Natal, Pre-natal and Post-natal Healthcare

Maternal and child health is recognized as one of the most crucial aspects of public health globally. A woman's health during pregnancy, childbirth, and the immediate period following delivery determines not only her own survival and well-being but also that of the newborn. According to the World Health Organization (WHO), maternal healthcare can be divided into three interlinked stages: **pre-natal care** (before birth), **natal or intra-natal care** (during delivery), and **post-natal care** (after birth).

Globally, maternal mortality has declined substantially over the past two decades, yet disparities remain stark. The United Nations Population Fund (UNFPA) estimates that nearly **287,000 women died of preventable causes related to pregnancy and childbirth in 2020**, with the majority concentrated in low- and middle-income countries. Similarly, the neonatal mortality rate—deaths within the first 28 days of life—remains high, with **2.4 million newborn deaths recorded in 2019** worldwide. These statistics highlight that maternal and newborn health is a global concern requiring international cooperation, effective laws, and robust healthcare delivery systems.

Pre-Natal Healthcare: The Global Scenario

Definition and Importance
Pre-natal (or antenatal) care refers to the healthcare provided to women during pregnancy before childbirth. WHO recommends a minimum of **eight antenatal visits**, where expectant mothers receive medical check-ups, nutritional guidance, screenings for complications, and counseling.

International Situation

- **Developed Countries:**
    - In countries such as **Sweden, Norway, and Finland**, pre-natal care is universal, free, and accessible. Maternal mortality rates in these countries are among the lowest in the world. For example, Finland records less than **3 maternal deaths per 100,000 live births**.
    - The **United States**, despite advanced medical technology, has one of the highest maternal mortality rates among high-income countries—about **23.8 deaths per 100,000 live births in 2020**—due to racial disparities, unequal access, and inadequate pre-natal coverage for low-income women.
- **Developing Countries:**
    - In **Sub-Saharan Africa**, access to quality pre-natal care is inconsistent. WHO reports that only **52% of pregnant women** attend the recommended four visits, and often healthcare centers lack essential equipment and skilled personnel.

    - **South Asia** (India, Pakistan, Bangladesh) has seen improvements due to government programs like India's Janani Suraksha Yojana (JSY), but rural women still face barriers such as transport, stigma, and cost.

- **Global Initiatives:**
    - The **Sustainable Development Goal (SDG) 3.1** aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.
    - WHO's **Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)** emphasizes strengthening pre-natal care, especially in fragile health systems.

Natal Healthcare: The Global Situation

Definition and Importance
Natal healthcare refers to care provided **during childbirth**. This stage is the most critical because maternal and neonatal deaths often occur during labor or within the first 24 hours of delivery. Safe natal care requires **skilled birth attendants**, emergency obstetric facilities, and proper referral systems.

International Situation

- **Developed Countries:**
    - Nations like the **UK, Canada, and Germany** ensure that nearly all births are attended by skilled professionals (midwives, doctors, or nurses). Cesarean sections are widely available, though rising rates of elective C-sections have sparked debates on over-medicalization.
    - Maternal deaths during delivery are extremely rare due to advanced obstetric technologies.
- **Developing Countries:**
    - In **Sub-Saharan Africa**, only about **60% of births are attended by skilled health personnel**, compared to near-universal coverage in high-income nations.
    - Countries like **Ethiopia and Nigeria** still face severe shortages of skilled attendants, contributing to high maternal and neonatal deaths.
- **International Interventions:**
    - The **Safe Motherhood Initiative (1987)** launched by WHO and partners highlighted the need for skilled birth attendance globally.

- Programs like **Every Woman Every Child** and the **Global Financing Facility** focus on financing and scaling up maternal healthcare services, especially during childbirth.

Post-Natal Healthcare: The Global Situation

Definition and Importance
Post-natal care refers to healthcare provided to the mother and newborn immediately after birth and for the first **six weeks (42 days)**. It includes monitoring recovery from childbirth, breastfeeding support, immunization, nutrition counseling, and detecting complications like postpartum hemorrhage or depression.

