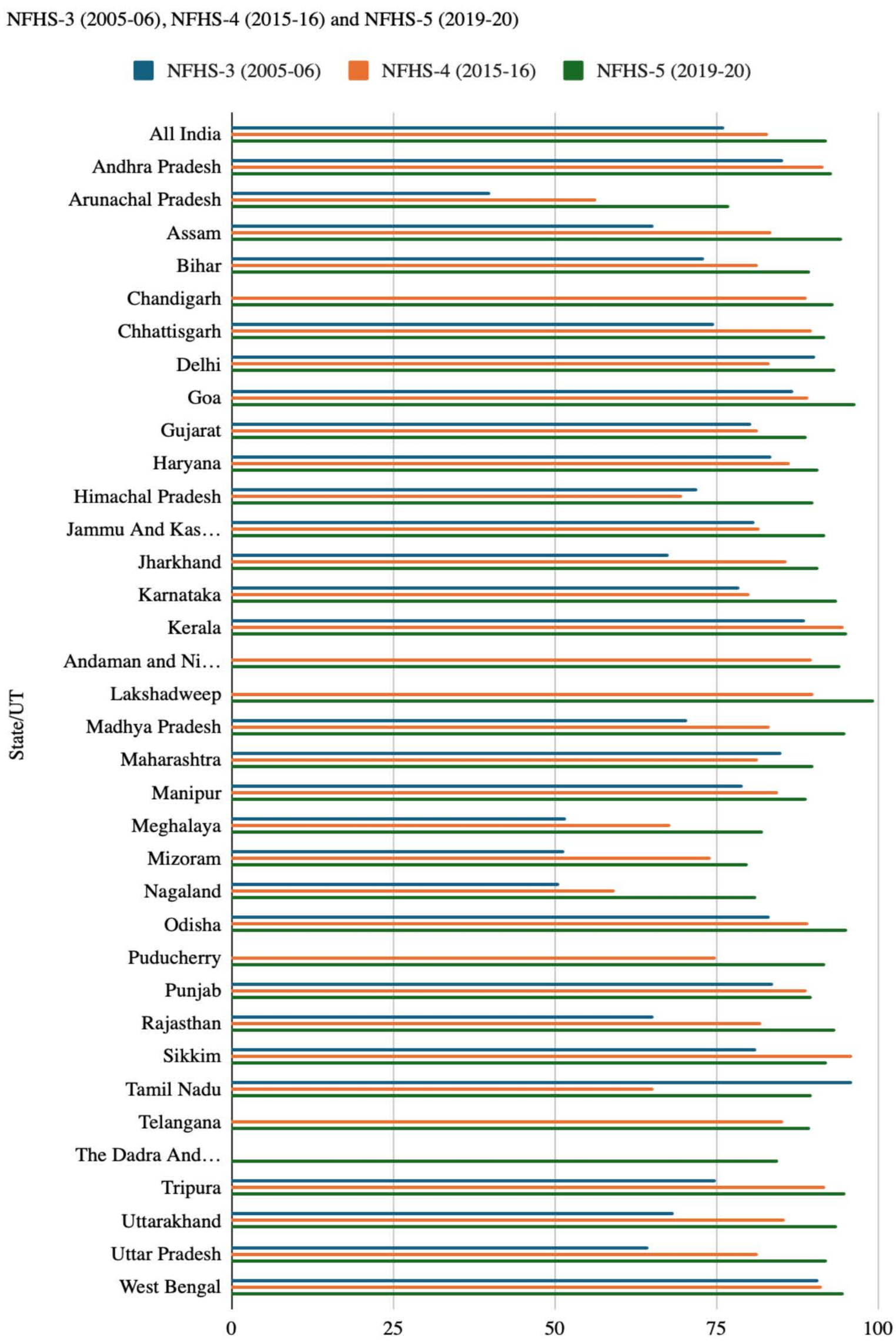


Fig 2: State/UT wise distribution of 3/4 or more ANC coverage in India by State (in %)

As per NFHS-5, the annual TT coverage rate in pregnant women is 92 per cent. Here, the State/UT wise distribution of percentage two or more TT injections received in the ANC is presented in Annexure 2. The majority of the State/UTs have recorded the coverage rate of TT injections above 80 per cent to 95 per cent. However, still in the northeastern States as well as EAG States the coverage rate is 80 to 90 per cent.

It is important to note that there have been substantial improvements in the coverage of TT injections among pregnant women under the progress of NRHM. In the year 2005-06, TT injection received by pregnant women was 76 per cent which increased to 83 per cent by 2015-16 and further increased to 92 per cent in the year 2019-20.

Regional variation in TT coverage mirrors MMR disparities. There is a regional variation in the coverage of TT injection to the total ANC registration, which has also certainly caused variations of MMR in the respective State/UTs. Please refer to a comparative increase in ANC coverage across States between NFHS-3 and 5 in Fig 3.

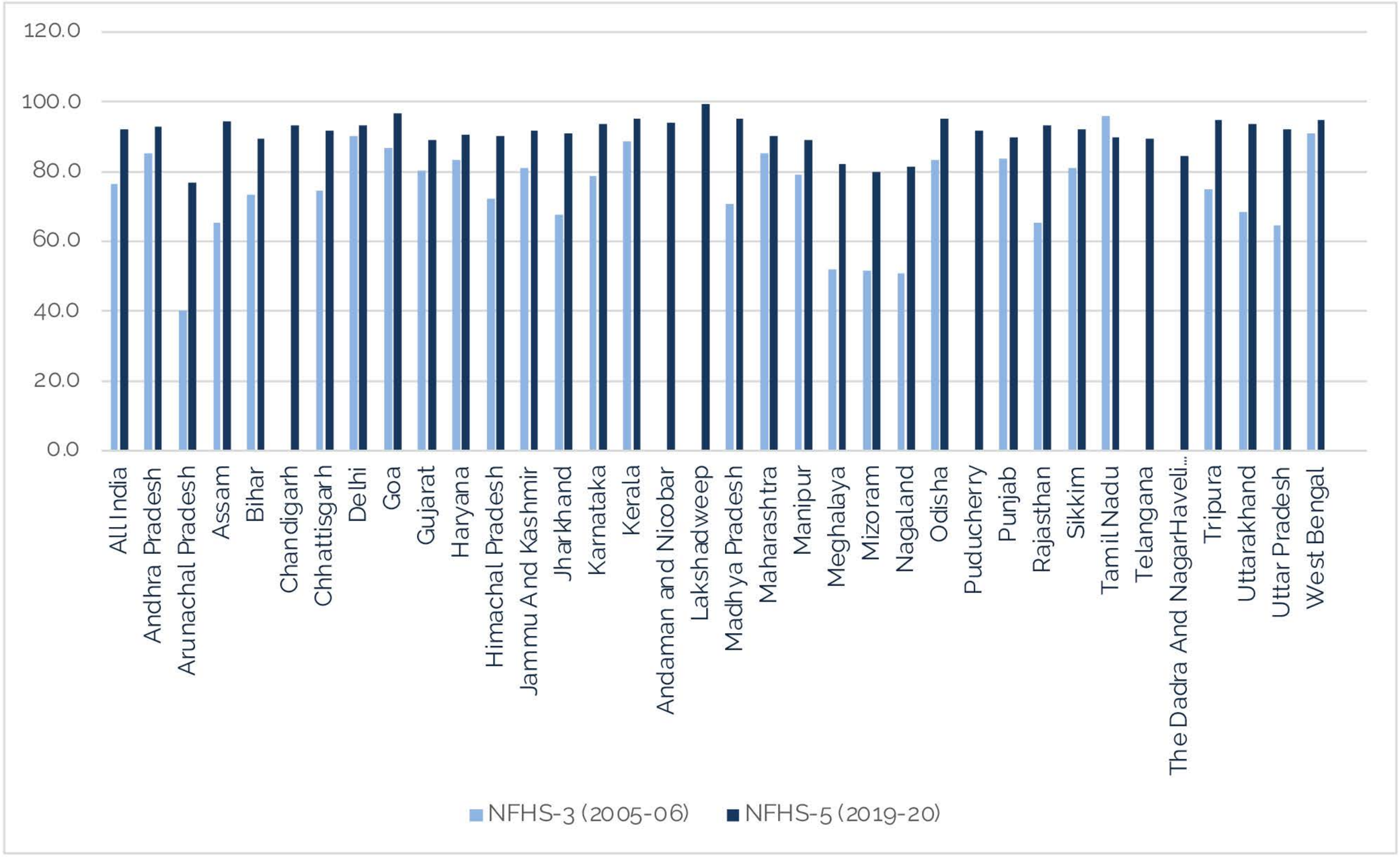


Fig 3: State/UT wise distribution of percentage two or more TT injections received in the ANC Registration

7.3. Institutional Deliveries

Under the National Health Mission (NHM), the Union Government has implemented significant reforms to strengthen rural healthcare, focusing on both infrastructure and human resources within the public health system. Before NHM's launch in 2005, maternal mortality rates in India were among the highest, largely due to limited access to skilled care and inadequate facilities. To address this, the Government enhanced primary and secondary healthcare services under the RMNCH+A framework and introduced the Janani Suraksha Yojana (JSY) to incentivize institutional deliveries, marking a decisive shift in maternal and child health strategy.

