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REVIEW ARTICLE

A CRITICAL AND PROGRESSIVE REVIEW ON MATERNAL AND CHILD HEALTH POLICIES IN INDIA

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ABSTRACT

BACKGROUND:

Mothers' survival and well-being are crucial for addressing major economic, societal, and child development issues. They are also significant in and of themselves. The current mother and child health situation in India is a complex topic with both hurdles and improvement. The Government of India has the foresight to reduce maternal mortality with the help of different programmes and healthcare facilities being introduced and cautiously implemented.

OBJECTIVE:

The author summarised the literature on maternal and child health programmes, investment in their impact, especially those initiated through national health missions and analysed the programmes.

RESULT:

This paper discussed the programmes and their current scenario with their benefits and problems. Some programmes are near to achieving their objectives such as Jannani Suraksha Yojana (JSY), and Janani Shishu Suraksha Karyakaram (JSSK) but not at their full potential. There is still some lacuna in these programmes. In this direction reviewed research papers highlighted the problems in the implementation and utilisation of the programmes and suggested further steps that should be taken to fully utilise these programmes and improve maternal and child health.

CONCLUSION:

Maternal deaths can be reduced if proper healthcare treatments are used to prevent or break the chains of problems. Although India outperformed the global average in terms of maternal mortality reduction between 1990 and 2016, we still have a long way to go to catch up with large economies such as Brazil, China and Japan where the maternal mortality ratios are 44, 27, and 5 respectively.

KEYWORDS

government programmes, institutional delivery, maternal and child health, maternal mortality ratio, national health mission.

INTRODUCTION

Maternal and Child Health is a crucial component of any nation's growth in increasing equity and combatting poverty. Mothers' survival and well-being are crucial for addressing major economic, societal, and child development issues.[1] The term "maternal health" describes the condition of women before, during, and after childbirth by the World Health Organization (W.H.O). Even though there has been significant progress over the past 20 years, in 2020 there were over 287,000 deaths of pregnant and postpartum women. Unacceptably high is this number. In addition to botched abortion, high blood pressure, excessive blood loss, obstructed labour, and indirect factors such as anaemia, malaria, and heart disease, these are the most frequent primary causes of maternal injury and death. [2]

By 2030, reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births, reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births and ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and integration of reproductive health into national strategies and programs and end preventable deaths of new-born and children under 5 years of age are some important target of Sustainable Development Goals 3(SDGs). [3] Maternal mortality and Adolescent fertility rates are used as indicators in the health dimension of the Gender Inequality Index (GII). Child mortality rate and Nutrition are used as an indicator in the health dimension of the Multidimensional Poverty Index published by the Human Development Report (HDR). [4]

India holds approximately 18% of the world's population of which 48.4% is female (World Bank, 2022). [5] Increasing sex ratio of females per thousand males is1,020 (NFHS-5) than 991 (NFHS-4). The percentage of the female population aged 6 years and above who ever attended school is 78.1. [6] whereas according to the Indian Census 2011, only 65.46% of females are literate. According to the Registrar General of India's (RGI), Special Bulletin on MMR, India's MMR has further improved by a stunning 6 points and currently stands at 97/ lakh live births. [7] Through different policies and activities, India is at the forefront of guaranteeing maternal and child health services to all mothers and children. Despite various socioeconomic and cultural challenges, the country has achieved commendable progress in providing healthcare services and lowering mother and child mortality. [8]

India is responsible for 20% and 25% of the world's baby and maternal deaths, respectively. Nearly one-fifth of all maternal deaths globally occurred in India in 2015.[9] Despite various policies and programmes the cost of maternal healthcare drove 46.6% of women into poverty, with the illiterate being particularly at risk. As many as 63% of households nationwide had a catastrophic maternal health cost of 40%, according to the study, which looked at data from the National Sample Survey Office.[10] Public facilities have a low rate of institutional births (61.9%), notwithstanding improvements in institutional delivery (88.6%).NFHS5 [6] Based on clinical symptoms and examinations, more than 0.55 million pregnant women were diagnosed with high-risk pregnancies and sent to a higher health facility or expert for proper care.[11] Therefore, there is a need for analysis of the various programmes and policies for the improvement of the status of maternal and child health.