International Situation

- **Developed Countries:**
  - Countries in **Europe and Scandinavia** provide extended parental leave policies, ensuring mothers have time for recovery and bonding with newborns. For example, **Norway offers 49 weeks of fully paid parental leave**.
  - Healthcare systems provide free or low-cost home visits by midwives/nurses within the first week after birth.
- **Developing Countries:**
  - In **South Asia**, post-natal care is often neglected compared to pre-natal and natal care. Studies in India and Bangladesh show that less than **40% of women receive post-natal check-ups** within 48 hours of delivery.
  - In **African countries**, cultural practices sometimes delay post-natal visits, leading to missed opportunities to prevent neonatal infections and maternal complications.
- **Global Policies:**
  - WHO recommends **three post-natal visits**: within 24 hours, between 3–7 days, and at six weeks postpartum.
  - UNICEF and WHO have emphasized early initiation of breastfeeding within one hour of birth as a key post-natal practice to reduce neonatal mortality.

International Legal and Policy Frameworks

1. **Universal Declaration of Human Rights (1948):** Recognizes the right to health and well-being, including maternity care.

2. **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979):** Requires states to ensure access to maternity and healthcare services.
3. **International Conference on Population and Development (1994, Cairo):** Stressed maternal health and safe motherhood as integral to reproductive rights.
4. **Sustainable Development Goals (2015–2030):** Goal 3 targets maternal and neonatal mortality reduction.
5. **WHO Recommendations (2016):** Emphasize evidence-based guidelines for antenatal, natal, and postnatal care.

Comparative Country Experiences

- **Sweden and Finland:** Exemplify best practices with universal coverage, strong midwifery-led systems, and negligible maternal deaths.
- **United States:** Struggles with racial inequities—African American women are three times more likely to die from childbirth-related causes compared to white women.
- **India:** Has reduced maternal mortality ratio from 556 (1990) to 103 (2019), but rural-urban disparities remain high.
- **Nigeria:** Contributes to nearly **20% of global maternal deaths**, reflecting weak healthcare systems.
- **Brazil and Argentina:** Expanded universal maternal healthcare under socialized health schemes, significantly reducing maternal mortality.

Challenges in the International Situation

1. **Inequity in Access:** Wealthier nations ensure universal coverage, while low-income countries face systemic healthcare shortages.
2. **Cultural Barriers:** In many regions, traditional practices or gender norms delay seeking medical care.
3. **Economic Constraints:** High out-of-pocket costs in countries lacking universal healthcare discourage hospital deliveries.
4. **Shortage of Skilled Professionals:** WHO estimates a global shortage of **7.2 million midwives and nurses**.
5. **Conflict Zones:** War-torn countries like Syria and Yemen see disproportionately high maternal mortality due to collapsed health systems.

6. **Over-medicalization in High-Income Countries:** Rising rates of unnecessary C-sections increase risks for both mother and child.
7. **Neglect of Post-Natal Care:** Despite being crucial, post-natal care remains the weakest link globally.

The Future…

1. **Universal Health Coverage (UHC):** Ensure free or subsidized maternal healthcare, especially in low-income countries.
2. **Investment in Midwifery:** Training and deploying skilled birth attendants is the single most effective intervention.
3. **Integration of Services:** Combine maternal care with nutrition, family planning, and child health programs.
4. **Technology and Telemedicine:** Use mobile apps and teleconsultations to reach rural women.
5. **International Aid and Partnerships:** Strengthen global financing (through WHO, UNICEF, World Bank) to support maternal programs.
6. **Addressing Inequities:** Tailored programs to reduce racial, geographic, and economic disparities in healthcare access.
7. **Promoting Post-Natal Care:** Greater emphasis on follow-ups, breastfeeding support, and mental health screening for mothers.

The international situation of natal, pre-natal, and post-natal healthcare presents a **mixed picture**—while developed nations have largely achieved universal maternal healthcare with low mortality, low- and middle-income nations continue to grapple with preventable deaths and inequitable access. Global initiatives like the SDGs, WHO guidelines, and international treaties provide frameworks, but translating them into ground realities requires political will, funding, and cultural change.

