THE GORADIA FOUNDATION

dasra

Reframing Maternal Health with a Gender Equity Lens in India

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ABBREVIATIONS

AID	Association for India's Development
ANC	Antenatal Care
BCC	Behavior Change Communication
CAG	Community Advisory Groups
CBM	Community-Based Monitoring
CHIP	Community Health Integrated Platform
CSE	Comprehensive Sexuality Education
CSSM	Child Survival and Safe Motherhood
DFID	The Department for International Development (UK)
GCACI	Global Comprehensive Abortion Care Initiative
GoI	Government of India
ICDS	Integrated Child Development Services
ICMR	Indian Council of Medical Research
IPRT	Institute for Policy Research and Training
JSSK	Janani-Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LaQSHAY	Labour Room Quality Improvement Initiative
MAS	Mahila Arogya Samiti
MASVAW	Men's Action for Stopping Violence Against Women Network
MMR	Maternal Mortality Ratio

ABBREVIATIONS

MO	Medical Officer
NCDs	Non-communicable diseases
NHM	National Health Mission
NPMs	Nurse Practitioner Midwifery
NRHM	National Rural Health Mission
OOPE	Out-of-pocket Expenditure
PGIMER	Postgraduate Institute of Medical Education and Research
RCH	Reproductive and Child Health
RMC	Respectful Maternity Care
RMNH+A	Reproductive, Maternal, Newborn, Child & Adolescent Health
SIDA	The Swedish International Development Cooperation Agency
SDG	Sustainable Development Goal
SHGs	Self-help Groups
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SMA	Surkashit Matritiva Aashwasan
SVRI	Sexual Violence Research Initiative
TNAI	Trained Nurses' Association of India
UNPFA	United Nations Population Fund
VHSNC	Village Health Sanitation and Nutrition Committee
WHO	World Health Organization

ABSTRACT

Maternal health remains a critical concern in India, requiring urgent attention to both health outcomes and systemic inequalities. Despite significant strides in reducing maternal mortality ratio (MMR) by 68% over the past two decades, India continues to face challenges in addressing broader maternal health indicators, including anemia, teenage pregnancies, and the accessibility of healthcare services for vulnerable populations. The paper identifies socio-cultural determinants of health as a core barrier, where patriarchal norms and resource inequalities prevent women from accessing necessary healthcare.

The paper advocates for a reframing of maternal health through a gender-transformative lens, shifting the focus from the narrow focus on the 'mother' to women's overall health. This approach requires addressing structural inequalities, intersectionality of identities, and promoting a collectivized model of care that includes families, communities, and healthcare systems. We argue that the improvement in maternal health status is not merely a question of improved resource accessibility or allocation of greater financial resources, it is also a question of women fundamentally negotiating their spaces and reclaiming their agency.

We spotlight civil society organizations that are pioneering gender-responsive and transformative interventions across India. By piloting innovative programs, gathering evidence, and advocating for policy reforms, these organizations play a pivotal role in shifting social norms, increasing women's agency, and driving systemic changes that promote lasting gender equity in maternal health. These civil society interventions are important whitespaces for philanthropic investment to transform maternal health care in India.

Disclaimer: The framing and perspectives in the report are authors' point of view and should not be considered definitive.

SETTING THE CONTEXT

The Overlooked Role of Motherhood in Gender Discourse

Even as women have made greater inroads across spheres which have traditionally been the prerogative of men, there has not been an adequate acknowledgement of their distinct biological and functional roles. Motherhood, an important lifecycle event, remains under-represented in the broader gender theory and feminist discourse. Despite its profound implications for a woman's overall health as well as participation across both domestic and paid work, a survey revealed that the discourse on motherhood features in less than three percent of the literature on modern gender theory.[1]

Additionally, the experience of motherhood is also deeply grounded in the societal context and the unique positionality of women (economic status, literacy, social identity, access to resources, etc.). The focus on motherhood in the Indian context has been largely in the context of sustainable development goals (SDGs), reduction of maternal mortality, and improvement of maternal health. This has, in turn, enabled India to make significant progress in the reduction of maternal mortality, with about 68% reduction in MMR over the last two decades.[2] However, India's progress on maternal health indicators has been far slower and India is set to miss at least eight of its SDG targets relating to maternal health.

The Need for a Gender-Transformative Approach to Maternal Health

We posit that India's lagging progress on maternal health is due to its insufficient focus on the socio-cultural determinants of health, which not only restrict women's access to healthcare but also accord limited importance to women's health as individuals. We have observed that the focus on motherhood is typically linked to protecting the mother, so the child is safe. While this discourse has been adequate for addressing the reduction in maternal mortality, any structural improvements in maternal health indicators hinge on reframing the maternal health discourse using a gender-transformative lens.

This entails addressing the root causes of gender inequalities and re-prioritizing women's health instead of the limited focus on maternal health. For instance, consider the case of iron deficiency anemia. In 2016, India ranked 170, among 180 countries for the incidence of iron deficiency anemia in women.[3] Much of the policy narrative has focused on pregnant women with a curative focus in terms of providing iron supplements. There is however limited acknowledgment of the notion that the disproportionate burden of anemia faced by women results from inequalities in the intra-household distribution of resources and patriarchal norms which provide preferential treatment to men.[4]

In the context of these gaps, a gender-transformative framing of maternal health policy would imply the following changes in both policy design and implementation. A shift in the perception of the mother, from a mere childbearing and child-rearing entity to an individual who has agency and autonomy about the decisions she makes. The improvement in maternal health status is not merely a question of improved resource accessibility or allocation of greater financial resources, it is also a question of women fundamentally re-negotiating their space and re-claiming their agency, from being passive recipients of services to actively choosing and demanding for how they wish to be supported and receive care.

Such an approach also actively shifts the power imbalances across men and women, and women and the health system to ensure greater equity in health outcomes. There is also recognition of the intersectionality of women's experiences, whereby women's access to the health system is in turn impacted by the unique positionality of women in terms of caste, location, literacy attainment, and socio-economic status. While there has been an explicit focus on women belonging to vulnerable communities, the intersectional focus has been missing in the current discourse.

Lastly, we argue that the current system also places the burden of care squarely on women as individuals. The gender transformative framing instead invites the larger community, men, family, and the health system towards the co-creation of a more empowering space for women i.e., a collectivized model of care.

Structure, Focus Areas, and Limitations of the Whitepaper

The key findings in this paper are informed by the review of the literature and conversations with stakeholders in civil society and academia. In this paper, we evaluate some of the key systemic initiatives in the context of maternal health to identify shortfalls in the design and implementation hindering India's holistic and equitable progress. The paper limits its focus to the experiences of cis-gendered heterosexual mothers and may apply to adoptive mothers in a limited capacity. However, the paper does not address the experiences of queer mothers. It also does not cover intentionally the experiences of adoptive mothers. We acknowledge the limitations of our scope and the need for further research on these themes.

While India has made rapid strides in the gender-transformative reframing of sexual and reproductive rights, a similar positioning of the maternal health agenda offers whitespace for philanthropic and civil society action. We underscore the important role being played by civil society in building narratives that emphasize shifting existing social norms, facilitating increased agency among women, and enabling them to seek greater accountability from the health system. We spotlight the work done by some of the not-for-profit organizations and identify the potential areas for further engagement. This white paper is divided as follows:

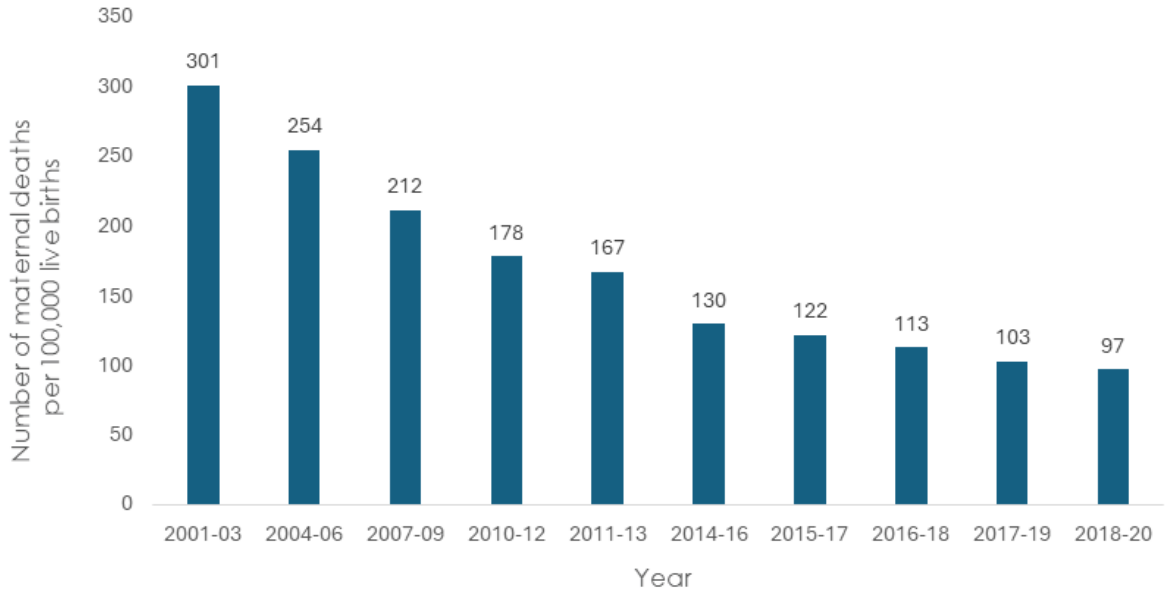
- **Chapter I** outlines the maternal health landscape in the country, reflecting on the progress made so far by providing a glance of key government initiatives and related opportunities.
- **Chapter II** frames the sector from the perspective of stakeholders including government, civil society organizations, and healthcare practitioners with a view of their unique approaches.
- **Chapter III** summarizes the gender equality continuum and builds the case for reframing the maternal health agenda with a gender-transformative lens.
- **Chapter IV** covers key recommendations for integrating a gender transformative lens into maternal health.
- **Section V** spotlights the initiatives by civil society organizations in the context of maternal health and identifies where these lie on the gender integration continuum.