DATABASE AND METHODOLOGY

Numerous internet databases, including The Press Information Bureau (PIB), the Annual Report of NITI Aayog, the National Family Health Survey(NFHS), report, PubMed, Google Scholar, relevant journals, different government sites and reports published such as NFHS, district-level household and facility survey (DLHS), PIB and also report published by World Health Organization (WHO) were searched for data related to indicators of maternal and child health since independence of India until now to analyse the impact of various public health programmes connected to maternal and child health in India.

OBSERVATION ON MCH PROGRAMMES AFTER INDEPENDENCE

The study discussed the steps taken by the government after the independence for the improvement of maternal and child health. The steps taken are discussed below:

FAMILY PLANNING AND MATERNAL AND CHILD HEALTH

A National Programme for Family Planning was first introduced in 1952 in India, making it the first in the world. By assisting women in having the number of children they want and preventing unplanned and untimely births, increased investments in family planning serve to lessen the effects of high population growth. These efforts also cut maternal death by 35%, infant mortality, and abortion rates dramatically. The Indian government committed to lowering the rates of maternal mortality (MMR) to 100/100,000, infant mortality (IMR) to 30/1000 live births, and total fertility (TFR) to 2.1 (MoHFW) by 2017[12]. Some major objectives for improving maternal and child health include lowering infant mortality rates to below 30 per 1,000 live births, maternal mortality rates to below 100 per 100,000 live births, ensuring that 80 per cent of deliveries take place in institutions and 100 per cent of deliveries are performed by trained personnel, and encouraging the use of contraception targeted in National Population Policy 2000.[13] The PM 20 Point Programmes, which were to be implemented in the fifth five-year planning cycle and would be monitored monthly, featured provisions including institutional delivery and child immunisation. A target for a birth rate of 25 per 1,000 people and a population growth rate of 1.4% by the conclusion of the sixth plan period had also been outlined in the fifth plan, and those targets were anticipated to be attained.[14]

In April 1976, the Ministry of Health and Family Planning unveiled a national population policy. That policy envisages a series of fundamental measures, such as raising the marriage age, and female education, spreading population values and the small family norm, strengthening research in reproductive biology and contraception, incentives for individuals, groups, and communities, and allowing state legislatures to enact legislation for compulsory sterilisation. [15] The 10th five-year plan referred to several vertical programmes for family planning, maternal and child health, integrated health care for women and children, centrally defined targets for community need assessment, and decentralised area-specific micro-planning and implementation of the programme for women's and children's health care. Monitorable targets for the 10th Five-year Plan included lowering the IMR to 28 per 1,000 by 2012, as well as lowering the maternal death ratio to 1 per 1,000 live births by 2012. [15] One of the goals of the Eleventh Five Year Plan was to lower the infant mortality rate to 28 and the maternal mortality rate to 0 to 1 per 1,000 live births. Other goals included lowering the level of malnutrition in children aged 0 to 3 to half what it was previously, as well as lowering anaemia in women and girls by 50% by the end of the plan. For a 950-child sex ratio, lower the MMR to 1 and raise the IMR to 25. The Twelfth Five-Year Plan had several objectives, including reducing child malnutrition in the 0–3 age group to half of the NFHS-3 level by bringing the total fertility rate (TFR) to 2.1.[15]

