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EDITORIAL ANALYSIS

India's Maternal Mortality Burden — Why Progress Has Stalled and What It Will Take to Reach SDG 3

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GS PAPERS

India's Maternal Mortality Burden — Why Progress Has Stalled and What It Will Take to Reach SDG 3

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INTERVIEW ANGLE

"India's institutional delivery rate has reached 89% — yet maternal mortality remains well above the SDG target. What does this paradox reveal about the limits of access-based health metrics and the imperative for quality-focused health governance?"

WHY IN NEWS

A peer-reviewed study published in March 2026 found that India accounted for approximately **24,700 of the 2.4 lakh global maternal deaths** in 2023 — one of the highest absolute burdens globally — while India's MMR of 116 remains significantly above the SDG 3.1 target of 70 per 1 lakh live births by 2030.

THE ACHIEVEMENT AND THE GAP

The last three decades have produced a remarkable reduction in India's Maternal Mortality Rate. From **508 per 1 lakh live births in 1990** to **116 in 2023**, India's MMR has fallen by 77% — one of the most dramatic improvements in any large developing country. This progress was achieved by a combination of institutional delivery incentivisation (Janani Suraksha Yojana, 2005), ANC quality improvement (PMSMA, 2016), facility quality certification (LaQshya, 2017), and assured care guarantees (SUMAN, 2019).

But the numbers also tell a story of deceleration. The sharpest MMR decline happened between 2000 and 2015, when the "easy" gains were available — persuading women to deliver in health facilities rather than at home, extending basic ANC coverage, deploying ASHA workers to every village. These interventions worked by addressing the first and second of the "three delays" — delay in deciding to seek care, and delay in reaching a facility.

What remains is Delay 3: **inadequate quality of care at the facility itself**. And this is structurally harder to fix.

THE QUALITY CRISIS IN PLAIN SIGHT

India's institutional delivery rate is now 89% (NFHS-5, 2020). This is a genuine achievement. But "institutional" includes a spectrum of facilities — from the AIIMS Delhi to a community health centre with one nurse, one table, and no blood bank. When a woman delivers at a sub-standard facility that lacks skilled obstetric staff, functional operation theatres, blood storage, or referral protocols, the "institutional delivery" metric flatters the reality of care received.

The core problem: **haemorrhage causes approximately 26% of maternal deaths** in India. Post-partum haemorrhage (PPH) — excessive bleeding after delivery — is medically manageable with oxytocin, blood transfusion, and skilled staff. Yet thousands of women die from PPH every year in facilities that cannot provide the necessary response. The failure is not at home; it is in the facility. The data has arrived; the will to reckon with it has been slower.

The LaQshya Programme, which certifies labour rooms against quality standards, has certified approximately 2,500 facilities as of 2024 — a fraction of India's 30,000 delivery points. Scale is the challenge.

THE GEOGRAPHY OF INEQUALITY

India's MMR statistics aggregate a tale of two countries:

In **Kerala**, the MMR is approximately 19 — comparable to OECD nations. In **Tamil Nadu**, it is around 54. These states have invested systematically in skilled birth attendants, district hospitals with blood banks, and medical education quality.

In **Madhya Pradesh** (MMR ~173), **Rajasthan** (~163), and **Uttar Pradesh** (~167) — the three states that account for disproportionate shares of India's births and maternal deaths — the challenges are layered: malnutrition, anaemia (57% of women of reproductive age are anaemic, NFHS-5), distance to functional facilities, and inadequate skilled staffing.

Achieving SDG 3.1 (MMR below 70 by 2030) requires a **northern state transformation** — not marginal improvement but a step-change in UP, Bihar, and MP. Given current rates of improvement (~5–8 MMR points per year nationally), reaching 70 by 2030 requires nearly doubling the pace of improvement, concentrated in states that start highest.