Maternal and newborn health is not just a medical issue—it is a **human rights imperative**. Guaranteeing safe and accessible healthcare across all three stages—before, during, and after birth—can transform maternal survival rates and secure a healthier future for generations worldwide.

Natal, Pre-Natal, and Post-Natal Healthcare in India and Associated Laws

Introduction

Maternal health—encompassing pre-natal (antenatal), natal (during delivery), and post-natal (after birth) care—is crucial to reducing maternal and infant mortality and morbidity. In India, improvements over the past decades have been substantial, but they remain uneven, with gaps across states, rural vs urban, socio-economic strata, and among marginalised communities. Legal and policy initiatives, backed by constitutional mandates and national schemes, have attempted to ensure that women have access to adequate care before, during, and after childbirth. But despite this, many problems persist: access, quality, equity, social and cultural barriers, infrastructure, human resources, and enforcement of laws.

Statutory, Constitutional, and Legal Foundations

Before looking at healthcare delivery and statistics, it is important to understand the legal and constitutional underpinnings that mandate or enable pre-natal, natal, and post-natal care in India.

1. **Constitutional Provisions**
    - *Article 21* of the Constitution of India guarantees the right to life and personal liberty. The Supreme Court has interpreted this to include a right to health and well-being. Maternal health, being essential to life, comes within this ambit.
    - *Article 14* (Equality) and *Article 15* (prohibition of discrimination) can also be used to challenge discriminatory practices in maternal care (e.g. access differences by caste, religion, marital status).
    - *Directive Principles* (in Part IV) such as Article 47 (duty of State to raise the level of nutrition and standard of living and to improve public health) impose a duty on the State to ensure maternal health services.
2. **Key Statutes and Regulations**
    - **Maternity Benefit Act, 1961 (amended 2017)**
      This law provides for maternity leave for women employed in establishments. Under the 2017 amendment:
      • First two children: 26 weeks paid maternity leave (with some distribution between pre- and post-natal periods).
      • Subsequent children: 12 weeks.
      • Also provisions for leave in case of miscarriage or medical termination, leave for tubectomy, etc.
    - **Medical Termination of Pregnancy (MTP) Act, 1971 (amended 2021)**
      While this is more directly about termination of pregnancy (which is

tangentially related to maternal health, pre-natal care etc.), it influences access to safe healthcare in pregnancy, especially in unwanted pregnancy situations. The 2021 amendments broadened access in some respects (e.g. easing spousal consent constraints, etc.).

- **Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT Act)**
  This law aims to prevent misuse of prenatal diagnostic techniques (ultrasound, etc.) for sex-selection, which has both ethical and public health implications (skewed sex ratios, unsafe abortions etc.). It regulates diagnostic clinics, ultrasound machines etc.

- **Right to Health Laws and State Legislation**
  Some Indian states have adopted more specific laws, e.g. the *Rajasthan Right to Health Care Act, 2022*, which gives residents the right to free outpatient and inpatient services in public health facilities (and certain private ones) in that state. While not specific to maternal care, it helps strengthen access.

- **Other related statutes** include those that secure rights of women, such as laws against domestic violence, laws securing child rights, and constitutional protections, which indirectly impact maternal health outcomes by influencing social determinants like safety, autonomy, nutrition, gender equality.

3. **Policy Schemes & Programme Frameworks**

Alongside laws, India has rolled out several national programmes aimed at improving maternal and child health, including pre-, natal and post-natal services. Some of the major ones:

- **National Health Mission (NHM)** (which subsumes the earlier NRHM—National Rural Health Mission) with components aimed at maternal health, including Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakararm (JSSK), etc.

- **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)** — providing guaranteed antenatal care for women in the second/third trimester on a fixed day in public health facilities.

- **Janani Shishu Suraksha Karyakaram (JSSK)** — focuses on free services for pregnant women and sick infants, including transport, stay, diet etc.

- **Janani Suraksha Yojana (JSY)** — a conditional cash transfer scheme to encourage institutional deliveries.

- **Nutrition programmes** such as the Integrated Child Development Services (ICDS) and National Nutrition Mission, which contribute to maternal nutrition during pregnancy and postpartum.