MATERNAL & CHILD HEALTH AND NITI AAYOG

In 2017, the National Institution for Transforming India (NITI Aayog) launched an annual Health Index in collaboration with the Ministry of Health and Family Welfare (MoHFW) and the World Bank to track overall and incremental performance across all states and Union Territories (UTs). Maternal Mortality Ratio (MMR), the proportion of pregnant women who received four or more antenatal care check-ups (ANC), and the level of death registration are included as new indicators. The major action carried out by the WCD division during the reporting year (2022-23) was the 'Publication of the National Nutrition Strategy' which the WCD Division published the strategy in preparation for the stage of incorporating the Nutrition Centre into the development agenda and other actions Pradhan Mantri Matru Vandana Yojna(PMMVY) in which the Maternity Benefit Programme must be implemented in all areas of the country in compliance with the provisions of the National Food Security Act of 2013. According to the PMO mandate, NITI Aayog is in charge of monitoring and evaluating the Maternity Benefit Programme.[16]

NATIONAL HEALTH MISSION

India has undertaken enormous efforts under the National Health Mission (NHM) to enhance access to high-quality maternal and newborn health services and decrease the statistically significant number of preventable maternal, neonatal, and infant deaths. According to the Registrar General of India's Special Bulletin on MMR, India's MMR has decreased by 10 points, which is an important achievement. The ratio decreased by 8.8% from 113 in 2016–18 to 103 in 2017–19. With this ongoing drop, India is on track to meet the SDG target of 70 lakh live births by 2030 and the National Health Policy (NHP) objective of 100 lakh live births by 2020.[17]To end all avoidable maternal and newborn deaths and morbidities and to promote a positive birthing experience, the Ministry of Health & Family Welfare (MoHFW), Government of India (GoI), has launched a new initiative called SUMAN- Surakshit Matritva Aashwasan. The expected outcome of this new initiative is "Zero Preventable Maternal and Newborn Deaths and high quality of maternity care delivered with dignity and respect". In keeping with this plan, the Maternal Health Division works to deliver high-quality services to expectant mothers and their babies through a variety of projects and programmes, improving routine health system strengthening operations and the capacity of health workers. Under the NHM, the Indian government has launched the following significant initiatives to lower maternal deaths [17]

JANANI SURAKSHA YOJNA

The National Health Mission's Janani Suraksha Yojana (JSY) promotes safe motherhood. The system was introduced on April 12, 2005, by the Hon. Prime Minister, and is currently being implemented in all states and UTs, with a concentration on Low Performing States (LPS). Encouraging institutional delivery among low-income pregnant women aims to lower maternal and newborn mortality. The scheme focuses on poor pregnant women with a special dispensation for states that have low institutional delivery rates, namely, the states of Uttarakhand, Uttar Pradesh, Bihar, Jharkhand, Madhya Pradesh, Assam, Chhattisgarh, Rajasthan, Orissa, and Jammu and Kashmir. While these states have been named Low Performing States (LPS), the remaining states have been named High Performing States (HPS).[17]

Current scenario of this programme: Achievement and Issues

Coverage of critical maternal health services has more than doubled since 2005, while the proportion of institutional deliveries in public facilities has nearly tripled, from 18% in 2005 to 52% in 2016 (including private facilities, institutional deliveries now account for 79%). Although institutional delivery has improved (88.6%), institutional birth in public facilities is low (61.9%) {NFHS5}[6]. However, the JSY scheme in practice is almost completely focused on the promotion of institutional delivery- to the exclusion of other related objectives. The payments on account of home delivery are low and not encouraged. Informally they could be actively discouraged. The exclusion of women below the age of 19 and women with more than two children is another issue. Undoubtedly, this would not help in terms of mortality reduction. Most women who die would be in these two categories. The quality of clinical care also needs to improve. After all, this is the single biggest reason for institutional delivery.[18] However, expenses were incurred by the beneficiaries on drugs, diagnostics, transport etc. which was a barrier to accessing quality services.