As a result, today except in the EAG States as well as in the northeastern States, institutional deliveries to the total deliveries in the rest of the States is around 80 to 99 percent. Interestingly in Lakshadweep and Telangana, institutional births recorded 100 per cent.

NFHS trends confirm sharp gains in facility births. The increased share of institutional births to total birth in different rounds of NFHS is presented in Annexure 3, and the status of institutional deliveries across State/UTs could be seen in Fig 4.

Home deliveries have steadily declined, replaced by safer institutional care. Community health workers, particularly ASHAs, Anganwadi workers, and ANMs, have been pivotal in driving awareness and shifting preferences. Where home births persist, SBA attendance has mitigated risks. Skilled attendants have provided a critical safety net in reducing complications and maternal deaths even in non-facility settings. This aspect is also noticeable in bringing down maternal deaths. In view of this Annexure 4 gives the overall picture on home deliveries attended by SBA in overtime from NFHS-3 to NFHS-5.

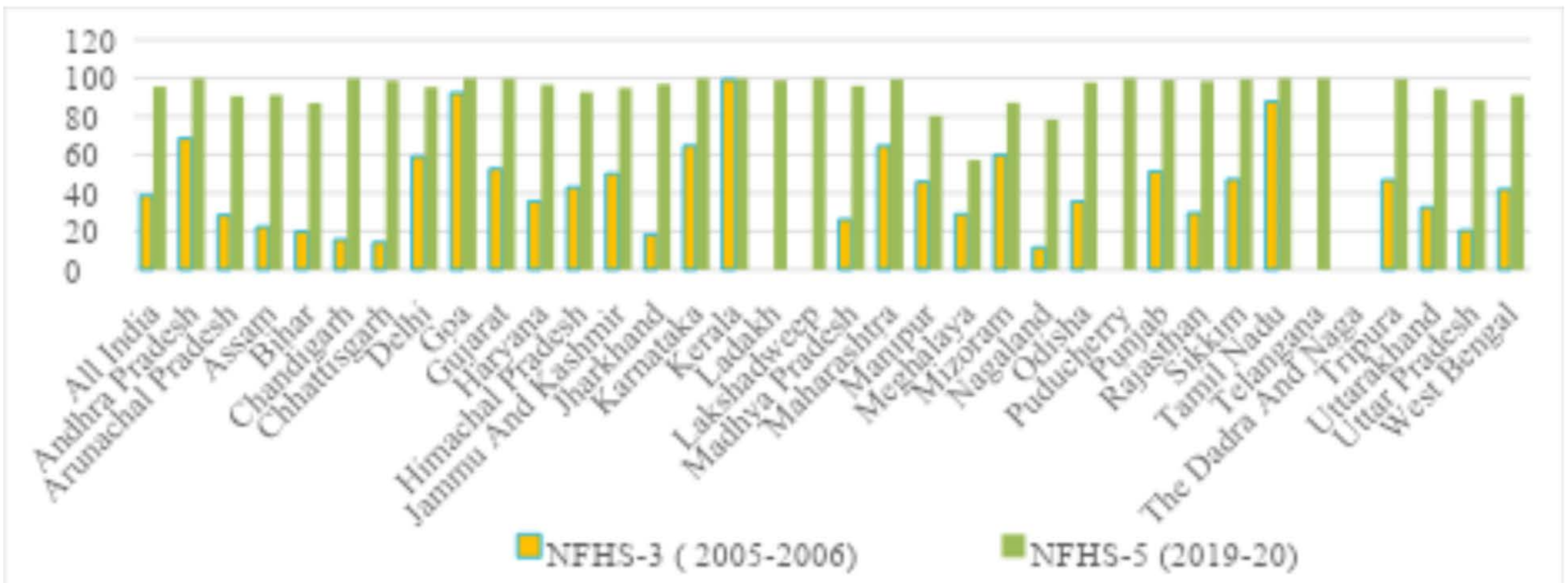


Fig 4: Institutional Births (both public and private Health Institutions) in India by State in Percentage to the total Deliveries

During NFHS-1, home deliveries attended by SBA were 8.2 per cent of total home deliveries, which has decreased to 3.2 per cent by NFHS-3 (2019-20).

For the last 20 years, the health department has made efforts to reduce home deliveries and to increase institutional deliveries. Hence, by and large, except in the EAG and a few northeastern States, there have been substantial improvements in the institutional deliveries. This has caused the decline of SBA in home deliveries. This has certainly helped to reduce maternal deaths in the country. Home deliveries attended by SBA in various rounds of NFHS are presented in Annexure 4 And the present status of SBA for home deliveries across State/UTs could be examined from Fig 5.

7.4. Prevalence of Anemia in Pregnancy

Anemia remains India's most stubborn maternal health challenge. Anemia remains one of the most prevalent nutritional deficiencies globally and disproportionately affects pregnant women, in whom the total iron requirement is approximately 1,000–1,200 mg over the course of gestation and far exceeds that of non-pregnant women. Although easily preventable and treatable, anemia continues to contribute substantially to maternal morbidity and mortality in India. In response, the Union and State Governments have implemented a series of nutritional interventions under the National Health Mission (NHM), including iron-folic acid supplementation, food fortification, and targeted community outreach, which have collectively helped curb anemia-related maternal deaths.

Despite these efforts, Health Management Information System (HMIS) data indicate that the national prevalence of anemia among pregnant women rose to 70 percent in 2021–22. The highest state-level burdens were observed in Haryana (97.5 percent), Himachal Pradesh (90 percent), Maharashtra (85 percent), Mizoram (82 percent), and Punjab (81 percent), whereas Kerala, Puducherry, and several northeastern States reported substantially lower rates. Given that anemia remains a key contributor to maternal mortality, State health authorities must intensify screening, ensure uninterrupted supplement supply chains, and strengthen nutrition-sensitive programming to improve maternal health outcomes.

8 HEALTH SCHEMES AND PROGRAMS FOR PREGNANT WOMEN

India's maternal health ecosystem is anchored in integrated schemes that provide financial protection, free entitlements, and nutrition support. Together, JSY, JSSK, PMMVY, and SNP have widened access, reduced out-of-pocket costs, and built momentum toward safer deliveries and better outcomes.

