

Digital Governance and Maternal Health Care in Tamil Nadu: Use of Technology in Promoting Maternal Health Care

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Abstract:

Maternal health remains a key focus in India's public health efforts, and Tamil Nadu stands out for its use of digital governance to improve outcomes for mothers and infants. This study takes a qualitative look at the Pregnancy and Infant Cohort Monitoring and Evaluation (PICME) scheme, a state digital registry that follows women from pregnancy registration through childbirth and infant immunisation. Using a constructivist qualitative approach, the research applies a six-phase thematic analysis to secondary sources like government policy documents, national health surveys, and peer-reviewed articles. The findings show that PICME's unique Reproductive and Child Health ID supports maintaining continuity of care and brings together services such as nutrition support, emergency referrals, and ambulance networks. This coordination is linked to better maternal and infant health outcomes compared to national averages.

However, the study also finds continuing issues, including digital illiteracy, poor internet access, and restrictions on women's mobility, which are mostly addressed by Accredited Social Health Activists and Village Health Nurses. The research also points out important gaps in PICME, such as the lack of mental health screening for mothers and constrained access for patients to their own health data. Overall, while digital governance has improved administrative supervision and responsibility, it needs to include psychosocial care better and focus more on patients' needs to become a truly comprehensive maternal healthcare model. These findings deliver lessons for wider digital health policy.

Keywords: Maternal health, PICME, RCH, ASHA, Psychosocial Care

Introduction

Health policy focuses on both preventing and treating illness. Some conditions can be treated after they appear, but others need to be prevented to avoid long-term problems. Modern medicine depends on accurate patient data for early diagnosis and intervention. Technology has always played a part in healthcare, from diagnostic equipment to lab tests. Digital governance is a newer development, where patient information is collected and analysed to improve care. Tamil Nadu's PICME scheme is an example of this, as it digitally tracks pregnancies and infants to lower risks and improve maternal health. Pregnancy brings specific health risks like anaemia,

gestational diabetes, and high blood pressure, which need ongoing monitoring. Early tracking of maternal health helps prevent complications, and digital systems like PICME make sure women get prompt care before and after childbirth.

Women make up almost half of India's population, but their health needs have often been overlooked in research and policy. (Pradhan & De, 2025) Pregnancy, which only affects women, needs special care and constant monitoring. India has made strong progress in lowering maternal deaths, with Tamil Nadu leading through digital solutions. (Padmanaban et al., 2009) The state's use of technology shows how digital governance can help address modern healthcare challenges. Digital governance also advances Sustainable Development Goal 3, which aims for good health and well-being for everyone. (Lubis et al., 2024) By adding digital tools to health systems, governments can improve service delivery, make care more efficient, Moreover, guarantee fair access for all.

A key benefit of digital governance for SDG3 is the growth of mobile health platforms and telemedicine, which help people in remote areas get access to care and keep services running smoothly (World Health Organisation, 2021). Digital governance also makes it easier to manage health data and track diseases, supporting targeted programs and universal health coverage like the Ayushman Bharat Digital Mission (Mishra, U. S. et al., 2024). Data is a powerful instrument for social change and policy (Fischli & Muldoon, 2024). On an individual level, digital health relies on trust and people being willing to share their information. On a larger scale, digital health data can be shared across organisations to drive new policies (Tiffin et al., 2019). Community involvement is now a key part of digital governance. When people are involved and informed, digital participation can help marginalised groups access public health services.

Review of Literature

Digital governance in Tamil Nadu has moved from simple e-governance projects to a more complete, citizen-focused digital strategy. Early use of information and communication technology (ICT) helped improve healthcare quality and delivery across India, showing how technology can make public administration more efficient (Wadhwa, 2019). In the last twenty years, both national and state policies have used digital tools to tackle public health challenges, shifting from just tracking outputs to focusing on real outcomes (Hu S et al., 2025). In healthcare, e-governance has changed how services are delivered by digitising patient records, making supply chains more transparent, and improving resource use in rural and underserved areas (Kumar R. et al., 2025). These changes are clear in Tamil Nadu, where new administrative health systems now link digital infrastructure directly to public health goals (Jabarethina et al., 2025).