CHAPTER 1: TRACKING INDIA'S STATUS ON MATERNAL HEALTH INDICATORS

Over the last decade, India has made rapid strides in attaining its goals in maternal health and mortality. Between 2001-03 and 2018-20, there has been a 68% reduction in maternal mortality, from 301 to 97, per 100,000 live births (See Figure 1).[5] This in turn has resulted in a decline in India's share of the global maternal death burden, from 16% in 2011 to 8.7% in 2020.[6]

While India appears to be on track to achieve the goal of reducing the MMR to 70 per 100,000 live births by 2030, India's progress on some of the maternal health indicators has been more of a mixed record. Although there has been an improvement in the accessibility of health facilities and coverage of the antenatal care (ANC) services, the progress on anemia, teenage pregnancy, sexual violence, and insurance coverage has been off-track and even decelerated in case of a few. Currently, India is on track to achieve only five of the 13 SDGs relating to maternal health by 2030. Of the remaining eight, it will achieve none by 2035 or before, one between 2035 and 2040 and five by 2041 or after. At the disaggregated level, given the vast inter-state inequalities in accessibility and availability to healthcare services, some of these indicators will be achieved much later than the timelines mentioned above. For instance, 86% (606 of 706) and 84% (591 of 707) of the districts were off target for reducing anemia in pregnant women and improving health insurance coverage for women, respectively. Concerningly, ANC services coverage in 2021 stood at or less than 50% in 81% of Indian districts.[8]

Figure 1 : India's progress on Maternal Mortality Ratio (MMR) per 100,000 live births



Source: MoHFW (2022)[7]

Table 1 : Progress on Maternal Health Indicators

Indicators of Maternal Health	SDG	Status (2021)	On Track to Attain Goal	Projected Timeline to Attain Goal
Adolescent Pregnancy (10–14)	3.7.2	Achieved	Yes	2021
Have Bank Account (Women)	8.10.2	On-Target	Yes	2030
Skilled Birth Attendants	3.1.2	On-Target	Yes	2030
Child Marriage (<15)	5.3.1	On-Target	Yes	2030
Teenage Sexual Violence	16.2.3	On-Target	Yes	2030
Teenage Pregnancy (15–19)	3.7.2	Off-Target	No	2039
Own Mobile Phone	5.b.1	Off-Target	No	2041
Child Marriage Girl (<18)	5.3.1	Off-Target	No	2045
Health Insurance Coverage	1.3.1	Off-Target	No	2051
Partner Violence (Physical or Sexual)	5.2.1	Off-Target	No	2090
Anemia (Non-Pregnant Women)	2.2.3	Off-Target	No	Worsened between 2016 and 2021, and therefore not predicted to meet the target
Anemia (Pregnant Women)	2.2.3	Off-Target	No	Worsened between 2016 and 2021, and therefore not predicted to meet the target
Anemia (Women)	2.2.3	Off-Target	No	Worsened between 2016 and 2021, and therefore not predicted to meet the target

Source: Subramaniam et al (2023)[9]

Key takeaways from this data are:

- **Scope for change:** While there has been an improvement in the overall status of maternal health and mortality when measured holistically, the data indicates room for improvement
- **Correlation to gender equity:** The off-target indicators indicate the prevalence of unequal gender norms, and in turn have implications for women's overall agency in society
- **Expanding the focus:** There is a need for a multi-sectoral approach to improving maternal health, a narrow programmatic focus on health status will yield limited results
- **High potential:** Being on target for bank account linkages, institutional deliveries, and a skilled workforce shows the power of possibility with intentional policy design and implementation

BREAKPOINTS IN MATERNAL HEALTH CARE AGENDA | POLICY PERSPECTIVE

Over the last few decades, GoI has been actively responding to various challenges in the context of maternal health, and the launch of the National Rural Health Mission (NRHM) in 2005 was an important turning point for the maternal health discourse in the country (See Table 2). While these initiatives have been instrumental in the reduction of MMR and improvement in maternal health status, the focus on maternal health has largely been in the context of its impact on the child's health. For instance, on the National Health Mission (erstwhile NRHM) website, the key indicators listed for tracking maternal health include: 1) mothers who had antenatal check-ups in the first trimester, 2) who had at least four antenatal visits, 3) who had full antenatal care, 4) who received postnatal care from some healthcare professional within two days of delivery; and 5) those who had institutional births.[10] All these indicators focused on antenatal care are directly tied to protecting the health of the child, and the focus on institutional births also caters to a certain extent to the protection of the child's life and overall health.

The efforts in the context of reproductive and child health before 2005 were fragmented and the policy focus was also limited.[11] The two key initiatives before 2005 were – CSSM Child Survival and Safe Motherhood Program in 1992 and RCH Reproductive and Child Health Program in 1997. The focus of these two were largely on ensuring institutional deliveries, provision of antenatal care, and emergency obstetric care for the reduction of MMR. In 2005, the RCH was integrated into NRHM, and a host of other schemes and interventions were introduced to reduce maternal mortality and child mortality. By 2013, GoI adopted Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNH+A), shifting the paradigm from the initial limited focus on RCH to a more comprehensive, lifecycle approach. There was increasing recognition of the fact that RCH was situated within the broader lifecycle, with adolescence being an important stage. These different stages cannot be looked at in silos, and lifecycle stages preceding and after motherhood were closely interlinked and have implications for both maternal and child health.[12]

Table 2 : Timeline of government interventions in the context of maternal health

Timeline	Milestones
1950-1999	• **The Government of India (GoI) incorporated maternal health into the country's five-year plan** with a focus on slowing population growth through family planning[13] • **The United Nations Population Fund (UNFPA) invested in family planning services between 1970s-80s**[14] • **GoI shifted its focus from family planning to reproductive and child health strategy** to the Family Welfare Program. The Child Survival and Safe Motherhood Program (1992-1995) focused on maternal health and mortality, and the Reproductive and Child Health (RCH-I) program (1997–2004) expanded the scope of the Family Welfare Program to incorporate additional dimensions of women's healthcare[15]

Timeline	Milestones
2000-2009	• The United Nations Millennium Declaration called for countries to reduce MMR and increase the proportion of births attended by skilled health personnel[16] • Philanthropic institutions and bilateral and multilateral agencies continued investments in maternal health service delivery, advocacy, and accountability focused on ANMs and ASHAs[17] • **GoI launched Reproductive and Child Health II (RCH -II) within the National Rural Health Mission (NRHM)**[18] In 2005, with joint funding from multilateral and bilateral agencies, the program aimed to enhance essential and emergency obstetrical care, improve referrals for pregnancy complications, strengthen infrastructure, and incentivize maternal health services through initiatives like Janani Suraksha Yojana, which provided payments for institutional deliveries
2010-present	• **Bilateral funders SIDA and DFID exited; government launched RMNCH+A in 2011, shifting focus to quality**, adding an adolescent health component, re-emphasizing family planning, and addressing disparities across states[19] • **GoI launched the National Urban Health Mission under the National Health Mission in 2013**, to focus on providing essential primary health care services and reducing out-of-pocket expenses for the urban poor[20]

Source: Dasra analysis from multiple sources

These initiatives and interventions are guided by tenets of equity, universal care, entitlement, and accountability.[21] There is also explicit policy focus on the social determinants of health, on the low-performing states, and specific vulnerable groups (Scheduled Castes – SC, Scheduled Tribes – ST, migrants, urban poor, and adolescents) and pro-poor focus in both planning and implementation. However, a review of the key initiatives reveals that some of these values have not been completely operationalized in the current intervention framework, due to gaps in implementation, and several gaps between the stated policy objectives and the actual policy output and outcomes (See Table 3).

Table 3: Key GoI Initiatives on promotion of maternal health

Name of the Initiative	Launch Date	Program Description / Objectives	Gaps in Design & Implementation
Janani Suraksha Yojana (JSY)	2005	• Largest conditional cash transfer program in the world for pregnant women aimed at promoting institutional deliveries	• While there has been a significant increase in the uptake of public facilities, inequalities in utilization persist based on demographic groups, residence & religion[22]

Name of the Initiative	Launch Date	Program Description / Objectives	Gaps in Design & Implementation
			• Lack of acknowledgment of intersectionality of identities and its impact on access[23] • Decline in MMR has not kept pace with the increase in institutional deliveries, highlighting gaps in the quality-of-service delivery[24]
Janani-Shishu Suraksha Karyakram (JSSK)	2011	• To complement the efforts of JSK, this scheme aims at reducing the out-of-pocket expenditure (OOPE) burden for pregnant mothers by providing institutional delivery and newborn care services free of cost in public facilities	• Progress has been made in the reduction of Out-of-pocket Expenditure (OOPE), but regional inequities in access to institutional facilities persist and high OOPE in public facilities[25]
Dakshata Implementation Package	2015	• Aim to improve the quality of care during intra and immediate postpartum period through a targeted training program to enhance the competencies of Medical Officers, nurses, and ANMs • Aim to ensure sufficient availability of physical inputs in labor rooms and establishing improved data monitoring mechanisms	• Limited supply-side, clinical focus on the notion of quality of care • Insufficient recognition of the impact of mother's caste, residence, and socio-economic profile on the quality of care provided[26] • Gaps in implementation (shortage of HR, mismatch between physical and human resources) and low awareness among doctors about the overall initiative[27 28]
Surkashit Matritiva Aashwasan (SUMAN)	2016	• To enhance the overall birthing experience of mothers, by providing dignified, assured, good quality, and respectful care at public facilities free of cost to both mother and child	• Lack of recognition of unequal power dynamics between mothers & health system professionals, and inadequate focus on formal training for obstetric violence is one of the key reasons for the persistence of violence despite the introduction of these initiatives[29]