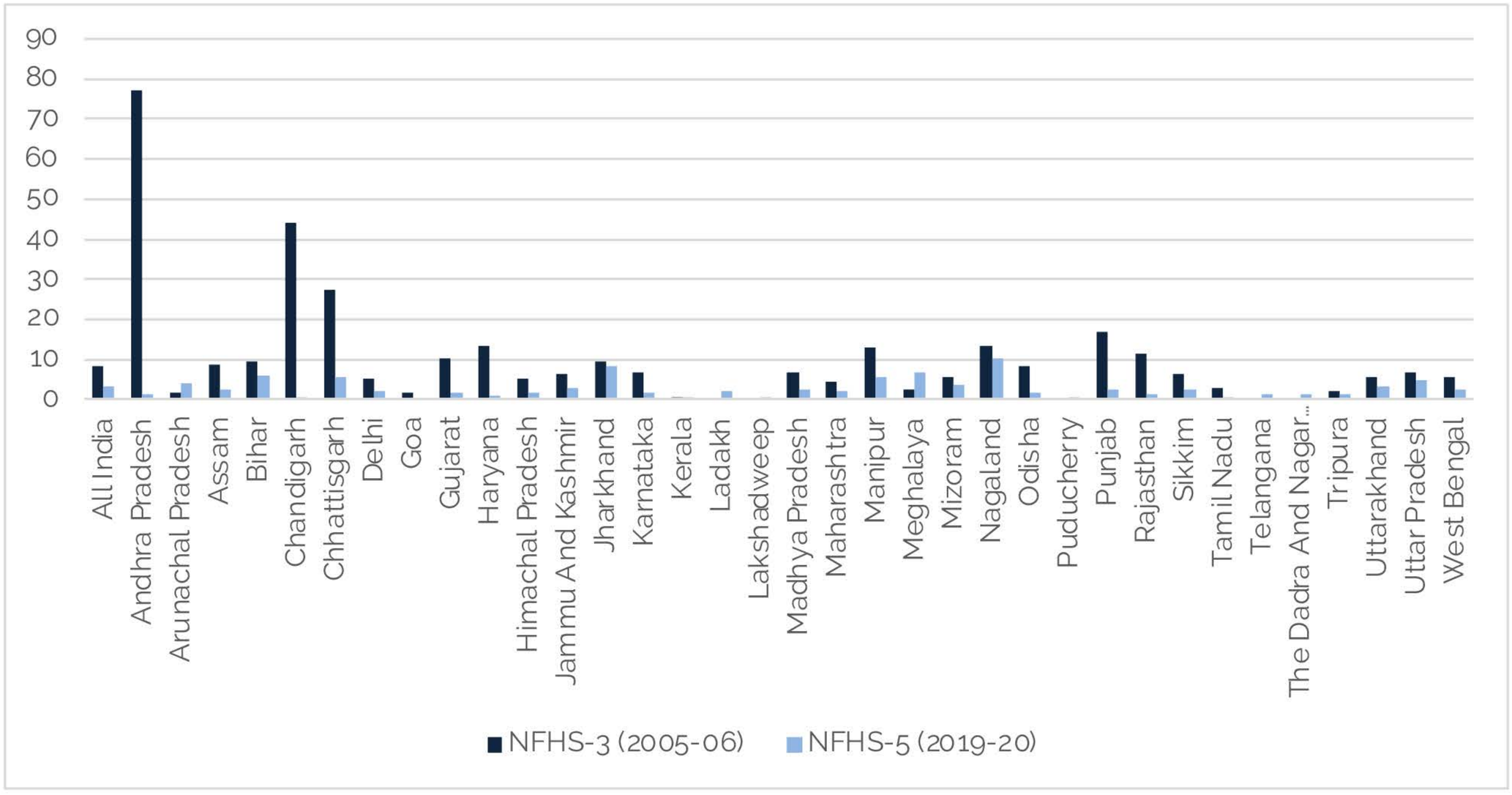


Fig 5: Home delivery conducted by skilled health personnel (out of total deliveries) (%)

8.1. Janani Shishu Suraksha Karyakaram (JSSK)

JSSK guarantees free, comprehensive maternity entitlements across public facilities. The annual number of pregnant women availing JSSK benefits has consistently risen. In the financial year 2024–25, a total of 1,99,08,272 pregnant women received benefits under JSSK at government health facilities across India (Lok Sabha Unstarred Question No. 1136). **Over the past three years, approximately 37.9 million pregnant women were provided free medicines under JSSK (MoHFW, 2025).**

In addition, the number of pregnant women who received free diet support under JSSK in this period was around 23.4 million. Free diagnostic services were extended to 38.9 million pregnant women. About 14.2 million were provided free transport from home to health facility; inter-facility transfer facilities were provided by 0.3 million pregnant women, and 14.4 million women were provided free drop-back transport after discharge (MoHFW, 2025).

Year	Number of Pregnant Women provided - Free Medicines under JSSK	Number of Pregnant Women provided - Free Diet under JSSK	Number of Pregnant Women provided - Free Diagnostics under JSSK	Number of Pregnant Women provided - Free Home to facility transport under JSSK	Number of Pregnant Women provided - Inter-facility transfers when needed under JSSK	Number of Pregnant Women provided - Free Drop Back home under JSSK
2018-19	1,02,11,852	68,78,833	1,12,90,658	38,96,711	8,78,827	41,90,983
2019-20	1,27,21,893	79,80,758	1,31,15,920	49,26,653	9,43,400	49,49,666
2020-21	1,50,16,945	85,59,415	1,44,97,305	54,39,611	11,77,112	53,43,727
2024-25	1,55,00,000	80,00,000	1,45,00,000	56,00,000	12,00,000	55,00,000
Total	**5,34,50,690**	**3,14,19,006**	**5,34,03,883**	**1,98,62,975**	**41,99,339**	**1,99,84,376**

Table 2: JSSK Benefit received by Pregnant Women in India from the year 2018-19 to 2024-25

8.2. Janani Suraksha Yojana (JSY)

JSY's cash incentives have mainstreamed institutional deliveries. Incentive transfer scheme implemented under NHM to promote institutional deliveries in the country. The total number of pregnant women who received JSY benefit after delivery from the health facility is given in Table 3.

In the financial year 2024–25, approximately 96.15 lakh pregnant women received JSY benefits after delivery at health facilities across India. This reflects a slight decrease from 1,02,54,979 beneficiaries in 2023–24 (Rajya Sabha Unstarred Question No. 2820 from March 25, 2025).

Cumulatively, from 2020–21 to 2024–25, the number of JSY beneficiaries nationally has exceeded about 48 million (Rajya Sabha Unstarred Question No. 2820 from March 25, 2025). The data indicates sustained support through financial incentives aimed at improving institutional delivery rates across all states and union territories

Conditional cash transfers incentivized institutional deliveries among low-income women, benefiting over 3.07 crore pregnant women in the same three-year period (see Table 3). Together, these schemes have not only expanded service coverage but also addressed affordability, accessibility, and continuity of care—three critical levers for improving maternal health outcomes.

(2018-19 to 2023-24)	
Year	**No. of beneficiaries (In Lakh)**
2018-19	100.41
2019-20	107.35
2020-21	99.92
2023-24	**102.54**

Table 3: JSY Beneficiary incentives Received by pregnant women in India (MoHFW, 2025)

8.3. Supplementary Nutrition Programme (SNP) and Mission Saksham Anganwadi & Poshan 2.0

Nutrition security has become a central pillar of India's maternal health agenda, with the Supplementary Nutrition Programme (SNP) now integrated within Poshan 2.0. Delivered through Anganwadi Centres, SNP provided fortified meals and take-home rations to over 83 million pregnant and lactating women during 2018–21, targeting anemia, low birth weight, and undernutrition (MWCD, 2025).

In 2021, SNP was subsumed under Mission Saksham Anganwadi and Poshan 2.0, which consolidates earlier nutrition schemes into a more integrated, outcome-focused framework for maternal and child nutrition. This revamped mission enhances convergence among ministries, emphasizes growth monitoring, digitized service delivery, behavior-change communication, and the provision of fortified food through Anganwadi centers. Transparency and real-time monitoring have significantly improved through the Poshan Tracker digital platform (MWCD, 2025).

As of July 2025, more than 72.22 lakh pregnant women were registered as beneficiaries under Mission Poshan 2.0. The Poshan Tracker facilitates real-time monitoring of beneficiary coverage, ration distribution, and identifies service gaps, marking a major step forward in accountability and last-mile delivery (MWCD, 2025).

Complementary initiatives under Janani Shishu Suraksha Karyakram (JSSK) and Janani Suraksha Yojana (JSY) have further enhanced maternal health service utilization. Transport entitlements—including home-to-facility transfers, inter-facility transfers, and drop-back services—supported more than 3.17 crore women, effectively addressing major barriers to institutional care access (MoHFW, 2025; MWCD, 2025).

The alignment of nutritional interventions with JSSK's service entitlements and JSY's financial incentives represents a multi-pronged, integrated approach. This synergy across programmes strengthens the continuum of care from pregnancy through the postpartum period, and underscores the value of coordinated implementation between the Ministry of Women and Child Development (MWCD) and the Ministry of Health and Family Welfare (MoHFW). Such cross-sectoral collaboration is vital for achieving Sustainable Development Goal (SDG) 3.1—reducing the maternal mortality ratio to below 70 per 100,000 live births by 2030.