Central to India's maternal and child health digital architecture is the systematic registration and monitoring of pregnancies. Nationally, the mother and Child Tracking System (MCTS) and subsequent Reproductive and

Child Health (RCH) platforms were introduced to track service delivery across antenatal, delivery, and postnatal care (Mohamed et al., 2025). Research indicates that timely pregnancy registration is heavily influenced by systemic and individual determinants, including pregnancy intention, socio-economic status, and healthcare availability (Mondal et al., 2023). In Tamil Nadu, these national tracking principles have been operationalised through the Pregnancy and Infant Cohort Monitoring and Evaluation (PICME) system. Operational evaluations of maternal and child health data systems in Tamil Nadu demonstrate that centralised digital registries considerably improve data completeness, streamline emergency obstetric referrals, and support institutional delivery tracking (Fishman et al., 2017). Furthermore, specialised state programs such as the Rashtriya Bal Swasthya Karyakram (RBSK) rely on integrated process documentation to manage early child health screening and intervention (Shinu Priya et al., 2022).

The application of digital health tracking also extends to specialised maternal and neonatal care interventions, such as community Kangaroo Mother Care (KMC) practices for vulnerable infants, where its digital follow-up supports continuity of care beyond health facilities (Pajalic et al., 2023). Moreover, digital governance mechanisms have played a key part in facilitating rigorous audit systems, such as stillbirth audits in health unit districts like Palani, by clarifying operational enablers and identifying structural barriers to care quality (Lakshmipathy et al., 2024). However, the success of e-governance in healthcare is strongly linked to rural citizen satisfaction and acceptance. Research shows that factors such as digital competence, system reliability, infrastructure quality, and the active support of frontline health workers determine whether rural populations effectively utilise digital health services. Addressing lasting challenges, including information privacy matters, technical downtime, and administrative burden on health personnel, is important to sustaining digital health transformation across India.

Methodology

This study uses a qualitative research approach based on a constructivist perspective, striving to go beyond numbers to understand the real experiences, barriers, and supports within digital maternal healthcare in Tamil Nadu (Tenny S et al., 2026). Although quantitative data gives a quick look at results, qualitative methods allow a deeper look at how digital governance affects the daily lives of healthcare workers and pregnant women. The research entails careful analysis of secondary sources, including government policy notes, Sample Registration System (SRS) bulletins, National Family Health Survey (NFHS-5) reports, Ayushman Bharat Digital Mission progress reports, and peer-reviewed studies on maternal healthcare registries in southern India.

The data were analysed using a six-phase thematic analysis framework. First, the researchers became familiar with the data by reading the selected policy documents and academic literature several times. Next, they created initial codes across the dataset in order to highlight important aspects related to digital health

governance, social and cultural barriers, and clinical outcomes. These codes were then grouped into wider themes. In the following phases, the themes were reviewed and refined, using India's health index reports (NITI Aayog, 2021) and global digital health plans (World Health Organisation, 2021) as reference points. This step-by-step process helped ensure the themes precisely reflected the complex relationship between digital infrastructure and maternal care.

By using only qualitative thematic analysis of reliable secondary data, this method avoids the limits of looking at statistics alone. It places Tamil Nadu's progress in maternal health within the wider social and environmental context of rural India. This qualitative approach is well-suited for studying digital governance because it spotlights the human side of technology use, such as the important role of frontline staff and issues regarding data privacy, which are often missed in purely quantitative studies.

Results

The synthesis of qualitative data and state health reports demonstrates that Tamil Nadu's systematic digital monitoring infrastructure correlates with superior maternal and child health outcomes when compared to national benchmarks. The combined analysis of qualitative data and state health reports shows that Tamil Nadu's digital monitoring system is linked to better maternal and child health outcomes compared to national averages. More than 95% of births in the state now happen in institutions, thanks to the close connection between digital registration and government maternity programs. As shown in Table 1, Tamil Nadu's Maternal Mortality Ratio (MMR) and Infant Mortality Rate (IMR) are much lower than the national average, helped by automated processes that quickly identify high-risk cases and refer them for care. (Archana & Rani, 2023) However, these improved outcomes are likely influenced by multiple factors, such as socioeconomic development, health infrastructure, policy interventions, and digital governance. This means that while digital systems have a significant role, they are not the sole explanation for health improvements in the state. Still, the findings also show that issues like gestational anaemia are common and need ongoing monitoring, not just occasional clinic visits.