Name of the Initiative	Launch Date	Program Description / Objectives	Gaps in Design & Implementation
		• Aim to achieve the target of zero preventable maternal and newborn deaths	
Pradhan Mantri Suraksha Matritiva Abhiyaan	2016	• Provide special ANC check-ups for pregnant women in the second and third trimesters, on the 9th of every month • Enable early identification and follow-up of high-risk pregnancies	• Only 20.3% of pregnant women reported availing ANC services of 'adequate quality', irrespective of the number of visits, as per NFHS V (2019-21)[30]
Pradhan Mantri Matru Vandana Yojana	2017	• Scheme entails an entitlement of Rs. 5,000 for pregnant women for live births in a public facility, and pre- and post-natal care of mother and child • Targeted towards women of the unorganized sector who are not entitled to maternity leave and any other benefits. It also specifically targets women belonging to the economically weaker section and those living in remote areas • Provision of partial compensation in terms of cash incentives to women for their wage loss	• Cash entitlement is restricted to one child and women with more than one child are ineligible for benefits • Gaps in identification and enrolment of beneficiaries and delays in disbursement of the funds to the identified beneficiaries[31] • Cash transfer was found to be not used for the intended purpose of buying nutritious food
Labour Room Quality Improvement Initiative (LaQSHYA)	2017	• Reduce maternal and newborn morbidity and mortality • Enhance the quality of care and birthing experience, respectful maternity care	• Largely input-focused quality assurance framework, with limited focus on output and outcomes

Source: Dasra analysis from multiple sources

Apart from the initiatives mentioned above, several community-based interventions have been undertaken by GoI, focused on increasing awareness about their rights and providing information about various aspects of maternal health. Community-driven initiatives like Mahila Arogya Samiti (MAS), Village Health Sanitation and Nutrition Committees (VHSNC), etc. introduced as part of the National Health Mission, have been instrumental in the context of altering social norms with respect to health-seeking behaviors and facilitated greater accountability from the health system. The role of civil society in supporting and supplementing these initiatives has been equally important. It has also been extensively involved in facilitating community-based monitoring of various initiatives, enabling greater participation of the public, increased awareness about various initiatives, and thereby ensuring greater accountability of health systems.[33]

CHAPTER 2:
FRAMING THE MATERNAL HEALTH SECTOR

LOOKING AT MATERNAL HEALTH AS A FIELD

To see maternal health as a field – it is important to understand its constituents. The approach below offers a comprehensive framing of the maternal health sector by recognizing the interconnectedness of individual, social, and systemic levels. This helps factor in personal experiences, community influences, and health systems working together to shape maternal health outcomes. By framing the sector in this way, we highlight the complexity of challenges and opportunities in the demand and supply of care, as well as the evidence and policy narrative. Such a framing can enable a more integrated and responsive approach to policy design, resource allocation, and service delivery.

Understanding the interrelationship between these three levels—individuals, surroundings, and health systems—is essential for addressing gaps and improving outcomes in maternal health.

- **Individuals**
  This refers to the mothers themselves. They are the primary recipients of maternal health services, and their experiences, needs, and behaviors drive the demand for these services.
- **Surroundings**
  This includes family dynamics, community support systems, cultural norms, and socioeconomic factors. These surroundings significantly impact maternal health by influencing access to care, health-seeking behaviors, and the availability of social support.
- **Health Systems**
  This encompasses the infrastructure, policies, and services designed to deliver maternal healthcare. It includes the quality and accessibility of services, the roles and responsibilities of healthcare providers, and the overall efficiency of the health system.

Connecting the Dots: Demand, Supply, and Policy

The interaction between each of these components is further mediated by the demand and supply dynamics within the larger healthcare ecosystem. We identify some of the key points of interaction across these different components (See Table 4), and the 'missing link' across these components (See Table 5), towards reframing the maternal health care agenda in the Indian context.

Table 4: Overview of the points of interaction among different components in maternal healthcare

Key Components	Demand	Supply	Evidence + Policy
Individual	Mothers seeking care for specific needs before, during, and after pregnancy	Access to services available through different systems (Ayurvedic, Homeopathy, Allopathy, etc.) and levels of care (primary care, institutional delivery support, specialized care for high-risk cases)	Policy narrative largely looks at the mother in conjunction with the child and focuses on the child's survival and well-being
Surroundings	Requisite encouragement and support from family and community (no discrimination, absence of barriers for vulnerable communities to seek care) enables health-seeking behavior among mothers so the child's needs are met	Surroundings impact the availability of services that address broader health needs like anemia or protection from domestic violence - services must be responsive to the socio-cultural context of the community	Limited development of policies that support family involvement in maternal health, address socio-cultural barriers and promote community-based health interventions
Health Systems	Ensuring accessibility, availability and affordability of maternal health services, enshrining a rights-based approach to health	Provision of quality maternal health services, adequately trained healthcare providers, sufficient medical supplies, & infrastructure to support maternal care	Evidence through robust data collection and research on maternal health outcomes, implementing policies that enhance maternal health services and resource distribution, integrating a more holistic view of maternal health

Source: Dasra analysis from multiple sources

DELVING INTO HEALTH SYSTEMS: ROLES AND RESPONSIBILITIES

Based on the framing above, we also examine the roles and responsibilities of key players within the system, as they are critical to the delivery and quality of maternal healthcare.

ASHA and ANM Workers

- **Role:** ASHA workers serve as the first point of contact for healthcare in villages, empowering communities, especially women and children, by raising health awareness and accompanying pregnant women for their medical check-ups. ANMs act as supervisors for ASHA and are also entrusted with the provision of maternity care and assistance.
- **Influence:** They track pregnancies, provide health information, and promote better health-seeking behaviors.
- **Challenges:** Both ASHA and ANM workers are frontline ,workers playing a crucial role in the delivery of last-mile health services. While ANM workers are paid a salary across most states, ASHA workers often work long hours as 'honorary volunteers' with limited personal time.

> *"I am the first point of contact but have no personal life. Work is life. If a mother needs me at the hospital, I'll go. My days start early, and odd hours are the norm. It's more than a job; it's a calling, tying my life to the health and happiness of those I serve."*
>
> *- ASHA Worker*

Medical Officers (MOs)

- **Role:** MOs is a trained allopathic physician who provides diagnostic and curative services.
- **Influence:** Their influence extends to ensuring the efficient functioning and quality of curative services.
- **Challenges:** They face challenges in managing health facilities, specifically with respect to addressing resource constraints – shortage of both physical and human infrastructure.

> *"We are here to improve the services to the patients and have big support from our partners. Our commitment is to enhance the quality of care and with strong partnerships, we strive for better outcomes in healthcare delivery."*
>
> *- Medical Officer, PHC Lucknow*

Community Officers and Field Staff in Non-Profit Organizations

- **Role:** These officers are generally females who provide door-to-door counseling for pregnant mothers, offering support and guidance.
- **Influence:** They foster a connection and understanding of maternal health within the community.
- **Challenges:** They work they do is time-consuming and dependent on building trust and honest communication.

> *"Women and families respect us and even offer us tea. The relationships we build through trust and understanding are the foundation of our work."*
>
> *- Community Officer*

A detailed examination of the critical components of the demand-side and supply-side dynamics reveals the breakpoints in the maternal health ecosystem. Breakpoints are posited interconnected challenges that are opportunities within the maternal health ecosystem. These breakpoints present entry points for stakeholders to develop innovative solutions, ensuring that maternal health services are not only comprehensive and accessible but also respectful and responsive to the needs of mothers.

Table 5 : Challenges That Transform into Opportunities: A Strategic Overview of Breakpoints

Broader Categories	Individuals	Surroundings	Health Systems
Knowledge and Evidence	While there is a focus on vulnerable communities, there is a lack of understanding of the different contexts and challenges faced by women and the intersectional nature of identities.	Various stakeholders (state, funders, civil society) are aligned around common outcomes and a core set of values. But there is a major gap between protecting the mother with the intention of protecting the child and not the mother herself with her right to care, self-hood, and health.	Healthcare quality & access for post-partum mothers lack a holistic approach, with post-natal care often focused more on the child than the mother. Quality is largely measured through input & process indicators, while intangible aspects like respectful maternity care receive limited attention & documentation. System-level knowledge remains highly clinical, requiring an expanded definition of care & improved skills to support broader maternal needs.
Access to Care	Access to maternal healthcare remains a significant gap, extending beyond institutional care to include hygiene, emotional support, and a safe environment. Vulnerable communities in remote locations face particularly inadequate support, further exacerbating disparities in care.	A lack of support for vulnerable families, coupled with instances of mistreatment, undermines the dignity of childbirth. Efforts to enable access to services are often framed through an individual lens rather than a community-driven approach, limiting their reach and impact. While community initiatives like Mahila Aarogya Samiti (MAS) and Village Health Sanitation and Nutrition Committee (VHSNC) are designed to foster local engagement and accountability, their infrequent implementation and limited public awareness hinder their effectiveness. This weakens their potential to serve as meaningful tools for ensuring better maternal healthcare outcomes.	Lack of training for outcomes linked to more holistic standard practices in quality care; Inadequate oversight of institutions with respect to standards of care, compliance, safety and security for mothers.