The Statistical & Service Delivery Picture: Pre-Natal, Natal, Post-Natal Healthcare in India

This section describes how far India has come, where it still lags, comparing across states and socio-economic categories, focusing on coverage, quality, equity.

1. **Pre-Natal / Antenatal Care**
    - Antenatal care (ANC) is vital for early detection of complications (e.g. hypertension, anaemia), provision of nutritional supplementation (iron, folate), immunisation (e.g. tetanus), health education etc.
    - According to NFHS (National Family Health Survey) data and other sources, the coverage of ANC has increased substantially over the decades. For example, more pregnant women are now attending at least one ANC visit, many are attending 4 or more visits (though WHO recommends 8 contacts).
    - However, significant disparities exist: by state, rural/urban, income, education. Some states (especially in southern India) have high ANC utilization; many poorer and North-East or Empowered Action Group (EAG) states lag behind.
2. **Natal / Intra-Natal Care / Delivery Care**
    - Institutional deliveries (births in hospitals or health facilities) have increased greatly. This is a key factor in reducing maternal mortality. Skilled birth attendants are more broadly available now.
    - Still, quality is uneven: many facilities especially in rural/remote areas may lack fully functional obstetric care, emergency referral, adequate staffing, hygiene, etc. Delays (in reaching facility, in getting care once there) remain problematic.
    - Caesarean section rates are rising, with variation across states and between private vs public facilities. Sometimes, C-sections are medically unnecessary, which also carries risks.
3. **Post-Natal (Postpartum) Care**
    - Post-natal care (PNC) for the mother and newborn is often the most neglected stage. The first 24 hours after birth are high risk for both. WHO recommends at least 3 postnatal visits: within 24 hours, between 3-7 days, and around 6 weeks.

- From recent data: NFHS-5 and other studies show that coverage of PNC has improved. For example, in their article, India's postnatal care coverage for mother or baby within 2 days of delivery improved from ~13.4% in NFHS-2 to ~82.8% in NFHS-5.
- Another study draws attention to the persistent exclusion: in a large sample (190,797 women) about **25.2% of newborns** and **63.4% of women** received postnatal care within 24 hours; within 48 hours, newborns about 27.1% and women 65.2%.

4. **Trends in Maternal Mortality Ratio (MMR) & Neonatal Mortality**
   - India's MMR has been falling, though not uniformly across regions. States with better infrastructure, higher literacy, and stronger health systems have seen sharper declines. (Exact current numbers vary, but NFHS, Sample Registration System show ongoing improvement.)
   - Neonatal mortality has also dropped, though early neonatal mortality (first week) remains a challenge, especially when postpartum care is delayed or suboptimal.
5. **Continuum of Care / Disparities**
   - Utilisation of the full continuum (ANC → Institutional delivery → Postnatal care) is still far from universal in many states. For rural India, some states show full continuum use of under 40%. For example, in some EAG states like Bihar, Jharkhand, Uttar Pradesh etc., rates are relatively low.
   - Socio-economic status, maternal education, caste, religion, geography (state, district, rural vs urban), access to transport, proximity to health facilities—all continue to influence whether women get full care.
6. **Nutrition and Other Health Interventions**
   - Maternal nutrition (e.g. anaemia) remains a problem. Large proportions of pregnant women are anaemic, which affects both maternal and neonatal outcomes.
   - Supplementation programmes, counselling, deworming, immunisation (especially tetanus), and periodic screening (blood pressure, sugar etc.) are part of pre- and post-natal care, but coverage is uneven in remote or poorer areas.

Policies, Programme Interventions & Recent Reforms

India has put into effect several measures and reforms in recent years to try to strengthen pre-, natal and post-natal care.