Table 1: Maternal and Child Health Care Benchmarks in Tamil Nadu

Health Indicator Domain	Tamil Nadu Performance	National Framework Context
Maternal Mortality Ratio (MMR)	Significantly below 50 per 100,000 live births	National average remains higher (97)
Institutional Deliveries	High (>95%), supported by state maternity benefit schemes	National baseline (89%)
Maternal & Infant Monitoring	Systematic 12-digit RCH ID tracking via PICME	Variable digital tracking across states
High-Risk Case Identification	Automated flagging & referral to emergency obstetric centres	Manual or paper-based risk referral in many regions

The PICME scheme works as a central platform that tracks mothers from early pregnancy to child immunisation. Women can register themselves using Aadhaar or get help from Village Health Nurses. The RCH ID they receive is required for birth certificates and cash benefits. By analysing the literature and reports, five main themes emerged about how this system changes the way care is delivered.

Theme 1: Digital Identity as a Vehicle for Continuity of Care. Across the government publications reviewed, the unique Reproductive and Child Health (RCH) ID recurs as the organising device of the entire system: it converts a pregnancy from a series of disconnected clinical encounters into a single, trackable case that follows a woman from registration through antenatal visits, delivery, and postnatal follow-up (Government of Tamil Nadu, Health and Family Welfare Department, 2024). Read qualitatively, this suggests that PICME's principal contribution is not any single clinical intervention but the creation of administrative continuity, a mechanism through which the state can see a pregnancy over time and intervene before a risk becomes an emergency.

Theme 2: Institutional Integration and Coordinated Response. A second theme concerns the deliberate stitching-together of previously separate services ICDS nutrition support, the 108-ambulance network, and designated emergency obstetric centres into a single referral pathway (Tamil Nadu Journal of Public Health and Medical Research [TNJPHMR], 2023). The recurrence of this combined motif across sources indicates that Tamil Nadu's model treats maternal health not as a standalone clinical service but as a coordination problem, in which digital infrastructure functions primarily to reduce the friction between agencies that previously operated in silos.

Theme 3: Structural and Socio-Cultural Barriers Beneath the Digital Layer. A distinctly different theme emerges from the critical literature. Gaitonde (2012) cautions that registration and digital monitoring can create an appearance of universal coverage while leaving untouched the underlying conditions of illiteracy, poor rural connectivity, and cultural restrictions on women's mobility and autonomy that determine whether a registered woman actually receives prompt care. The Johns Hopkins SAIS (2016) assessment similarly finds that field workers' capacity to use digital tools, rather than the technology itself, is often the binding constraint. In reply to these challenges, the Tamil Nadu government and local NGOs have launched a range of initiatives including digital training workshops for women, expansion of community internet centres in rural areas, and efforts such as mobile health outreach programs that specifically target families in remote locations. For example, the Kudumbashree model and the Tamil Nadu State Rural Livelihoods Mission have components aimed at empowering women with basic digital skills. At the same time, public-private partnerships have piloted dedicated transportation and escort services to help overcome mobility restrictions. Despite these efforts, the literature notes that coverage is still patchy and funding limitations can limit program reach, pointing to the need for ongoing investment and monitoring. These sources suggest that digital governance in

Tamil Nadu operates as a layer superimposed on a pre-existing social terrain, and that its benefits are unevenly distributed depending on the literacy, infrastructure, and gender norms already present in a given community.

Theme 4: Community Intermediaries as Translators of the System. A recurring counterpoint to Theme 3 is the role of ASHA workers and Village Health Nurses, who appear across sources as the human interface that makes the digital system usable for women who might otherwise be excluded from it. This positions frontline health workers not simply as data-entry operators but as translators who convert an abstract digital record into a locally trusted relationship of care, a function that the technology itself cannot perform.

Theme 5: Data as Policy Evidence and as a Site of Risk. Finally, the documents reveal a double character to the data PICME generates. On one hand, real-time aggregated data is presented as the basis for evidence-based resource planning and for the state's claims about declining maternal and infant mortality (RGI, 2022). On the other hand, both the National Health Authority (2025) and the critical literature (Gaitonde, 2012) flag unsettled questions of consent, storage, and security. This tension suggests that the same infrastructure that enables population-level accountability simultaneously introduces new, individual-level privacy risks that policy discussion has not fully resolved.