Broader Categories	Mothers/Individuals	Surrounding Contexts	Health Systems
Socio-Cultural Norms	Agency for individual women is missing, which is not solvable by only increasing awareness, since behavior change is a mindset and societal issue. Socio-cultural norms affect care to be provided for the mother despite global health standards; patriarchal norms around the distribution of household resources.	Gap of protecting the mother with the intention of protecting the child and not the mother herself with her own right to care, self-hood, and health. Limited notions of antenatal and post-partum care, focused largely on diet and nutrition; limited attention on mental health, post-partum depression, and other related issues.[34]	Power dynamics between mothers and healthcare providers; obstetric violence, are all mediated by intersectional identities of the mother such as SC/ST or rural background, with low literacy or belonging to low-income groups, etc.
Behavior and Attitudes	Decision-making and responsive care lie in the hands of others, especially for younger mothers.	There is limited dialogue involving fathers, their role in care, and parenting as a unit or a family system. Gender norms are persistent in caregiving.	Apathy of duty bearers and service providers is usually not addressed during skill building, which is essential for dignified maternal care.
Policies and Governance	Policy focus has been on vulnerable communities, but acknowledgment of the inter-sectional identities of mothers is missing. The launch of RMNCAH+N in 2013 some ways has enabled in broadening the focus of maternal care beyond immediate focus on its linkages with child	Focus on community-driven initiatives in form of VHSNC, MAS has been instrumental in spreading awareness regarding health-seeking behaviors among mothers and enhancing their sense of personal autonomy, but gaps in implementation persist.	Standard Operating Procedures (SOPs) are implemented at both national and local levels, but the volume of childbirth and maternal care required in India far exceeds the services available. There is also inadequate oversight of institutions concerning standards of care, compliance, and the safety and security of mothers, further contributing to gaps in maternal healthcare.
Collaboration and Support	There are limited leaders/practitioners advocating for large-scale behavior change covering all stakeholders in the family or household as a unit.	Systemic structures in maternal healthcare lack sufficient focus on rights-based strategies aimed at improving outcomes for individuals. Additionally, there is a need to establish feedback loops & accountability mechanisms within the maternal health system to ensure continuous improvement & responsiveness to community needs.	NGOs often do not collaborate effectively to scale their operations, leading to fragmented efforts in addressing maternal health challenges. There are inadequate field structures to incorporate community voices, particularly from grassroots levels, & there is low awareness of initiatives aimed at improving maternal health. As a result, the perspectives of women in rural & remote areas who rely on these services are often overlooked.

Source: Authors' conceptualization based on literature review and stakeholder consultations

CHAPTER 3:
OVERVIEW OF INTERVENTIONS TO IMPROVE MATERNAL HEALTH

Improving maternal health requires a multi-pronged strategy that considers the individual, community, and health systems. The role of civil society practice in contributing to success in the reduction of infant and maternal mortality rates has been significant. Formulating programs geared towards women, demystifying neonatal & maternal healthcare, and protecting women and children from violence and harm are among the many ways in which NGOs have been at the frontline of public health initiatives. Even the ASHA worker program, used nationally by GoI, is also inspired by the community health worker program of The Comprehensive Health & Development Project – a 1977 NGO program in Panchod (Maharashtra).[35] This section highlights critical interventions implemented by NGOS designed to strengthen maternal health outcomes by focusing on quality care, health system strengthening, behavior change, community engagement, and women's empowerment. For all these interventions, NGOs work in conjunction with the government authorities, community-based organizations and associations, as well as the practitioners in the health system.

1. **Improving the Quality of Care by Supplying Greater Number of Well-Trained Nurses and Midwives**

   The intervention focuses on setting quality benchmarks for institutions that train nurses and midwives, and ensuring these benchmarks are adhered to rigorously. It also focuses on developing facilitator's guides, reference manuals, and job aids to support the capacity building of ASHAs, ANMs, nurses, and MOs, to ensure that women receive appropriate referrals, treatment, and follow-up support. Overall, fostering peer-level training and capacity-building initiatives further strengthens the workforce.

   Level of Intervention: Health Systems

   This intervention strengthens health systems by improving the capacity of nurses and midwives, ensuring high-quality care, and supporting primary healthcare efforts.

2. **Strengthening Public Health Systems by Ensuring Effective Implementation of SOPs**

   Strengthening public health systems involves ensuring the effective implementation of SOPs across health facilities. Apart from training and building the capacity of nurses, assistants, and hospital staff to adhere to SOPs rigorously, it also necessitates that robust monitoring and evaluation systems are in place. These systems enable bringing in greater accountability in the health system. The data gathered also enables in provisioning of critical care to high-risk pregnant mothers promptly.

   Level of intervention: Health Systems

   This intervention primarily affects health systems by reinforcing the standards of care through proper training and adherence to protocols.

3. **Enabling Behavior Change by Supporting Mothers with Health-Seeking Behavior**

   Supporting mothers to improve their health involves equipping them with tools and knowledge to monitor their well-being. This includes providing resources and counseling relating to nutrition and self-care practices, raising awareness on dangers of tobacco use, and adopting preventive measures, such as taking daily folic acid and calcium supplements. To achieve this, reference manuals and community training programs are developed for health workers to educate mothers.

Level of Intervention: Family/Community
By engaging families and communities in promoting healthy practices and preventing health risks, the intervention leverages existing social structures to create a supportive environment for mothers.

4. **Emphasizing Service Delivery through Community Interventions with Mothers and Frontline Workers**
Strengthening service delivery is essential for improving maternal health outcomes. This intervention focuses on bolstering the cadre of frontline workers and technical professionals through targeted training and capacity building. It also facilitates community-based models, such as pregnancy clubs and forums, where mothers can share experiences and receive support. Identifying and training women from local communities as field officers ensures that families receive consistent, high-quality care. These field officers use technology innovations to counsel mothers and families on health and nutritional practices, making care accessible to a wider range of people.

Level of intervention: Family/Community
By building the capacity of frontline workers and conducting group education sessions, this approach strengthens community health and fosters long-term, sustainable improvements.

5. **Focusing on the Agency of Women by Improving Access to Information and Building Awareness**
This intervention prioritizes enhancing the agency of women by improving access to critical information and building awareness on topics such as gender-based violence, family planning, abortion, and women's rights. It also aims to build women's self-confidence in making informed decisions about their bodies and lives. Through counseling and educational initiatives, women are encouraged to assert their agency and take control of their health, mobility, and choices.

Level of Intervention: Individual Level
This intervention empowers women to assert control over their health and well-being, leading to more confident and autonomous lives.

THE INTERVENTIONS IN CONTEXT TO THE GENDER INTEGRATION CONTINUUM

The Gender Integration Continuum serves as a powerful lens to analyze and design programs, categorizing them based on how they engage with and address gender dynamics. It ranges from gender-neutral to gender-transformative approaches, each progressively aiming for deeper engagement with and transformation of gender norms and inequalities. In the context of maternal health, each stage offers unique perspectives and strategies to improve health outcomes for women by addressing gender-specific challenges and barriers. In this paper, we make a case for rethinking the maternal health agenda with a renewed focus on the mother as an individual entity. This framework is adapted to look at maternal health from the mother's point of view, focusing on the barriers and facilitators that influence their access to care and health outcomes. While the original gender-integration continuum has five stages, we illustrate an adapted version split across three stages.[36]

The continuum in the context of development programs and maternal health is described below.

1. **Gender-Neutral Programs**
   These programs are designed to improve health outcomes but do not explicitly acknowledge existing gender norms and the differing needs of men and women. They assume that interventions will have the same impact on all individuals, regardless of gender. For instance, the initiatives in the context of telemedicine and digital health presuppose similar levels of digital literacy, access to mobile phones, and internet usage for both men and women.

2. **Gender-Responsive Programs**
   These programs are designed to ensure equity in health outcomes, and they recognize and respond to the different needs and constraints of individuals based on their gender. They aim to ensure that individuals of various genders benefit from interventions, acknowledging that gender differences affect access to and control over resources and opportunities. For instance, the initiatives focused on the reduction of anemia in women, improvement of nutrition, and ensuring that health education sessions are held at times when women, who often have caregiving duties, can attend would be part of this category. Additionally, these programs might include training for healthcare providers on gender-sensitive care practices and ensuring respectful and equitable treatment of all patients.

3. **Gender-Transformative Programs**
   These programs aim to transform the underlying social norms, roles, and power relations that perpetuate gender inequalities. Promoting gender equality by challenging and changing discriminatory practices and beliefs is the process. A gender-transformative maternal health program would involve community engagement activities that challenge traditional gender roles & promote shared responsibilities in maternal health. For instance, initiatives that encourage men's involvement in maternal health care—such as attending prenatal visits with their partners, counseling for other family members including in-laws, and supporting equitable decision-making in family planning. Similarly, community-driven initiatives like VHSNC meetings and MAS empower women by providing a platform to discuss their grievances relating to health service provision, gain awareness on various aspects of health-seeking behavior and make informed decisions. These programs aim to change societal norms and behaviors around gender, and thereby help in promoting more equitable and supportive environments for women.

We make a case for rethinking the maternal health agenda with a renewed focus on the mother as an individual entity, at the center of healthcare discourse. We argue that reframing maternal health using a gender-transformative lens can address critical breakpoints in maternal health outcomes. By viewing maternal health through this lens, we can better understand and address the social, cultural, and economic factors that influence maternal health and well-being.