JANANI-SHISHU SURAKSHA KARYAKARAM (JSSK)

After the Janani Suraksha Yojana (JSY) was introduced, institutional deliveries significantly increased in India. However, 25% of women still fear delivering in a hospital because they have to pay for their medications, food, diagnoses, blood workups, etc. while they are there. The Janani Shishu Suraksha Karyakaram (JSSK) programme, which aims to eliminate out-of-pocket expenditure (OOPE) for both pregnant women and unwell babies, was introduced in June 2011 as a follow-up to the safe motherhood program's success. Within 48 hours, the mother and newborn need critical care. Identification and treatment of difficulties following delivery depend on this postnatal phase. All pregnant women giving birth in public health facilities are entitled to completely free and expense-free deliveries, including caesarean sections. [17]

Current scenario of this programme: Achievement and Issues

With the launch of JSSY, a considerable increase in institutional deliveries was reported from different parts of the country. Despite the provision of free services, the families often meet with OOPE during institutional deliveries.[19]It has largely closed the urban-rural divide traditionally seen in institutional births. Overall, 87% of rural births are now supervised, as

compared to 94% of urban deliveries (NFHS-5)[6]. Various studies reported that the utilization pattern of the JSSK program is variable for different components. A study from Himachal Pradesh showed that the utilization is highest for tests and diagnostics, user fees and blood transfusion; one out of seven families pay for drugs, while two-thirds pay for consumables.[19]On the contrary, a higher utilization pattern (94%–97%) for different components of JSSK was reported by Chaudhary et al.[20]

Although average out-of-pocket expenditure per delivery in a public health facility decreased from 3197 to 2916 (NFHS-5), still 25% of pregnant women hesitate to access these services. [21]According to the study done by researchers from Jawaharlal Nehru University and Indian Institute of Technology, Roorkee in December 2016 study Maternal healthcare expenses pushed 46.6% of mothers in India into poverty – with the illiterate being especially susceptible. Childbirth, antenatal care, and postnatal care are all included in the costs. According to the study, which examined data from the National Sample Survey Office, as many as 63% of households nationally had a catastrophic maternal health cost of 40%.[10]There are some possible barriers to the system such as delayed fund flow, low food quality and quantity, door-to-door drug delivery, lab logistics issues, a lack of understanding of transportation facilities, a lack of blood banks, and informal behaviour by health staff. By focusing on removing such
barriers we can achieve the objectives of this programme.[21]

VILLAGE HEALTH, SANITATION AND NUTRITION DAYS (VHSND)

Since 2007, Village Health Sanitation and Nutrition Day (VHSND) has been conceptualised as part of the National Health Mission (NHM) across the country. The VHSND strategy is designed to reach all geographical areas under the jurisdiction of health and wellness centres, including hilly, tribal, underserved, and difficult-to-reach locations. Some actions taken by VHSND for antenatal services that are all pregnant women are to be registered and registered pregnant women to be given ANC and all eligible children are to be given vaccines as per the immunization schedule, all dropout children who do not receive vaccines as per the scheduled doses are to be vaccinated, vitamin A solution is to be administered to under five children for immunisation service.[22]

Current scenario of this programme: Achievement and Issues

According to Sharma et al., who showed in their studies, that basic amenities such as electricity, bathrooms, and drinking water are required to provide comfortable and excellent service delivery. At the end of the pilot period, the proportion of model locations with drinking water increased from 76% to 86%, while the proportion of model sites with toilets increased from 48% to 66%. The availability of all three types of equipment, namely equipment for providing ANC services, immunisation, and growth monitoring, has significantly improved. However, there was no statistically significant change in drug supply at these locations.[23] Studies in different states have shown that contrary to the guidelines, only a limited range of services was being provided at the VHSND. Registration of pregnant women and immunization of children were prime tasks undertaken at VHSND.[24–26] Several studies have identified deficiencies in VHSND planning, operation, infrastructure, and service delivery. A few scholars have also shown that 3 months of concentrated effort can result in significant changes in VHSND.[25,27] Timely detection of risk factors during pregnancy and childbirth can prevent deaths due to preventable causes. This can only be possible if the complete range of the required services is accessed by pregnant women.[28]

PRADHAN MANTRI SURAKSHIT MATRITVA ABHIYAN (PMSMA)