Data as on	Number of beneficiaries of SNP under Anganwadi Services (Pregnant Women and Lactating Mothers)
31.03.2018	1,73,35,216
31.03.2019	1,71,86,549
31.03.2020	1,68,74,975
31.03.2021	1,56,73,127
30.06.2021	1,69,25,928
Total	**8,39,95,795**
Source: Ministry of Women and Child Welfare, 2021	

Table 4: The number of beneficiaries of Supplementary Nutrition (Pregnant Women and Lactating Mothers) under Anganwadi Service (31-03-2018 to 30-06- 2021) before subsuming with Poshan 2.0 in 2021

8.4. Pradhan Mantri Matru Vandana Yojana (PMMVY)

The Pradhan Mantri Matru Vandana Yojana (PMMVY) is a centrally sponsored maternity benefit programme implemented by the Ministry of Women and Child Development (MWCD) to promote health-seeking behaviours among pregnant and lactating women. PMMVY complements other maternal health initiatives such as Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK) by addressing a critical socio-economic determinant, income security during pregnancy. The scheme's direct benefit transfer (DBT) mechanism ensures transparency, reduces leakage, and supports timely delivery of benefits.

Table 5 gives the details of the number of beneficiaries received by Pradhan Mantri Matru Vandana Yojana from 2017-18 to 2021-22. Starting from 2017-18, the highest number of Beneficiaries paid incentive was remarkably high in the year 2019-20. There were 96,33,566 women who benefited from this incentive program in India.

Incentives Received by women in India			
Sl.No	**Year**	**Parameter**	**Total**
1	2017-18	No. of Beneficiaries enrolled	25,70,009
		No. of Beneficiaries Paid	11,08,929
2	2018-19	No. of Beneficiaries enrolled	60,60,011
		No. of Beneficiaries Paid	67,29,575
3	2019-20	No. of Beneficiaries enrolled	70,73,619
		No. of Beneficiaries Paid	96,33,566
4	2020-21	No. of Beneficiaries enrolled	64,35,280
		No. of Beneficiaries Paid	75,31,575
5	2021-22	No. of Beneficiaries enrolled	52,30, 020
		No. of Beneficiaries Paid	44,55,993
6	2022-23	No. of Beneficiaries enrolled	61,58,383
		No. of Beneficiaries Paid	72,88,165
7	2023-24 (change to new portal)	No. of Beneficiaries enrolled	53,40,914
		No. of Beneficiaries Paid	22,47,006
8	2024-25 (till 17 Mar 2025)	No. of Beneficiaries enrolled	45,94,048
		No. of Beneficiaries Paid	54,50,573
	Total		**5,37,09,926**

Table 5: Number of Beneficiaries under Pradhan Mantri Matru Vandana Yojana (PMMVY)

Source: Ministry of Women and Child Welfare, 2025

The overall analysis affirms that, under the National Health Mission (NHM), the Union Government has undertaken substantial measures to extend comprehensive health benefits to pregnant women through multiple schemes and programmes. These interventions, ranging from financial incentives to free maternal healthcare services have collectively contributed to a significant decline in maternal mortality at the national level.

However, persistent regional disparities, particularly in the Empowered Action Group (EAG) and North-Eastern states, reflect the influence of uneven socio-economic development and healthcare access. These regions continue to lag behind national targets, underscoring the need for targeted, context-specific strategies to accelerate progress toward maternal mortality reduction.

8.5. Role of Private Health Care Sector in Reducing Maternal Mortality in India

The private sector strengthens India's maternal health architecture. Public health services remain the foundation, but the private sector adds critical capacity. It supports delivery of maternal care in areas where public infrastructure is overstretched, especially in urban and peri-urban regions.

A. Enhancing Institutional Delivery Coverage

a. Approximately one-fourth of institutional deliveries in India are conducted in private facilities (NFHS-5, 2019–21), showcasing the sector's significant footprint in maternity care. Moreover, private players have introduced innovations in quality of care, emergency obstetric services, and patient-centered models which have contributed to improvement in maternal health outcomes (Mishra et al., 2020).

b. Skilled attendance at birth is a key determinant of maternal survival. By absorbing a substantial fraction of deliveries, private centres reduce delays in receiving emergency obstetric care, especially in regions where public FRUs are overwhelmed or understaffed (Chaudhuri et al., 2023).

B. Infrastructure and Human Resource Contributions

a. Private hospitals and centers often maintain round-the-clock access to obstetricians, anesthetists, and neonatal support, services that may be intermittent in under-resourced government centres (Sharma et al., 2016).

b. Many private institutions possess blood banks, operating theatres, and neonatal intensive care units, enabling management of complications such as postpartum hemorrhage and neonatal asphyxia (WHO, 2019).

C. Engagement in Government Schemes and Public–Private Partnerships

a. Many of the private facilities nationwide are empanelled under JSY/JSSK to provide cash-incentivized delivery care to women below the poverty line, thereby extending coverage beyond public facilities (Ministry of Health & Family Welfare [MoHFW], 2023).

b. Under PMSMA, private-sector obstetricians volunteer their services on fixed "safe motherhood" days (the 9th day of each month), providing free antenatal check-ups and risk screening at designated public health facilities in collaboration with government districts (MoHFW, n.d.; FOGSI, 2016)

c. Nearly 6,000 private hospitals across India are empanelled under PMJAY, processing over 250,000 maternal health claims annually. Empanelment has been associated with reduced out-of-pocket spending for eligible women, improving financial access to cesarean sections and high-risk deliveries (Nayak et al., 2023).

d. Recent advancements in maternal health exemplify effective public–private collaboration. With government support, evidence-based clinical interventions such as standardized protocols for postpartum haemorrhage (PPH) management and calibrated PPH blood collection drapes under development with the Indian Council of Medical Research (ICMR) must move toward national integration. Parallelly, technology platforms like ImTeCHO ("Innovative Mobile-phone Technology for Community Health Operations") demonstrate how digital tools can strengthen community surveillance, case tracking, and referrals. Together, these innovations and many others illustrate how strategic PPPs can accelerate scalable, system-wide improvements in managing high-risk pregnancies.

The private sector's role is critical, but inequities and systemic gaps hinder its full potential. The private sector plays a pivotal role in India's maternal healthcare landscape, augmenting government efforts by increasing access to skilled birth attendance and emergency obstetric services through high caseload management and participation in public schemes. **Key challenges:**

a. Catastrophic out-of-pocket costs: Median expenditure for institutional delivery in private facilities (₹25,600) far exceeds public hospital costs (₹2,067), imposing severe financial strain on low-income families (Chaudhuri et al., 2023).

b. Quality and safety variability: Wide differences in clinical protocols and staffing standards across private providers undermine care consistency and patient safety (Basu & Andrews, 2008).

c. Geographic inequities: Urban concentration of private facilities leaves rural and semi-urban women underserved, exacerbating access gaps (Mishra et al., 2020).

d. Regulatory and financing shortfalls: Insufficient price regulation, limited health-insurance penetration, and lack of performance-linked incentives hinder equitable private-sector engagement.

Sustaining India's significant maternal-mortality decline—driven by this public–private partnership—will require robust accreditation mechanisms (e.g., NABH), fair funding strategies, and targeted incentives to encourage private investment in disadvantaged regions, thereby ensuring every woman receives timely, high-quality maternity care.

8.6. The Role of Technology

Technology is a powerful enabler to move maternal health from reactive care to proactive, life-saving interventions. The deaths of mothers and newborns caused by non-communicable and nutrition-related diseases pose a significant public health challenge in India, leading to numerous fatalities each year. These diseases, which can affect either the mother or baby, can be contracted during pregnancy, delivery, postpartum, or even during childhood, and may be difficult to detect early on, putting patients at risk of severe complications later. To address this, early screening, detection, and diagnosis are crucial in reducing maternal and neonatal mortality. With the emergence of Artificial Intelligence (AI) and other digital technologies, there is potential for these tools to support maternal and neonatal healthcare in low-resource settings, although their development in this field is still in its early stages.