By mapping these interventions on a continuum – from gender-neutral to gender-responsive to gender-transformative – we highlight the potential for progression from basic awareness to systemic change. This comprehensive strategy can address immediate health needs while fostering long-term changes. Eventually, applying a gender-transformative lens can build agency and health-seeking behaviors among women, making a dent on gender equity.

Balancing Immediate Needs with Long-Term Transformative Goals

Table 6 illustrates the need for a balanced approach to maternal health that incorporates both immediate, responsive actions and long-term, transformative goals. While gender-responsive interventions address urgent gender-specific needs in the present, gender-transformative interventions aim to alter the underlying norms and power dynamics that perpetuate inequalities over a longer period. This balanced strategy helps with immediate improvement in women's health and fosters systemic changes that promote lasting gender equity.

Even as most of the government initiatives in their current form can be classified as gender-responsive, NGOs have already been making strides in delivering gender-responsive and transformative interventions. Besides directly working with the state in supporting various community-level initiatives, NGOs also have an entire spectrum of initiatives and innovations focused on improving women's overall health. Through direct implementations, NGOs are demonstrating the effectiveness of these interventions by piloting innovative programs, gathering evidence, and advocating for policy changes.

Table 6 : A tabular representation of the gender integration continuum

Intervention Level	Gender-Neutral	Gender-Responsive	Gender-Transformative
Health Systems	Improving the quality of care by supplying a greater number of well-trained nurses and midwives	Strengthening public health systems by ensuring effective implementation of SOPs	
Family/ Community		Emphasizing on present service delivery through community interventions with mothers + frontline workers	Enabling behavior change by supporting mothers with health and care-seeking behavior
Individual			Focusing on the agency of women by improving access to information and building awareness

Source: Author's conceptualization based on literature review and stakeholder consultations

CHAPTER 4: RECOMMENDATIONS

A shift towards a gender-transformative maternal health discourse necessitates multi-stakeholder collaboration, increased resource allocation, and systemic reform. We outline key areas of intervention for government, civil society, and philanthropists.

Government

Currently, the focus on maternal health is largely in the context of its impact on child health, necessitating a need to broaden the focus on women's health. The ambit of interventions needs to expand beyond healthcare to also include an explicit focus on addressing the structural causes of gender-based inequalities in the accessibility of healthcare. The broadened ambit of interventions also provides opportunities for increased collaboration with civil society, given the latter's more evolved understanding of gender transformative interventions.

Philanthropists

The reframing of the maternal health agenda entails building momentum towards under-funded areas of maternal health care, with championing of civil society interventions which are pushing the frontier of innovation. This underscores the need to increase big bets on enabling behavior change, especially in moving focus from supply to generating demand for quality care and holistic services.

Civil Society

While the current interventions of the leading NGOs straddle across gender-responsive and gender-transformative interventions, there is a need to ensure this knowledge transfer to the larger civil society. This dissemination is critical as these interventions entail localized efforts to improve women's agency and are not amenable to scale like some of the other solutions. Evidence generation, training, and capacity building can help facilitate replication of solutions across the sector. There is also a need to integrate the gender transformative lens in their support of community-led interventions with the government.

Mainstreaming a gender-transformative maternal healthcare agenda can bridge key gaps in India's progress toward achieving the SDGs, not only for maternal health indicators but also for gender equity. Maternity is a milestone in a woman's journey to receiving healthcare, addressing their needs at this critical stage can unlock a ripple of change across their lifecycles, and within their communities, and have lasting inter-generational benefits.

CHAPTER 5:
SPOTLIGHT ON NGOS

Based on our landscaping of the sector, and an internal due diligence process, we have identified 16 NGOs that have a mix of gender-responsive and gender-transformative interventions in maternal health. We map the interventions listed above to the focus areas of the NGOs. In the pages below, short profiles of the organizations are detailed. The list of organizations profiled here is indicative and not exhaustive.

Table 7 : Mapping civil society interventions across gender-responsive & gender-transformative approach

S.No.	Name	Improving quality of care by capacity building for nurses and midwives	Strengthening public health systems by ensuring effective implementation of SOPs	Enabling behavior change by supporting mothers with health-seeking behaviors	Strengthening service delivery through community interventions with mothers + frontline workers	Focusing on the agency of women by improving access to information and building awareness
1.	Armman	✓	✓	✓	✓	✓
2.	C3	✓	✓	✓	✓	✓
3.	CEHAT	✓	✓		✓	
4.	Chetna			✓		✓
5.	FMCH			✓	✓	✓
6.	FPA India	✓		✓	✓	✓
7.	Jhpiego	✓	✓		✓	✓
8.	JSS	✓		✓	✓	
9.	Khushi Baby	✓	✓	✓	✓	
10.	Noora Health		✓		✓	✓
11.	PATH		✓		✓	✓
12.	SAHAJ			✓	✓	✓
13.	Sahayog		✓	✓	✓	✓
14.	SATHI		✓		✓	✓
15.	SNEHA		✓	✓	✓	✓
16.	Sukarya			✓	✓	✓

ADVANCING REDUCTION IN MORTALITY AND MORBIDITY OF MOTHERS, CHILDREN AND NEONATES (ARMMAN)

Organisation Overview
Founded: 2008 | **Head Office:** Mumbai| **Budget:** INR 25.2 Cr
Website: https://armman.org/

- **Geographical Focus:** Andaman & Nicobar, Assam, Bihar, Chandigarh, Chhattisgarh, Delhi, Jammu & Kashmir, Haryana, Himachal Pradesh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Tripura, Uttar Pradesh, Uttarakhand, West Bengal, Maharashtra, Telangana
- **Leadership:** Dr. Aparna Hegde
- **Partners and Funders:** Johnson and Johnson, LGT, Google India, VIP Industries, Tara Trusts, USAID, UKaid, SBI Foundation, Skoll Foundation, Chevron, Grand Challenges Canada, Ripple works, GEP Social Initiatives, and Bajaj FinServ

ARMMAN addresses systemic issues contributing to maternal and child mortality in India, focusing on delays in care, accessibility, and quality. Using a tech-enabled approach, they empower women and influence families and communities. ARMMAN aims to improve health outcomes by leveraging the public health system and partner NGOs, targeting 70 million women and children over the next seven years.

Program Overview

ARMMAN leverages the expansive outreach of mobile health technology (mHealth) and the existing health infrastructure to provide preventive care information to women during pregnancy and infancy enabling them to seek care in time. ARMMAN is proactively embracing equity-based and gender-transformative approaches, through innovations in their programs.

Key Interventions

- **Mobile Health Education and Support:** As part of its mMitra initiative, a free mobile voice call service containing preventive care information is provided to enrolled women during pregnancy and infancy in their chosen language and timeslot. There is also live telephonic counselling for caregivers of infants aged 6-36 months with moderate malnutrition.
- **Increased awareness and accountability:** ARMMAN developed an RMNCH course to update ASHA workers on preventive health. The Home-Based Care Training enables frontline workers to conduct diagnostic tests, screen for high-risk factors, and ensure timely referrals. The Integrated High-Risk Pregnancy program trains ANMs, MOs, and
- specialists to manage high-risk pregnancies using color-coded protocols for 20 conditions.

  Respectful Maternity Care (RMC): The organization is working closely with select state governments to improve the data quality by focusing on improving the robustness of the protocols and processes underlying data entry.

CENTRE FOR CATALYZING CHANGE (C3)

Organisation Overview
Founded: 1987 7 (as Centre for Development and Population Activities) | **Head Office:** New Delhi| **Budget:** INR 21.5 Cr

- **Geographical Focus:** Assam, Bihar, Chhattisgarh, Haryana, Jharkhand, New Delhi, Uttar Pradesh, Uttarakhand, Odisha, West Bengal
- **Leadership:** Dr. Suneeta Mukherjee is the Chairperson at C3
- **Partners and Funders:** Amazon, Azim Premji Philanthropic Initiatives, Bill and Melinda Gates Foundation, Barr Foundation, Charities Aid Foundation, Cairn, Flora Family Foundation, Ford Foundation, Global Alliance for Improved Nutrition, The Grassroots

Centre for Catalyzing Change (C3) has been active in India for over 30 years, focusing on improving the condition of women. C3 builds evidence-based solutions for issues like violence against women, barriers to workforce participation, and the integration of gender in reproductive health.

Program Overview

C3 promotes a rights-based approach to sexual and reproductive health (SRH) in India, focusing on childbirth and family planning. Their work spans advocacy, capacity building, program implementation, and research. C3 leverages government programs to scale their initiatives and develops curricula to teach life skills, health education, and promote gender equity. They partner with self-help groups (SHGs), panchayats, and others to strengthen women's political participation and leadership.

Key Interventions

- **Mentoring and capacity building:** C3 is building women's leadership at the grassroots level to enhance their role in governance and decision-making, by mentoring elected women panchayat representatives and training them to address structural problems that perpetuate gender inequalities.
- **Increased awareness and accountability:** A White Ribbon Alliance India campaign led by C3 to help women demand quality reproductive and maternal healthcare, reached over 300,000 women across India and 1.2 million worldwide.
- **Respectful Maternity Care (RMC):** Institutionalizing RMC in the mainstream healthcare provisions and policies through collaboration with professional organizations such as the Indian Council of Medical Research (ICMR) and the Trained Nurses Association of India (TNAI).

CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES (CEHAT)

Organisation Overview
Founded: 1994 (as Research Centre of the Anusandhan Trust) | **Head Office:** Mumbai| **Budget:** INR 7.3 Cr
Website: https://www.cehat.org/

- **Geographical Focus:** Extensive work in Bihar, Odisha, Maharashtra, but pan-Indian operation.
- **Leadership:** CEHAT is led by Director Sangeeta Rege.
- **Partners and Funders:** American Jewish World Service, Ford Foundation, World Health Organization, Azim Premji Foundation, Azim Premji University, Rohini Nilekani Philanthropies, Bajaj FinServ, Sexual Violence Research Initiative, UNFPA, MacArthur Foundation, Tata Trust.
- **Awards and Endorsements:** CEHAT was one of the ten awardees to receive a Grant award from SVRI World Bank Group Development Marketplace for Innovation on Gender-Based Violence Prevention and Response.

Centre for Enquiry into Health and Allied Themes (CEHAT) is at the forefront of reimagining health systems to foster gender-sensitive care and pro-people practices. They leverage research to inform evidence-based actions and advocacy aimed at addressing gendered welfare needs.

Program Overview

CEHAT shapes the narrative on women's and maternal health through research and advocacy, working with state governments to promote gender-sensitive healthcare and health rights for marginalized communities. CEHAT hosts workshops with diverse stakeholders and provides them with gender-sensitive information, and support skills to bring about a change in attitudes, perceptions, and biases.

Key Interventions

- **Maternal Health Research:** CEHAT has conducted several notable studies focusing on women's and maternal health, revealing significant gaps in policy implementation, particularly concerning referral services and emergency obstetric care in Bihar and Odisha.
- **Raising Awareness of Gender-Sensitive Healthcare:** They collaborate with the Maharashtra Government on initiatives such as developing and disseminating awareness materials, training public health functionaries, and raising stakeholder awareness across six state districts. CEHAT continues to play a pivotal role in advancing gender-sensitive healthcare and advocating for the health rights of marginalized communities.
- **Abortion Research:** Conducting studies on abortion needs and practices in rural Maharashtra, alongside surveys on reproductive illnesses in informal settlements in Mumbai and Nashik, with findings from the abortion study anchored in advocating for stricter monitoring of abortion practices in Maharashtra.

CHETNA

Organisation Overview
Founded: 1980 | **Head Office:** Ahmedabad| **Budget:** INR 6.3 Cr
Website: https://www.chetnaindia.org/

- **Geographical Focus:** Gujarat, Madhya Pradesh, Rajasthan
- **Leadership:** Chetna is led by Pallavi Patel (director)
- **Partners and Funders:** Larsen & Toubro Public Charitable Trust, DCM Shriram Foundation, HDB Financial Services, Transform Rural India (TRI)
- **Awards and Endorsements:** Indian CSR Award, Best Women Health Care Initiative (2022)

Chetna works to enhance access to nutrition, healthcare, and education for women, children, and adolescents. The organization employs a life-cycle approach to women's health, offering comprehensive care from childhood through old age, addressing all aspects of physical, mental, and emotional health beyond reproductive roles. Chetna also focuses on optimizing early childhood development, advocating for reproductive and sexual health rights, and increasing HIV/AIDS awareness among adolescents. Additionally, it promotes women's empowerment by fostering confidence, and awareness to access entitlements and improve overall health and well-being.

Key Interventions

- **Training and capacity building:** Conducts training for NGOs, governments, and corporates on gender-sensitive health programs. Provides ongoing mentoring for the implementation of village-level strategies, ensuring equitable health access for underprivileged communities.
- **Advocacy and policy:** Advocates for people-centered, gender-sensitive policies and programs at all levels by including community voices in their formulation. Contributions include the National Health Policy (2018), National Adolescent Health Strategy (2014), National Youth Policy (2014), National Early Childhood Care and Education Policy (2013), National Policy for Children (2013), and Rajasthan State Adolescent and Youth Policy (2006)
- **Communication and Awareness:** Develop interactive and user-friendly Behavior Change Communication (BCC) materials for effectively communicating health and nutrition education tailored for semi-literate and non-literate communities.

FOUNDATION FOR MOTHER AND CHILD HEALTH (FMCH)

Organisation Overview
Founded: 2014 | **Head Office:** Mumbai | **Budget:** INR 3.5 Cr
Website: https://www.fmch-india.org/

- **Geographical focus:** Madhya Pradesh, Maharashtra, Karnataka
- **Leadership:** FMCH is led by Shruthi Iyer (CEO)
- **Partners and Funders:** RBL Bank, Roddenberry Foundation, San Fransisco Foundation, The Waterloo Foundation, Koita Foundation, HDFC Life, Wipro, Blue Star, Meta, The Nudge Institute, MCKS Trust Fund
- **Awards and Endorsements:** Awardee of Acumen Angels Program (2024); CSR Health Impact Awards Gold Category (2022)

Program Overview

FMCH addresses maternal health and malnutrition by providing families in vulnerable communities with timely, actionable information and services. They promote health-seeking behaviors, by providing counseling to mothers on the importance of antenatal and postnatal check-ups, offering guidance on breastfeeding techniques, and advising on nutritious food choices for both mothers and children. Their approach aims to improve maternal health outcomes, reduce child malnutrition, and ultimately break the cycle of poverty.

Key Interventions

- **Counselling and Education:** FMCH identifies and trains local women as field officers to use the in-house developed NuTree app to counsel families on health and nutrition during the first 1,000 days of a child's life. They offer guidance on food, nutrition, lactation, and pregnancy practices, and dispel misconceptions, building trust within communities.
- **Community engagement and peer support:** FMCH runs a community-organized 'Pregnancy Club,' where pregnant women are equipped with requisite knowledge for a healthy pregnancy. This includes guidance on effective breastfeeding, proper nutrition, and the importance of regular antenatal and postnatal checkups. FMCH also builds awareness of the importance of good nutrition and health behaviors through community events and health camps.
- **Health-systems strengthening:** Anganwadi workers, critical in delivering essential health services, often lack adequate training, support, and resources. Through the Anganwadi Accelerator Program, FMCH aims to build the capacity of the Anganwadi system, ensuring sustained reduction of maternal and child malnutrition by building agency and providing support for mothers during the first 1,000 days.

FAMILY PLANNING ASSOCIATION OF INDIA (FPA INDIA)

Organisation Overview
Founded: 1949 | **Head Office:** Mumbai | **Budget:** NA
Website: https://fpaindia.org/

- **Geographical focus:** Bihar, Gujarat, Haryana, Jammu and Kashmir, Jharkhand, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Nagaland, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, West Bengal, and Delhi
- **Leadership:** FPA India is led by Dr Rathnamala M Desai (President) and Dr Kalpana Apte (Director General).
- **Partners and Funders:** Deshpande Foundation, HCL Foundation, IndiaCares, Impact India Foundation, Microsoft, NASSCOM Foundation, The David & Lucile Packard Foundation, Tata Trusts, United Way Mumbai, UNFPA, and Morris Foundation

FPA operates across 18 states and union territories in India, focusing on regions with poor developmental indicators and high gender disparities. It provides essential health services, particularly sexual and reproductive health, reaching over 30 million people annually.

Program Overview

FPA's Maternal and Child Health project has succeeded in 115 villages across Odisha, Jharkhand, and Maharashtra, with plans to expand to 240 more. Key interventions include health camps, treatment for minor ailments, micronutrient supplementation, nutrition distribution, and health awareness sessions focused on nutrition and comprehensive sexuality education for youth.

Key Interventions

- **Global Comprehensive Abortion Care Initiative (GCACI):** Implemented with the aim to enhance access to comprehensive, safe, and legal abortion care and related services, with a special emphasis on reaching marginalized, rural, and displaced groups. This initiative was made possible through sensitization of staff towards people's rights, accompanied referrals facilitated by Five Link workers, a no-refusal policy, customized counseling services, and assured privacy and confidentiality.
- **Messengers of Hope Project:** Launched in 2019, this initiative aims to improve the sexual and reproductive health of adolescent girls and women in Manoramanagar, Thane. The initiative focuses on haemoglobin screening, nutritional supplementation, menstrual health awareness, and comprehensive sexuality education sessions.
- **The Abortion Stigma Project:** This initiative aims to empower young women to exercise their sexual and reproductive rights; to reduce stigma around sexual activity, unintended pregnancy and abortion, and to create a gender-just society, including a youth center to foster safe conversations.

JAN SWAYSTHA SAHYOG (JSS)

Organisation Overview
Founded: 1996| **Head Office:** Bilaspur, Chattisgarh| **Budget:** INR 19.9 Cr
Website: https://www.jssbilaspur.org/

- **Geographical focus:** Chhattisgarh
- **Leadership:** JSS is led by Dr Saibal Jana (President) and Dr Anurag Bhargava (Vice President).
- **Partners and Funders:** Oxfam India, Oxfam Netherlands, Tata Trusts, MacArthur Foundation, Association of India's Development, Terre Des Hommes, AIIMSonians of America, Hospital for Indian, South Eastern Coalfields Limited Hospital for Indian (HFI) Germany, State Bank of India, Bharat Aluminum Ltd. Company, Galaxy Surfactants Ltd., SPA Education Foundation, Jiv Daya Foundation, Rotary Club Bilaspur Midtown, Rotary Club Lake Buena Vista

JSS is a registered non-profit organization of health professionals dedicated to delivering affordable and efficient healthcare services. They operate a community health program and a rural health center, including a hospital, to offer both preventive and curative care to tribal and rural populations in Bilaspur, Chhattisgarh.

Program Overview

JSS provides first-contact health care for common and important health problems, organizing referrals for those problems that they can't manage, education of the communities such as Self-help Groups (SHGs), parents' groups, adolescent girls and boys, support patient support groups such as those for epilepsy and sickle cell disease, organize and run programs for antenatal care, tuberculosis, falciparum malaria, and non-communicable diseases.