1. **Janani Suraksha Yojana (JSY)**
    - Launched under the NHM, JSY provides conditional cash incentives to pregnant women to deliver in health facilities. The goal is to reduce home births, increase institutional deliveries, and hence reduce maternal mortality.
    - JSY has contributed to very large increases in institutional births nationwide.
2. **Janani Shishu Suraksha Karyakram (JSSK)**
    - JSSK ensures free services to pregnant women and sick infants—this includes free delivery, free drugs, diagnostics, transport to and from facility, and free drop-back after delivery.
3. **Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)**
    - A guarantee of free quality antenatal services to pregnant women in public facilities during second and third trimester, once every pregnancy, on 'Surakshit Matritva Diwas'.
4. **Maternity Benefit (Amendment) Act, 2017**
    - Extended maternity leave, included adoptive mothers and commissioning mothers in case of surrogacy, increased benefits, etc. This law supports pre- and post-natal care indirectly by ensuring that women have income protection and leave.
5. **Regulatory Laws**
    - PCPNDT Act (1994) to regulate prenatal diagnostics and prevent sex-selection. It helps ensure that pre-natal diagnostic techniques are not misused.
    - MTP Act and its amendments ensure regulation of abortion services to reduce unsafe abortion. Some unsafe abortion incidents contribute to maternal mortality.
6. **Recent State Laws**
    - *Rajasthan Right to Health Care Act, 2022* is an example of state-level legislation that promises the right to free healthcare (OPD/IPD) in public and select private facilities. Although not specifically limited to maternal care, such laws help to remove cost-barriers for pre-natal, natal, post-natal care.
7.

8. **Other supportive measures**
    - Role of community health workers (e.g. ASHAs) in home-based newborn care, counselling, visits after delivery etc.
    - Special Newborn Care Units (SNCUs) and facility upgrades to manage complications.
    - Nutritional programmes (ICDS, National Nutrition Mission) to improve maternal nutrition.

Gaps, Challenges, Loopholes

Even with the legal and policy framework, India faces many challenges in fully realizing high-quality, equitable pre-, natal, and post-natal care for all.

1. **Uneven Access & Geographic Disparities**
    - States like Kerala, Tamil Nadu, states in the South/East tend to have better maternal and newborn health indicators, higher institutional delivery rates, better continuity of care. In contrast, many states in the North, Central, East, and the North-East lag significantly. Rural and remote areas have lower access to good facilities. For example, full utilization of continuum of care is only 7% in Nagaland vs ~89% in Tamil Nadu in rural areas.
2. **Socio-economic, Caste, Demographic Disparities**
    - Poorer, less educated women, women from Scheduled Castes / Scheduled Tribes, minority communities, younger mothers, women with less autonomy are more likely to miss out on care.
    - For postnatal care especially, the drop-off is steep: even when mothers have good antenatal visits, many newborns and mothers are not visited within 24-48 hours after delivery. As per study: only ~25.2% of newborns, ~63.4% of mothers get PNC within 24 hours.
3. **Quality & Infrastructure**
    - Even where healthcare facilities exist, they may not have full capacity: lack of skilled personnel (obstetricians, anaesthetists, nurses), inadequate supplies, diagnostics, blood storage, neonatal intensive care, functioning ambulances and transport.
    - Delay in referral chains, delay in reaching facility, shortage of emergency obstetric care in many districts.
4. **Post-Natal Care Neglect**

- PNC is often the weakest link; many programmes focus more on antenatal and natal care, less on follow-ups, breastfeeding counselling, mental health (postpartum depression), post-partum complications.
- Home visits by ASHAs or health workers are often inconsistent.

5. **Cultural, Social Barriers**
    - Traditional beliefs, mobility restrictions, lack of women's decision-making power, early marriages, workloads, socio-cultural preferences (e.g. sex selection) hinder uptake of care.
    - Stigma or fear associated with certain medical interventions or facility deliveries.
6. **Legal and Regulatory Gaps / Implementation Issues**
    - Laws like PCPNDT are strong on paper, but enforcement is uneven; clinics may be registered improperly; illegal sex determination still happens.
    - Regulatory oversight of private facilities is often weak: quality, cost, unnecessary interventions (e.g. unnecessary C-sections) may not be properly controlled.
7. **Financial Barriers**
    - Even with schemes providing free services, there are often out-of-pocket expenditures: for transport, medicines not available in facility, informal payments etc.
    - Hunger, malnutrition, lack of nutritious food during pregnancy etc.
8. **Data Gaps & Monitoring Weaknesses**
    - Data reporting may be delayed or incomplete; disparities can be hidden in aggregate numbers.
    - Monitoring quality of services, maternal death reviews, perinatal mortality reviews are often not done thoroughly in many districts.