AI and digital innovations can accelerate early detection and improve quality of care. AI has the capability of transforming maternal and child health in low and middle-income countries by supplementing conventional practices with advanced technology, thus improving the accuracy of diagnoses, increasing access to care, and ultimately saving lives. While adoption in India remains nascent, the direction is clear: leveraging AI alongside existing tools like ultrasound can help identify high-risk pregnancies earlier—whether linked to blood pressure, diabetes, or anemia—and prepare families and providers for safe delivery well in advance.

Strengthening grassroots systems through digital tools builds resilience and reach. In parallel, India is already making serious strides by investing in frontline capacity building, training ASHAs, Anganwadi workers, and ANMs, while reinforcing CHCs, PHCs, and sub-divisional hospitals. Teleconsultations, video calls, and digital follow-up mechanisms are increasingly enabling timely access to emergency services, even in resource-constrained settings. These advances not only reduce maternal deaths during delivery but also create a stronger foundation for integrating more advanced AI-driven tools in the future.

9 KEY CHALLENGES IN REDUCING MATERNAL DEATHS

Maternal deaths remain preventable but persist due to multiple systemic barriers. Despite national progress, intersecting clinical, infrastructural, systemic, and socio-cultural constraints continue to drive preventable maternal deaths.

A. Clinical/Medical

a. High-risk pregnancies require stronger risk stratification. Conditions such as gestational diabetes, hypertensive disorders of pregnancy, anemia, and pre-eclampsia account for a substantial share of maternal mortality, yet timely risk stratification remains inconsistent. Delayed diagnosis often due to inadequate screening protocols at primary levels and financial barriers to advanced diagnostics compound morbidity risks among pregnant women (International Institute for Population Sciences & ICF, 2021; Kruk et al., 2018).

b. Postpartum haemorrhage remains India's single largest clinical challenge. PPH is responsible for approximately 27% of maternal deaths in India, but many facilities lack round-the-clock emergency obstetric and newborn care (EmONC) teams or readily available blood products. This gap in emergency readiness, exacerbated by intermittent blood-bank networks and referral delays, increases the fatality rate of otherwise manageable haemorrhages (World Health Organization, 2022).

c. Pre-pregnancy malnutrition and anemia continue to undermine outcomes. Over 50% of women of reproductive age are anaemic, and stunting or underweight status prior to conception elevates the likelihood of intrauterine growth restriction and obstetric complications (Ganju S, 2025). Persistent micronutrient deficiencies even under existing supplementation programs highlights the implementation bottlenecks in community outreach and supply-chain logistics (IIPS & ICF, 2021).

B. Access & Infrastructure

a. Geographic barriers delay life-saving care. Inadequate road networks and transport services delay arrival of pregnant women to obstetric facilities, with one JSY evaluation in Karnataka reporting that 50% of pregnant women could not secure ambulance transport when needed. Such delays convert treatable intrapartum complications into high-mortality events, particularly in tribal and hilly districts (Mishra et al., 2020).

b. **Facility overload undermines service readiness.** While a majority of Primary Health Centres (PHCs) and Community Health Centres (CHCs) in India now provide 24×7 obstetric and newborn care—86% of PHCs and 98% of CHCs as of June 2024; gaps persist in certain geographies, where the absence of round-the-clock services compels referrals to already overburdened district hospitals. Such referrals prolong wait times for critical interventions and divert limited human resources from preventive and antenatal care (NHM, 2024; Exemplars in Maternal & Newborn Health India Study, 2023).

C. System-Level Gaps

a. **Out-of-pocket costs remain prohibitively high in private care.** Median delivery costs in private facilities (₹25,600) are more than twelve times higher than in public hospitals (₹2,067). This steep financial barrier forces many low-income families to defer or forgo institutional births, undermining financial protection goals and increasing maternal risk (Chaudhuri et al., 2023).

b. **Human-resource shortages weaken emergency response.** Shortfalls of qualified obstetricians, midwives, anaesthetists, and critical-care nurses, especially in high-burden districts and rural and remote areas undermine emergency response capacity. Vacancies and attrition in rural postings perpetuate referral overload and erode community trust in public services (NITI Aayog, 2023).

c. **Weak adherence to SOPs undermines care quality.** Despite accreditation drives, many smaller facilities inconsistently apply standardized EmONC protocols, partograph use, and infection-control practices. Such variability correlates with higher rates of preventable complications, signaling the need for stronger audit mechanisms and supportive supervision (Basu & Andrews, 2008).

d. **Emergency referral coordination remains fragmented.** Fragmented communication and non-documentation between Primary Health Centres (PHCs) and referral hospitals, often characterized by less than half of referrals being accompanied by pre-notification, incomplete referral slips, and minimal feedback loops leads to critical time losses. In many districts, the absence of unified call-centres or digital tracking systems means referral coordination is poor, and manageable obstetric complications frequently escalate into life-threatening emergencies (Das et al., 2023; Dalal et al., 2022; Ameyaw et al., 2020).

D. Behavioral & Socio-Cultural

a. **Delayed care-seeking during labour increases risk.** Perceptions of prohibitive out-of-pocket costs and mistrust regarding unnecessary surgical interventions contributes to delayed presentation at healthcare facilities, with many women arriving in advanced stages of labour. This delay significantly increases the risk of fetal distress, obstructed labour, and postpartum haemorrhage. NFHS-5 findings indicate that financial barriers and fear of operative delivery remain prominent reasons for not seeking timely institutional care among marginalized populations (IIPS & ICF, 2021; Iyengar et al., 2012; Ghosh-Jerath et al., 2015; Chaturvedi et al., 2016).

b. **Postnatal follow-up remains the weakest link.** According to NFHS-5, only 58% of women who had a live birth in the five years preceding the survey, received a postnatal health check within 48 hours of delivery, with coverage within the first seven days only marginally higher. This gap leaves a substantial proportion of mothers without timely detection and management of potentially life-threatening conditions such as sepsis, anemia exacerbation, and hypertensive crises. Strengthening structured home-visit protocols and deploying digital reminder systems remain critical to closing this high-risk monitoring gap (IIPS & ICF, 2021).

10 STRATEGIC INSIGHTS FROM STAKEHOLDER CONSULTATIONS

The white paper draws heavily on structured stakeholder consultations, designed to surface practitioner-level insights, test innovation pathways, and align sectoral priorities with India's maternal health goals and global SDG 3.1 commitments. These dialogues brought together professional associations, development partners, and private-sector representatives, creating a platform that was both practice-oriented and forward-looking.

Key themes from the consultations included:

a. **Service delivery innovations** for improved quality and equity in maternal care.

b. **Digital health integration,** including interoperable platforms and AI-enabled surveillance systems.

c. **Emerging technologies** such as telemedicine for bridging geographic and human resource gaps.

d. **Private sector engagement** as a complementary pillar to government programs.

e. **Global best practices** adaptable to the Indian context, as well as Indian innovations with potential for global replication.

FOGSI, representing over 46,000 gynecologists across 286 societies, anchored the practitioner perspective. Drawing on partnerships with WHO, UNICEF, and the Gates Foundation, FOGSI emphasized evidence-based program design, technical capacity building, and quality improvement. Their flagship Sampoorna Swasth Janm Abhiyan illustrates how preconception care—risk assessment, nutritional supplementation, and counselling, can be institutionalized as part of the maternal health continuum. Evidence shows that such interventions significantly reduce adverse pregnancy outcomes (Dean et al., 2014; Mason et al., 2014).

a. A central recommendation emerging from the consultations was the institutionalization of preconception care as an integral component of maternal health services. FOGSI's Sampoorna Swasth Janm Abhiyan exemplifies this proactive approach, embedding risk assessment, nutritional supplementation, and counselling into the pre-pregnancy period. The WHO defines preconception care as "the provision of biomedical, behavioural, and social health interventions before conception occurs" to improve maternal and neonatal outcomes (WHO, 2013). Evidence indicates that preconception interventions, particularly those addressing anemia, micronutrient deficiencies, and chronic conditions, can significantly reduce adverse pregnancy outcomes (Dean et al., 2014; Mason et al., 2014).

b. On the digital health front, for one of the standout models from the consultations, stakeholders pointed to Karnataka's Thayi Card system, a portable maternal health record that enables seamless antenatal and postnatal care. Public-sector adoption has been strong, but private-sector integration remains limited. Scaling such interoperable systems would improve referral coordination, strengthen outcome tracking, and enhance governance across the maternal health ecosystem.

c. From a managerial perspective, the consultations underscored three priority actions for achieving Sustainable Development Goal (SDG) 3.1—reducing the Maternal Mortality Ratio (MMR) to below 70 per 100,000 live births by 2030:

i. **Integrate preventive care** across the continuum, embedding preconception health, family planning, and nutrition into standard maternal health services.

ii. **Strengthen workforce capacity,** particularly paramedical staff and medical officers, through structured quality-improvement programs such as FOGSI's MANYATA, already active in 3,000+ private hospitals.

iii. **Leverage PPPs** to align resources, expand reach, and accelerate adoption of innovations across both public and private sectors.