Key Interventions

- **iGUNATMAC (Quality Improvement in Maternal and Newborn Healthcare services):** Launched in 2016, Project iGUNATMAC enhances maternal and newborn healthcare across 16 public facilities in six districts of Madhya Pradesh and two in Chhattisgarh. It focuses on training, mentoring, and supervision to strengthen systems that meet Government of India's Quality Assurance standards, improve accountability, ensure continuous care, and advocate for quality assurance expansion in additional facilities.
- **Maternal Death Reviews(MDRs):** Crucial for identifying areas needing improvement in both provider skills and facility processes-insights from MDRs have led to the creation of additional training modules for managing varying conditions in pregnant women. Facilitated by JSS are three-day CMEs for various medical professionals, while the nursing staff mentoring program aims to enhance nursing care, as overall quality improvement requires teamwork among all facility staff.

JOHNS HOPKINS PROGRAM FOR INTERNATIONAL EDUCATION IN GYNECOLOGY AND OBSTETRICS (JHPIEGO)

Organisation Overview
Founded: 1980| **Head Office:** New Delhi| **Budget:** INR 3,262 cr (globally)
Website: https://www.jhpiego.org/

- **Geographical Focus:** Andhra Pradesh, Assam, Bihar, Chhattisgarh, Delhi-NCR, Gujarat, Haryana, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Tamil Nadu, Uttarakhand, Uttar Pradesh, West Bengal
- **Leadership:** Jhpiego is led by Leslie D. Mancuso (CEO)
- **Partners and Funders:** Bill & Melinda Gates Foundation, Children's Investment Fund Foundation, Gavi, the Vaccine Alliance, David and Lucile Packard Foundation, Novartis, Tata Trusts (ĀSMĀN)
- **Awards and Endorsements:** MOMENTUM Award (2020)

Jhpiego collaborates with governments, health experts, and local communities to build the capacity of healthcare providers, develop sustainable health systems, and ensure equitable access to high-quality, lifesaving care. Within India, Jhpiego works across technical areas such as adolescent and youth health, gender and equity, family planning and reproductive health, maternal, newborn and child health, HIV and TB, among others.

Program Overview

Jhpiego focuses on strengthening healthcare systems by fostering innovation, enhancing service delivery, and building capacity among healthcare providers. Their approach combines technology, policy advocacy, and skill development to ensure access to lifesaving care, particularly for underserved communities.

Key Interventions

- **Innovation for Maternal and Newborn Care:** Through the Born Healthy program, Jhpiego is testing an improved antenatal care model in Rajasthan, focusing on maternal infections, supplementation, high-risk pregnancy management, and using technology for efficient diagnostics and digital records.
- **Integrated Women in Health Network Project (iWIN):** Based in Madhya Pradesh, this initiative leverages technology and innovative financing to address systemic and operational challenges in maternal and newborn care, integrating machine learning, point-of-care diagnostics, and empowering healthcare workers through comprehensive training.
- **Training and capacity building:** Training and Capacity Building: Since 2018, Jhpiego has supported the GoI in enhancing nursing education to develop Nurse Practitioner Midwives (NPMs) as a separate cadre.. This initiative aims to provide standardized resources, technical guidance, and policy support to promote woman-centered maternal care.

KHUSHI BABY

Organisation Overview
Founded: 2014| **Head Office:** Udaipur| **Budget:** INR 5.2 Cr
Website: https://www.khushibaby.org/

- **Geographical Focus:** Andhra Pradesh, Karnataka, Maharashtra, Rajasthan
- **Leadership:** Khushi Baby is led by Ruchit Nagar (CEO)
- **Partners and Funders:** Government of Rajasthan, PATH, ARMMAN, Jhpiego, Wadhwani AI, Microsoft Research, Google Health
- **Awards and Endorsements:** PATH Primary Health Care Technology Challenge-Digital Health (2022); PATH Climate x Health Challenge-Risk Mitigation and Adaptation (2022), Social Innovation Health Care Initiative, India Healthcare Excellence Award (2022)

Khushi Baby uses a digital platform to monitor and strengthen community health, especially maternal and child health in last-mile settings. They do this by improving access to longitudinal and informed care, clinical decision-making, and data accountability for healthcare workers and beneficiaries.

Program Overview

Khushi Baby employs innovative technologies such as Near Field Communication, biometrics, GPS, artificial intelligence, and voice-assisted regional language engagement, working across areas such as reproductive, maternal, newborn, and child health (RMNCH), non-communicable diseases (NCDs), and communicable diseases.

Key Interventions

- **Improved monitoring of service provision:** The in-house Community Health Integrated Platform (CHIP) provides an offline mobile health interface for tracking health indicators, supporting ASHAs, ANMs, and Medical Officers with decision-support, care coordination, education, and streamlined reporting. CHIP includes a dedicated evidence-based module for the RMNCH continuum of care: family planning, antenatal care, intrapartum care, and childcare.
- **Tech-supported targeted interventions towards high-risk groups:** Khushi Baby supports Departments of Health across Indian states with data analytics, aiming to enhance care delivery at the grassroots level through four key strategies. They focus on improving data quality among community health workers, predicting risks for vulnerable beneficiaries, highlighting at-risk communities, and optimizing communication interventions (e.g., target messaging campaigns) to improve health outcomes.

NOORA HEALTH

Organisation Overview
Founded: 2014| **Head Office:** San Francisco| **Budget:** INR 66.2 Cr (Globally)
Website: https://noorahealth.org/

- **Geographical Focus:** India (Andhra Pradesh, Haryana, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Punjab, and Telangana), Bangladesh, Indonesia (East Java)
- **Leadership:** Noora Health is led by Co-Founders and Co-CEOs Shahed Alam and Edith Elliott
- **Partners and Funders:** Ashoka, Henry Ford Health, Jhpiego, Mulago, MacKenzie Scott, USAID, Skoll, World Economic Forum
- **Awards and Endorsements:** TED Audacious Project Grantee (2022); Skoll Foundation Award for Social Innovation (2022)

Noora Health envisions a world where patients and their caregivers are a core component of healthcare delivery, and family-member training is a standard of care. They have achieved this by creating a scalable program for caregiving education and training which is delivered to families by trained healthcare providers. This approach seeks to expand the care umbrella to include those closest to the patient — their family and community.

Program Overview

By placing patients and their families at the center of the healthcare journey, Noora Health aims to transform patient outcomes through collaboration with health systems and governments. The program's focus areas include maternal and newborn health, cardiac care, oncology, tuberculosis, COVID-19 care, non-communicable diseases, general medical care, and surgery.

Key Interventions

- **Identify priority family care practices:** Partners with local health systems including hospitals and community clinics to identify health conditions that drive morbidity and mortality but can be prevented through home-based actions, such as managing medications or recognizing warning signs
- **Awareness building:** Develops high-quality, culturally contextualized, and medically accurate multimedia materials including open-access digital resources to support program implementation
- **Training and capacity building:** Integrate initiatives into hospitals and clinics by training healthcare workers to lead caregiver sessions and coach colleagues
- **Post-discharge support:** Supports families post-discharge with additional training and information through a remote engagement service, creating a reliable on-demand support network

PATH

Organisation Overview
Founded: 1977| **Head Office:** New Delhi | **Budget:** INR 3023 Cr (Globally)
Website: https://www.path.org/

- **Geographical Focus:** Gujarat, Assam, Maharashtra
- **Leadership:** Neeraj Jain, Director Growth Operations, Asia, Middle East, and Europe
- **Partners and Funders: :** https://www.path.org/who-we-are/annual-report-2023/supporters/

PATH has been strengthening public health in India for over four decades. By collaborating with public and private partners, PATH addresses health challenges, shares technical expertise, and supports local innovation. The organization forms partnerships to develop, adapt, and scale solutions that advance health equity.

Program Overview

PATH is dedicated to reducing the disease burden in India. The organization collaborates with several states to bring sustainable improvements to health systems, tackling India's health challenges through innovation and partnerships.

Key Interventions

- **MNCH Accelerator- Saksham:** Under this initiative, PATH India works towards improving access to high quality MNCH services especially in remote and tribal areas, deploying a blend of expertise in capacity building, private provider engagement, and community participation. Through the Aavishkar Challenge, Saksham identified low-cost and high-impact innovative solutions that can contribute towards improving MNCH outcomes. The initiative also facilitated the formation of the National Technical Advisory Group (NTAG), a first-of-its-kind MNCH, adolescent health, and nutrition expert group to serve as a national platform to foster the sharing of experiences among a diverse set of stakeholders.
- **Family planning supply chain management:** PATH in India has worked with the government to increase access to affordable, high quality reproductive health supplies, contraceptives, and medicines. We have provided technical support to eight states in India to strengthen the supply chain of contraceptives to far-flung areas.
- **Establishing Comprehensive Lactation Management Centers (CLMCs):** In India and Nepal, we provide technical support to establish (CLMCs) that improve early and exclusive breastfeeding, provide safe donor human milk to at-risk babies, and increase the use of kangaroo mother care. We also help support the development of affordable and easy-to-use tools and technologies to increase access and uptake of human milk.

SAHAJ

Organisation Overview
Founded: 1984| **Head Office:** Gujarat | **Budget:** INR 2.4 Cr
Website: https://www.sahaj.org.in/

- **Geographical Focus:** Gujarat, Assam, Maharashtra
- **Leadership:** Renu Khanna, Co-founder & Trustee

Society for Health Alternatives (SAHAJ), works across sectors to address the social determinants of health, particularly for women, adolescents, and marginalized communities, with a key focus on equity. The organization has been instrumental in translating policy into practice, both in urban and in rural areas, by supporting participatory research, building leadership among grassroots actors, and working in close collaboration with civil society networks and public institutions.