Legal / Judicial Landmarks & Interpretations

Some court decisions and legal interpretations have expanded rights related to maternal healthcare, pre- and post-natal services.

- **X v. Principal Secretary, Health and Family Welfare Department, Govt. of NCT of Delhi (2022)**: The Supreme Court affirmed that all women, regardless of marital status, have equal access to legal abortion up to 24 weeks. While this is about

termination of pregnancies, it has implications for pre-natal decision-making and healthcare rights.

- Judicial interpretations of *Article 21* have increasingly included right to health and maternal health as part of fundamental rights. Courts have held that lack of maternal healthcare, and deaths due to preventable causes, can be challenged under the right to life.

Recent Trends and Progress

Despite gaps, India has made important strides:

1. **Large Improvements in Post-Natal Care Coverage**
    - As noted, PNC within two days rose from very low single digits in early 2000s to over 80% in NFHS-5.
    - Also improvements in institutional deliveries, skilled birth attendance etc.
2. **Shrinking Gaps**
    - The gap in PNC coverage between high-mortality states and others has narrowed. For example, higher mortality state clusters improved more rapidly.
3. **Policy Expansion**
    - More schemes, more funding, better focus on maternal health in national budgets.
    - Greater role of community health workers & home-based newborn care.
4. **Statutory Reforms**
    - Maternity Benefit Act amendment (2017) giving longer paid leave, more inclusive definitions.
    - Strengthened regulatory acts like PCPNDT; MTP amendments.

Gaps in Laws vs Implementation & Areas for Improvement

Here are areas where legal or policy provisions exist (or could exist), but implementation is lacking, and where the law could be improved.

1. **Ensuring Minimum Standards of Care**

- Laws could more explicitly mandate minimum quality standards for all delivery facilities (public and private), including infrastructure, staffing, diagnostics, emergency obstetric care, neonatal care etc.
- Enforce accreditation and regular audits of maternal and child health centres, especially for natal and postnatal care.

2. **Strengthening Enforcement of Existing Laws**
    - Better implementation of PCPNDT to prevent misuse of prenatal diagnostics.
    - Strengthening oversight of private hospitals (where many deliveries happen) to ensure no over-charging, no unnecessary C-sections, and proper postnatal follow-ups.
3. **Making Post-Natal Care a Legal Right / Guarantee**
    - Consider legal provisions or state laws that explicitly guarantee postnatal visits / care at home or facility, especially in the first 24-48 hours.
    - Penalties or incentives for failure to provide early postnatal care by public health system or community health workers.
4. **Addressing Financial Barriers**
    - Expand and ensure the free services under JSSK are accessible in practice: free transportation, food, medicines, diagnostics.
    - Perhaps bolster schemes that cover maternity entitlements for informal sector / women not in formal employment.
5. **Maternity Leave Laws**
    - The Maternity Benefit Act gives leave to employed women. However, many women in India work in informal sectors or agriculture etc., where formal leave laws do not apply. Laws and social protection schemes could be expanded to cover informal workers.
6. **Postpartum Mental Health**
    - Legal recognition and policy provision for maternal mental health (e.g. postpartum depression). Laws could require screening, counselling, integration into PNC.
7. **Data, Monitoring, Transparency**
    - Laws or regulations requiring timely reporting of maternal deaths, near misses, neonatal mortality, PNC coverage etc., with disaggregation by caste, religion, geography.

    - Strengthen maternal death review mechanisms, perinatal death audits.

8. **Equity Focus**
    - More legal/policy focus on marginalized groups: Scheduled Castes / Tribes, remote rural areas, minorities, adolescent mothers.
    - Ensuring that cultural barriers or discrimination are addressed in law / regulation / service delivery.
9. **Integration with Child Health & Nutrition**
    - Since newborns' health depends heavily on both natal and postnatal care, integrating child immunisation, breastfeeding support, nutrition counselling with maternal care services. Laws/policies could ensure this integration.
10. **Community & Home-Based Care**
    - Strengthen legal/policy backing for home visits by ASHAs / health workers for PNC, especially in remote areas. Guarantee support for infrastructure (transport, supplies) for these workers.