11 POLICY RECOMMENDATIONS

India has demonstrated that maternal mortality can be reduced at scale. The next challenge is to sustain the momentum and ensure that progress reaches every woman, everywhere. Doing so requires a **shift from expansion to precision**—from counting institutional deliveries to ensuring that every delivery is safe, equitable, and supported by quality systems. The following recommendations translate evidence and stakeholder insights into actionable priorities for government, private sector, and development partners.

A. Pre-Pregnancy: Build a Culture of Preparedness

a. **Scale Preconception Services:** Implement standardized preconception care interventions, including maternal and partner assessment, nutritional screening, risk evaluation, counseling, and micronutrient supplementation. Evidence suggests such services significantly improve birth outcomes (e.g. fewer preterm births and low birth weight) (Doke et al., 2024).

b. **Guideline Development and Digital Integration:** Develop nationally standardized preconception care protocols defining service packages, screening criteria, and counselling standards aligned with the RMNCH+A framework, and integrate them into national digital health platforms such as the RCH portal and HMIS to enable real-time tracking, service monitoring, and automated follow-up reminders (WHO, 2013; MoHFW, 2021).

B. Antenatal Care: Use Digital to Keep Women in the Care Continuum

a. **Digital Health Infrastructure Enhancement:** India must move from fragmented records to interoperable digital systems that track women through pregnancy, delivery, and postpartum. A national digital pregnancy card, accessible across public and private facilities, can strengthen referral coordination and reduce care dropouts.

b. **Real-Time Monitoring Dashboards:** Deploy state- and district-level dashboards tracking key maternal health indicators for timely decision-making and accountability. Leverage digital tools such as ImTeCHO for high-risk pregnancy surveillance, community case tracking, and automated referral alerts.

c. **Leverage AI for Engagement & Retention:** Promote AI-enhanced outreach tools (e.g., voice call programs paired with predictive dropout models) that have been shown to increase beneficiary retention and improve health behaviours like supplement adherence (Agarwal et al., 2022).

d. **High-Risk Tracking & Remote Triage:** Pilot AI-driven maternal health monitoring systems (e.g., Pilot AI-driven maternal health monitoring systems Janani Mitra app piloted Anantapur empowers pregnant women with nutrition tracking and early anaemia detection via a food scanner (Rao, 2024; Adusei-Mensah, F., et al. 2025), and the IIT Kharagpur collaboration with Sri Sathya Sai Sanjeevani Hospitals deploying a smartphone-based, AI-powered eye-image screening tool across Mamatva centres for non-invasive anemia detection in pregnant women (Khandelwal et al., 2025)) enable early detection, surveillance of high-risk pregnancies, and prompt remote support to limit transport delays and loss to follow-up (Chaudhary and Chaudhary, 2024)). to enable early detection, surveillance of high-risk pregnancies, and prompt remote support to limit transport delays and loss to follow-up (Chaudhary and Chaudhary, 2024).

C. Delivery: Guarantee Emergency Readiness Everywhere

a. **Clinical Protocols for Postpartum Hemorrhage (PPH):** Institute evidence-based PPH care bundles and hospital-level SOPs—including administration of uterotonics (oxytocin or misoprostol), use of tranexamic acid within three hours, uterine tamponade, and timely blood transfusion readiness—to reduce maternal deaths due to hemorrhage (up to 93% preventable) (Patel, 2024; Akter et al., 2022; Dhali et al., 2021).

b. **Facility-Level Training & Blood Bank Readiness:** Ensure First Referral Units (FRUs) and CHCs in high-burden areas have trained personnel, simulation-based PPH drills, and on-site blood storage units for emergency obstetric care

D. Postnatal Care: Close the Most Neglected Gap

a. **Dedicated Postnatal Follow-Up:** Strengthen continuity into the postnatal period, especially in underserved rural areas by reinforcing maternal-postnatal home visits, telephonic check-ins, and community tracking of warning signs in the early weeks postpartum.

b. Leverage mHealth for Retention & Education: Use mobile health platforms (group calls, chatbots) to sustain engagement and improve knowledge and care-seeking behaviours during the postnatal period (for example: Punjab pilot MeSSSSage project) (Ayadi et al., 2025).

E. System-Level Reforms: Embed Equity and Accountability into the Core

a. **Optimize Referral & Transport:** Deploy ambulances and National Mobile Medical Units in geographically challenging areas (e.g. Chamarajanagar, Assam, UP, MP, Rajasthan), with strong inter-facility transfer protocols to ensure timely referral from CHCs/SDHs to higher centres.

b. **Facility Quality Improvement & Accountability:** Establish quality improvement processes at facility level, integrate accountability frameworks, and supervisory mechanisms beyond private-sector initiatives like MANYATA to enforce SOP adherence and clinical governance.

c. **Address Financial Barriers:** Expand free diagnostics, strengthen Janani Shishu Suraksha Karyakram (JSSK) and Janani Suraksha Yojana (JSY) frameworks, and consider redesigning benefits structure to eliminate informal payments and out-of-pocket expenses—the evidence shows financial protection improves maternal outcomes in Haryana and similar states.

d. **Private Sector Engagement & Innovation Partnerships:** Formalize public-private partnerships to scale innovations in digital tracking, teleconsultation, private facility inclusion in digital pregnancy card systems, and AI-based service delivery models.

e. **Urban Congestion & Referral Efficiency:** In urban centres, strengthen referral algorithms, enable task-shifting to 24×7 PHC hubs, and decongest secondary hospitals by creating integrated urban maternal care networks.

f. **Foster Public–Private–Development Sector Partnerships:** The consultation emphasized the catalytic role of PPPs and establishing formal PPP frameworks at state level to co-design, co-finance, and co-monitor maternal health initiatives. Encourage joint training (public & private), technology sharing, and pooled procurement mechanisms.

By embedding clinical protocols, digital tools, community engagement, financial protection, and systems reform, the framework becomes more holistic—positioning India to make targeted progress toward SDG maternal and neonatal mortality goals.

12 CONCLUSION

India's maternal health journey reflects the impact of deliberate strategy, strong institutions, and continuous course correction. The National Health Mission (NHM) has provided the policy backbone, while the Ministry of Health and Family Welfare (MoHFW), through its Statistics Division, has ensured accountability by mandating all 18 Population Research Centres (PRCs) to conduct annual field monitoring. These evidence-based reviews have enabled timely policy adjustments and ensured that maternal health remains a national priority aligned with RMNCH+A+N objectives.

Field insights show that public health infrastructure is steadily strengthening, with expanded coverage, digital innovations, and improved nutrition linkages through initiatives such as Mission Poshan 2.0. Where challenges remain, they are being clearly identified—particularly the need to accelerate human resource deployment, strengthen high-burden geographies, and further integrate preconception, antenatal, and postnatal care into a seamless continuum. These are not barriers but opportunities for sharper focus and targeted investment.

The next phase must therefore be guided by three imperatives: ensuring quality alongside coverage, deepening integration across health and nutrition platforms, and embedding equity into every layer of program delivery. With PRCs providing the feedback loop, digital health platforms driving real-time accountability, and partnerships with private and community actors expanding reach, India is positioned to sustain momentum and close the remaining gaps.

The trajectory is clear. By building on the gains of the last two decades, and by steering strategy with precision and collaboration, India can deliver on its commitment to achieve the SDG 3.1 target ahead of time—transforming maternal health from a developmental challenge into a demonstrable national success.