Program Overview

SAHAJ implements programs that center adolescent, youth and women's leadership to improve sexual and reproductive health and rights in underserved areas. The organization's initiatives are grounded in a belief that young people must be active agents in shaping their health outcomes. Through peer education, leadership development, and accountability processes, SAHAJ enables youth—especially girls and those from marginalized communities—to influence systems and services that affect their lives. Their work spans tribal and urban low-income areas in Gujarat, focusing on health equity, access to SRHR information, and gender-transformative community engagement.

Key Interventions

- **Social Accountability for Health Systems Strengthening:** SAHAJ places social accountability at the center of its programming by building capacities of women, adolescents and youth to collect data, analyze gaps in health service delivery, and present findings to local authorities. They have enabled the formation of women's collectives and adolescent forums, which conduct health rights assessments and demand redressal through structured dialogues with state actors, improving responsiveness and inclusiveness in the system
- **Community Participation and Monitoring:** SAHAJ supports community-based organizations in forming and strengthening women's collectives to demand better maternal health services. These collectives review services at anganwadis and health centers and engage with local governance structures like the Village Health Sanitation and Nutrition Committees to address issues in maternal care delivery
- **Youth Leadership on SRHR:** SAHAJ builds youth leadership through its Youth-led Accountability program, engaging adolescent girls and boys in participatory research, community dialogues, and interface meetings with duty-bearers. These young leaders monitor SRHR services and advocate for improvements in access and quality.
- **Community Score Cards and Social Audits:** In partnership with local health institutions and governance bodies, SAHAJ has institutionalized tools like community scorecards to assess the availability and quality of adolescent health services. These platforms create space for youth and women to hold providers accountable in constructive, evidence-based ways.

SATHI- SUPPORT FOR ADVOCACY AND TRAINING TO HEALTH INITIATIVES

Organisation Overview
Founded: 2007| **Head Office:** Pune, Maharashtra| **Budget:** NA
Website: https://sathicehat.org/

- **Coverage (geography):** Maharashtra (13 districts covering about 800 villages)
- **Leadership:** Prof. Dr. Vibhuti Patel, Managing Trustee of Anushandhan Trust
- **Partners and Funders:** Azim Premji Philanthropic Initiatives, Association for India's Development (AID), Population Action International (PAI), Bajaj Housing Finance Ltd, Bajaj Finserv Limited, EdelGive Foundation, and National Health Mission (NHM), Maharashtra.

Support for Training and Advocacy to Health Initiatives (SATHI) works on health rights issues, through partnerships with civil society organizations to progress health rights issues and facilitates advocacy at the various levels of bureaucracy. Centering a rights-based approach, the organization promotes the perspective that it is essential to make public health systems accountable and responsive to public needs.

Program Overview

SATHI has implemented community-based monitoring (CBM) as part of the National Rural Health Mission since 2007. As a state nodal NGO, they coordinate CBM activities across districts with stakeholders and the State health department. A key tool is 'village report cards,' filled by community representatives with guidance from NGOs/CBOs, covering health, living conditions, care quality, fund utilization, and adverse outcomes.

Key Interventions

- **Strengthening Maternal and Child Health and Nutrition services through Women's Group participation:** Strengthening access to maternal and child health nutrition services in the tribal area of four districts of Maharashtra by empowering the local community, and raising awareness of government schemes and nutrition services, thereby improving ANC, PNC and reducing malnutrition.
- **Improving maternal health and nutrition services for urban poor:** They empowered pregnant and lactating women by improving awareness about public health and nutrition services and increasing access to these services through local interventions. This includes project orientation workshops conducted for officers and other community-level stakeholders to enlist their involvement in the project, including frontline service providers ANM, Anganwadi, and ASHA workers, in the selected slum areas.

SAHAYOG

Organisation Overview
Founded: 1992| **Head Office:** Lucknow, Uttar Pradesh| **Budget:** INR 1.6 Cr
Website: https://sahayogindia.org/

- **Geographical Focus:** Uttar Pradesh, Uttarakhand, West Bengal
- **Leadership:** SAHAYOG is led by Dipta Bhog as Chairperson
- **Partners and Funders:** Oxfam, MacArthur Foundation, Ford Foundation, Department for International Development, King Baudouin Foundation

SAHAYOG engages in capacity-building, research, and documentation, publications and advocacy with network partners working in women's health and gender equality. In 2000, they relocated headquarters from Almora to Lucknow with a defined vision of working on Sexual and Reproductive Health Rights of women and youth, nutrition, gender-based violence, food security and addressing social determinants of health.

Program Overview

SAHAYOG works on maternal health services, nutrition and food security for women and adolescent girls, and access to reproductive and sexual health services. They emphasize the participation of women and youth in program design and accountability and involve men and boys in gender equality efforts, including preventing violence against women.

Key Interventions

- **Mahila Swasthya Adhikar Manch (MSAM):** A key part of SAHAYOG's work on Sexual and Reproductive Health Rights, MSAM is a grassroots forum of 8,000 marginalized women, including rural, Dalit, tribal, and Muslim women, operating across eight districts of Uttar Pradesh since 2006. MSAM advocates for better public health through campaigns, dialogues, data collection, and monitoring services, engaging at local and district levels.
- **Tarang forum for adolescents and youth:** Launched in 2007, SAHAYOG works with young people to raise awareness on Youth Sexual and Reproductive Health Rights using a leadership approach. The Tarang forum empowers youth to learn about their health and rights and take collective action for community betterment.
- **Lead behavioural change among men:** Along with women and girls, they also work with men to bring about behavior change, engaging them to take responsibility for the health and rights of women and girls. They pioneered involving men as allies, such as the Men's Action for Stopping Violence Against Women (MASVAW) network – which served as a model for other similar networks to work with men and boys towards gender justice.

SOCIETY FOR NUTRITION, EDUCATION AND HEALTH ACTION (SNEHA)

Organisation Overview
Founded: 1999| **Head Office:** Mumbai| **Budget:** INR 30 Cr
Website: https://www.snehamumbai.org/

- **Geographical Focus:** Mumbai and its suburbs
- **Leadership:** SNEHA is led by Vanessa D'Souza (CEO) and Archana Redkar (COO)
- **Partners and Funders:** HT Parekh Foundation, Koita Foundation, Mariwala Health Initiative, Harish and Bina Shah Foundation, ATE Chandra Foundation, The Wellcome Trust
- **Awards and Endorsements:** Tejaswini Award by Earth NGO for Prevention of Violence against Women and Children Program (2021); Winner Urban Nutrition Category for Child Health and Nutrition Program (Aahar) (2019)

SNEHA works with vulnerable communities and public health systems, including municipal bodies and local clinics, to develop evidence-based models tackling urban health challenges. Its key focus areas are maternal and child health, preventing violence against women and girls, and adolescent empowerment.

Program Overview

SNEHA seeks to improve community capacity to access public health services and collaborates with health systems to enhance service quality. Addressing gender-based inequities, a core factor in health disparities is central to all its programs.

Key Interventions

- **Health-system strengthening:** Supports existing government health and safety systems to improve the quality of healthcare delivery. They partner with municipal corporations in and around Mumbai to strengthen maternal and newborn referral processes and build the capacity of primary healthcare providers. This includes enabling providers to carry out effective awareness-building interventions in communities. For example, the early identification of pregnant women to encourage timely access to antenatal, perinatal, and postnatal care services.
- **Empowering Communities:** To build a strong volunteer-driven culture, SNEHA establishes Community Advisory Groups (CAG) and trains community residents to hold Anganwadis accountable for their service delivery. They also conduct public awareness campaigns to increase the uptake of Integrated Child Development Services (ICDS).
- **Research and Advocacy:** Prioritizes research, monitoring and evaluation, and impact mapping to create evidence-based health intervention models that inform policy and drive change

SUKARYA

Organisation Overview
Founded: 1998| **Head Office:** Gurugram| **Budget:** INR 2.3 Cr
Website: https://sukarya.org/

- **Geographical Focus:** Delhi, Haryana, Rajasthan
- **Leadership:** Sukarya is led by Meera Satpathy (founder and chairperson)
- **Partners and Funders:** Girls Opportunity Alliance, Give2Asia, Give India, Eran Fund for Women, Wipro, Godfey Philips India Limited, Fidelity International, Pidilite, Bharat Petroleum, Ambuja Cement, HCL Infosystems, Maruti Suzuki, TATA, IDFC Limited

Sukarya works towards improving maternal and child health outcomes by preventing malnutrition and anemia among vulnerable communities. It empowers women by enhancing their physical, and emotional well-being, and economic stability, and educates children and youth to lead healthier, more dignified lives. Additionally, Sukarya champions gender equality, equity, and justice in all its initiatives.

Program Overview

Sukarya focuses on advancing health, nutrition, and gender equity through community-driven initiatives. Its programs target underprivileged and rural populations, emphasizing maternal and child health, adolescent empowerment, and livelihood promotion. By fostering partnerships and leveraging local networks, Sukarya integrates healthcare services, education, and capacity-building interventions to create sustainable impact.

Key Interventions

- **Rural Community Health Action Program:** Strengthens detection, treatment, and prevention of anemia and malnutrition among mothers and children, improves immunization coverage, and enhances access to health checkups, vaccination, and essential medicines to reduce maternal and child morbidity.
- **Enhancing women's agency:** Empowers adolescent girls (aged 10-19) by providing education on reproductive and sexual health, gender discrimination, and WASH best practices. Enhances digital literacy among adolescent girls to improve employability.
- **Promoting entrepreneurship:** Empowers rural women through self-help groups, promoting livelihoods, building confidence, and facilitating skill development, resource pooling, revenue generation, and market linkages.

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