THE MALNUTRITION LINK

An underappreciated dimension: **anaemia and malnutrition are major contributors to maternal mortality**, particularly through indirect causes. India has the world's highest burden of anaemia among women of reproductive age — 57% (NFHS-5). Anaemia weakens a pregnant woman's tolerance for haemorrhage, increases susceptibility to infection, and contributes to low birth weight in infants.

Poshan Abhiyan (2018), India's flagship nutrition mission, targets reducing anaemia in women of reproductive age by 3 percentage points per year. But NFHS-5 data showed anaemia has actually **increased** among children and remained stubbornly high among women despite the programme. Without resolving the malnutrition substrate, clinical interventions at facilities will remain insufficient.

THE WAY FORWARD

The analytical prescription for closing the remaining gap is clear, even if implementation is hard:

1. **Scale LaQshya:** From 2,500 to 20,000 certified facilities by 2028 — with external certification, not self-assessment
2. **District-level blood banks:** Every district hospital in the 100 highest-MMR districts must have a functional blood bank with at least 10 units of stock at all times
3. **Midwifery reform:** Professionalise and upskill the midwifery cadre — India has only ~1,600 nurse-midwives trained to WHO standards; the target should be 50,000 by 2030
4. **Anaemia mission:** Treat the anaemia crisis as a nutrition emergency, not a gradual improvement programme
5. **Data feedback loops:** Monthly MMR tracking at district level — not annual SRS estimates — to enable rapid response

CONCLUSION

India's maternal mortality story is one of genuine progress shadowed by deceleration. The gains from institutional delivery are real. The challenge from here is quality — ensuring that every delivery point offers evidence-based emergency obstetric care. The SDG 3.1 target is in reach if India treats the next five years with the urgency that the 2000s treatment of JSY brought to institutional delivery. But if the current pace continues unchanged, 2030 will arrive with India's MMR at 80–90 — outside the target, and with millions of preventable deaths having occurred along the way.

UPSC RELEVANCE

India MMR 2023 = 116; SDG 3.1 = below 70 by 2030; LaQshya; SUMAN; JSY; PMSMA; Poshan Abhiyan; anaemia prevalence 57% women.

MAINS GS-2 (SOCIAL JUSTICE/HEALTH):

Maternal health governance; quality vs. access; SDG 3; ASHA workers; centre-state cooperation on health.

MAINS GS-1 (SOCIETY):

Women's health; regional disparities; demographic implications.

📌 FACTS CORNER — KNOWLEDGEPEDIA

MATERNAL MORTALITY — COMPLETE REFERENCE:

India MMR (2023): 116 per 1 lakh live births (from 508 in 1990 — 77% reduction)

India maternal deaths (2023): ~24,700 of 2.4 lakh globally

SDG 3.1 target: MMR below 70 per 1 lakh live births by 2030

India institutional delivery rate: 89% (NFHS-5, 2020); from 38.7% (2005)

India anaemia in women of reproductive age: 57% (NFHS-5, 2019–21)

STATE MMR COMPARISON (APPROX. 2020 SRS):

Kerala: ~19 | Tamil Nadu: ~54 | Andhra Pradesh: ~45

Rajasthan: ~163 | Madhya Pradesh: ~173 | Uttar Pradesh: ~167

SCHEMES AND TARGETS:

JSY (2005): Rs 1,400 rural / Rs 1,000 urban for institutional delivery

PMSMA (2016): Free ANC on 9th of every month

LaQshya (2017): Labour room quality certification; ~2,500 facilities certified (2024)

Poshan Abhiyan (2018): Target: reduce anaemia 3% per year

SUMAN (2019): Zero-expenditure guaranteed maternity care at all public facilities

OTHER RELEVANT FACTS:

Three delays model: Delay 1 (decision to seek care), Delay 2 (reaching facility), Delay 3 (quality care at facility)

Top cause of maternal death: Haemorrhage (~26% of maternal deaths in India)

NFHS-5 (2019–21): National Family Health Survey 5; primary data source for India health indicators

WHO skilled birth attendant definition: Trained nurse-midwife or physician; India"s SBA data uses broader definition

Sources: Indian Express , MoHFW

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