Overall, these themes show that PICME's value is not simply in its technical features, but in how it changes maternal health care into a matter of visibility, coordination, and accountability. Tamil Nadu's improvements in maternal and infant health are clear in the numbers. (Paramasivan & Prakash, 2026) However, the qualitative data suggest that these results depend on factors digital systems alone cannot fix, such as literacy, infrastructure, gender norms, and the ongoing, essential role of community health workers who connect the state with the women they serve.

Discussion

The qualitative analysis provides a deeper understanding of digital health governance, going beyond measuring how much it is used. PICME makes pregnancy registration easier and helps coordinate care from different providers, showing the value of centralised tracking. Still, it is important to recognise ongoing social and infrastructure barriers. The system depends on human intermediaries like Village Health Nurses and ASHAs, showing that digital governance does not replace traditional health workers but relies on their efforts, especially in rural areas.

Facilitating Care and Overcoming Systematic Barriers

Digital governance in Tamil Nadu works well mainly because it is connected to financial incentives. By linking the digital RCH ID to cash benefits for mothers, the state encourages early registration. This plan helps reduce delays in antenatal care. However, there is a challenge: while the system intends to include everyone,

people with less digital knowledge regularly rely on busy frontline staff to manage their digital identity (Thakur, A. et al., 2025).

Psychological Well-being and Stress Management: A Gap in the PICME Framework

An important finding from this review is that the PICME platform mainly tracks physical and biological measures, such as blood pressure, haemoglobin, and immunisation schedules. It does not include structured ways to assess mothers' mental health. However, stress, anxiety, and depression in mothers can greatly affect pregnancy outcomes and child development. Introducing standard mental health screening tools and automatic counselling referrals to the digital system would help make maternal healthcare more holistic and address both physical and psychological needs (Bränn et al., 2026).

Evaluating PICME as a Person-Centered Point of Service System (PCPOSS)

Looking at PICME through the Person-Centered Point of Service System (PCPOSS) framework indicates that the system mainly supports healthcare workers, not the patients themselves. Pregnant women have little direct access to their own data on the platform. For digital governance to truly focus on people, future versions should improve features for patients. Giving women interactive mobile access to their records, reminders in local languages, and personalised health education would help them take a more active role in managing their health. Similar patient-facing digital health platforms have demonstrated positive effects in other settings. For example, Kenya's MomConnect initiative allows pregnant women to obtain tailored health information and communicate directly with medical professionals, which has led to greater engagement and service uptake. In Sweden, mobile health tools are used to provide mothers with direct access to their health records and personalised support, resulting in higher patient satisfaction and improved self-management. (Moll & Rexhepi, 2020) Introducing these kinds of patient-facing features into PICME could similarly foster greater empowerment and participation among women in Tamil Nadu.

Conclusion

This study provides a detailed qualitative look at how digital governance works in maternal healthcare in Tamil Nadu. The findings show that bringing together electronic health records through the PICME scheme has helped lower maternal and infant deaths by guaranteeing continuous care, fast emergency referrals, and timely financial support. (Vaidyanathan et al., 2022, pp. 22-30) However, the analysis also reveals challenges in this digital transition. The system relies heavily on frontline staff to close the digital gap, and there are ongoing worries about data privacy and the lack of mental health measures. This suggests that digital tools alone are not enough without strong social and cultural support.

Based on the results, several policy steps are suggested. First, the state should invest in improving the digital skills and workload management of Village Health Nurses so that data entry does not take away from patient

care. Second, digital maternal registries should include required mental health screenings for mothers, giving mental health the same priority as physical health. Finally, to truly empower women, patient-facing apps should be created so women can securely access their own health data.

While these recommendations ensure considerable improvements, pragmatic obstacles in implementation can arise. Resource restrictions, for example, limited funding or human capital, may affect the scale and speed of digital skill training and the assimilation of new mental health modules. Additionally, resistance to change among staff or communities could slow the adoption of new digital tools, and technical barriers may limit access in remote areas. Recognising and proactively addressing these barriers will be essential to ensure that policy changes are both successful and sustainable. Addressing these gaps can help Tamil Nadu move from tracking data to delivering a more complete, person-focused model of care that could guide global health policy.

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