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ANNEXURES

Annexure 1: State/UT wise distribution of percentage of 3-4 or more ANC in India to Total ANC Registration

SL NO	State/UT	2005-06 (NFHS-3)	2015-16 (NFHS-4)	2019-20 (NFHS-5)
1	**All India**	**52**	**51.2**	**81.41**
2	Andhra Pradesh	85.4	76.3	104.24
3	Arunachal Pradesh	35.5	26.7	35.68
4	Assam	39.3	46.4	83.22
5	Bihar	17	14.4	63.17
6	Chandigarh	-	64.5	103.31
7	Chhattisgarh	54.2	59.1	93.28
8	Delhi	75.1	67.9	69.01
9	Goa	94.9	89	73.86
10	Gujarat	67.5	70.5	87.62
11	Haryana	59.2	45.1	78.82
12	Himachal Pradesh	62.6	69.1	80.3
13	Jammu And Kashmir	73.5	81.3	83.16
14	Jharkhand	35.9	30.3	75.57
15	Karnataka	79.5	70.1	93.51
16	Kerala	93.6	90.1	90.4
17	Andaman and Nicobar	-	92.1	65.7
18	Lakshadweep	-	82.3	79.39
19	Madhya Pradesh	40.7	35.7	76.85
20	Maharashtra	75.1	72.2	97.16
21	Manipur	68.6	69	35.66
22	Meghalaya	54	50	52.86
23	Mizoram	59.3	61.4	62.57
24	Nagaland	32.7	15	18.92
25	Odisha	61.8	61.9	88.88
26	Puducherry		87.7	84.15
27	Punjab	74.8	68.4	76.18
28	Rajasthan	41.2	38.5	65.17
29	Sikkim	70.1	74.7	74.52
30	Tamil Nadu	95.9	81.1	93.28
31	Telangana	-	74.9	80.73
32	The Dadra And NagarHaveli And Daman And Diu	-	75.6 and 62.7	
33	Tripura	60	64.3	79.51
34	Uttarakhand	44.9	30.9	85.4
35	Uttar Pradesh	26.6	26.4	83.03
36	West Bengal	62	76.4	80.75

Source: NFHS-3, 4 and 5, published by IIPS, Mumbai

Annexure 2: State/UT wise distribution of percentage two or more TT injections received in the ANC Registration to total ANC Registration

S.No.	State/UT	NFHS-3 (2005-06)	NFHS-4 (2015-16)	NFHS-5 (2019-20)
1	**All India**	**76.3**	**83**	92
2	Andhra Pradesh	85.3	91.7	92.8
3	Arunachal Pradesh	40.1	56.5	76.9
4	Assam	65.4	83.6	94.5
5	Bihar	73.2	81.5	89.5
6	Chandigarh	-	89.1	93.2
7	Chhattisgarh	74.6	89.7	91.9
8	Delhi	90.3	83.3	93.4
9	Goa	86.8	89.3	96.5
10	Gujarat	80.4	81.4	89.1
11	Haryana	83.4	86.3	90.7
12	Himachal Pradesh	72.1	69.7	90
13	Jammu And Kashmir	81	81.6	91.9
14	Jharkhand	67.6	85.9	90.8
15	Karnataka	78.6	80.1	93.6
16	Kerala	88.7	94.8	95.2
17	Andaman and Nicobar	-	89.9	94.2
18	Lakshadweep	-	90	99.4
19	Madhya Pradesh	70.6	83.3	95
20	Maharashtra	85.1	81.4	90.1
21	Manipur	79.2	84.5	88.9
22	Meghalaya	51.8	67.8	82.1
23	Mizoram	51.4	74.2	80
24	Nagaland	50.7	59.4	81.3
25	Odisha	83.3	89.3	95.2
26	Puducherry		75	91.9
27	Punjab	83.8	89	89.7
28	Rajasthan	65.2	81.9	93.4
29	Sikkim	81.1	95.9	92
30	Tamil Nadu	95.9	65.4	89.7
31	Telangana	-	85.4	89.6
32	The Dadra And NagarHaveli And Daman And Diu	-	81.1 and 61.1	84.6
33	Tripura	74.9	91.9	94.9
34	Uttarakhand	68.5	85.7	93.6
35	Uttar Pradesh	64.5	81.4	92.1
36	West Bengal	90.9	91.4	94.6

Annexure 3: Institutional births in percentage to the total births

SL No	State/UT	NFHS-3 (2005-2006)	NFHS-4 (2015-16)	NFHS-5 (2019-20)
1	**All India**	38.7	78.9	95.51
2	Andhra Pradesh	68.6	91.5	99.97
3	Arunachal Pradesh	28.5	52.2	90.66
4	Assam	22.4	70.6	91.27
5	Bihar	19.9	63.8	87.02
6	Chandigarh	15.7	91.6	99.9
7	Chhattisgarh	14.3	70.2	98.7
8	Delhi	59	84.4	95.31
9	Goa	92.3	96.9	99.96
10	Gujarat	52.7	88.5	99.79
11	Haryana	35.7	80.4	96.53
12	Himachal Pradesh	43.1	76.4	92.68
13	Jammu And Kashmir	50.2	85.6	94.87
14	Jharkhand	18.3	61.9	96.91
15	Karnataka	64.7	94	99.95
16	Kerala	99.3	99.8	99.86
17	Ladakh		90.8	98.82
18	Lakshadweep		99.3	100
19	Madhya Pradesh	26.2	80.8	95.95
20	Maharashtra	64.6	90.3	99.39
21	Manipur	45.9	69.1	80.3
22	Meghalaya	29	51.4	57.23
23	Mizoram	59.8	79.7	87.21
24	Nagaland	11.6	32.8	78.39
25	Odisha	35.6	85.3	97.8
26	Puducherry		99.9	99.99
27	Punjab	51.3	90.5	99.02
28	Rajasthan	29.6	84	98.45
29	Sikkim	47.2	94.7	99.45
30	Tamil Nadu	87.8	98.9	99.99
31	Telangana		91.5	100
32	The Dadra And Nagar Haveli And Daman And Diu		90.1	
33	Tripura	46.9	79.9	99.58
34	Uttarakhand	32.6	68.6	94.52
35	Uttar Pradesh	20.6	67.8	88.47
36	West Bengal	42	75.2	91.21

Annexure 4: Home delivery conducted by skilled health personnel (out of total deliveries) (%)

SL No	States	NFHS-3 (2005-06)	NFHS-4 (2015-16)	NFHS-5 (2019-20)
1	**All India**	8.2	4.3	3.2
2	Andhra Pradesh	77.1	3.7	1.3
3	Arunachal Pradesh	1.6	2.1	4
4	Assam	8.7	3.9	2.6
5	Bihar	9.7	8.2	6.1
6	Chandigarh	44.3	1.7	0.2
7	Chhattisgarh	27.3	8.4	5.8
8	Delhi	5.4	3.6	2.3
9	Goa	1.9	1.8	0
10	Gujarat	10.4	2.2	1.6
11	Haryana	13.3	5.8	1.1
12	Himachal Pradesh	5.4	3.4	1.7
13	Jammu And Kashmir	6.5	2.2	3
14	Jharkhand	9.5	8	8.4
15	Karnataka	6.8	3.1	1.6
16	Kerala	0.1	0.1	0.2
17	Ladakh		2	2.3
18	Lakshadweep		0.7	0.4
19	Madhya Pradesh	6.6	2.3	2.5
20	Maharashtra	4.6	3.6	2
21	Manipur	13.2	8	5.8
22	Meghalaya	2.4	2.6	6.6
23	Mizoram	5.8	3.9	3.5
24	Nagaland	13.3	8.8	10.4
25	Odisha	8.3	3.3	1.9
26	Puducherry		0.1	0.3
27	Punjab	16.8	4.5	2.6
28	Rajasthan	11.5	3.2	1.4
29	Sikkim	6.5	2.4	2.6
30	Tamil Nadu	2.9	0.6	0.2
31	Telangana		2.8	1.3
32	The Dadra And Nagar Haveli And Daman And Diu		1.4	1.4
33	Tripura	2.1	1.2	1.2
34	Uttarakhand	5.8	4.6	3.4
35	Uttar Pradesh	6.8	4.1	4.7
36	West Bengal	5.8	6.8	2.6

Annexure 5: India and State/UT-wise number of beneficiaries under JSSK scheme for FY 2024–25