Case Study: Contrasts between States

To illustrate how the situation varies, some contrasts:

- **Tamil Nadu**: Among the top performers. Very high institutional deliveries, high continuum of maternal and newborn care, good health infrastructure; better coverage in antenatal, natal and postnatal care.
- **States like Bihar, Uttar Pradesh, Jharkhand**: Lower rates of full continuum of care; higher maternal mortality; lower PNC coverage within 24 or 48 hours; gaps in nutrition etc.
- **North East states**: Also show lower utilization in some cases.

These differences are influenced by state health budgets, governance/administration, socio-cultural factors, literacy, transport infrastructure, geography etc.

Legal / Policy Reforms That Could Strengthen Care: Proposals

Based on the above, here are suggested reforms and improvements, combining law, policy, and practice:

1. **Statutory Guarantee of Maternal Health Services**

- Enact a national (or state) law that explicitly guarantees access to pre-, natal, and post-natal care as a right: specifying timelines (e.g., first antenatal visit by a certain week, facility delivery, postnatal visit within X hours).

2. **Universal Financial Protection**
    - Expand schemes that reduce or eliminate out-of-pocket expenditure for poor women; ensure that benefits reach informal economy workers; possibly conditional cash transfers, vouchers, or social health insurance cover maternity and neonatal care fully.
3. **Mandatory Accreditation & Regulation**
    - All facilities that offer delivery services must meet minimum standards; accreditation schemes should be made mandatory; private facility regulation tightened.
4. **Emphasis on First 24-48 Hours Post Delivery**
    - Laws or policies to enforce or guarantee a postnatal visit (by health worker or facility staff) within 24-48 hours, since many deaths occur in that period.
5. **Maternity Benefit for Informal Sector**
    - Extending maternity leave / benefit / financial support to women working in informal sectors, self-employed, agricultural labor etc.
6. **Maternal Mental Health Legal Mandates**
    - Include mental health screening and support in postnatal care as a legally required component.
7. **Stronger Oversight of Prenatal Diagnostic Services**
    - More robust inspection & penal provision under PCPNDT; ensure no misuse of prenatal testing; making equipment sales/licensing more tightly controlled.
8. **Increased Support for Community Health Workers**
    - Legally or through well-funded policy ensure that ASHAs and others have the resources, training, supplies, logistical support to do home visits, follow-ups, PNC, nutrition counselling etc.
9. **Improve Transport & Referral Infrastructure**
    - Guarantee transport availability under schemes like JSSK; stricter accountability when transport fails.
10. **Data Transparency & Accountability**

- Mandate public release of maternal health indicators disaggregated by geography, caste, socio-economic status; stronger maternal death audits; judicial review where rights violated.

India has made remarkable progress over the past few decades in improving pre-natal, natal, and post-natal healthcare. Institutional deliveries, skilled birth attendance, antenatal visits, and postnatal care coverage have all increased. Legal frameworks (Maternity Benefit Act, MTP Act, PCPNDT etc.), national health missions, schemes like JSY, JSSK, PMSMA have collectively played a large role.

Yet, many challenges remain, particularly in the equitable delivery of services, quality of care, postnatal follow-ups, and addressing socio-economic and demographic disparities. Laws are strong in many areas, but enforcement, regulation, quality assurance, and inclusion of marginalized groups are weaker links.

To ensure India meets its goals under Sustainable Development Goals (SDGs), especially in reducing maternal mortality and neonatal mortality, there must be continued focus on:

- making maternal care a guaranteed right,
- closing the gaps in the first 24-48 hours post delivery,
- extending protections and benefits to women outside the formal sector,
- ensuring quality in both public and private facilities,
- improving data, monitoring and accountability, and
- finally, integrating legal, policy, administrative, and social measures to address the social determinants of maternal health.

Through these improvements, India can move closer to ensuring that every woman receives full, safe, and equitable pre-, natal, and post-natal care—not just in aspirational policy, but in lived reality.