PMSMA was created in 2016 to provide universal fixed-day assured, comprehensive, and quality prenatal care to all pregnant women (in the second and third trimesters) on the 9th of every month One of the critical components of the Abhiyan is the identification and follow-up of high-risk pregnancies and red stickers are added to the Mother and Child Protection cards of women with high-risk pregnancies.[17]

Current scenario of this programme: Achievement and Issues

PMSMA completed 13 million antenatal check-ups in just 13 months, resulting in the diagnosis of 0.65 million high-risk pregnancies. [21] According to the Union Minister of State for Health and Family Welfare, 3,090,270 pregnant women received ANC in the first year of its implementation. Over one billion prenatal check-ups have been performed. Maharashtra has reported the highest number of check-ups among Non-Empowered Action Group (EAG) States, and

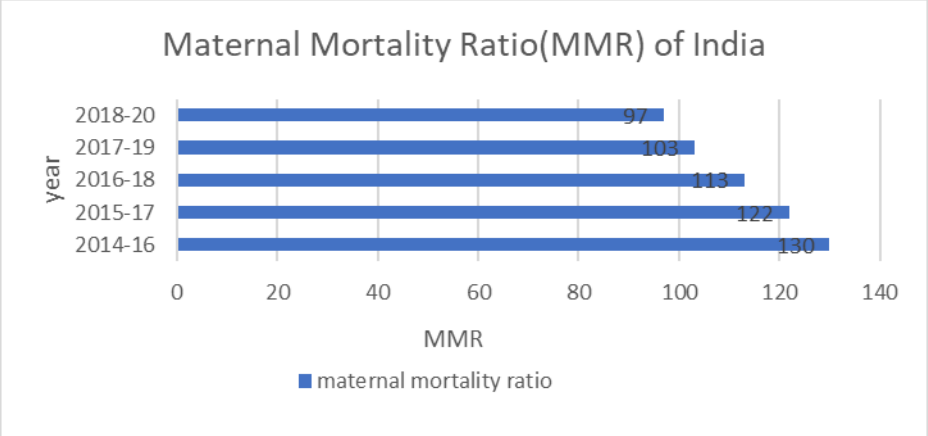
Rajasthan has recorded the highest number of check-ups among Empowered Action Group States. The scheme has resulted in 84 lakh haemoglobin tests, 5.5 million HIV tests, 4.1 million gestational diabetes tests, 3.3 million syphilis tests, and more than 15 lakh ultrasounds, allowing for the early discovery of high-risk pregnancies. Over 0.55 million pregnant women were recognised as having high-risk pregnancies based on clinical symptoms and investigations and were referred to a specialist or a higher health facility for appropriate care.[29]

DISCUSSION

ACHIEVEMENTS OF THE PROGRAMMES:

The World Health Organisation applauds India for making historic gains in recent years in lowering the maternal mortality ratio (MMR) by 77%, from 556 per 100,000 live births in 1990 to 130 per 100,000 live births in 2016. The National Health Policy (NHP) 2017 established the goal of lowering India's MMR to less than 100 per lakh live births by 2020. 'Beti Bachao Beti Padaho' programmes supported India in dealing with the social determinants of maternal health. Women in India are more literate than ever before, with 68% reading and writing now. They are also getting married later in life, with only 27% getting married before the age of 18. For these reasons alone, Indian women now have more control over their reproductive lives, allowing them to make decisions that reflect their interests and wishes. [30] The government has made significant efforts to promote beneficial collaboration between public and private healthcare providers. Campaigns such as the 'Pradhan Mantri Surakshit Matritva Abhiyan' have had a significant impact, providing women with access to antenatal check-ups, obstetric gynaecologists, and tracking high-risk pregnancies - exactly what is required to make further progress and meet the SDG targets [30] Mothers who underwent a prenatal check-up in the first trimester increased from 58% to 70% (NFHS-5). 58.1% of mothers had at least four prenatal care visits, compared to 51.2% in NFHS-4.[6] It seeks to improve the quality and coverage of diagnostics and counselling services and provide assured comprehensive and quality antenatal carefree of cost. Providing a positive birthing experience to pregnant women such as Registered pregnancies for which the mother received a Mother and Child Protection (MCP) card and Mothers whose last birth was protected against neonatal tetanus are 92% (NFHS-5) has been made an imperative through programmes like 'Surakshit Matritva Anushasan (SUMAN), and Labour Room & Quality Improvement Initiative '(LaQshya). In addition, the Union Ministry of Health and Family Welfare established the Anaemia Mukt Bharat initiative in 2018 to reduce anaemia prevalence due to both nutritional and non-nutritional reasons across the lifespan. The initiative is expected to benefit 450 million people, including 30 million pregnant women. These initiatives by the Government of India have played a pivotal role in increasing the number of institutional deliveries in the country. [31] Institutional deliveries in India have increased substantially from 79 per cent in 2015-16 to 89 per cent in 2019-20. Around 87% of births in rural areas and 94% of births in urban areas are institutional deliveries.[6] Over the last eight years, the Government of India's concerted interventions aimed at addressing all elements of maternal care have resulted in a continuous drop in MMR. The country's MMR fell from 130 per lakh live births in 2014-16 to 103 in 2017-19 see Figure 5.1.[31,32]

FIGURE 5.1 THE MATERNAL MORTALITY RATIO IN INDIA (2014 TO 2020)



source: Trends in maternal mortality in India. [32]

Target 3.1 of the SDGs adopted in 2015 is to reduce the worldwide MMR to less than 70/100,000 live births by 2030. With its programmes for women's health and well-being, India is steadily advancing towards this target ahead of schedule. The Central Government's actions have permitted excellent development by several states, eight of which have already met the SDG objective. Kerala (19), Maharashtra (33), Telangana (43), Andhra Pradesh (45), Tamil Nadu (54), Jharkhand (56), Gujarat (57), and Karnataka (69) are among them. [33]

ISSUES RELATED TO MATERNAL HEALTH PROGRAMMES IN INDIA

The current mother and child health situation in India is a complex topic with both hurdles and improvement. The high maternal and newborn mortality rates are one of the most significant concerns. India accounts for 20% and 25% of global maternal and infant mortality, respectively. While 15% of moms face potentially life-threatening difficulties during pregnancy and childbirth, about 40% of mothers experience general issues. (source-UNFPA 2011, NFHS-3).[32] According to the World Health Organisation (WHO), 63,000 maternal deaths occur in India each year, accounting for nearly 18% of all maternal deaths. Worldwide maternal mortality has declined internationally, but it is still high in several low and middle-income countries (LMICs), including India, where maternal health is still a major public health problem (WHO). In 2015, India was responsible for nearly one-fifth of all maternal deaths worldwide.[9], and there are large inter-state and intra-state disparities. When compared to southern states like Kerala (66) and Tamil Nadu (90), the maternal mortality ratio (MMR) in northern states like Assam, Uttar Pradesh (including Uttarakhand), and Rajasthan is relatively high (328, 292, and 255 maternal deaths per 100,000 live births, respectively).[34]Between states and different demographic groups within states, especially among populations formed by socioeconomic divisions, significant disparities in the use of maternal health services (antenatal and maternity care) are also documented.[35,36].The budgeted health spending for the federal, state, and local governments reached 2.1% of the GDP in 2022–2023, according to the Economic Survey 2023.[37] India's relatively stagnant performance with reference to maternal and child health indicators is linked with low levels of government investment in health. other neighbours have higher health spending in per cent of their GDP. Pakistan and Sri Lanka's public expenditure on healthcare was 3.4 per cent and 4.1 per cent of their GDP respectively.[38]