S. No.	States/UTs	Total number of Pregnant Women benefitted under JSSK	Total number of Sick Infants benefitted under JSSK
—	**All India**	**1,99,08,272**	**16,85,447**
1	Andaman & Nicobar Islands	4,687	185
2	Andhra Pradesh	2,51,558	47,101
3	Arunachal Pradesh	24,520	676
4	Assam	10,80,610	65,920
5	Bihar	9,05,155	45,260
6	Chandigarh	60,385	14,618
7	Chhattisgarh	3,47,851	39,698
8	Delhi	1,26,960	8,632
9	Goa	28,785	1,927
10	Gujarat	7,47,466	1,11,396
11	Haryana	4,12,660	27,886
12	Himachal Pradesh	1,50,142	26,100
13	Jammu and Kashmir	2,26,258	55,255
14	Jharkhand	5,36,166	31,676
15	Karnataka	5,10,341	69,750
16	Kerala	4,76,211	25,662
17	Ladakh	4,139	1,153
18	Lakshadweep	470	93
19	Madhya Pradesh	12,04,732	1,21,870
20	Maharashtra	18,93,689	1,24,669
21	Manipur	28,242	3,039
22	Meghalaya	1,87,417	19,215
23	Mizoram	7,106	853
24	Nagaland	12,634	886
25	Odisha	11,36,483	69,623
26	Puducherry	8,977	1,789
27	Punjab	6,22,956	43,138
28	Rajasthan	6,27,230	1,29,852
29	Sikkim	4,997	1,068
30	Tamil Nadu	13,68,660	74,477
31	Telangana	86,803	6,711
32	The Dadra And Nagar Haveli And Daman And Diu	13,022	5,446
33	Tripura	38,029	7,492
34	Uttarakhand	2,24,280	14,775
35	Uttar Pradesh	55,19,612	2,60,101
36	West Bengal	10,29,039	2,27,455

Annexure 6: sState/UT-wise number of Janani Suraksha Yojana (JSY) beneficiaries

S. No.	State/UT	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	FY 2024-25 (Provisional)
1	Andaman & Nicobar Islands	142	188	232	226	102
2	Andhra Pradesh	2,82,264	2,64,265	2,35,028	2,54,588	1,76,959
3	Arunachal Pradesh	13,710	18,433	13,780	17,847	11,446
4	Assam	2,94,472	2,99,901	3,46,174	3,28,013	2,34,206
5	Bihar	13,60,330	12,90,487	13,24,435	13,70,438	9,13,564
6	Chandigarh	411	312	117	203	195
7	Chhattisgarh	3,25,929	3,33,976	3,73,699	3,58,625	2,55,299
8	Dadra & Nagar Haveli and Daman & Diu	1,972	595	3,378	2,474	1,776
9	Delhi	4,476	5,502	2,446	3,648	3,681
10	Goa	292	75	284	372	377
11	Gujarat	2,07,735	1,69,452	2,05,888	2,25,784	74,254
12	Haryana	27,970	26,909	35,331	31,587	26,493
13	Himachal Pradesh	16,354	11,453	10,449	8,987	8,531
14	Jammu & Kashmir	1,00,267	95,215	1,06,397	63,536	89,645
15	Jharkhand	4,43,693	4,42,723	4,80,148	4,79,039	3,35,826
16	Karnataka	4,81,604	3,25,312	2,87,414	4,02,122	2,38,099
17	Kerala	72,475	60,969	1,10,056	49,884	44,658
18	Ladakh	3,507	3,263	3,874	3,241	1,981
19	Lakshadweep	1,650	717	1,343	770	1,074
20	Madhya Pradesh	8,56,967	9,60,747	10,85,146	10,16,205	6,19,546
21	Maharashtra	3,04,258	3,38,860	4,15,424	3,70,408	2,64,699
22	Manipur	4,672	2,185	10,632	2,330	10,631
23	Meghalaya	21,754	13,782	20,888	18,050	12,055
24	Mizoram	5,636	7,185	11,545	13,491	3,883
25	Nagaland	7,744	9,050	9,656	11,730	10,191
26	Odisha	4,55,246	4,66,299	4,47,780	4,21,699	2,89,458
27	Puducherry	1,769	2,398	6,692	5,290	3,762
28	Punjab	56,009	47,021	60,423	57,012	33,691
29	Rajasthan	9,55,792	8,98,371	8,68,242	10,40,390	4,52,623
30	Sikkim	2,363	3,507	2,565	2,800	938
31	Tamil Nadu	3,68,295	3,36,304	3,86,227	3,07,030	2,83,033
32	Telangana	2,66,867	2,79,484	3,08,862	2,85,608	1,92,184
33	Tripura	11,416	12,748	16,593	16,235	10,069
34	Uttar Pradesh	24,35,658	24,39,126	24,21,088	25,68,228	17,85,714
35	Uttarakhand	74,509	74,132	73,345	78,828	49,461
36	West Bengal	5,23,682	4,54,166	4,43,647	4,38,261	2,68,189

Source: As per reports from States/UTs

Confederation of Indian Industry

The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the development of India, partnering Industry, Government and civil society through advisory and consultative processes.

CII is a non-government, not-for-profit, industry-led and industry-managed organisation, with around 9,700 members from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 365,000 enterprises from 318 national and regional sectoral industry bodies.

For more than 130 years, CII has been engaged in shaping India's development journey and works proactively on transforming Indian Industry's engagement in national development. CII charts change by working closely with the Government on policy issues, interfacing with thought leaders, and enhancing efficiency, competitiveness, and business opportunities for industry through a range of specialised services and strategic global linkages. It also provides a platform for consensus-building and networking on key issues.

Through its dedicated Centres of Excellence and Industry competitiveness initiatives, promotion of innovation and technology adoption, and partnerships for sustainability, CII plays a transformative part in shaping the future of the nation. Extending its agenda beyond business, CII assists industry to identify and execute corporate citizenship programmes across diverse domains, including affirmative action, livelihoods, diversity management, skill development, empowerment of women, and sustainable development, to name a few.

For 2025-26, CII has identified "Accelerating Competitiveness: Globalisation, Inclusivity, Sustainability, Trust" as its theme, prioritising five key pillars. During the year, CII will align its initiatives to drive strategic action aimed at enhancing India's competitiveness by promoting global engagement, inclusive growth, sustainable practices, and a foundation of trust.

With 70 offices, including 12 Centres of Excellence, in India, and 9 overseas offices in Australia, Egypt, Germany, Indonesia, Singapore, UAE, UK, and USA, as well as institutional partnerships with about 250 counterpart organisations in almost 100 countries, CII serves as a reference point for Indian industry and the international business community.

Confederation of Indian Industry
The Mantosh Sondhi Centre
23, Institutional Area, Lodi Road, New Delhi – 110 003 (India)
T: 91 11 45771000
E: info@cii.in • W: www.cii.in

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Reach us via CII Membership Helpline: 1800-103-1244

About The Women's Collective Forum (WCF)

The Women's Collective Forum (WCF) is a pan-sectoral platform focused on equity-led systems transformation through scalable, institutionally grounded models.

Its enterprise initiative, SPARK – The 100K Collective, addresses the "missing middle" of women-led businesses—enterprises that are already established but remain excluded from formal finance, markets, digital systems, and regulatory frameworks. Through bootcamps in 300 locations, SPARK will work with 100,000 women entrepreneurs to strengthen their capacity to engage with capital, platforms, and institutions, ensuring that systems become navigable for those already building.

Beyond enterprise, WCF collaborates with leading health, technology, and management institutions to advance maternal health protocols, disease elimination, and the integration of new health technologies. In law and governance, WCF supports implementation of India's evolving criminal law frameworks with a focus on survivor-centricity and institutional accountability.

WCF also convenes cross-sectoral dialogues to highlight India's leadership in frugal innovation and systems change, engaging with global leaders and national platforms to translate research into policy and practice.

Across all these areas, WCF's model is consistent: build partnerships that connect evidence to institutions, and design approaches that can scale to strengthen systems for equity.

Connect with Us

Website: womenscollectiveforum.org
Email: richa.sharma@womenscollectiveforum.com ;
womenscollectiveforum@gmail.com

NOTES

INDIA'S WHITE PAPER ON

PROGRESS IN IMPROVING MATERNAL HEALTH OUTCOMES