Some other indirect causes of maternal health are lack of maternal education, lack of sound healthcare facilities, lack of pregnancy care, lack of cleanliness concerning maternal health, and inadequate postpartum checkups. In India, a large portion of the female population remains unaware of maternal health issues. Even they are not aware of the facts of birth control, reproduction, fertility, and sex education. Most women in India's rural and semi-urban areas fail to reach the hospital on time owing to the worst traffic congestion and lose their lives on the way. Hospitals have deteriorated due to a lack of equipment and efficient workers. Healthy food consumption and getting enough sleep are essential for pregnant women. One of the biggest indirect causes is a lack of prenatal care. In India, a lack of cleanliness and hygiene can hurt maternal health. [39]

KEY POLICY SOLUTION

Maternal deaths can be reduced if proper healthcare treatments are used to prevent or break the chains of problems. During pregnancy and after childbirth, all women must have access to high-quality healthcare.[39] By implementing tactics like encouraging prenatal care, tackling malnutrition with focused interventions, and utilising community-based health professionals, such as ASHAs, to provide home-based care can improve maternal and child health status.[40] Prioritise tracking weight growth during pregnancy, guaranteeing iron-folic acid pill availability, and integrating maternal nutrition into ANC services through home visits and platforms like VHSND.[41] With its distinct geopolitical and sociological realities, India does not need to adopt ideas that have proven successful in other nations. Instead, she must develop solutions centred on women, culturally acceptable, cost-effective, and easily accessible. Such a strategy has the potential to be implemented at multiple levels. We can start by combining existing traditional/community service providers (dais) or people's health traditions or formal Indigenous health care systems like Ayurveda, Unani, yoga, and so on with existing health care infrastructure.[42] Improving maternal health necessitates intersectoral work from a stronger gender and human rights perspective in order to promote women's empowerment, eliminate poverty, and reduce gender-based inequalities. Gender-sensitive interventions are required to address established inequities and achieve gender justice in health.[8] In order to reduce maternal mortality, it is critical to increase the availability of knowledge on these topics. It is also essential that parents educate their children on topics such as maternal health and sex education. Healthy food consumption is essential for pregnant women. Including prenatal vitamins in the everyday food- routine

would help moms and their babies acquire enough important nutrients. Women's lives can be saved by obtaining life-saving antibiotics in an emergency. All hospitals should consider prioritising postpartum checkups.[39] health facilities must be LaQshya certified and consistent efforts to meet SDG targets and goals for maternal and neonatal health. These will help maintain and accelerate extraordinary progress towards eliminating all preventable maternal, neonatal, and child deaths.[17]

CONCLUSION

India's success in lowering MMR strengthens the Government's commitment to achieving 'Surakshit Matritva Aashwasan' (programmes started by government of India and it means to provide assured, dignified, respectful and quality healthcare, at no cost and zero tolerance for denial of services, for every woman and newborn) for women by establishing a responsive healthcare system that strives for zero preventable maternal and newborn deaths. As India celebrates 'Amrit Kaal,' (the time period of 25 years until 2047 'The Era of Elixir' to the entire nation of India introduced on its 75th Independence Day). the goal is to keep MMR below the target of 70/lakh live births and to maintain a steady drop in the future. To attain this goal, India is focused on improving the quality of in-facility maternity care and boosting awareness about the importance of reproductive health.[7]. Matching global standards is critical in every aspect to preserve women's lives. Although India outperformed the global average in terms of maternal mortality reduction between 1990 and 2016, we still have a long way to go to catch up with large economies such as Brazil (44), China (27) and Japan (5). However, even one maternal death is too many, and all stakeholders must work together to guarantee that no woman dies from a preventable cause. [43]. The Government of India sees a future in which maternal mortality is no longer a problem; with the different programmes and healthcare facilities being introduced and cautiously implemented, this vision is well on its way to becoming a real.

ABBREVIATIONS:

MMR- Maternal Mortality Rate
SDG -Sustainable Development Goals
NHM - National Health Mission
IMR - Infant Mortality Ratio
NFHS- National Family Health Survey

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